2005 PRC
COMMUNITY HEALTH ASSESSMENT

COMMUNITY REPORT

The Rapides Foundation Service Area, Central Louisiana

Prepared for
The Rapides Foundation

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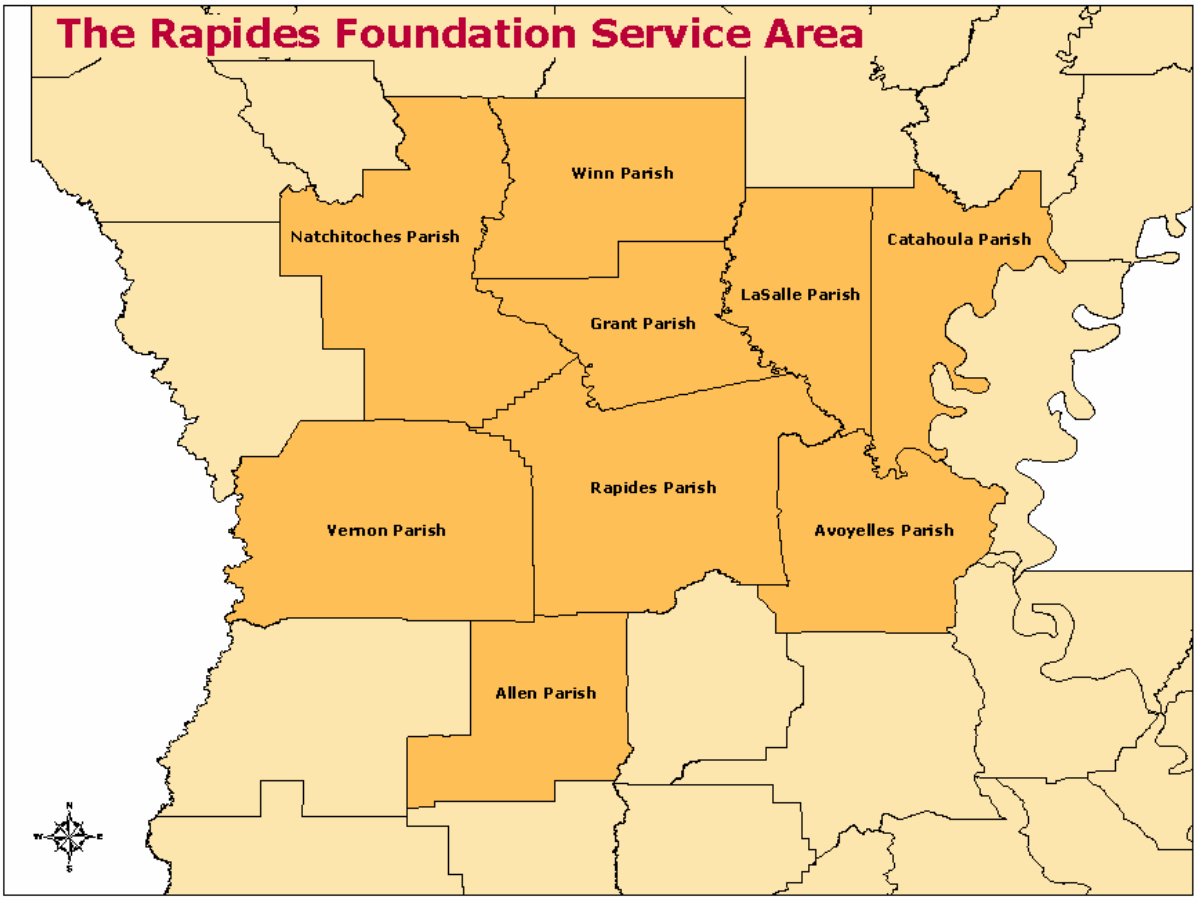
INTRODUCTION

PROJECT OVERVIEW

Project Goals

This *2005 PRC Community Health Assessment* is a systematic, data-driven approach to identifying the health status, behaviors and needs of community members in the nine-parish **Rapides Foundation Service Area (RFSA)*** in Central Louisiana, as a follow-up to a similar survey conducted by PRC in 2002.

The following map describes this geographical definition.



**For the purposes of this report, the nine-parish service area of The Rapides Foundation will be referred to as the "RFSA."*

METHODOLOGY

2005 PRC Community Health Survey

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 was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random selection capabilities.

Sample Design

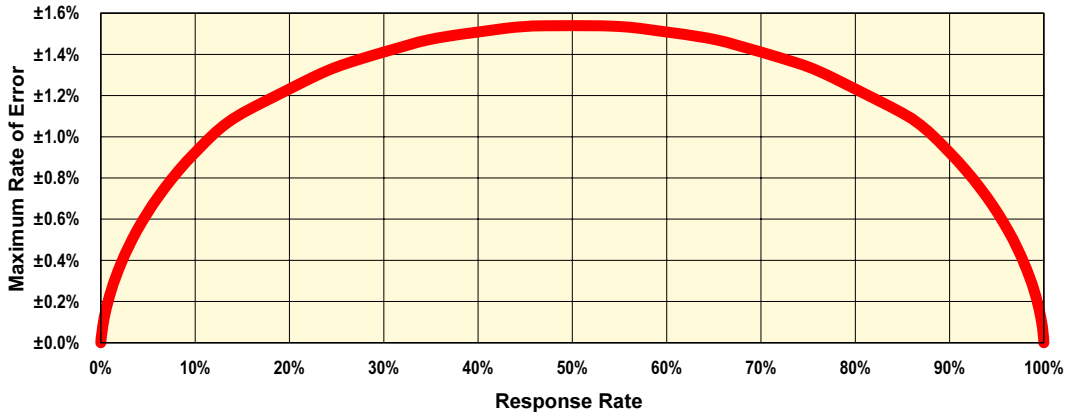
The sample design used for this effort consisted of a random sample of 4,052 individuals aged 18 and older in the RFSA in Central Louisiana. Once these data were collected, the sample was weighted in proportion to the population distribution at the ZIP Code level. Population estimates were based on census projections of adults aged 18 and over provided in the latest *Business Information Systems Demographic Portfolio* from Environmental Systems Research Institute, Inc. (ESRI).

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 4,052 respondents is ±1.5% at the 95 percent level of confidence.

Expected Error Ranges For A Sample Of 4,052 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.

Example 1: For example, if 10% of the sample of 4,052 respondents answered a certain question with a "yes," it can be asserted that between 9.1% and 10.9% (10% ± 0.9%) of the total population would offer this response.

Example 2: If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 48.5% and 51.5% (50% ± 1.5%) of the total population would respond "yes" if asked this question.

In addition, for further analysis, keep in mind that each percentage point recorded among the total sample of survey respondents is representative of approximately 2,587 RFSA adults aged 18 and older (based on current population estimates). Thus, in a case where 3.4% of the total

sample gives a particular response to a survey question, this is representative of nearly 8,800 adults and therefore must not be dismissed as too small to be significant.

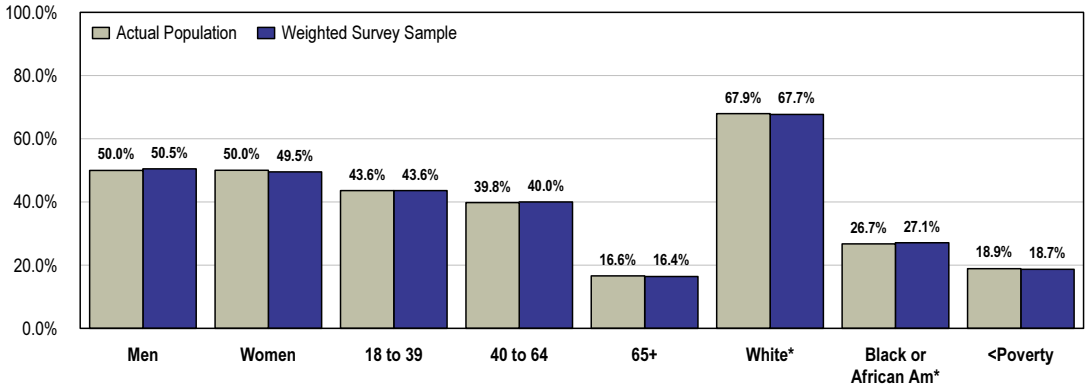
Sample Characteristics

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

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

Population And Sample Characteristics

(Rapides Foundation Service Area, 2005)



Source:
- ESRI BIS Demographic Portfolio (Estimates based on US Census 2000).
- 2005 PRC Community Health Survey, Professional Research Consultants.
- *White and Black or African American sample percentages do not include Hispanic respondents who did not offer a race response.

Further note that the poverty descriptions and segmentation used in this report are based on 2005 administrative poverty thresholds determined by the U.S. Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2005 guidelines place the poverty threshold for a family of four at $19,350 annual household income or lower). In sample segmentation: "Very Low Income" includes community members living in a household with defined poverty status (below poverty); "Low Income" includes those living between 100% and 200% of poverty (i.e., just above the poverty level, earning up to twice the poverty threshold); and "Middle/High Income"

refers to households with incomes more than twice the poverty threshold (>200% of poverty) defined for their household size.

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

Public Health, Vital Statistics & Other Data

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

- Centers for Disease Control & Prevention (CDC)
- ESRI BIS Demographic Portfolio (Estimates Based on Census 2000)
- Louisiana Commission on Law Enforcement
- Louisiana Department of Health & Hospitals
- National Center for Health Statistics

Benchmark Data

Statewide Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local findings. These data are published online by the Centers for Disease Control and Prevention and the U.S. Department of Health & Human Services.

National Risk Factor Data

National risk factor data provided in comparison charts are taken from the *2005 PRC National Health Survey*. The methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the U.S. population with a high degree of confidence.

Healthy People 2010

Healthy People 2010: Understanding and Improving Health is part of the Healthy People 2010 initiative that is sponsored by the U. S. Department of Health & Human Services. Healthy People 2010 outlines a comprehensive, nationwide health promotion and disease prevention agenda. It is designed to serve as a roadmap for improving the health of all people in the United States during the first decade of the 21st century.

> *"With [specific] health objectives in 28 focus areas, Healthy People 2010 will be a tremendously valuable asset to health planners, medical practitioners, educators, elected officials, and all of us who work to improve health. Healthy People 2010 reflects the very best in public health planning—it is comprehensive, it was created by a broad coalition of experts from many sectors, it has been designed to measure progress over time, and, most important, it clearly lays out a series of objectives to bring better health to all people in this country."*
> — Donna E. Shalala, (Former) Secretary of Health & Human Services

Like the preceding Healthy People 2000 initiative—which was driven by an ambitious, yet achievable, 10-year strategy for improving the nation's health by the end of the 20th century—Healthy People 2010 is committed to a single, overarching purpose: promoting health and preventing illness, disability and premature death.

Trends in Survey Data

Throughout this report, for survey-derived indicators, comparisons with prior year data (2002, or in some cases, 1997) will also be provided where available. The statistical significance of the difference between trend year data is noted in the text of this report.

NOTE: Tests for statistical significance take into account (and error rates vary according to) variables such as the number of persons responding to a specific question and where a particular response rate falls between 0% and 100%. *In other words, trend comparisons may be found to be statistically significant for one indicator but not for another, even though the net difference found for each is the same.*

TRACKING THE NATION'S LEADING HEALTH INDICATORS

Healthy People 2010 & the Nation's Leading Health Indicators*

A major challenge throughout the history of Healthy People has been to balance a comprehensive set of health objectives with a smaller set of health priorities. Thus, Healthy People 2010 has identified the following health issues as the Leading Health Indicators for the Nation:

Healthy People 2010: Nation's Leading Health Indicators	
Physical Activity	Overweight & Obesity
Tobacco Use	Substance Abuse
Responsible Sexual Behavior	Mental Health
Injury & Violence	Environmental Quality
Immunization	Access to Healthcare

The Leading Health Indicators reflect the major public health concerns in the United States and were chosen based on their ability to motivate action, the availability of data to measure their progress, as well as their relevance as broad public health issues. The Leading Health Indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education.

The process of selecting the Leading Health Indicators mirrored the collaborative and extensive efforts undertaken to develop Healthy People 2010. The process was led by an interagency work group within the U.S. Department of Health and Human Services. Individuals and organizations provided comments at national and regional meetings or via mail and the Internet. A report by the Institute of Medicine, National Academy of Sciences, provided several scientific models on which to support a set of indicators. Focus groups were used to ensure that the indicators are meaningful and motivating to the public.

For each of the Leading Health Indicators, specific objectives derived from Healthy People 2010 will be used to track progress. This small set of measures will provide a snapshot of the health of the Nation. Tracking and communicating progress on the Leading Health Indicators through national- and State-level report cards will spotlight achievements and challenges in the next decade. The Leading Health Indicators serve as a link to the 467 objectives in Healthy People 2010 and can become the basic building blocks for community health initiatives.

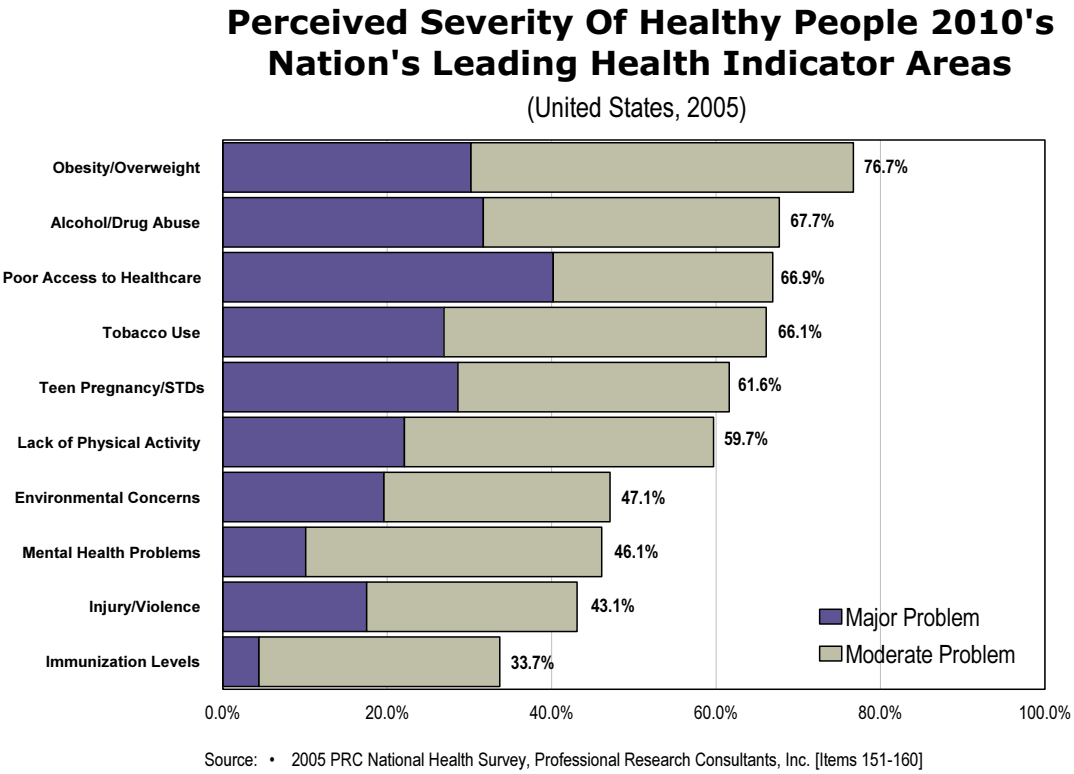
* Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

The Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. Developing strategies and action plans to address one or more of these indicators can have a profound effect on increasing the quality of life and the years of healthy life and on eliminating health disparities—creating *healthy people in healthy communities*.

Americans' Perceptions of the Leading Health Indicator Areas

In the *2005 PRC National Health Survey*, respondents were presented with problems associated with these 10 "Leading Health Indicators" and were asked to evaluate each as a "major problem," "moderate problem," "minor problem," or "not a problem" in their own community. As shown in the following chart:

- **Obesity/overweight** is perceived to be a "major" or "moderate" problem by more than three-fourths of Americans.
- Roughly two-thirds also view alcohol/drug abuse, poor access to healthcare, and tobacco use as "major/moderate" problems in their communities.



Source: • 2005 PRC National Health Survey, Professional Research Consultants, Inc. [Items 151-160]

COMPARISON WITH BENCHMARK DATA

The following charts summarize The Rapides Foundation Service Area (RFSA) for key indicators, and visually depict comparison with benchmark data, where available, for Louisiana and the United States. Trend comparisons, where available, are also depicted.

Note the following key used for benchmark comparisons: ☼ (denotes a favorable comparison or trend), 🌧 (denotes an unfavorable comparison or trend), and ☁ (denotes statistically similar findings, or no clear trend). A "blank" cell means that no data is available to make a comparison or view a trend for this indicator.

ACCESS TO HEALTHCARE

Barriers To Access	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
% Difficulty Accessing Healthcare In The Past Year	37.4	☼		☁	🌧
% Cost Prevented Physician Visit In The Past Year	16.0	☼		🌧	
% Cost Prevented Getting Prescription In The Past Year	19.5	☼		🌧	
% Transportation Prevented Doctor Visit In The Past Year	7.9	☼		☁	
% Inconvenient Hours Prevented Doctor Visit In The Past Year	12.4	☼		☁	
% Difficulty Getting Appointment In The Past Year	13.0	☼		☁	
% Difficulty Finding Physician In The Past Year	9.3	☼		☁	
% Difficulty Getting Child's Healthcare In The Past Year	4.7			☁	
Emergency Room Services	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Gone To ER More Than Once In The Past Year	12.7	☁		🌧	
Health Insurance	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Lack Health Insurance (18-64)	23.8	☁		🌧	🌧
Oral Health Services	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Have Visited Dentist In The Past Year (18+)	55.6	🌧		🌧	☁
Vision Services	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Had An Eye Exam In The Past Year (18+)	43.4	☼		☁	
Primary Care Services	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Have A Specific Source Of Ongoing Care	72.2			🌧	🌧
% Have Had A Routine Checkup In The Past Year	70.8	☁		☼	
% Child Has Had Checkup In The Past Year	85.5	☁		☼	

KEY: ☼ = Favorable comparison or trend 🌧 = Unfavorable comparison or trend ☁ = Statistically similar, or no clear trend

Blank = No data is available to make a comparison or view a trend

* Trends for survey data represent changes from the 2002 to the 2005 surveys; trends for secondary data represent overall trends over the past decade (or time period for which data were available).

** Death rates are per 100,000 population, age-adjusted to the 2000 Standard Population.

DEATH & DISABILITY

Cancer	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
Cancer Deaths**	230.1				
Lung Cancer Deaths**	72.6				
Breast Cancer Deaths**	27.3				
Prostate Cancer Deaths**	32.0				
Colorectal Cancer Deaths**	23.3				
% Mammogram In The Past Two Years (Women 40+)	74.9				
% Pap Smear In The Past Three Years (Women)	78.6				
% Prostate Exam In The Past Two Years (Men 50+)	75.1				
% Sigmoid/Colonoscopy Ever (Men/Women 50+)	52.9				
% Blood Stool Test In The Past Two Years (Men/Women 50+)	35.4				
Cardiovascular Disease	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Heart Disease Deaths**	310.4				
% Chronic Heart Disease	8.9				
Stroke Deaths**	69.3				
% Stroke	3.6				
% 1 or More Cardiovascular Risk Factors	92.4				
% Blood Pressure Checked In The Past Two Years	95.4				
% Told Have High Blood Pressure	38.2				
% Taking Action To Control High Blood Pressure	91.0				
% Cholesterol Checked In The Past Five Years	83.3				
% Told Have High Cholesterol	30.1				
% Taking Action To Control High Cholesterol	87.2				
Chronic Pain	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Arthritis/Rheumatism	30.3				
Diabetes	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Diabetes Mellitus Deaths**	34.0				
% Diabetes/High Blood Sugar	12.7				
HIV/AIDS	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
HIV/AIDS Deaths**	5.7				

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DEATH & DISABILITY (continued)

Injury & Violence	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
Unintentional Injury Deaths**	48.6	☼	☁	⛈	⛈
Motor Vehicle Accident Deaths**	24.6	☼	⛈	⛈	⛈
% "Always" Wear Seat Belt	77.1	☼		☁	⛈
% Child (<5) "Always" Uses Auto Child Restraint	96.1	☼		☁	⛈
% Child (5-17) "Always" Uses Seat Belt	83.9	☼		☼	⛈
Violent Crime Rate Per 100,000 Population	551.9	☼	☼	⛈	
% Victim Of Violent Crime In The Past Five Years	2.5	☁		⛈	
% Victim Of Domestic Violence In The Past Five Years	2.7	☼		☁	
Homicide Deaths**	7.5	☼	☼	⛈	⛈
Suicide Deaths**	11.0	☁	☁	☁	⛈
Kidney Disease	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Kidney Disease Deaths**	26.2	☁	⛈	⛈	
% Kidney Disease	3.7	☁			
Respiratory Disease	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Pneumonia/Influenza Deaths**	29.3	☼	⛈	⛈	
Chronic Lower Respiratory Disease Deaths**	51.4	⛈	⛈	⛈	
% Chronic Lung Disease	10.1	☁		☁	
% Asthma	11.9	⛈	☁	☁	
% Child Has Asthma	15.5	☁		⛈	
Vision & Hearing	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Blindness/Trouble Seeing	12.6	☁		⛈	
% Deafness/Trouble Hearing	11.6	☁		⛈	

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MODIFIABLE HEALTH RISKS

Nutrition & Overweight	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
% Eat 5+ Servings Of Fruit Or Vegetables/Day	32.4	☀		☔	
% Child Eats 3+ Fast Food Meals Per Week	34.7	☔			
% Overweight (Body Mass Index = 25+)	67.5	☁	☔	☁	
% Obese (Body Mass Index = 30+)	31.3	☔	☔	☔	☔
% Overweight Trying To Lose	29.7	☁		☔	
% Children (6-17) Overweight	30.6	☁		☔	
Physical Activity & Fitness	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% No Leisure-Time Physical Activity	34.1	☔	☔	☔	
% Participate In Moderate Physical Activity	23.5	☀		☔	☔
% Participate In Vigorous Physical Activity	28.1	☔		☔	☔
% Participate In Strengthening Activity	23.0	☔			☔
% Child Watches 3+ Hours Of TV Per School Day	35.4	☁			
% Child Exercises 5+ Days Per Week For 20+ Minutes	58.0	☔			
Substance Abuse	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Cirrhosis/Liver Disease Deaths**	9.4	☁	☔	☁	☔
% Current Drinker	39.2	☁		☀	
% Chronic Drinker	5.1	☁		☁	
% Binge Drinker	14.1	☁	☁	☁	☔
% Drinking & Driving In The Past Month	2.4	☀		☁	
% Riding With Drunk Driver In The Past Month	4.8			☔	
% Sought Help For Alcohol Or Drug Problem	3.7	☀		☁	
% Illicit Drug Use In The Past Month	1.9			☁	☁
Tobacco Use	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Current Smoker	24.9	☁	☁	☁	☔
% Received Advice To Quit Smoking (Smokers)	61.0			☁	
% Have Quit 1+ Days In The Past Year (Smokers)	50.9	☁		☁	☔
% Use Smokeless Tobacco	8.5	☔		☔	☔
% Someone Smokes At Home	21.1			☁	
% Children <7 Exposed To Smoke At Home	16.0			☁	☔

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SELF-REPORTED HEALTH STATUS

Physical Health	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
%"Fair" Or "Poor" Physical Health	22.6				
% Activity Limitations	24.6				
Mental Health	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
%"Fair" Or "Poor" Mental Health	13.8				
% Feel Sad, Blue, Depressed On 3+ Days Per Month	28.4				
% Prolonged Depression (2+ Years)	32.1				
Alzheimer's Disease Deaths**	24.7				
% Child Takes Medication For ADD/ADHD	8.2				

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BIRTHS

Family Planning	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
% Births To Teenagers	18.2				
% Births To Unwed Mothers	41.1				
Maternal, Infant & Child Health	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% Mothers Not Receiving Adequate Prenatal Care	20.8				
% Of Low Birthweight Births	9.8				
Neonatal Death Rate Per 1,000 Live Births	6.7				
Infant Death Rate Per 1,000 Live Births	9.6				

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INFECTIOUS & CHRONIC DISEASES

Immunization & Infectious Diseases	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
% Flu Shot In The Past Year (65+)	69.7				
% Flu Shot In The Past Year (High-Risk 18-64)	26.8				
% Pneumonia Vaccine Ever (65+)	79.3				
% Pneumonia Vaccine Ever (High-Risk 18-64)	30.5				
Hepatitis C Incidence Per 100,000 Population	1.1				
Sexually Transmitted Diseases	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Chlamydia Incidence Per 100,000 Population	368.4				
Gonorrhea Incidence Per 100,000 Population	199.4				
Primary & Secondary Syphilis Incidence Per 100,000 Population	3.0				
Hepatitis B Incidence Per 100,000 Population	5.2				
Tuberculosis	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Tuberculosis Incidence Per 100,000 Population	2.4				
Enteric Diseases	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
Salmonellosis Incidence Per 100,000 Population	15.1				
Shigellosis Incidence Per 100,000 Population	11.7				
Campylobacteriosis Incidence Per 100,000 Population	2.8				
Hepatitis A Incidence Per 100,000 Population	0.3				

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OTHER

Housing	RFSA	TREND*	vs. LA	vs. US	vs. HP2010
% Had To Go Live With A Friend Or Relative	8.6				
% View Condition Of Neighborhood Homes As "Fair/Poor"	16.3				
% View Affordability Of Neighborhood Homes As "Fair/Poor"	42.4				
Perceptions Of Teen Issues	**RFSA**	**TREND***	**vs. LA**	**vs. US**	**vs. HP2010**
% View Teen Drug Use As A "Major Problem"	59.2	HIGHER			
% View Teen Alcohol Use As A "Major Problem"	57.4	HIGHER			
% View Teen Tobacco Use As A "Major Problem"	54.1	LOWER			
% View Teen Drinking/Driving As A "Major Problem"	50.6	similar			
% View Teen Pregnancy Use As A "Major Problem"	43.3	LOWER			

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SIGNIFICANT TRENDS

The following section highlights both positive and negative trends observed in health indicators for The Rapides Foundation Service Area.

- **Survey Data Indicators:** Trends for survey-derived indicators represent significant changes measured between the 2002 and 2005 PRC Community Health Surveys.
- **Other Data Indicators:** Trends for other indicators (e.g., public health indicators) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of a decade).

Positive Trends for The Rapides Foundation Service Area

Health status and risk indicators have *improved* for the following:

Barriers to Access

- Difficulty Accessing Healthcare in Past Year
- Cost of Prescriptions/Physician Visits
- Transportation
- Inconvenient Office Hours
- Difficulty Getting An Appointment
- Difficulty Finding A Physician

Cancer

- Sigmoidoscopy/Colonoscopy Ever (Men/Women 50+)

Cardiovascular Disease

- Heart Disease Deaths
- Stroke Deaths
- Taking Action To Control High Blood Pressure
- Taking Action To Control High Blood Cholesterol
- Recent Cholesterol Screening

Enteric Diseases

- Hepatitis A Incidence Per 100,000 Population

Family Planning

- Births To Teenagers

Housing

- Temporarily Had To Live With Friends/Relatives

HIV/AIDS

- Age-Adjusted HIV/AIDS Deaths

Immunization & Infectious Diseases

- Pneumonia Vaccine Ever (65+)

Injury & Violence

- Unintentional Injury Deaths
- Motor Vehicle Accident Deaths
- "Always" Wear Seat Belt
- Child (<5) "Always" Uses Auto Child Restraint
- Child (5-17) "Always" Uses Seat Belt
- Violent Crime Rate
- Victim of Domestic Violence
- Homicide Deaths

Maternal/Infant/Child Health

- Mothers Not Receiving Adequate Prenatal Care

Mental Health

- Feel Sad, Blue, Or Depressed On 3+ Days/Month

Nutrition & Overweight

- Eat 5+ Servings Of Fruit Or Vegetables/Day

Physical Activity & Fitness

- Moderate Physical Activity

Respiratory Disease

- Pneumonia/Influenza Deaths

Sexually Transmitted Diseases

- Primary & Secondary Syphilis Incidence

Substance Abuse

- Drinking And Driving In The Past Month
- Seeking Professional Help

Tuberculosis

- Tuberculosis Incidence

Vision Care

- Recent Eye Exam

Negative Trends for The Rapides Foundation Service Area

Health status and risk indicators have *gotten worse* for the following:

Cancer

- Blood Stool Test In The Past Two Years (Men/Women 50+)
- Pap Smear Testing (Women 18+)

Cardiovascular Disease

- Prevalence Of Stroke
- Hypertension
- High Blood Cholesterol

Diabetes

- Diabetes Deaths
- Prevalence Of Diabetes

Enteric Diseases

- Salmonellosis
- Shigellosis
- Campylobacteriosis

Family Planning

- Births To Unwed Mothers

Immunization & Infectious Diseases

- Hepatitis C Incidence

Maternal/Infant/Child Health

- Low Birthweight Births
- Neonatal Deaths

Mental Health

- Prolonged Depression
- Alzheimer's Disease Deaths

Oral Health

- Recent Dental Care

Nutrition & Overweight

- Child's Fast Food Consumption
- Obesity

Physical Activity & Fitness

- Leisure-Time Physical Activity
- Participate In Vigorous Physical Activity
- Participate In Strengthening Activity
- Child's Exercise

Physical Health

- "Fair" Or "Poor" Physical Health
- Activity Limitations

Respiratory Disease

- Chronic Lower Respiratory Disease (CLRD) Deaths
- Prevalence Of Asthma

Sexually Transmitted Diseases

- Chlamydia
- Hepatitis B

Tobacco

- Smokeless Tobacco

Significant Changes in Perceptions

RFSA respondents noted a *statistically significant change* in perception between 2002 and 2005 with regard to:

Perceptions Of Teen Issues

- View Teen Drug Use As A "Major Problem" (Increase)
- View Teen Alcohol Use As A "Major Problem" (Increase)
- View Teen Tobacco Use As A "Major Problem" (Decrease)
- View Teen Pregnancy As A "Major Problem" (Decrease)

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States… Limitations in access to care extend beyond basic causes, such as a shortage of healthcare providers or a lack of facilities. Individuals also may lack a usual source of care or may face other barriers to receiving services, such as financial barriers (having no health insurance or being underinsured), structural barriers (no facilities or healthcare professionals nearby), and personal barriers (sexual orientation, cultural differences, language differences, not knowing what to do, or environmental challenges for people with disabilities).

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

HEALTH INSURANCE COVERAGE

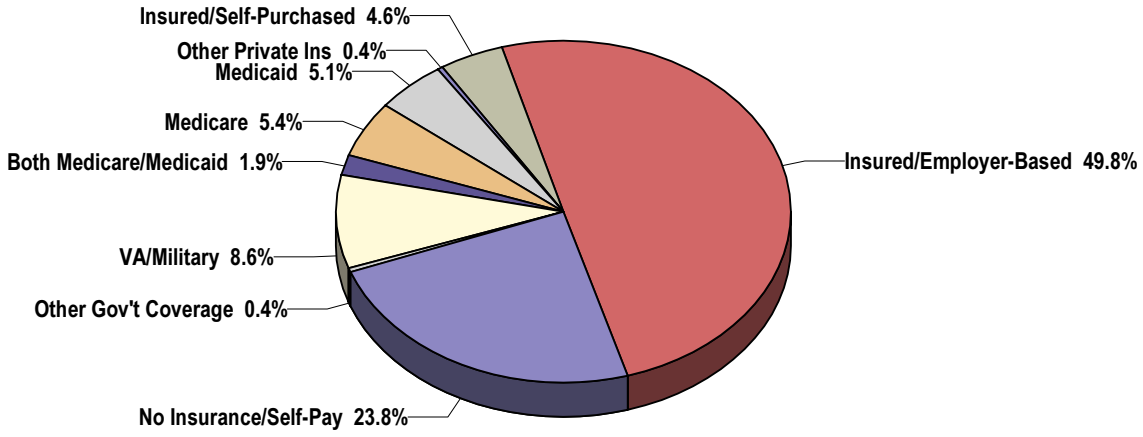
Healthcare Coverage

A total of 76.2% of RFSA adults aged 18 to 64 report having some type of health insurance coverage.

- A total of 54.8% of RFSA adults aged 18 to 64 report having healthcare coverage through private insurance.
- A total of 8.6% report coverage through military benefits, and another 12.8% rely on another government-sponsored plan, including Medicaid, Medicare, and/or "other" (unspecified) government programs.

Healthcare Insurance Coverage

(Among Adults Age 18 To 64; Rapides Foundation Service Area, 2005)



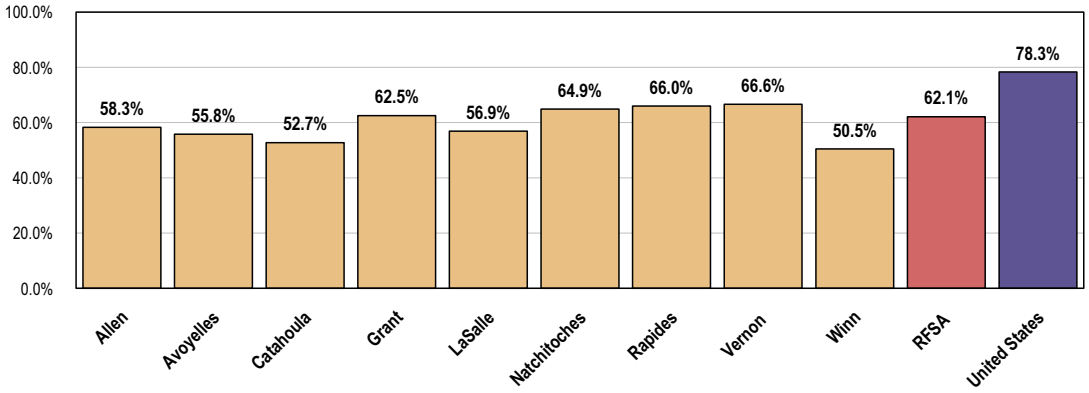
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 164]
Note: • Reflects respondents age 18 to 64.

Among Medicare recipients, more than 6 in 10 (62.1%) have supplemental healthcare coverage.

- Lower than the 78.3% reported nationally.
- Ranges from 50.5% in Winn Parish to 66.6% in Vernon Parish.

Have Additional Supplemental Coverage

(Among Recipients Of Medicare; By Parish, 2005)



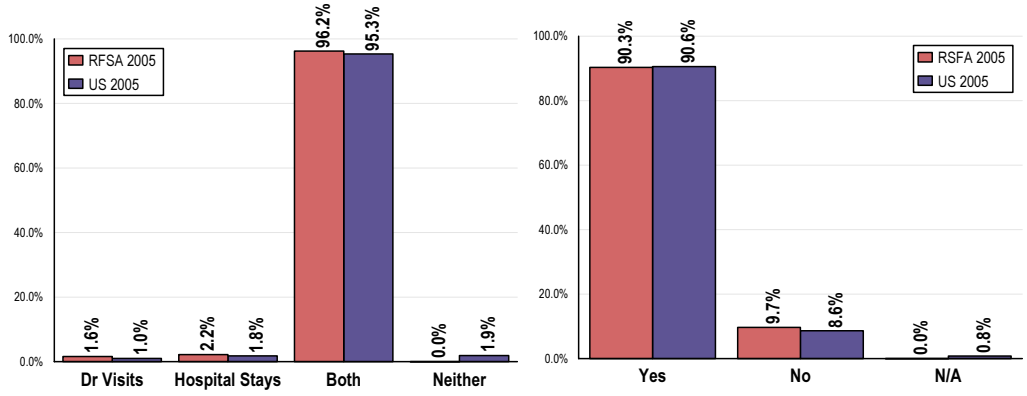
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 79]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Reflects those respondents who currently receive Medicare.
• State data not available.

Healthcare Benefits

Among adults with healthcare coverage, nearly all report coverage for both physician visits and hospital visits; however, 9.7% have no coverage for prescriptions.

Aspects Of Healthcare Coverage

(Among Those With Health Insurance Coverage; By Region, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Items 80-81]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Reflects those respondents who have health insurance coverage.
• State data not available.

Lack Of Health Insurance Coverage

Uninsured Population

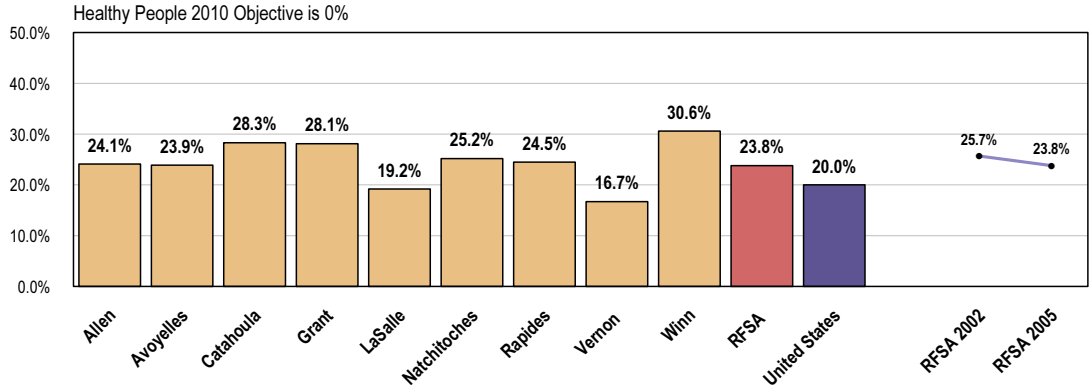
A total of 23.8% of RFSA adults between the ages of 18 and 64 have no insurance coverage for healthcare expenses (neither private nor government-sponsored insurance).

- Less favorable than the 20.0% reported nationwide.
- The Healthy People 2010 target is universal coverage (0% uninsured).
- Ranges from 19.2% in LaSalle Parish to 30.6% in Winn Parish.

TREND: The prevalence of uninsured adults in the RFSA is statistically similar to 2002 findings.

Lack Healthcare Insurance Coverage

(Among Adults Aged 18 To 64; By Parish; 2002-2005 Trend Data)



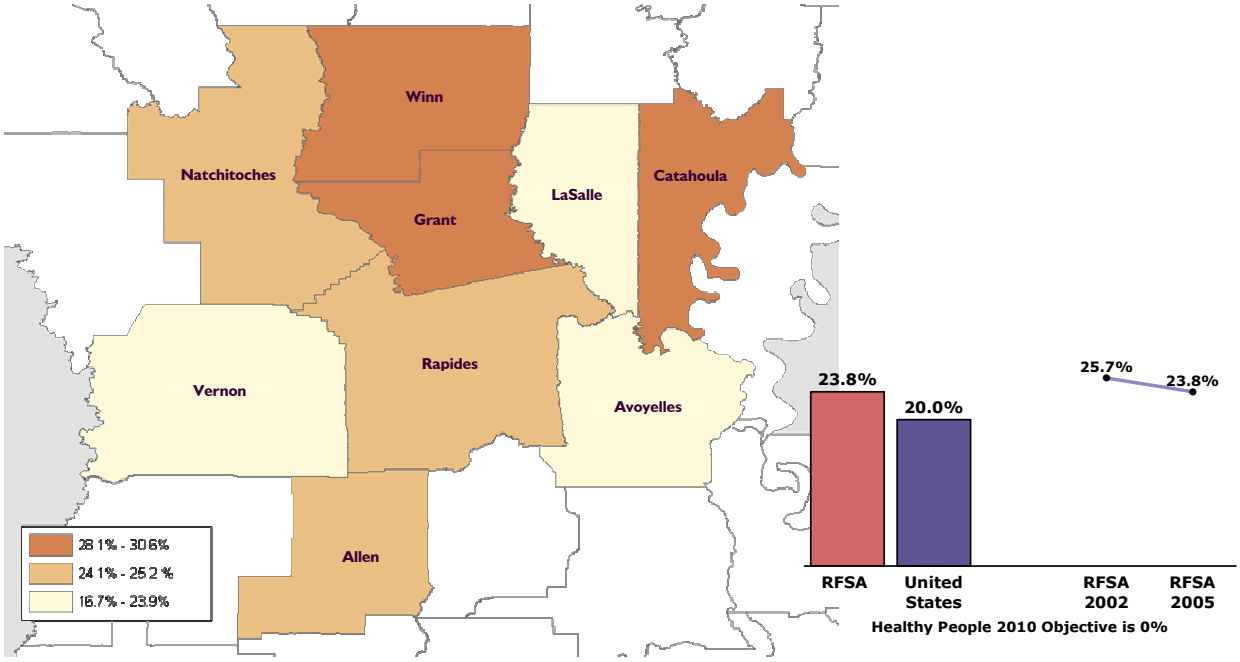
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 164]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-1]

Note:
- Reflects respondents aged 18 through 64.
- State data not available.

The following map further describes the parish-level findings regarding lack of health insurance coverage.

Lack Health Care Insurance Coverage

(Among Adults Aged 18 To 64; By Parish, 2005)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 164]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-1]

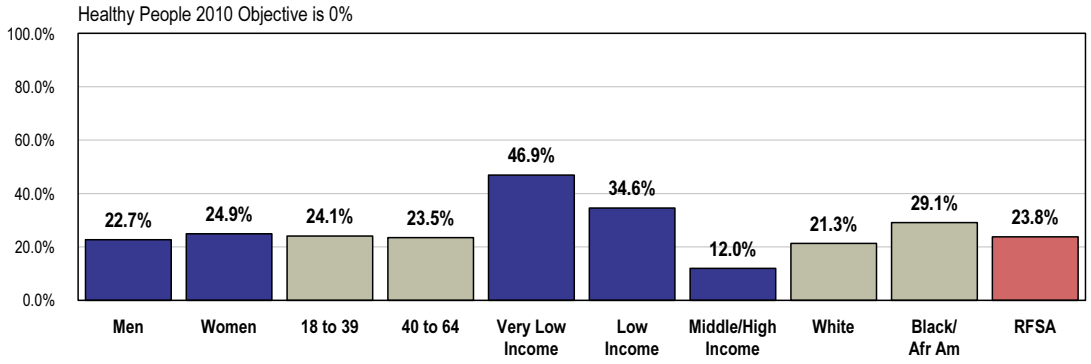
Note:
- Reflects respondents aged 18 through 64.

Further, note the following:

- As might be expected, lack of healthcare insurance coverage decreases as incomes across the RFSA increases.
- White respondents are less often without insurance coverage than are Black/African American respondents. [Note that, because the parish sample was random and conducted in proportion to the actual population, other races were not sampled in numbers large enough to allow for segmentation.]

Lack Healthcare Insurance Coverage

(Among Adults Age 18 To 64; Rapides Foundation Service Area, 2005)

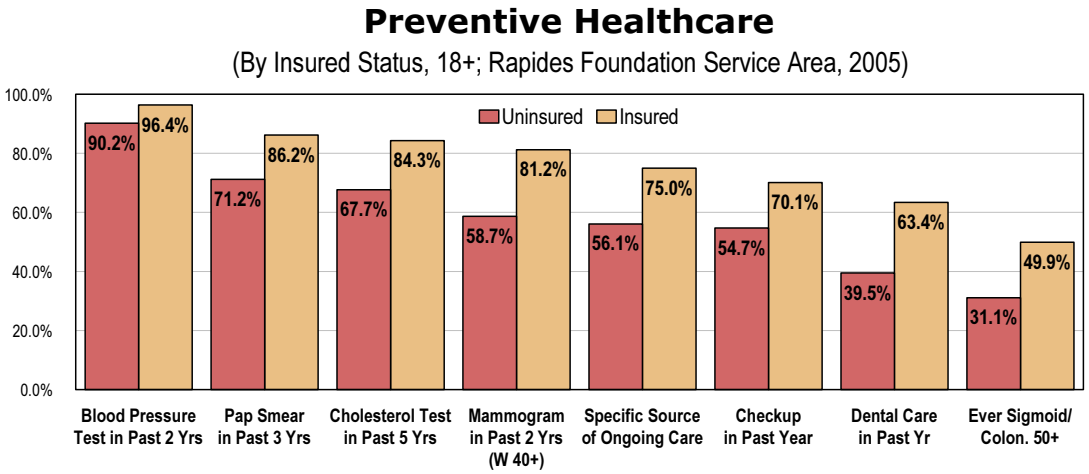


Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 164]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-1]

Note:
- Reflects respondents age 18 through 64.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Impact Of Poor Access

Persons without health insurance coverage are much less likely to have a regular medical care provider, receive routine care, or receive preventive healthcare screenings.



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Items 27,29,30,49,52,85,156,160]
Note: • Reflects all respondents.
• Insured respondents include those with either private or government-sponsored insurance plans.

DIFFICULTIES ACCESSING HEALTHCARE

Difficulties Accessing Services

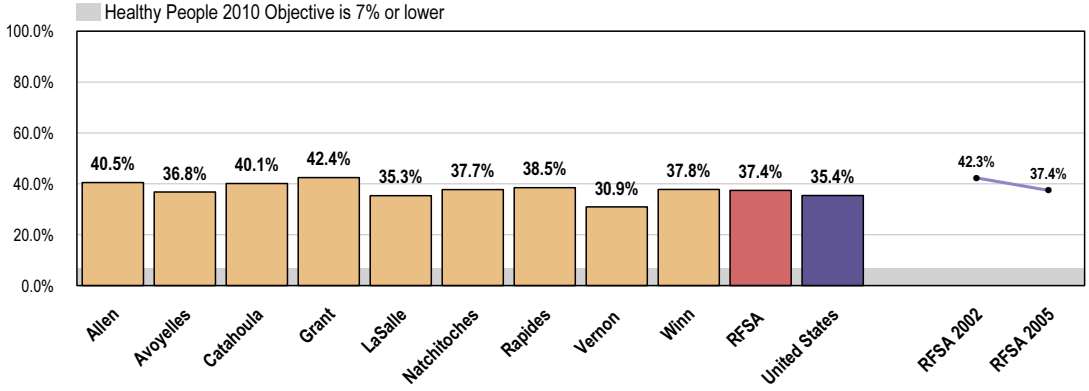
In all, 37.4% of RFSA adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Statistically similar to the 35.4% reported nationwide.
- Fails to satisfy the Healthy People 2010 target (7% or lower).
- Varies from 30.9% in Vernon Parish to 42.4% in Grant Parish.

TREND: Marks a *statistically significant decrease* from the 42.3% reported in 2002.

Experienced Difficulties Or Delays Of Some Kind In Receiving Needed Healthcare In The Past Year

(By Parish; 2002-2005 Trend Data)



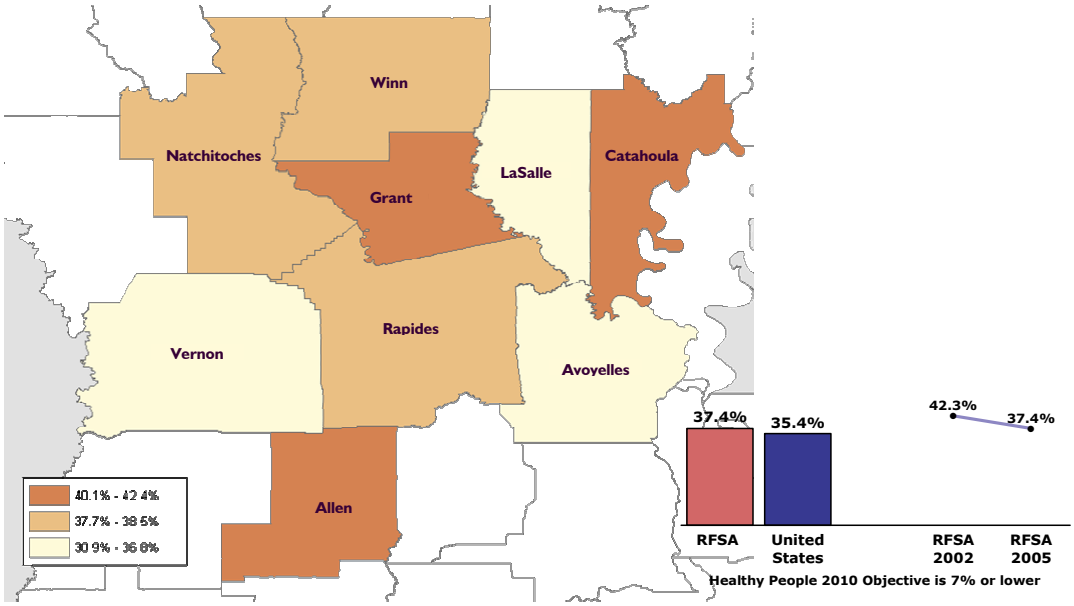
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 170]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-6]

Note:
- Asked of all respondents.
- Includes difficulties related to availability, cost, office hours, transportation or other unspecified troubles/delays.
- State data not available.

The following map visually depicts access difficulties among the nine parishes of the RFSA.

Experienced Difficulties Or Delays Of Some Kind In Receiving Needed Health Care In The Past Year

(By Parish, 2005)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 170]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-6]

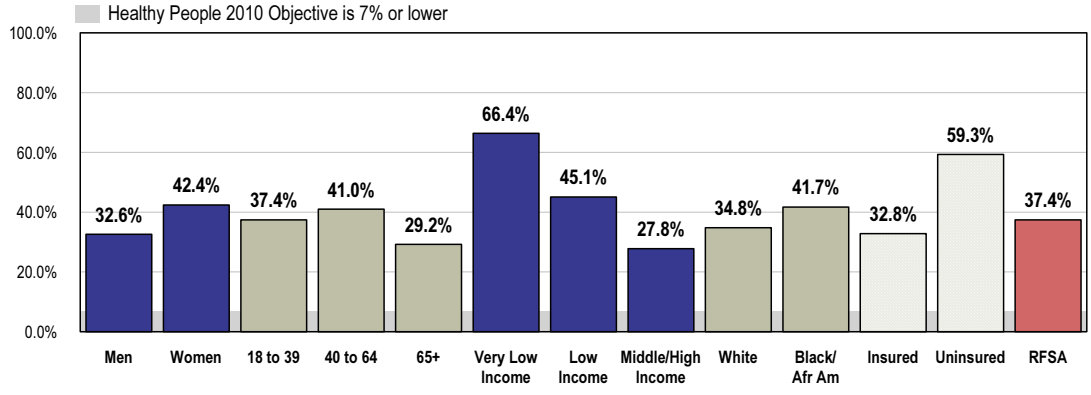
Note:
- Asked of all respondents.
- Includes difficulties related to availability, cost, office hours, transportation or other unspecified troubles/delays.

The following demographic segments are more likely to report access difficulties:

- Women, persons living at lower incomes, adults under 65, Blacks/African Americans.
- Further, persons without health insurance coverage much more often report difficulties or delays in accessing healthcare than do insured respondents.

Experienced Difficulties Or Delays Of Some Kind In Receiving Needed Healthcare In The Past Year

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 170]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-6]

Note:
- Asked of all respondents.
- Includes difficulties related to availability, cost, office hours, transportation or other unspecified troubles/delays.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Barriers To Healthcare Access

Adults

Specifically, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a prescription in the past year.

Of the six tested barriers, cost of prescription medicines impacted the greatest share of adults in the RFSA (19.5% say they were unable to obtain a needed prescription in the past year because of the cost).

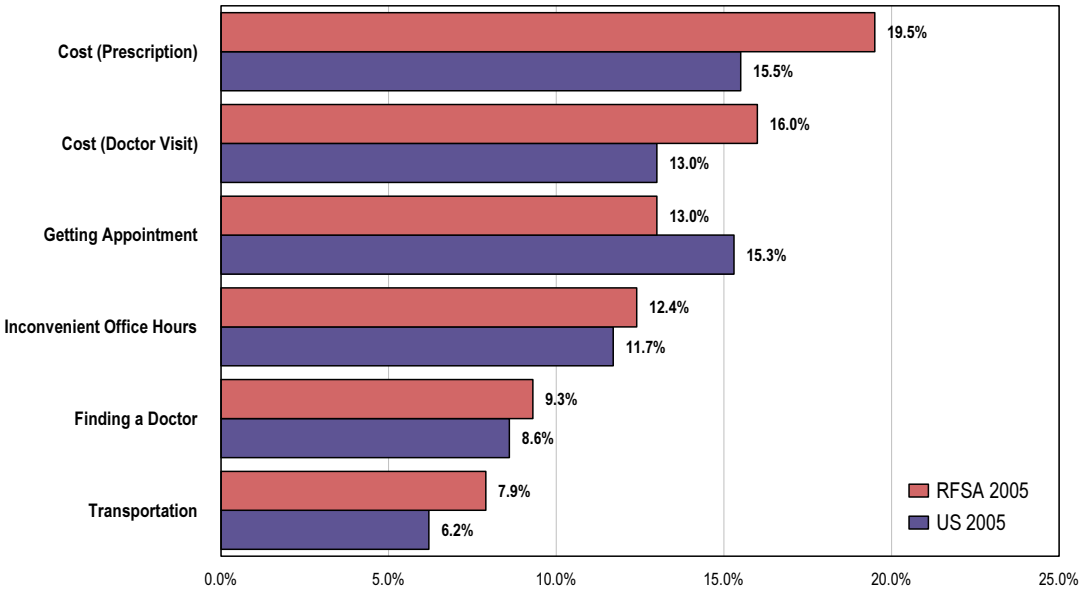
- **Cost of the doctor visit** and **difficulty obtaining a physician visit** were the second and third most common barriers to healthcare services (affecting 16.0% and 13.0% of respondents, respectively).

In the following chart, note that:

- Compared with survey findings across the United States, the RFSA received less favorable responses for cost as a barrier to both prescriptions and doctor visits.

Barriers To Access Have Prevented Medical Care In The Past Year

(By Region, 2005)

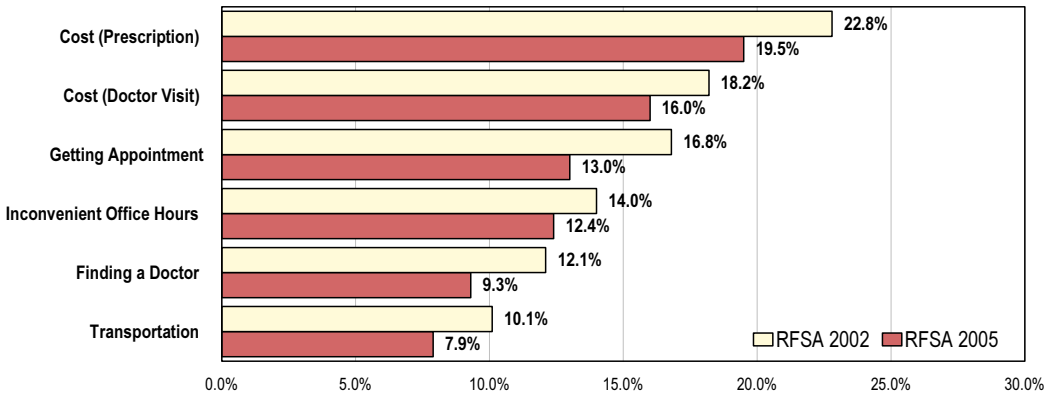


Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Items 18-23]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

TREND: Across the RFSA, responses regarding each of the barriers to access *improved significantly* since 2002.

Barriers To Access Have Prevented Medical Care In The Past Year

(Rapides Foundation Service Area, 2002-2005)



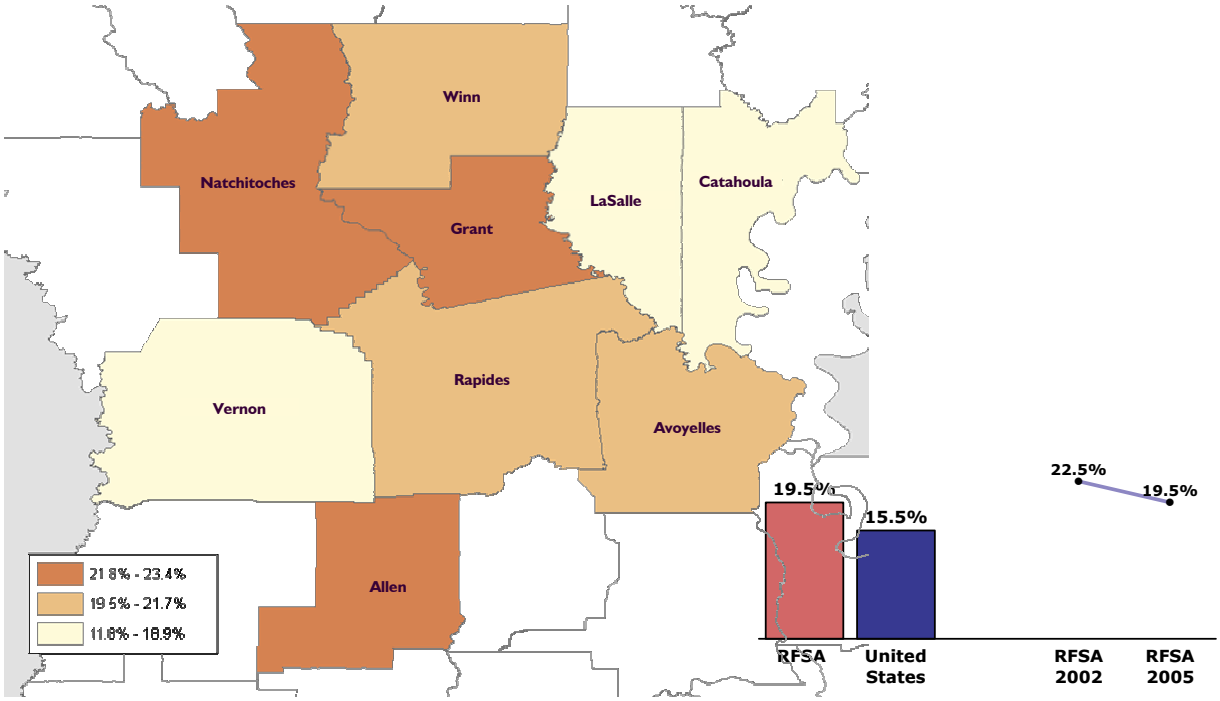
Source: • PRC Community Health Surveys, Professional Research Consultants. [Items 18-23]
Note: • Asked of all respondents.

Access to Prescriptions

The following map further illustrates parish-level findings regarding access to prescription medications. Note that the greatest barriers appear in Allen, Grant and Natchitoches parishes.

Cost Has Prevented Getting A Prescription Medicine In The Past Year

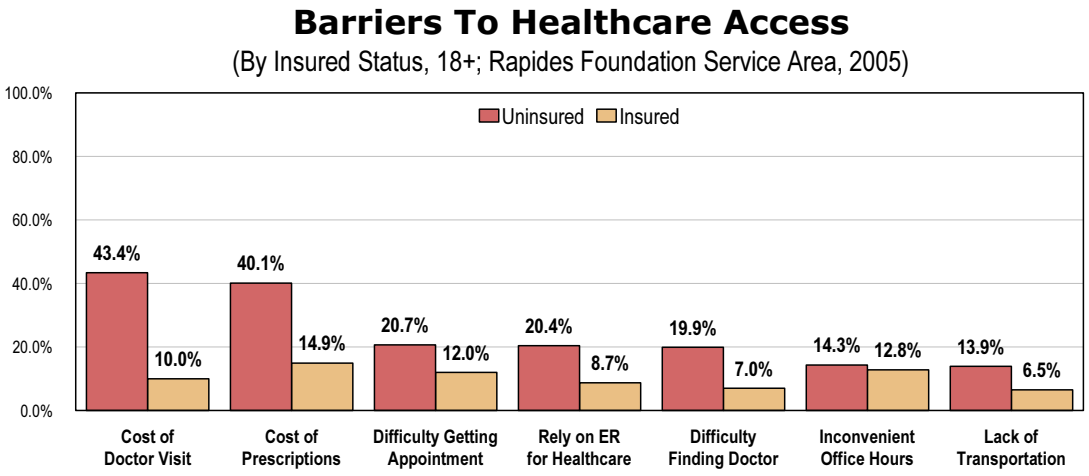
(By Parish, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Items 18-23]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

Uninsured Adults

RFSA residents without health insurance coverage are more likely to experience specific barriers to healthcare access.



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Items 18-26,30]
Note: • Reflects all respondents.
• Insured respondents include those with either private or government-sponsored insurance plans.

Children

Surveyed parents were also asked if, within the past year, they experienced any trouble in receiving medical care for a randomly selected child in their household.

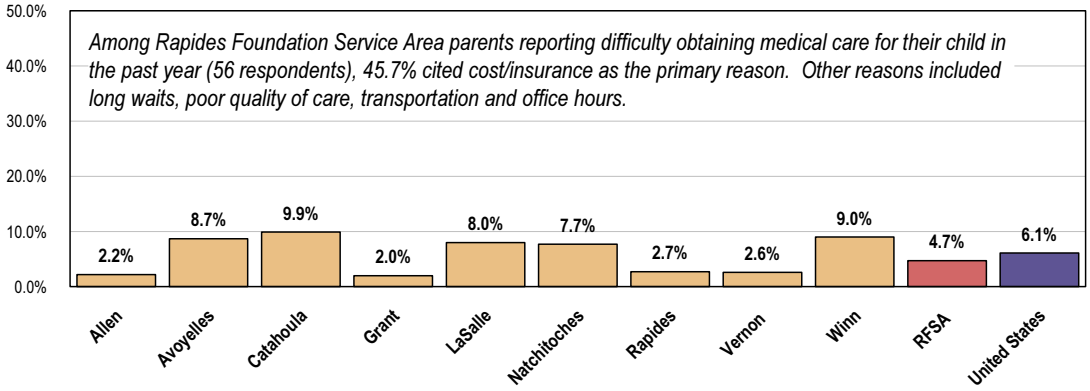
A total of 4.7% of surveyed parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Similar to the 6.1% reported nationwide.
- Ranges from 2.0% in Grant Parish to 9.9% in Catahoula Parish.

Specific types of difficulties encountered included references to **cost/lack of insurance**, **long waits**, **poor quality of care**, **transportation** and **office hours.**

Have Had Trouble Obtaining Medical Care For Child In The Past Year

(By Parish, 2005)



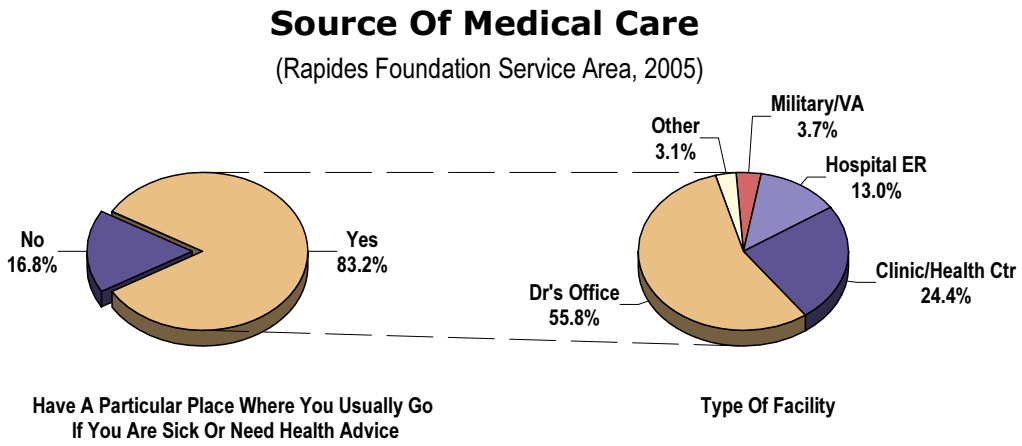
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 122-123]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of respondents with children under the age of 18.
• State data not available.

PRIMARY CARE SERVICES

A majority (83.2%) of RFSA adults say they have a particular place where they usually go for healthcare; this is predominantly a doctor's office.

- Note, however, that 13.0% of people reporting a source of medical care say that this is a hospital emergency room.



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 25-26]
Note: • Asked of all respondents.

Specific Source Of Ongoing Care

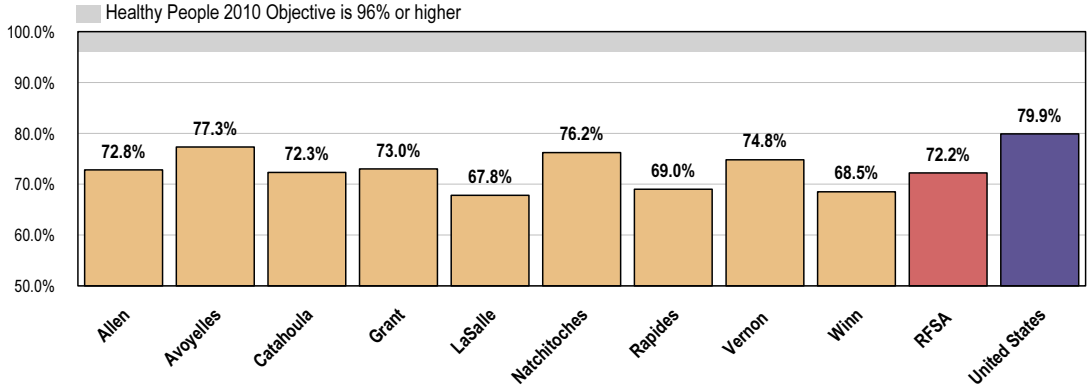
Having a "specific source of ongoing care" includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. A hospital emergency room is <u>not</u> considered a source of ongoing care in this instance.

More than 7 in 10 (72.2%) RFSA adults were determined to have a specific source of ongoing medical care.

- Less favorable than the 79.9% reported nationally.
- Fails to satisfy the Healthy People 2010 target (96% or higher).
- Ranges from 67.8% in LaSalle Parish to 77.3% in Avoyelles Parish.

Have A Specific Source Of Ongoing Medical Care

(By Parish, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 171]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-4]

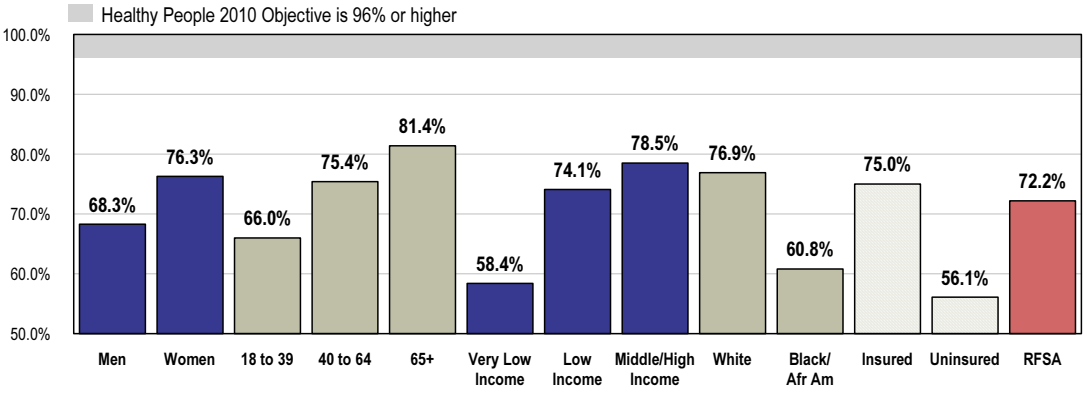
Note:
- Asked of all respondents.
- A specific source of ongoing care includes having a doctor's office, clinic, urgent care/walk-in clinic, health center facility, hospital outpatient clinic, HMO (health maintenance organization)/pre-paid group, military/VA healthcare, or some other kind of place to go if one is sick or needs advice about his/her health. A hospital emergency room is NOT considered a source of ongoing care in this instance.
- State data not available.

The following demographic segments are <u>less</u> likely to report having a specific source of care:

- Men.
- Adults under age 40.
- Those at very low income levels.
- Blacks/African Americans.
- Adults without healthcare insurance coverage.

Have A Specific Source Of Ongoing Medical Care

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 171]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-4]

Note:
- Asked of all respondents.
- A specific source of ongoing care includes having a doctor's office, clinic, urgent care/walk-in clinic, health center facility, hospital outpatient clinic, HMO (health maintenance organization)/pre-paid group, military or other VA healthcare, or some other kind of place to go if one is sick or needs advice about his/her health. A hospital emergency room is NOT considered a source of ongoing care in this instance.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

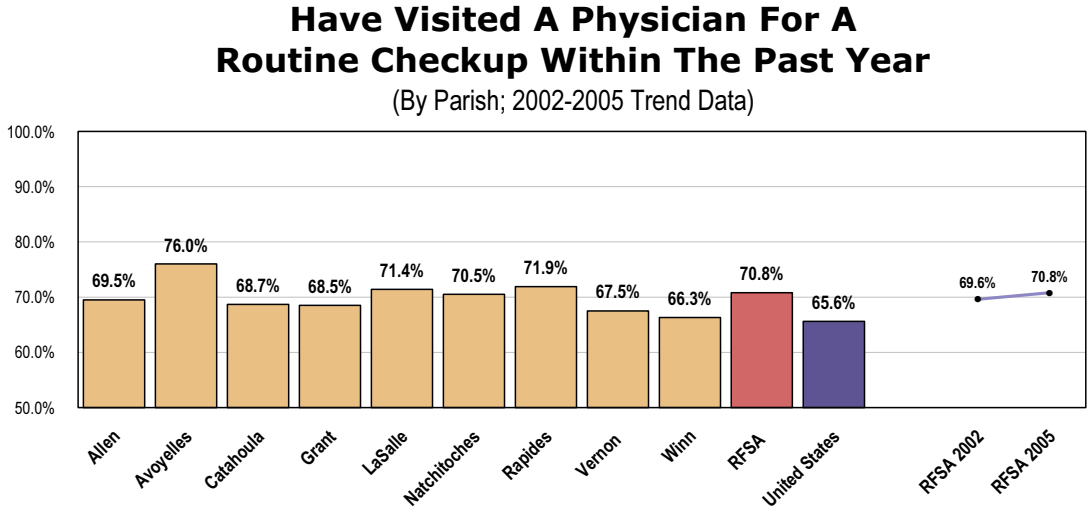
Utilization Of Primary Care Services

Adults

In the past year, 70.8% of RFSA adults visited a physician for a routine checkup.

- More favorable than the 65.6% reported nationwide.
- Highest (76.0%) in Avoyelles Parish.

TREND: Statistically unchanged from the 69.6% reported across the RFSA in 2002.



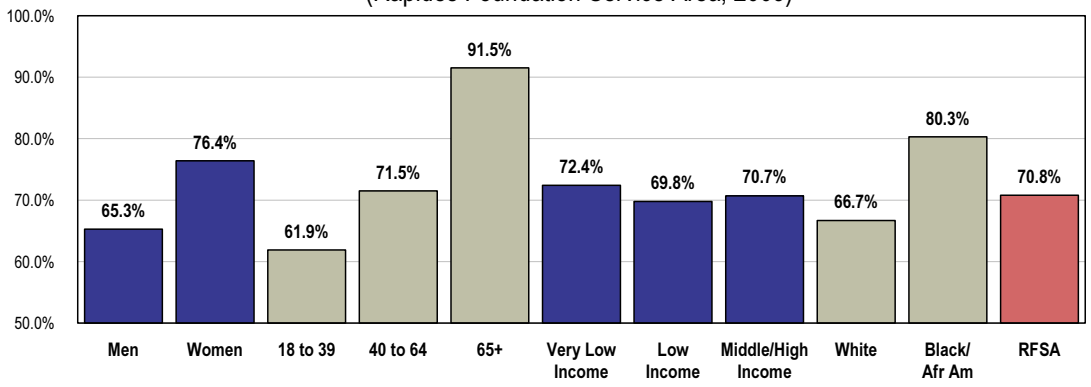
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 27]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

Note the following demographic findings:

- Women more often report routine physician visits than do men.
- As might be expected, there is a strong correlation with age: 91.5% of RFSA adults aged 65 and older have had a checkup in the past year, compared to 61.9% of those aged 18 to 39.
- Recent checkups are more common among RFSA Blacks/African Americans
  - Although this finding may seem contradictory with findings that show that Blacks/African Americans experience poorer access to health services, it is consistent with other PRC research. One possible explanation is that Blacks/African Americans tend to experience higher prevalence of chronic conditions (such as high blood pressure, diabetes, etc.) that require more frequent monitoring.

Have Visited A Physician For A Routine Checkup Within The Past Year

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 27]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Children

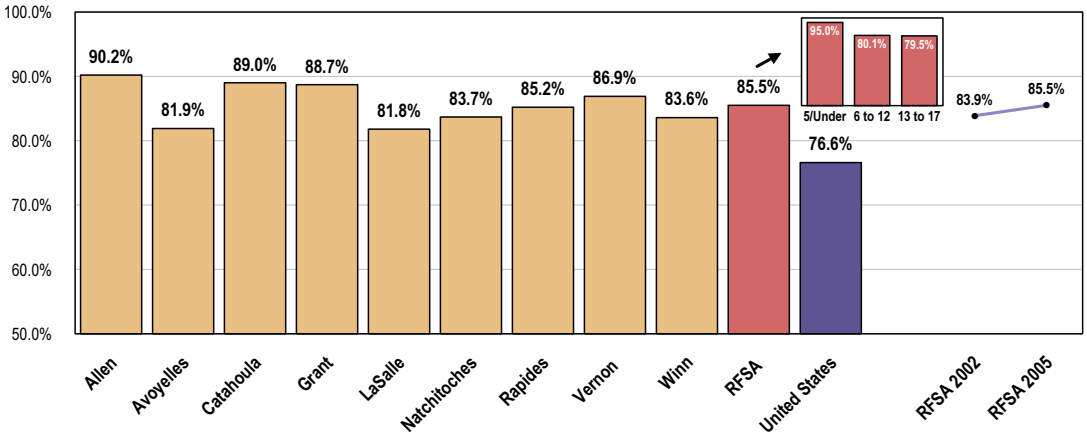
A total of 85.5% of surveyed RFSA parents report that their child had a routine checkup in the past year.

- More favorable than the 76.6% reported nationwide.
- Varies from 81.8% in LaSalle Parish to 90.2% in Allen Parish.
- Higher among children aged five and under.

TREND: Statistically unchanged from the 83.9% reported in the RFSA in 2002.

Child Has Visited A Physician For A Routine Checkup Within The Past Year

(By Parish And Age; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 124]
Note: • Asked of respondents with children under the age of 18.
• State data not available.

Availability Of Primary Care & Other Health Services

Health Professional Shortage Areas

Health professional shortage areas (HPSAs) are designated by the federal Shortage Designation Branch (SDB) in the Health Resources and Services Administration (HRSA) based on the shortage/underserved criteria established by regulation (e.g., the ratio of population to available health providers).

Types Of HPSA Designations & Sub-Categories[*]

- **Primary Care Designations**
- **Dental Designations**
- **Mental Health Designations**

For each of the three HPSA Designation types, there are three sub-categories, which include:

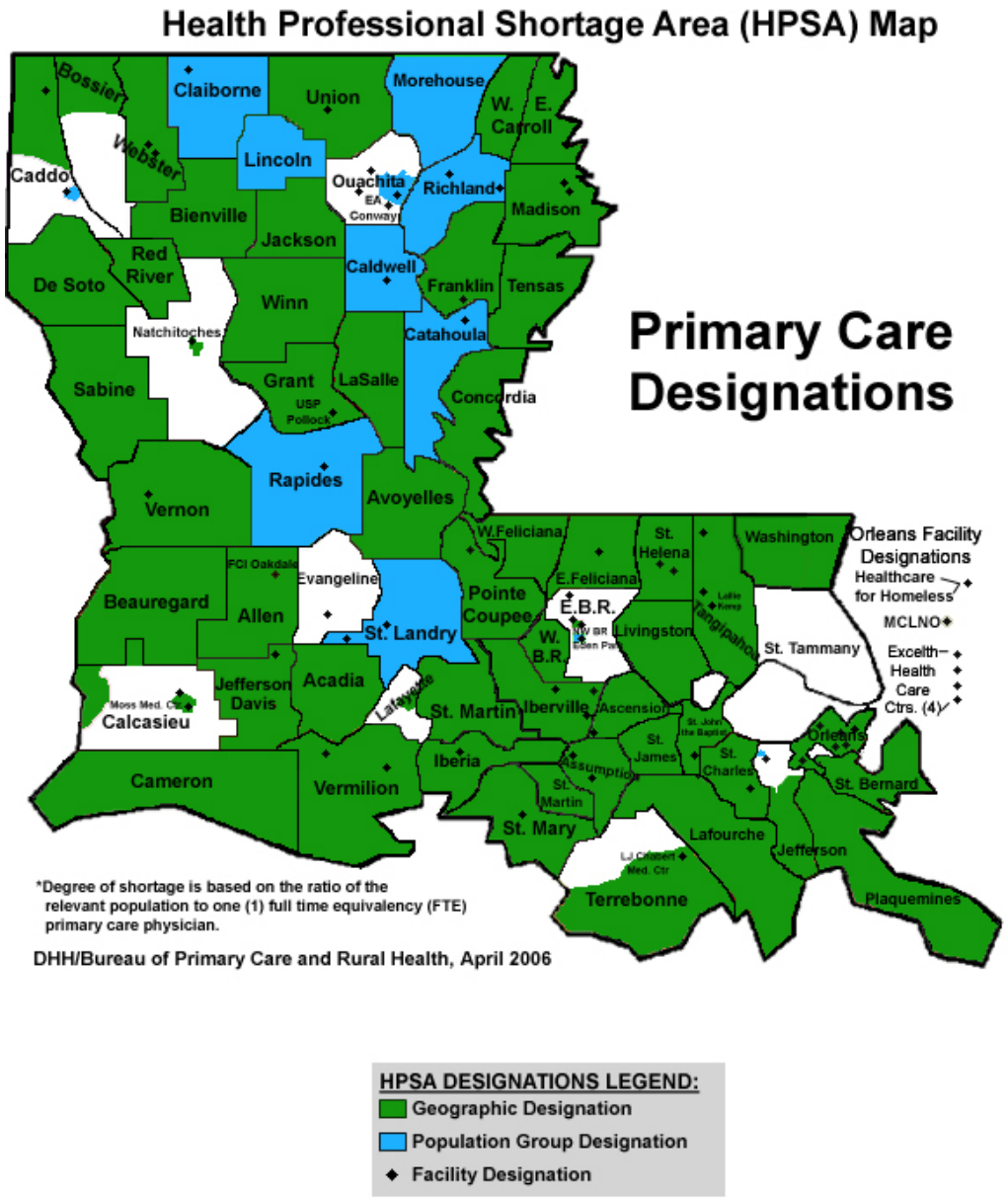
- **Geographic designations** - these take into account the entire population of the requested area to all available primary care physicians.
- **Population Group designations** - these are special groups. The most common of these are Low Income and Medicaid Eligible designations. Low income designations use a ratio built upon the low income population of the area and the physicians providing services to this population. Medicaid eligible designations are based on the number of Medicaid eligible people in the area and the physicians that accept Medicaid.
- **Facility designations** look at a facility's outpatient census, waiting times, patients' residences and in-house faculty to evaluate a facility's designation eligibility.

Maps of the most current designations of parishes in The Rapides Foundation Service Area are presented on the following pages.

[*] Louisiana Department of Health and Hospitals, Office of the Secretary. Primary Care & Rural Health Website. http://www.dhh.state.la.us/offices/page.asp?id=88&detail=3814.

Primary Care

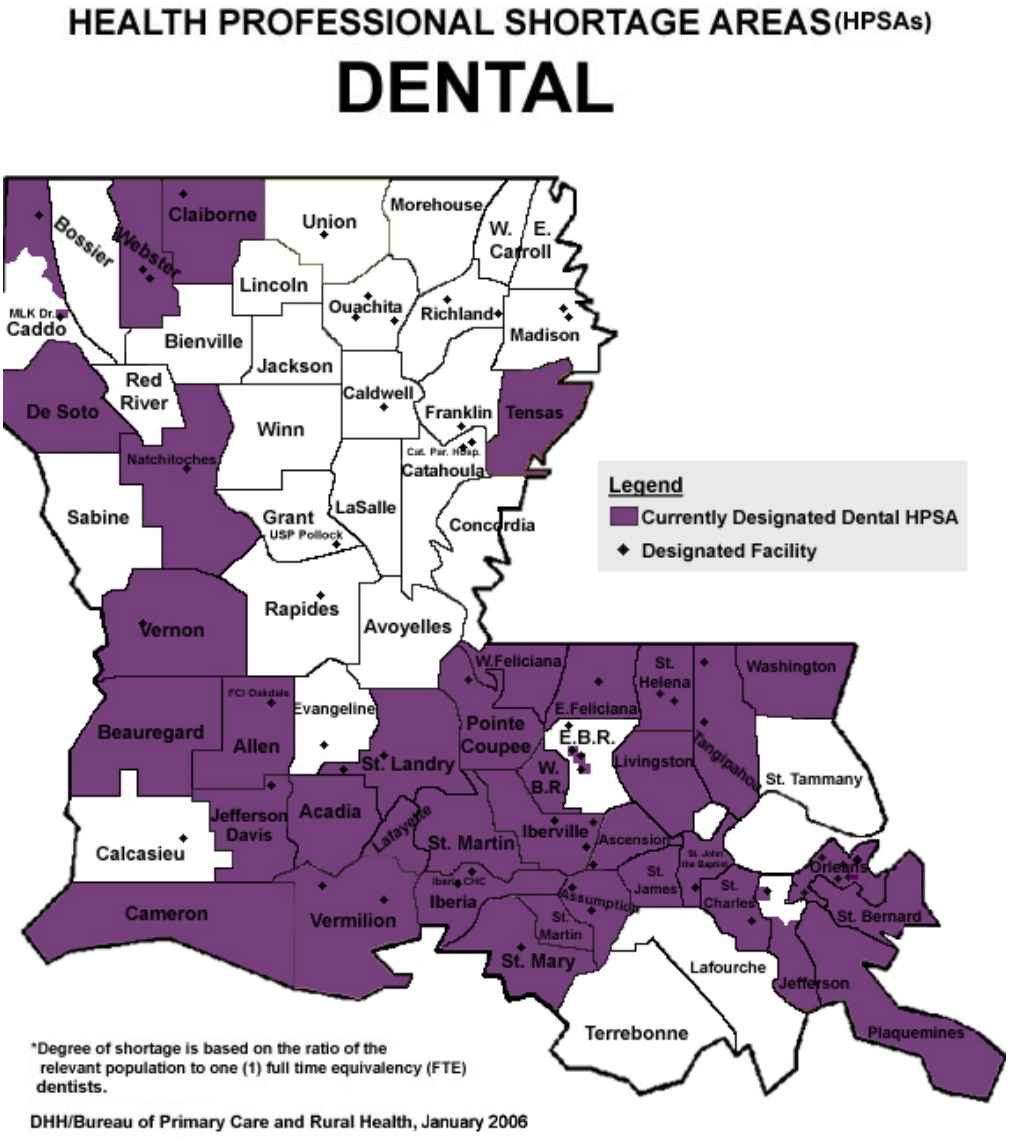
Primary care designations pertain to an area's access to physicians that principally practice in one of the following: family practice, general practice, internal medicine, pediatrics and OB/GYN. A ratio is used to measure the level of primary care access. To be considered underserved, most areas in the state are considered to be high needs areas; therefore, a ratio of ≥3,000 possible patients to one primary care physician full-time equivalent (FTE) is usually required. Provider FTEs are determined by taking the number of hours per week the physician spends in primary care services, either in-office or on-rounds at a hospital, divided by 40. The total of these FTEs is divided by the total resident/civilian population of the area.†



† Louisiana Department of Health and Hospitals, Office of the Secretary. Primary Care & Rural Health Website. http://www.dhh.state.la.us/offices/page.asp?id=88&detail=3814.

Dental Care

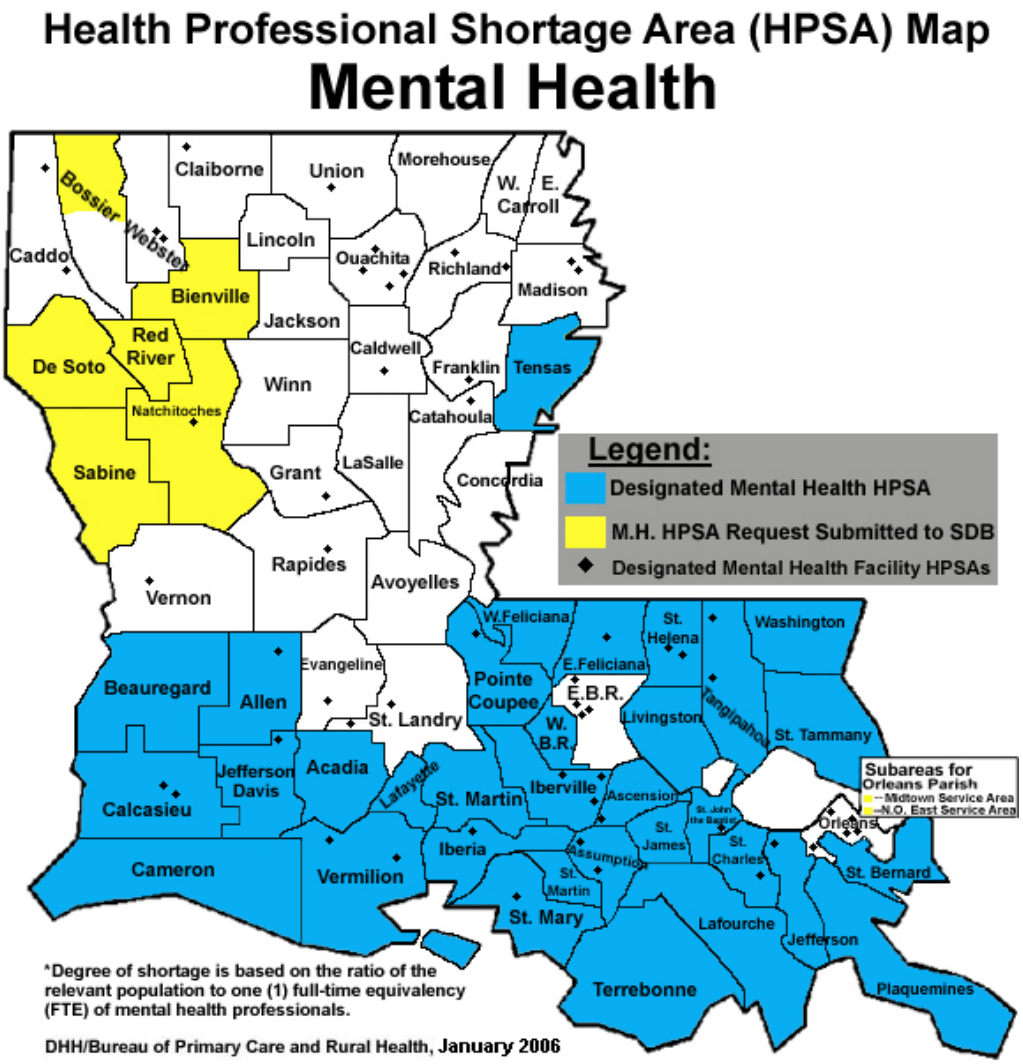
Dental designations are also approved by the Shortage Designation Branch. These are designated on a similar ratio scheme. Dental FTEs are calculated by starting with the number of hours of patient care provided by a dentist per week . The FTE is then weighted according to the dentist's age and the number of assistants the dentist employs. A ratio of ≥4,000 possible patients to one dentist FTE is usually required (in high needs areas).‡



‡ Louisiana Department of Health and Hospitals, Office of the Secretary. Primary Care & Rural Health Website. http://www.dhh.state.la.us/offices/page.asp?id=88&detail=3814.

Mental Health Care

Mental health designations are also approved by the Shortage Designation Branch. There are several ways to figure an area's mental health ratio that include looking at the number of psychiatrists and/or that number plus the other core mental health providers in the area. [§]



Medically Underserved Areas

Medically Underserved Areas (MUAs) identify areas or populations with a shortage of healthcare services. Documentation of shortage for MUAs includes several indicators in addition to the availability of healthcare providers. These factors include infant mortality rate, poverty rate, and percentage of population aged 65 or over.

All parishes throughout the RFSA are designated as MUAs.

[§] Louisiana Department of Health and Hospitals, Office of the Secretary. Primary Care & Rural Health Website. http://www.dhh.state.la.us/offices/page.asp?id=88&detail=3814.

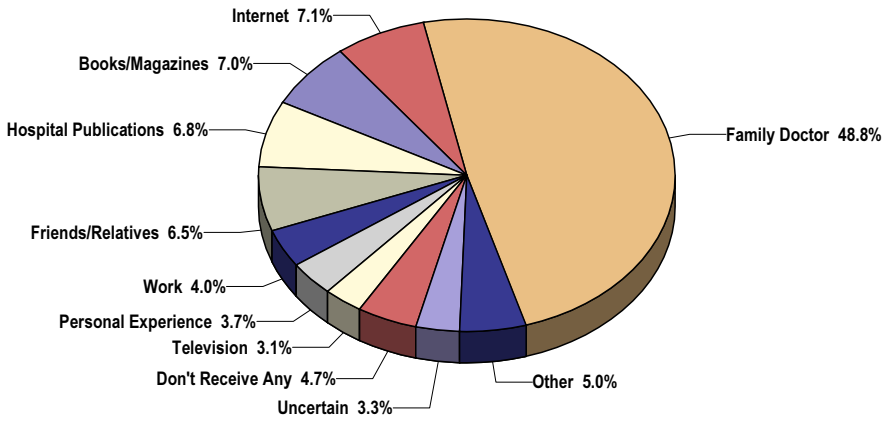
Healthcare Information Sources

One-half (48.8%) of RFSA adults relies on family physicians as their primary source of healthcare information.

- The Internet, books/magazines, hospital publications, and friends/relatives are also important sources of healthcare information.

Primary Source Of Healthcare Information

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 108]
Note: • Asked of all respondents.

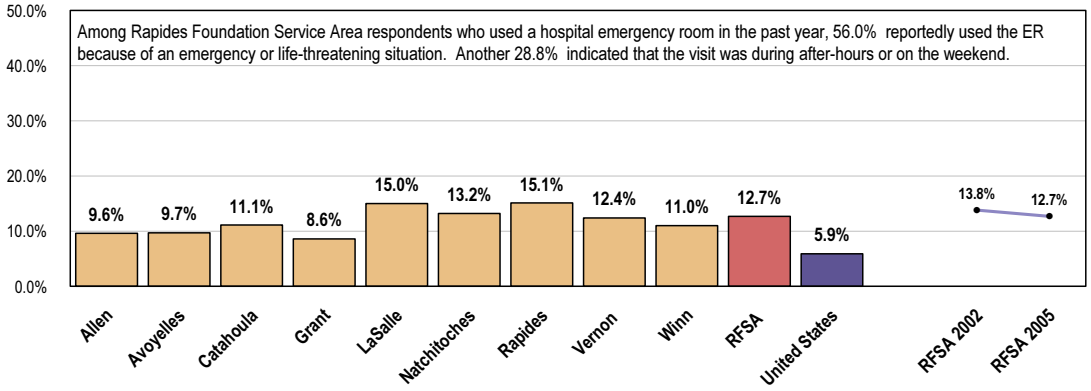
EMERGENCY ROOM SERVICES

A total of 12.7% of RFSA adults have gone to a hospital emergency room more than once in the past year about their own health.

- More than twice the U.S. finding (5.9%).
- Ranges from 8.6% in Grant Parish to 15.1% in Rapides Parish.
- **TREND:** Statistically unchanged from the 13.8% reported in 2002.

Have Used A Hospital Emergency Room More Than Once In The Past Year

(By Parish; 2002-2005 Trend Data)

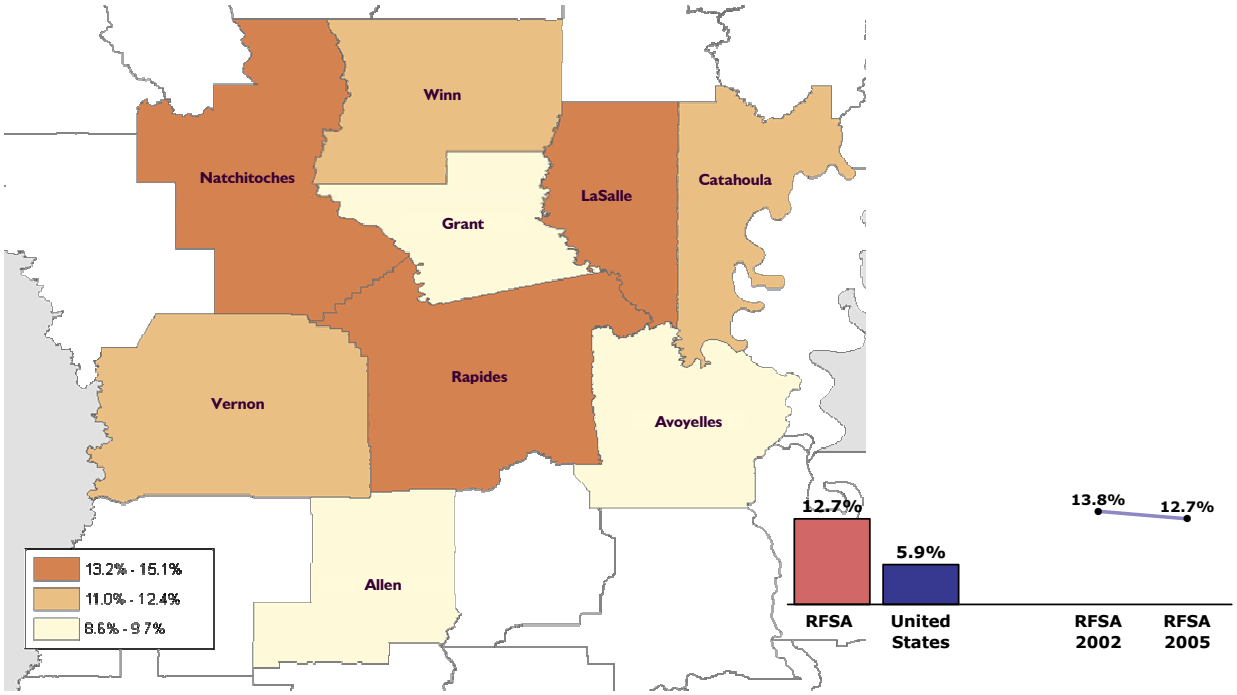


Source: • PRC Community Health Surveys, Professional Research Consultants. [Items 30, 31]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

The following map further details these findings.

Have Used A Hospital Emergency Room More Than Once In The Past Year

(By Parish, 2005)

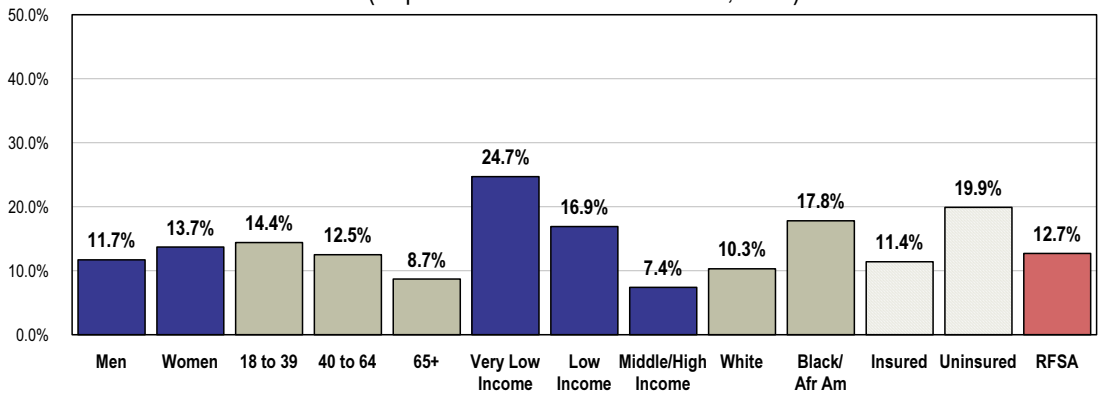


Source: • PRC Community Health Surveys, Professional Research Consultants. [Items 30, 31]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

Note the considerable variation (by age, income, race and insured status) when examining ER utilization by demographic characteristics.

Have Used A Hospital Emergency Room More Than Once In The Past Year

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 30]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

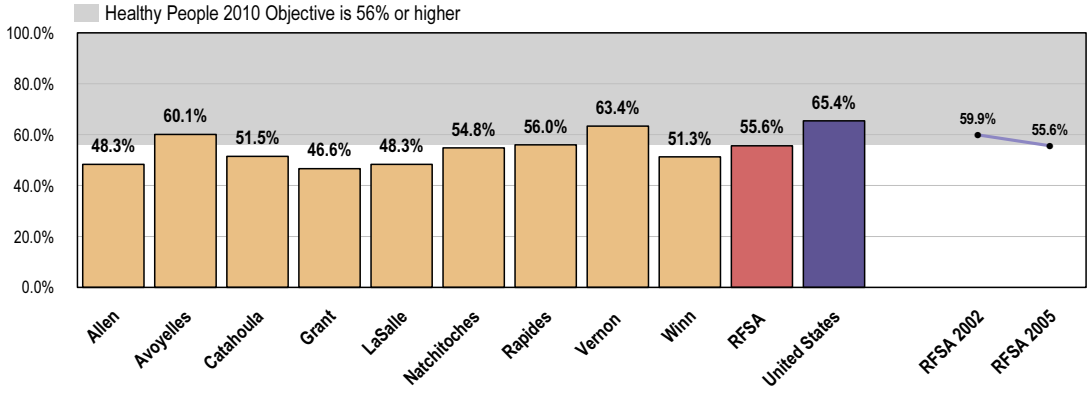
ORAL HEALTH

Just over one-half (55.6%) of RFSA adults visited a dentist or dental clinic (for any reason) in the past year.

- Less favorable than the 65.4% found nationwide.
- Comparable to the Healthy People 2010 target (56% or higher).
- Ranges from 46.6% in Grant Parish to 63.4% in Vernon Parish.
- **TREND:** Marks a *statistically significant decrease* since 2002.

Have Visited A Dentist Or Dental Clinic Within The Past Year

(By Parish; 2002-2005 Trend Data)



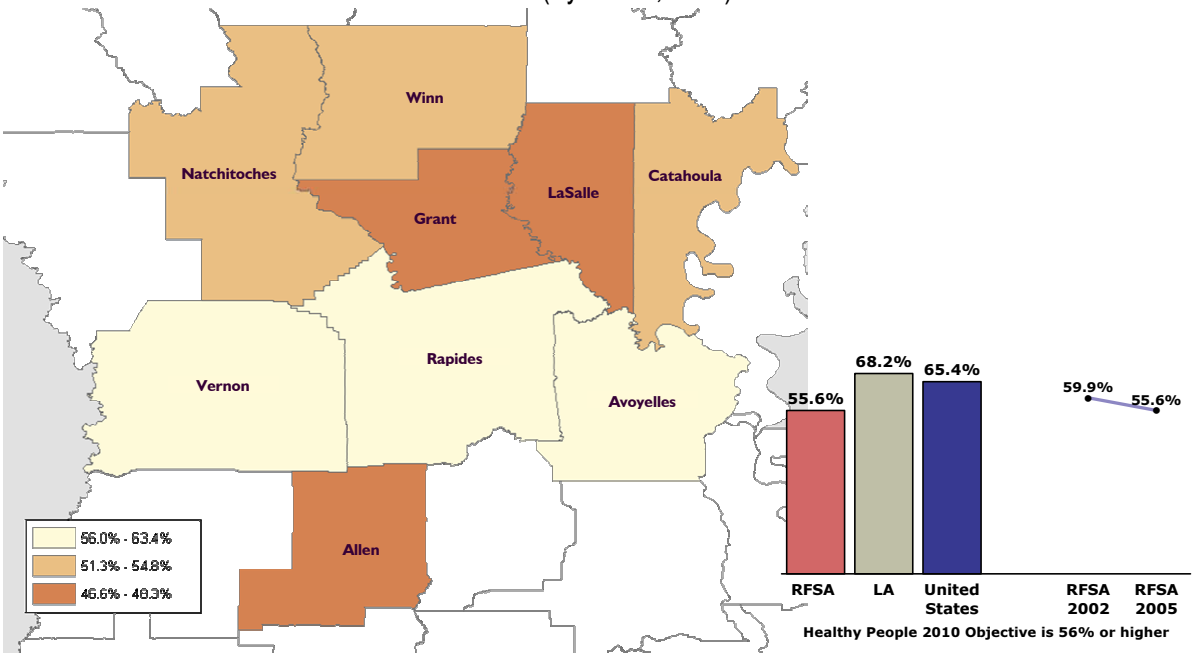
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 29]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 21-10]

Note:
- Asked of all respondents.
- State data not available.

The following map further describes dental care among the nine parishes of the RFSA.

Have Visited A Dentist Or Dental Clinic Within The Past Year

(By Parish, 2005)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 29]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 21-10]

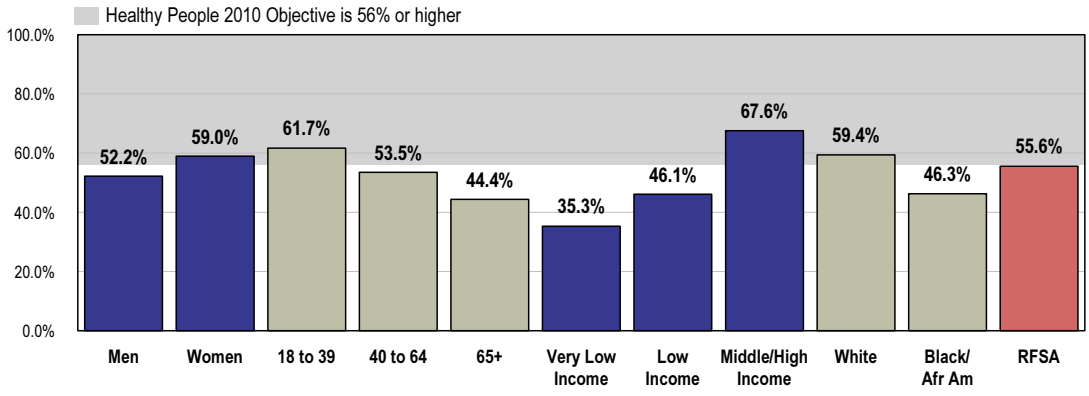
Note:
- Asked of all respondents.

Further note the following:

- RFSA women are more likely than RFSA men to report recent dental care.
- The incidence of recent dental care decreases in the higher age categories.
- Persons living at lower incomes report much lower utilization of oral health services (well below the Healthy People 2010 objective).
- Black/African American respondents report much lower utilization of oral health services.

Have Visited A Dentist Or Dental Clinic Within The Past Year

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 29]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 21-10]

Note:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

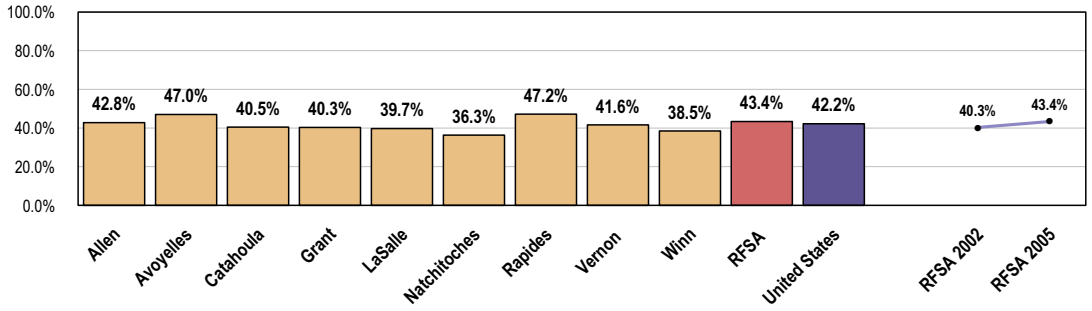
VISION HEALTH

Just over 4 in 10 (43.4%) RFSA respondents had an eye exam in the past year during which their pupils were dilated.

- Similar to the 42.2% reported nationally.
- Varies from 36.3% in Natchitoches Parish to 47.2% in Rapides Parish.
- **TREND:** Marks a *statistically significant increase* from the 40.3% reported in 2002.

Had An Eye Exam In The Past Year During Which The Pupils Were Dilated

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 28]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 21-10]

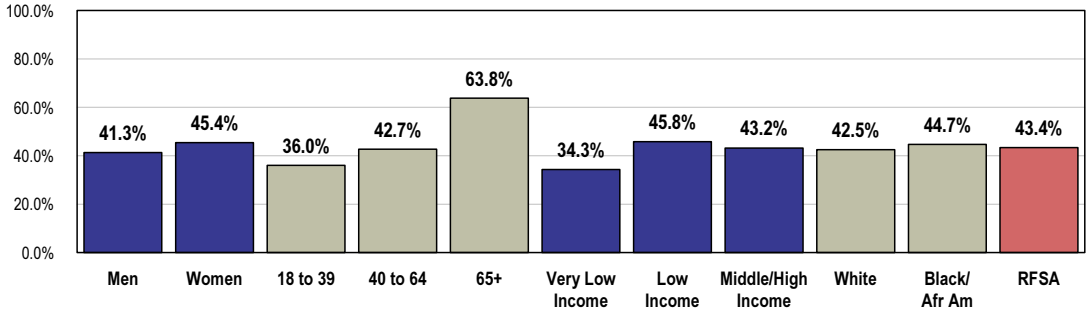
Note:
- Asked of all respondents.
- State data not available.

Recent vision care is more prevalent among:

- Women.
- Adults aged 65 and older.
- Those living above the lowest income level.

Had An Eye Exam In The Past Year During Which The Pupils Were Dilated

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 28]

Note:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

LEADING CAUSES OF DEATH

Leading Causes Of Death

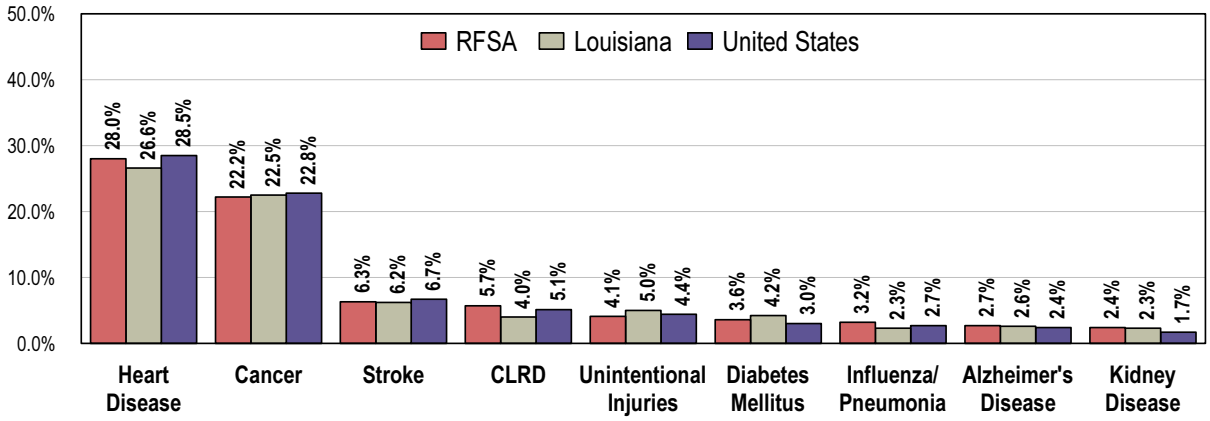
Together, the top five causes of death account for two-thirds (66.3%) of all 2002 deaths in the RFSA.

- **Heart disease** is the leading cause of death, accounting for 28.0% of all deaths.
- **Cancers** (malignant neoplasms) are the second leading cause of death, accounting for 22.2% of all deaths.
- **Stroke** is the third leading cause of death, accounting for 6.3% of all deaths in 2002.
- **Chronic lower respiratory disease** (CLRD) is the fourth leading cause of death, with 5.7% of all deaths.
- **Unintentional injuries** are the fifth leading cause of death, accounting for 4.1% of deaths.
- Other leading causes include diabetes mellitus, influenza/pneumonia, Alzheimer's disease, and kidney disease.

Note the many similarities in percentages when comparing with those throughout the nation.

Leading Causes Of Death

(By Region, 2002)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

Note: • 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 All Causes

In order to compare data among regions, 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.

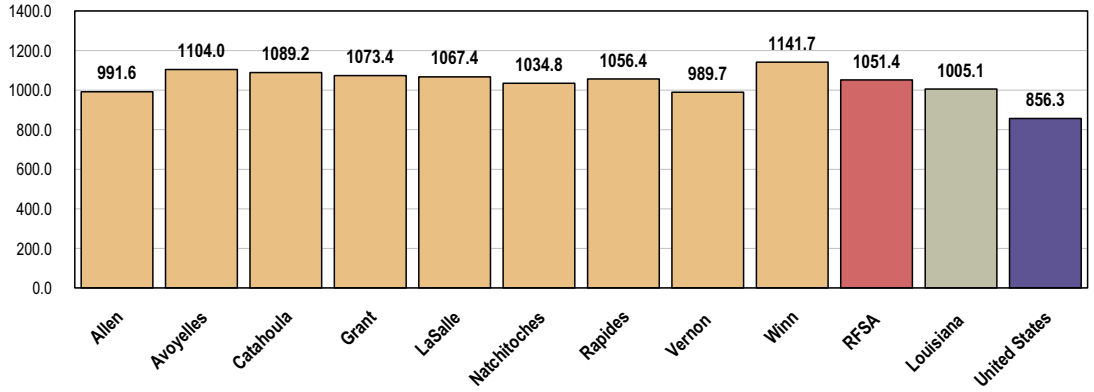
Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to a common baseline age distribution (e.g., the 2000 U.S. population, as is used here). Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against normative or benchmark data, as well as Healthy People 2010 targets.

Between 2000-2002, the RFSA experienced an overall annual average age-adjusted death rate of 1,051.4 per 100,000 population for deaths due to <u>all</u> causes.

- Higher than the overall U.S. rate (856.3).
- Ranges from 989.7 in Vernon Parish to 1,141.7 in Winn Parish.

Age-Adjusted Mortality: All Causes

(By Parish; 2000-2002 Deaths Per 100,000 Population)

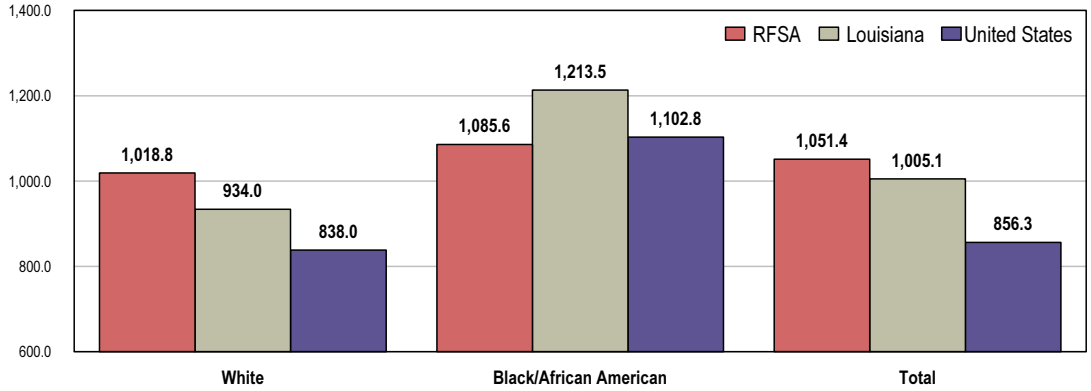


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

Age-Adjusted Mortality: All Causes

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

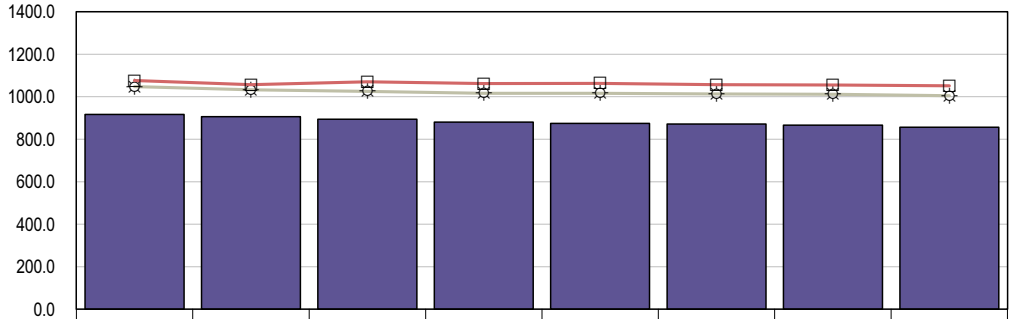
By race:

- Higher among RFSA Blacks/African Americans than among Whites, reflecting what is found statewide and nationwide.

TREND: The age-adjusted mortality rate in the RFSA (all causes) has declined over the past decade. This is mirrored both statewide and nationwide.

Age-Adjusted Mortality: All Causes

(By Region, 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	1076.1	1057.1	1070.5	1061.8	1063.1	1056.9	1054.8	1051.4
Louisiana	1047.2	1032.6	1025.4	1016.5	1016.4	1013.0	1011.7	1005.1
United States	916.5	905.8	894.0	880.9	874.8	871.7	866.4	856.3

Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

Age-Adjusted Death Rates For Selected Causes

The following chart outlines 2000-2002 annual average age-adjusted death rates per 100,000 population for selected causes of death.

- **Versus Healthy People 2010:** RFSA age-adjusted death rates fail to satisfy the outlined Healthy People 2010 targets for the following conditions: heart disease, cancer, stroke, diabetes, motor vehicle accidents, cirrhosis/liver disease, homicide and suicide.
- **Versus United States:** Further, RFSA death rates exceed those reported across the nation for each cause listed, with the exception of cirrhosis/liver disease.

Age-Adjusted Death Rates For Selected Causes

(2000-2002 Deaths Per 100,000 Population)

	RFSA	LA	US	HP2010
Diseases of the Heart	310.4	279.7	248.7	213.7*
Malignant Neoplasms (Cancers)	230.1	226.1	196.4	159.9
Cerebrovascular Disease (Stroke)	69.3	63.8	58.3	48.0
Chronic Lower Respiratory Diseases	51.4	41.9	43.8	
Diabetes Mellitus	34.0	41.8	25.2	15.1*
Alzheimer's Disease	24.5	24.3	19.2	
Influenza/Pneumonia	29.3	23.9	22.8	
Motor Vehicle Accidents	24.6	22.0	15.5	9.2
Cirrhosis/Liver Disease	9.4	8.2	9.5	3.0
Homicide/Legal Intervention	7.5	12.8	6.4	3.0
Intentional Self-Harm (Suicide)	11.0	11.1	10.7	5.0

Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population and coded using ICD-10 codes.
- *The Healthy People 2010 Heart Disease target is adjusted to account for all diseases of the heart; the Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
- Parish, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

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

CARDIOVASCULAR DISEASE

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

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

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

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

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

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

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease

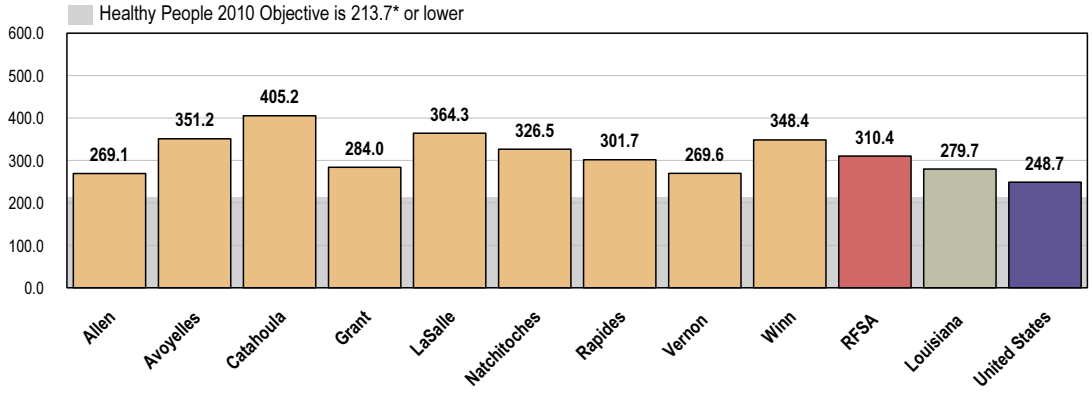
The greatest share of cardiovascular deaths are attributed to heart disease.

Between 2000 and 2002, there was an annual average age-adjusted heart disease death rate of 310.4 deaths per 100,000 population in the RFSA.

- Less favorable than the rate reported statewide (279.7).
- Less favorable than that found nationwide (248.7).
- Fails to satisfy the Healthy People 2010 objective (213.7, adjusted to account for all diseases of the heart).
- Ranges from 269.1 among residents of Allen Parish to 405.2 in Catahoula Parish.

Age-Adjusted Mortality: Diseases Of The Heart

(By Parish; 2000-2002 Deaths Per 100,000 Population)

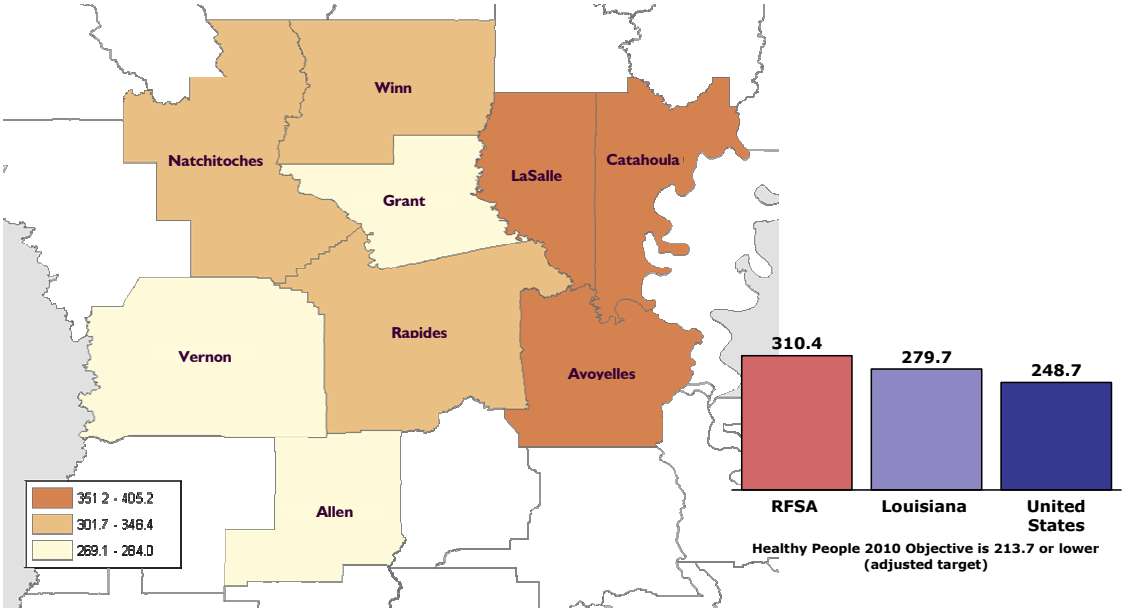


Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Parish, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
- *The Healthy People 2010 Heart Disease target is adjust to account for all diseases of the heart.

Age-Adjusted Mortality: Diseases Of The Heart

(By Parish, 2000-2002 Deaths Per 100,000 Population)



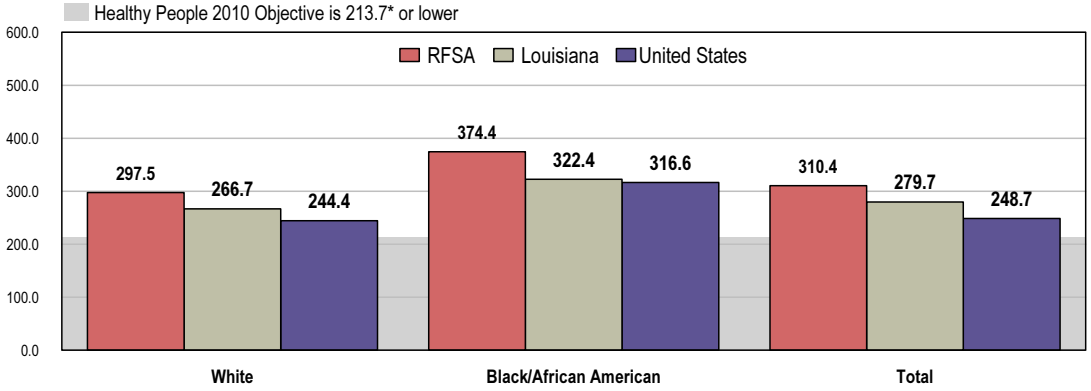
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office,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

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

- Deaths due to diseases of the heart are more prevalent among Blacks/African Americans than among Whites in each of the three regions depicted.

Age-Adjusted Mortality: Diseases Of The Heart

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



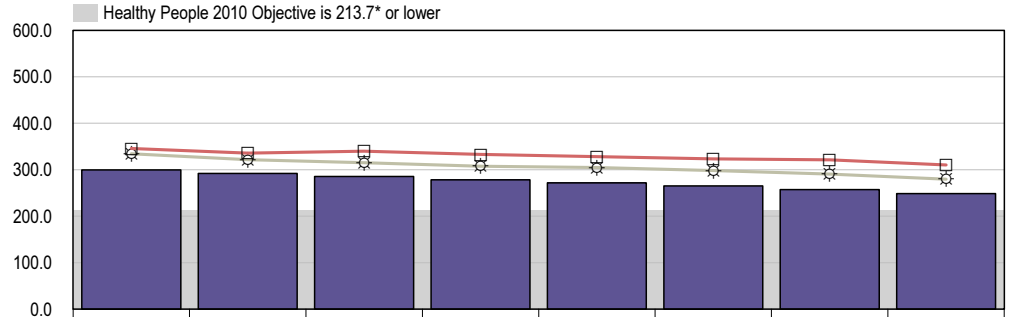
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Parish, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
- *The Healthy People 2010 Heart Disease target is adjust to account for all diseases of the heart.

TREND: RFSA age-adjusted heart disease death rates decreased steadily between 1993 and 2002; this was also the case across Louisiana and the nation overall.

Age-Adjusted Mortality: Diseases Of The Heart

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	345.8	335.9	339.8	332.9	328.2	323.5	321.3	310.4
Louisiana	334.3	321.6	315.0	307.6	304.7	298.3	290.6	279.7
United States	299.7	292.2	285.6	278.2	271.8	265.1	257.3	248.7

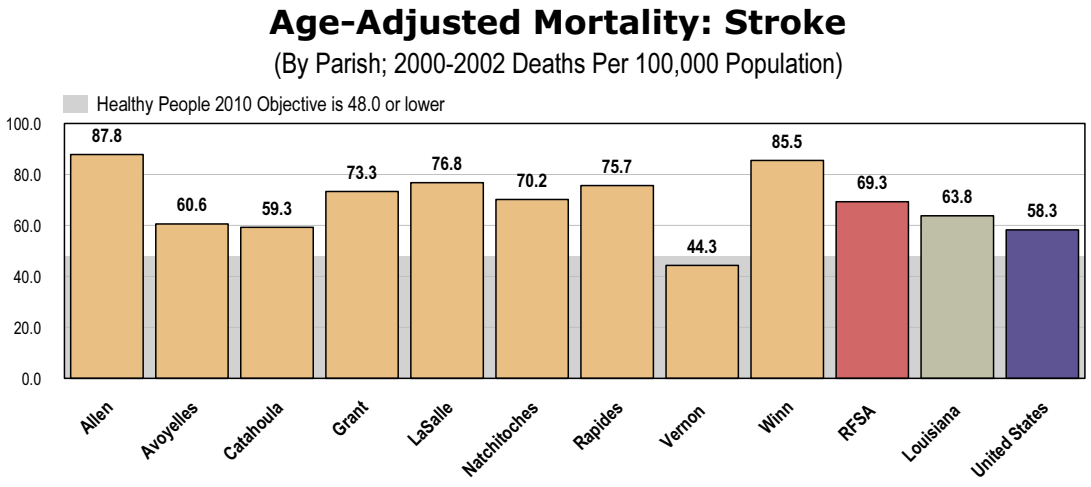
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
- *The Healthy People 2010 Heart Disease target is adjust to account for all diseases of the heart.

Stroke Deaths

Between 2000 and 2002, there was an annual average age-adjusted stroke death rate of 69.3 deaths per 100,000 population in the RFSA.

- Higher than state (63.8) and national (58.3) rates.
- Fails to satisfy the Healthy People 2010 objective of 48.0 or lower.
- Ranges dramatically from 44.3 in Vernon Parish (meeting the HP2010 goal) to 87.8 in Allen Parish.



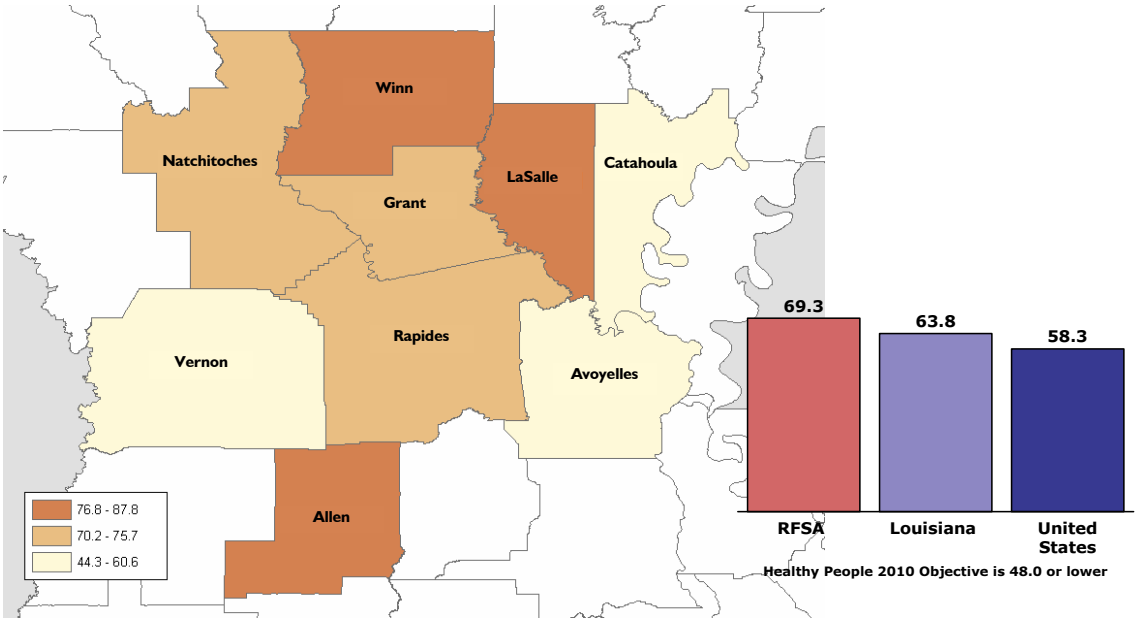
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

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

The following map further describes these rates across the nine-parish area.

Age-Adjusted Mortality: Stroke

(By Parish, 2000-2002 Deaths Per 100,000 Population)



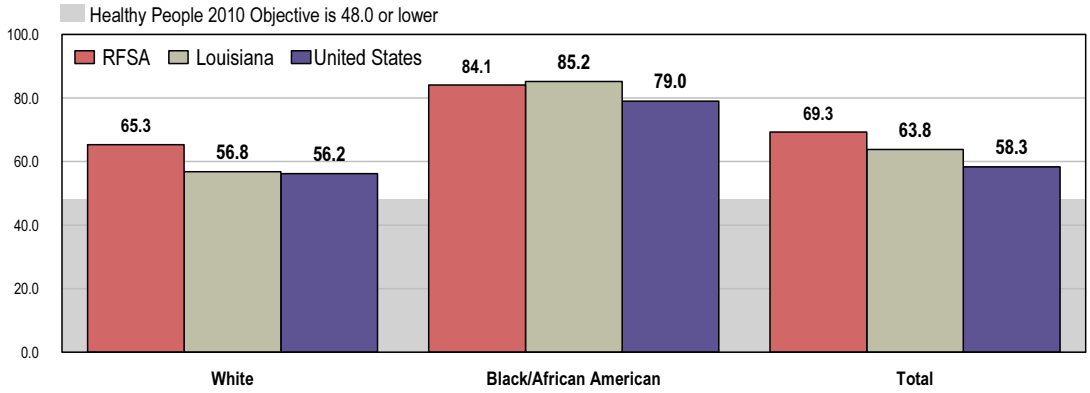
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office,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

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

- Stroke deaths in the RFSA are much higher among the Black/African American population when compared with Whites in the region. The same is true across both the state and nation overall.

Age-Adjusted Mortality: Stroke

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

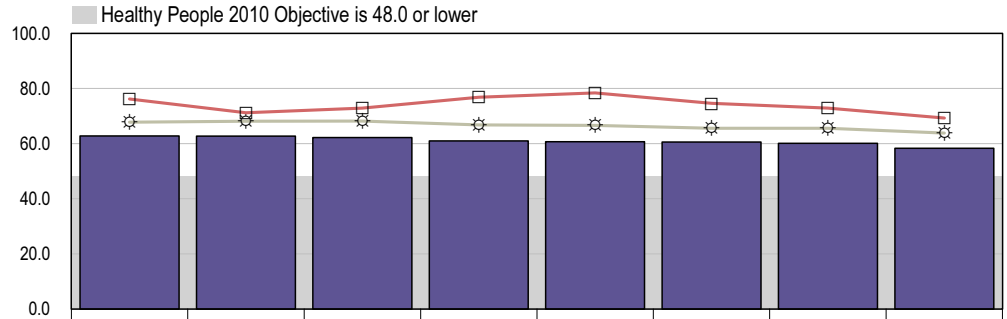
Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• State and national data are simple three-year averages, the RFSA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

TREND: Age-adjusted mortality due to stroke has trended downward since the late 1990s.

- Since 1993, rates across Louisiana and the U.S. overall have also trended downward.

Age-Adjusted Mortality: Stroke

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	76.2	71.2	72.9	76.8	78.4	74.6	72.9	69.3
Louisiana	67.8	68.1	68.2	66.8	66.6	65.6	65.6	63.8
United States	62.8	62.7	62.2	61.0	60.7	60.6	60.1	58.3

Source:
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Data for 1999 and subsequent years are not fully comparable to data from 1998 and prior years, due to changes in coding of causes of deaths resulting from the switch from the ninth revision of the International Classification of Diseases (ICD9) to the tenth revision (ICD10).
- State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

Prevalence Of Heart Disease & Stroke

Prevalence Of Heart Disease

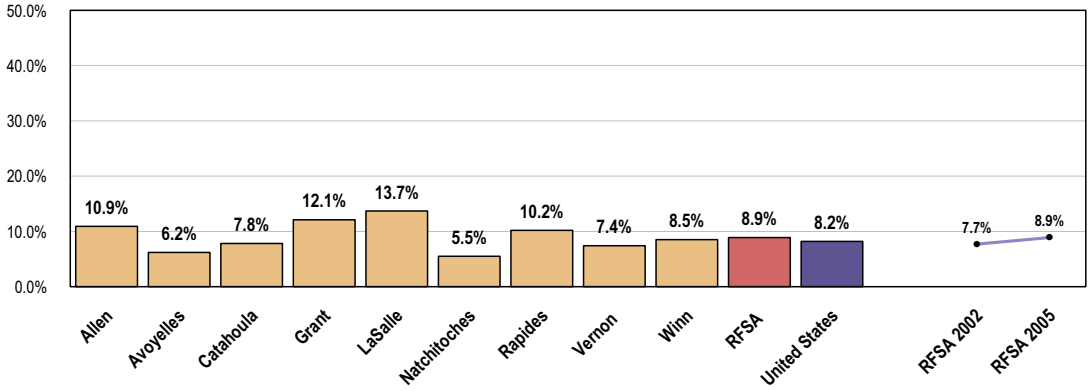
A total of 8.9% of RFSA adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Statistically similar to the 8.2% reported nationwide.
- Ranges from 5.5% in Natchitoches Parish to 13.7% in LaSalle Parish.

TREND: This year's prevalence of heart disease is statistically unchanged from 2002.

Prevalence Of Chronic Heart Disease

(By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 36]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• Respondents were asked if they have ever been diagnosed with chronic heart disease, including coronary heart disease, angina, or a heart attack.
• State data not available.

Prevalence Of Stroke

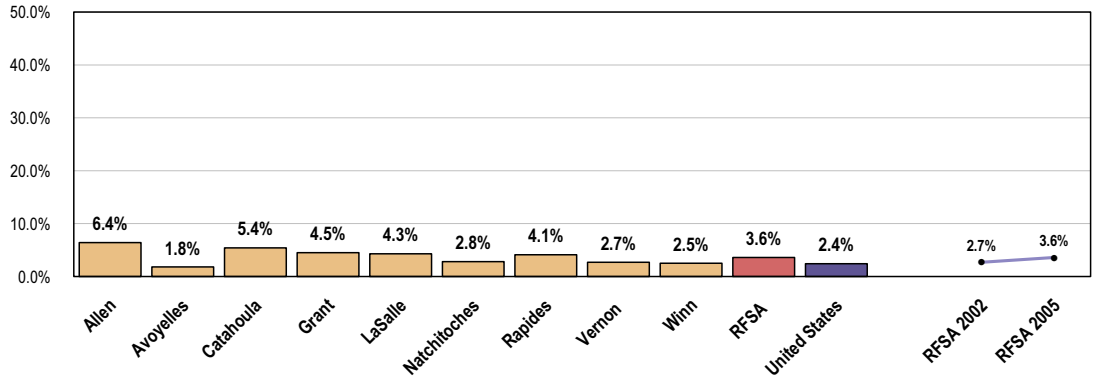
A total of 3.6% of RFSA adults report that they have suffered from or been diagnosed with cerebrovascular disease (stroke).

- Less favorable than the percentage noted nationwide.
- Ranges from 1.8% in Avoyelles Parish to 6.4% in Allen Parish.

TREND: Marks a *statistically significant increase* from the 2.7% reported in 2002.

Prevalence Of Stroke

(By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 37]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

Cardiovascular Risk Factors

Hypertension (High Blood Pressure)

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

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

High Blood Pressure Testing

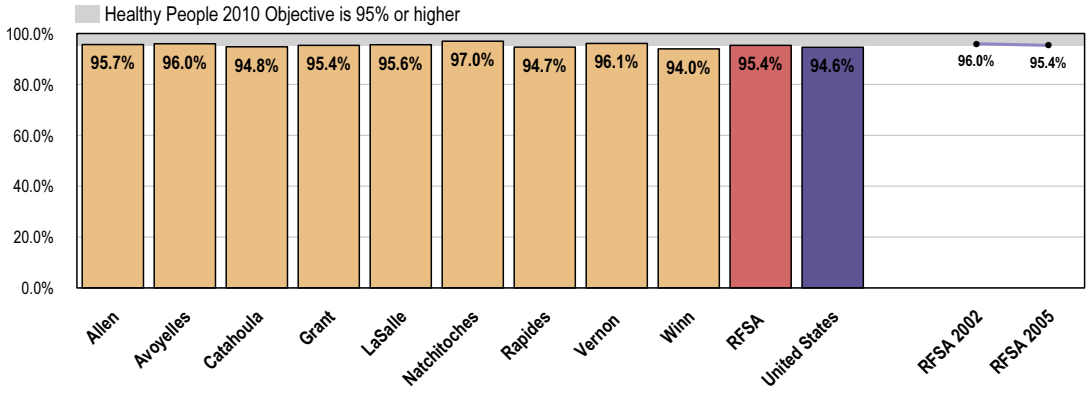
95.4% of RFSA adults have had their blood pressure tested within the past two years.

- A percentage was recorded throughout the U.S.
- Statistically similar to the Healthy People 2010 target (95% or higher).

TREND: Statistically unchanged from the 96.0% reported three years ago.

Have Had Blood Pressure Checked Within The Past Two Years

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 49]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-12]

Note:
- Reflects the total sample of respondents.
- State data not available.

Prevalence of Hypertension

38.2% of adults across the RFSA have been told at some point by a health professional that their blood pressure was high.

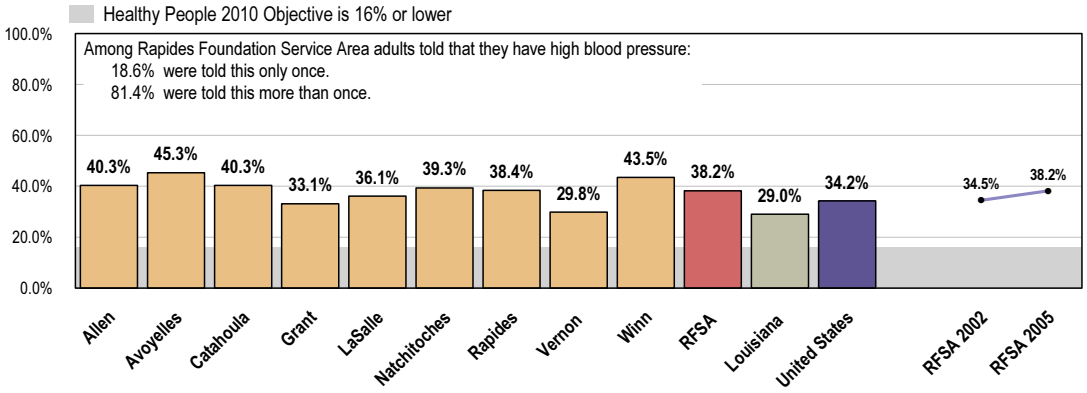
- Less favorable than the statewide prevalence of hypertension (29.0%).
- Less favorable than the 34.2% reported nationally.
- More than twice the Healthy People 2010 target (16% or lower).
- Ranges from 29.8% in Vernon Parish to 45.3% in Avoyelles Parish.

TREND: The 2005 proportion is statistically higher than the 34.5% reported in 2002.

Note also that 81.4% of persons reporting hypertension report that they have been told their blood pressure was high on more than one occasion.

Prevalence Of High Blood Pressure

(By Parish; 2002-2005 Trend Data)



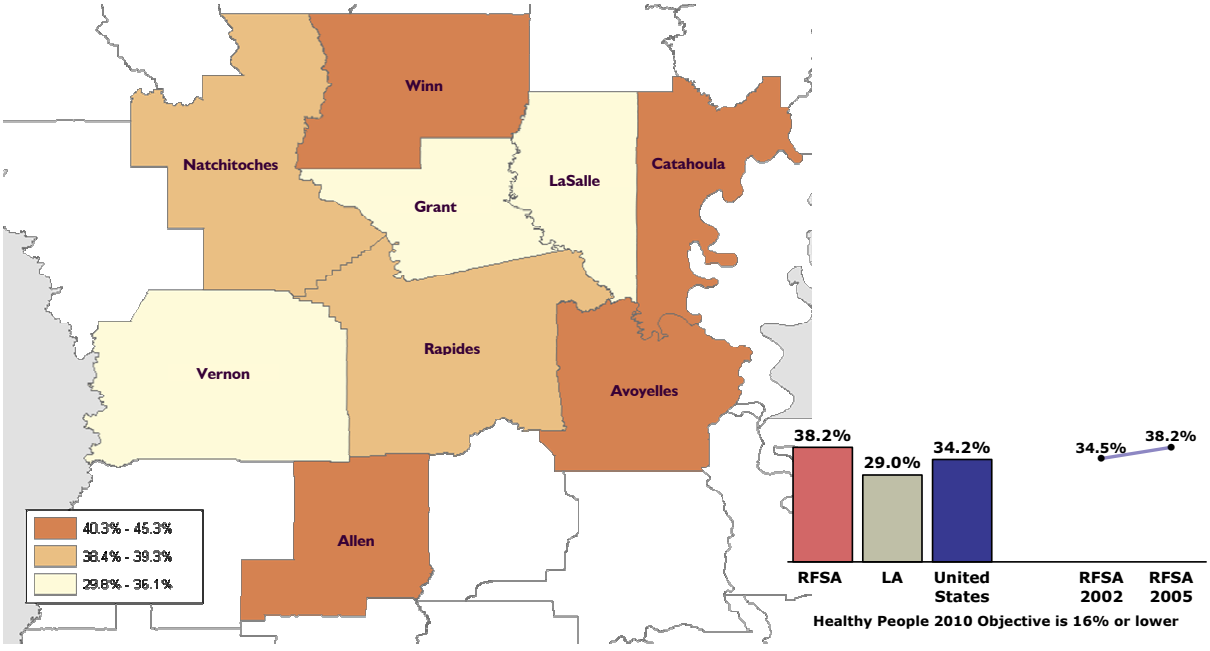
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 46,47]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2003 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-9]

Note:
- Reflects the total sample of respondents.

This is further described in the following map.

Prevalence Of High Blood Pressure

(By Parish, 2005)



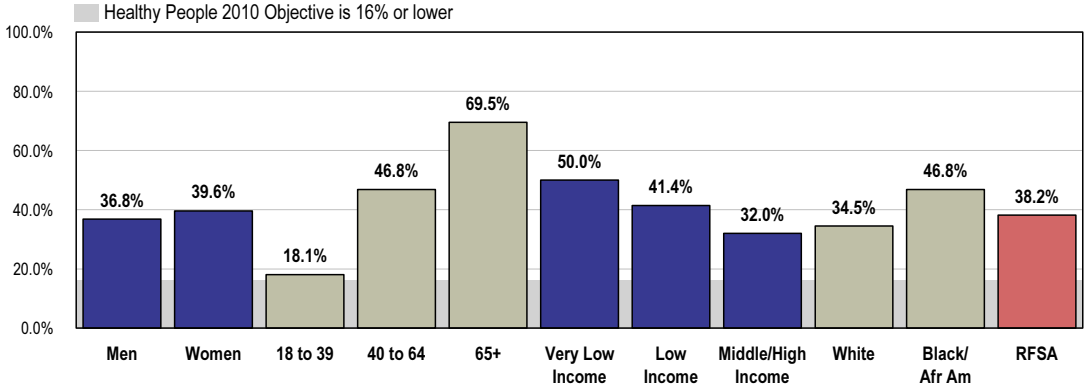
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 46,47]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2003 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-9]

Note:
- Reflects the total sample of respondents.

Demographic analysis reveals that only the 18-39 segment comes close to satisfying the Healthy People 2010 target, and prevalence is particularly high among older adults in the RFSA.

Prevalence Of High Blood Pressure

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 46]
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-9]

Note: • Reflects the total sample of respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Hypertension Management

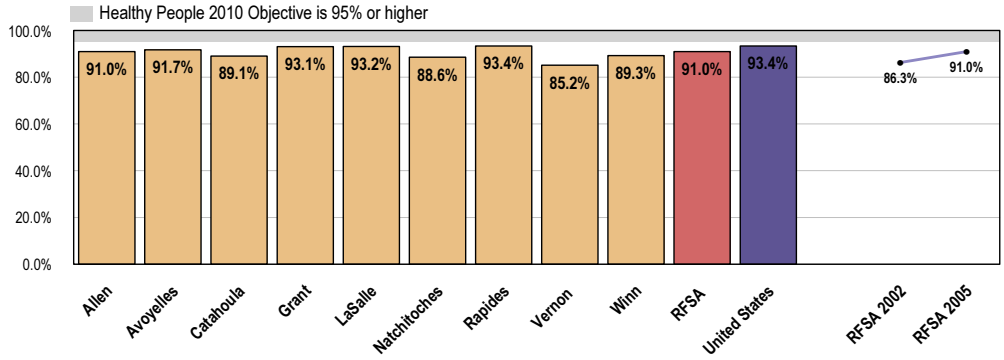
More than 9 in 10 adults (91.0%) with high blood pressure (multiple high readings) are currently taking action to control their hypertension (such as taking medication, changing diet, exercising).

- Nationwide, a similar percentage of hypertensive adults is taking action to control blood pressure levels.
- Fails to satisfy the Healthy People 2010 target (95% or higher).

TREND: Marks a *statistically significant increase* since 2002.

Taking Action To Control High Blood Pressure

(Among Respondents With High BP Readings; By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 48]
• 2005 PRC National Health Survey, Professional Research Consultants.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-11]

Note: • Asked of respondents who have been told that their blood pressure was high.
• In this case, the term "action" includes medication, change in diet, and/or exercising.
• State data not available.

High Blood Cholesterol

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

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

Blood Cholesterol Testing

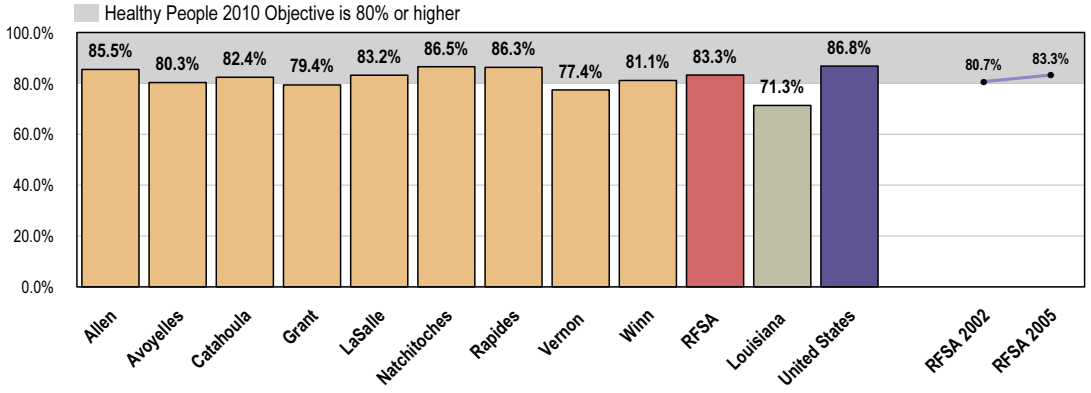
83.3% of surveyed adults have had their blood cholesterol checked within the past five years.

- Much higher than the statewide prevalence.
- Less favorable than the 86.8% reported nationwide.
- Meets the Healthy People 2010 target (80% or higher).

TREND: This year's proportion marks a *statistically significant increase* from 80.7% in 2002.

Have Had Blood Cholesterol Level Checked Within The Past Five Years

(By Parish; 2002-2005 Trend Data)



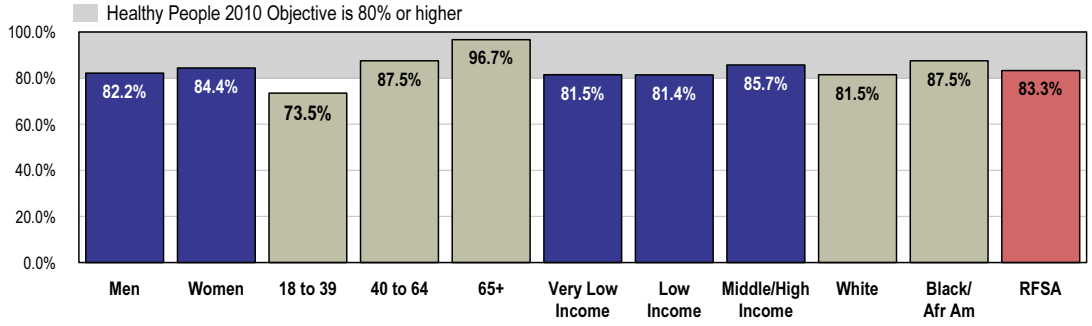
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 52]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2003 Louisiana data.
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-15]

Note:
- Reflects the total sample of respondents.

Note in the following chart that young adults (aged 18 to 39) exhibit notably lower percentages.

Have Had Blood Cholesterol Level Checked Within The Past Five Years

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 52]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-15]

Note:
- Reflects the total sample of respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Prevalence Of High Blood Cholesterol

30.1% of adults throughout the RFSA have been told by a health professional that their cholesterol level was high.

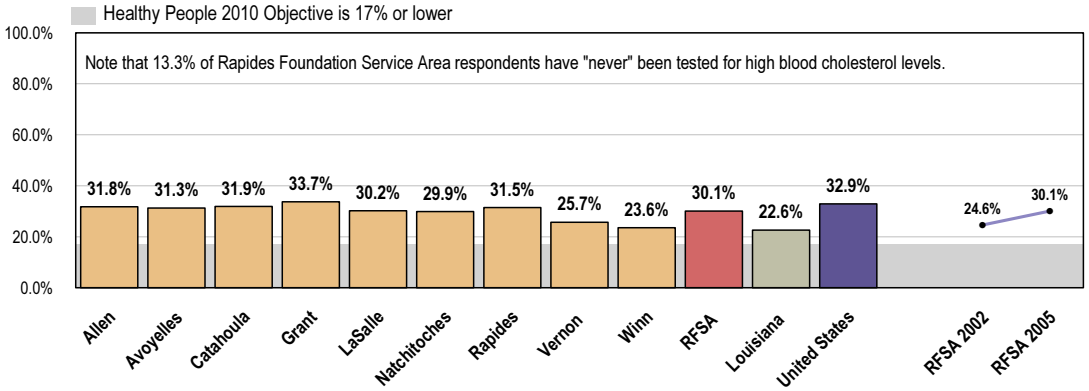
- Less favorable than the statewide prevalence.
- Comparable to that found nationwide (32.9%).
- Fails to satisfy the Healthy People 2010 target (17% or lower).

TREND: Denotes a *statistically significant increase* from the prevalence reported in 2002.

Note that another 13.3% of RFSA adults have never had their blood cholesterol tested, meaning that the true prevalence of high blood cholesterol is likely higher still.

Prevalence Of High Blood Cholesterol

(By Parish; 2002-2005 Trend Data)



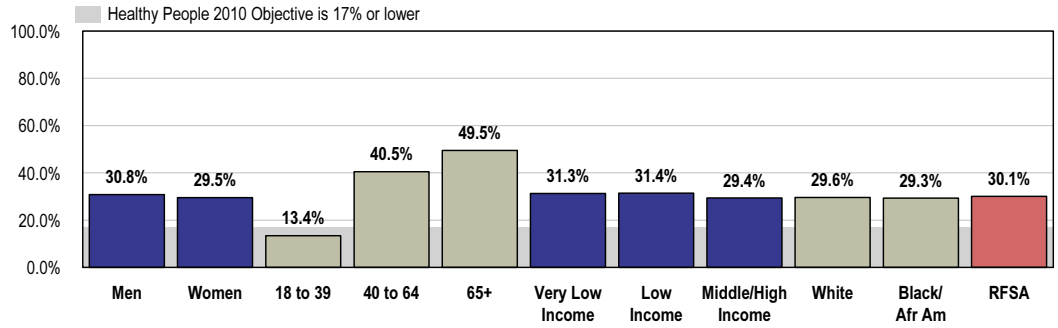
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 50]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2003 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-14]

Note:
- Reflects the total sample of respondents.

- There is again a strong positive correlation with age.

Prevalence Of High Blood Cholesterol

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 50]
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-14]

Note: • Reflects the total sample of respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Cholesterol Management

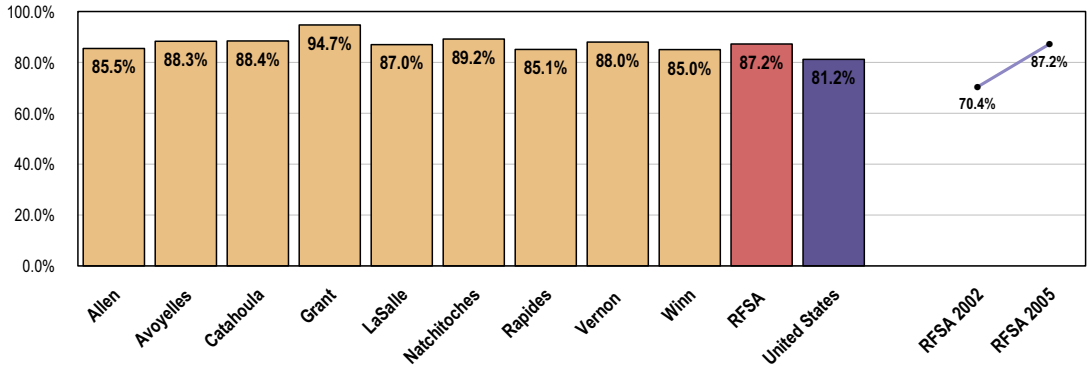
Among adults who have been diagnosed with high cholesterol levels, 87.2% are currently taking action to control their cholesterol (such as medication, change in diet, and/or exercising).

- More favorable than the prevalence reported throughout the U.S. overall.

TREND: Marks a *statistically significant increase* since 2002.

Taking Action To Control High Blood Cholesterol

(Among Respondents With High Blood Cholesterol; By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 51]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of respondents who have been told that their blood cholesterol was high.
• In this case, the term "action" includes medication, change in diet, and/or exercising.
• State data not available.

Total Cardiovascular Risk

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

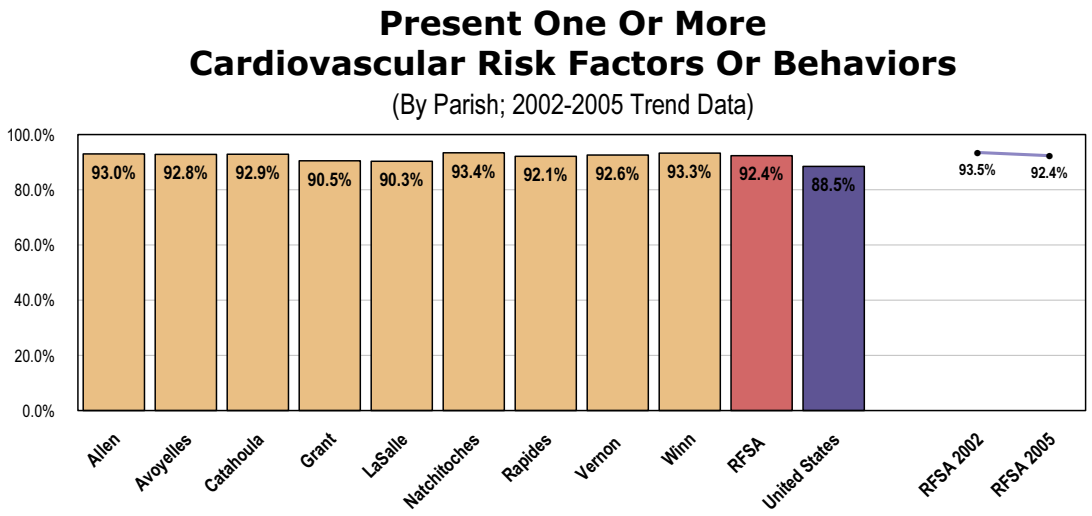
- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

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

More than 9 out of 10 RFSA adults exhibit one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Less favorable than the 88.5% reported nationwide.

TREND: Statistically unchanged since 2002.

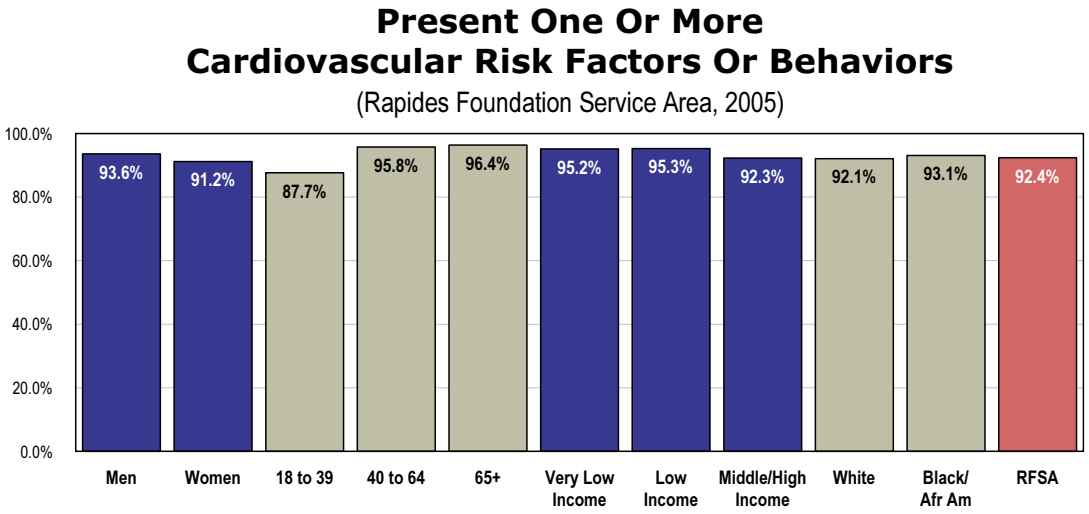


Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 142]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Includes respondents reporting any of the following: overweight, cigarette smoking, high blood pressure, high cholesterol, or physical inactivity.
• State data not available.

By RFSA demographics:

- Adults aged 40 and older are at greater risk than younger adults.



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 142]
Note: • Includes respondents reporting any of the following: overweight, cigarette smoking, high blood pressure, high cholesterol, or physical inactivity.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Three health-related behaviors contribute markedly to cardiovascular disease:

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

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

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

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

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

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

CANCER

Cancer, the second leading cause of death among Americans, is responsible for one of every four deaths in the United States. In 2005, over half a million Americans—or more than 1,500 people a day—will die of cancer. Black Americans are more likely to die from cancer than people of any other racial or ethnic group.

The financial costs of cancer are staggering. According to the National Institutes of Health, cancers cost the United States more than $170 billion in 2002. This includes more than $110 billion in lost productivity and over $60 billion in direct medical costs.

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

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

Age-Adjusted Cancer Deaths

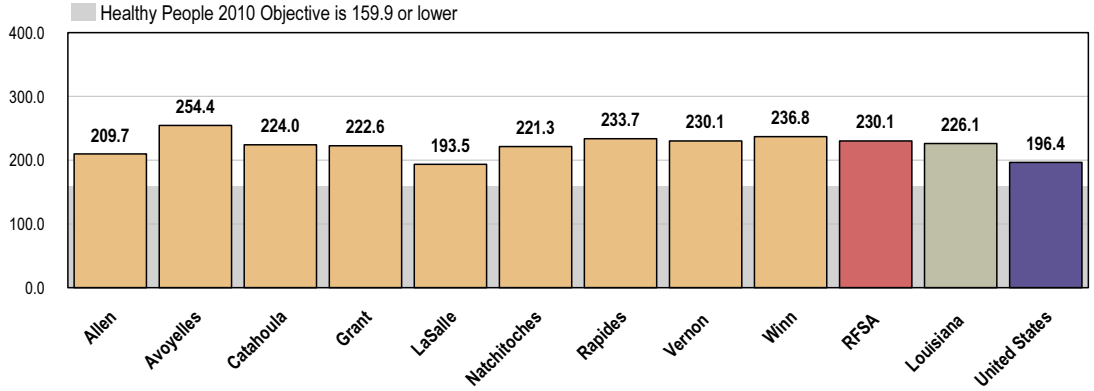
All Cancer Deaths

Between 2000 and 2002, there was an annual average age-adjusted cancer death rate of 230.1 deaths per 100,000 population in the RFSA.

- Comparable to the state rate (226.1).
- Less favorable than the 196.4 reported nationwide.
- Ranges from 193.5 in LaSalle Parish to 254.4 in Avoyelles Parish.

Age-Adjusted Mortality: Cancer

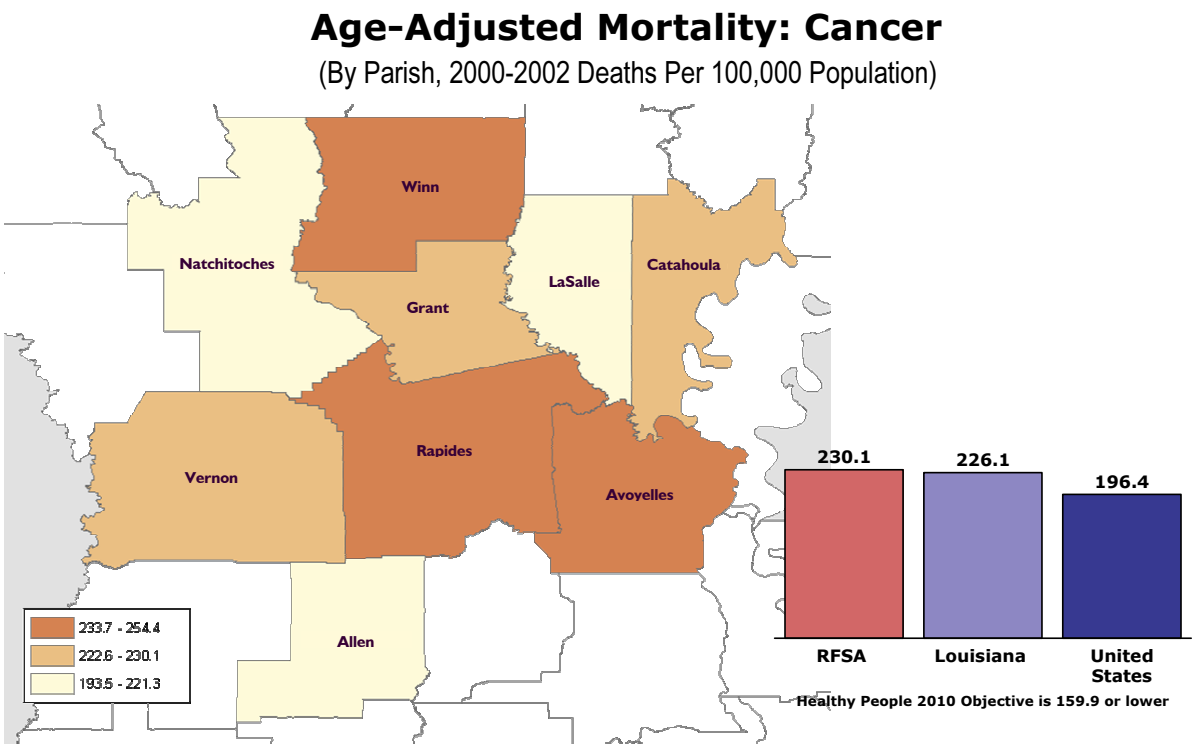
(By Parish; 2000-2002 Deaths Per 100,000 Population)



Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

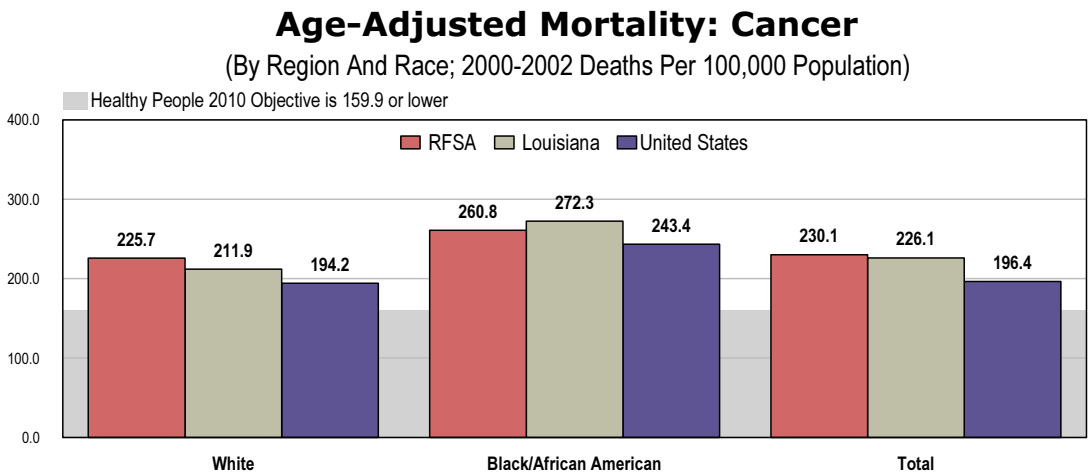
Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Parish, state and national data are simple three-year averages,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

Note the distribution of rates among the nine-parishes of the RFSA.



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office,Division of Public Health Surveillance and Informatics.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.
Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Parish, county, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

Higher among Blacks/African Americans than among Whites in the RFSA.

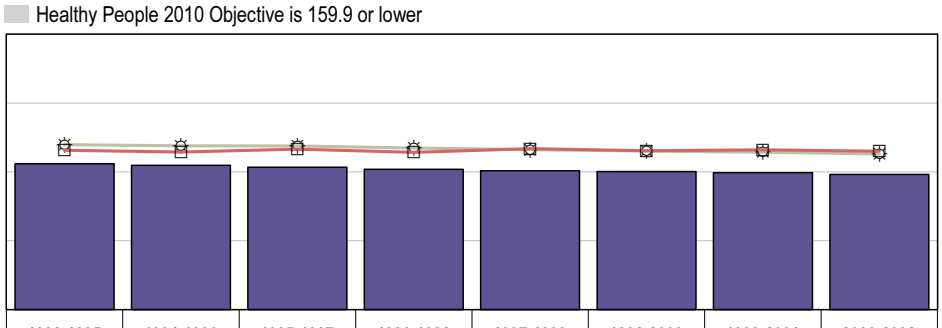


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.
Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

TREND: Cancer death rates in the RFSA remained fairly stable in recent years, differing from the downward trend seen across Louisiana and the United States.

Age-Adjusted Mortality: Cancer

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	231.4	228.9	233.1	228.4	233.7	230.7	232.1	230.1
Louisiana	239.5	237.8	237.6	234.7	232.4	230.2	228.7	226.1
United States	211.7	209.4	206.7	203.6	201.6	200.4	198.8	196.4

Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

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

Leading Cancer Diagnoses By Site

LUNG CANCER

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

PROSTATE CANCER

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

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

FEMALE BREAST CANCER

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

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

COLORECTAL CANCER

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

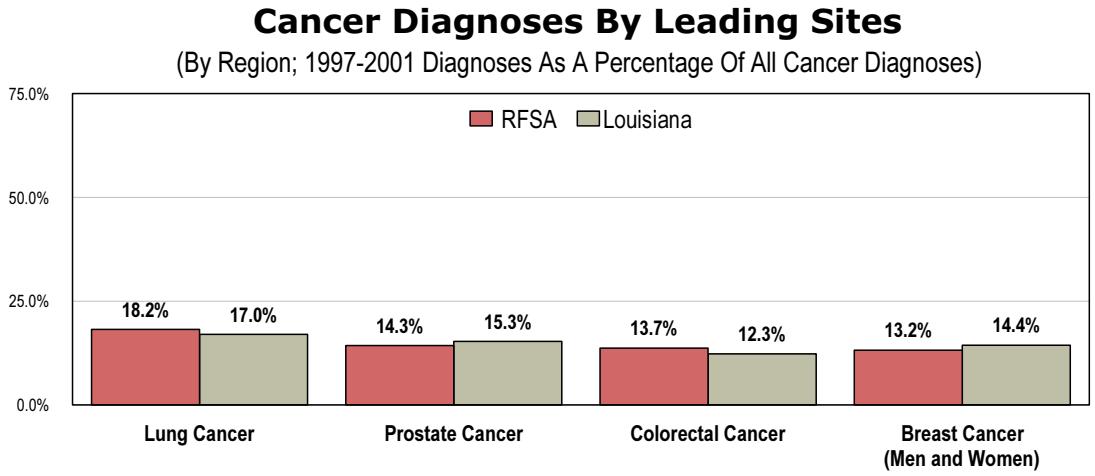
Risk factors for CRC may include age, personal and family history of polyps or colorectal cancer, inflammatory bowel disease, inherited syndromes, physical inactivity (colon only), obesity, alcohol use, and a diet high in fat and low in fruits and vegetables. Detecting and removing precancerous colorectal polyps and detecting and treating the disease in its earliest stages will reduce deaths from CRC. Fecal occult blood testing and sigmoidoscopy are widely used to screen for CRC, and barium enema and colonoscopy are used as diagnostic tests.

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

Cancer Diagnoses By Site

Lung cancer is the leading cancer diagnosis across the RFSA.

- Other leading diagnoses include prostate cancer, colorectal cancer, and breast cancer.

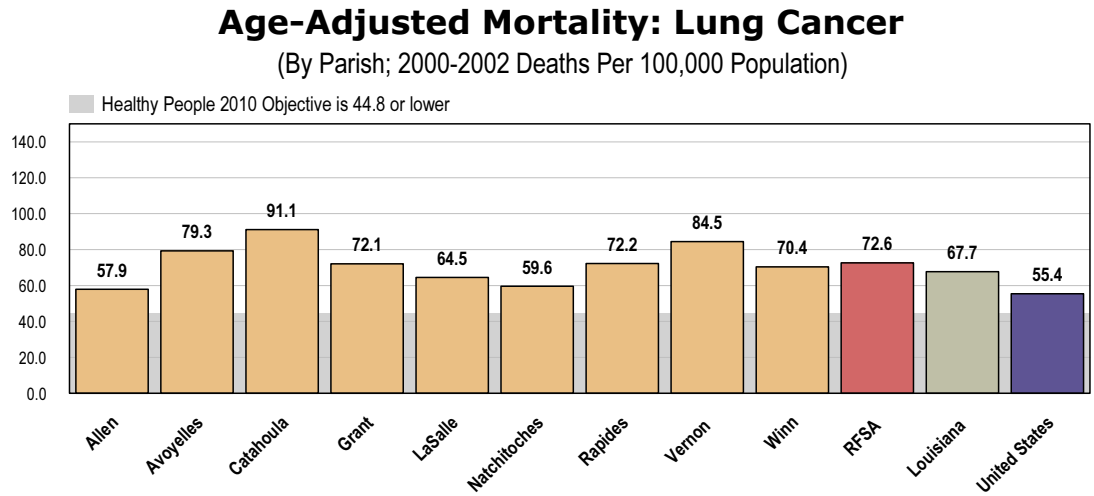


Source: • Lousiana Department of Health & Hospitals; 1997-2001 data.
Note: • Numbers represent percentage of diagnoses as a ratio of all cancer diagnoses.
• National data not available.

Lung Cancer Deaths

Between 2000 and 2002, there was an annual average age-adjusted lung cancer death rate of 72.6 deaths per 100,000 population in the RFSA.

- Less favorable than the 67.7 recorded throughout Louisiana.
- Well above the 55.4 recorded across the United States.
- Ranges from 57.9 in Allen Parish to 91.1 in Catahoula Parish.



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 3-2].
Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Parish, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

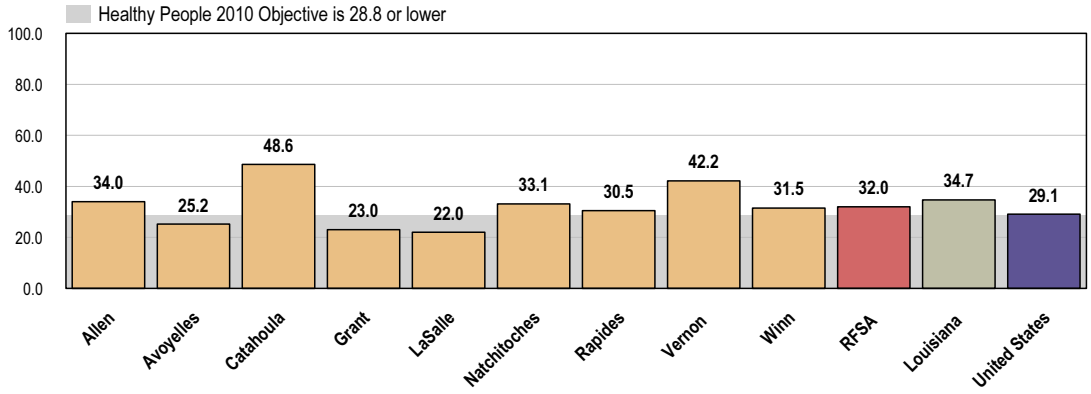
Prostate Cancer Deaths

Between 2000 and 2002, there was an annual average age-adjusted prostate cancer death rate of 32.0 deaths per 100,000 male population in the RFSA.

- Statewide, prostate cancer claimed 34.7 lives per 100,000 males.
- Less favorable than the 29.1 found nationwide.
- Fails to meet the Healthy People 2010 objective of 28.8 or lower.
- Highest (48.6) in Catahoula Parish.

Age-Adjusted Mortality: Prostate Cancer

(By Parish; 2000-2002 Deaths Per 100,000 Male Population)



Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

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

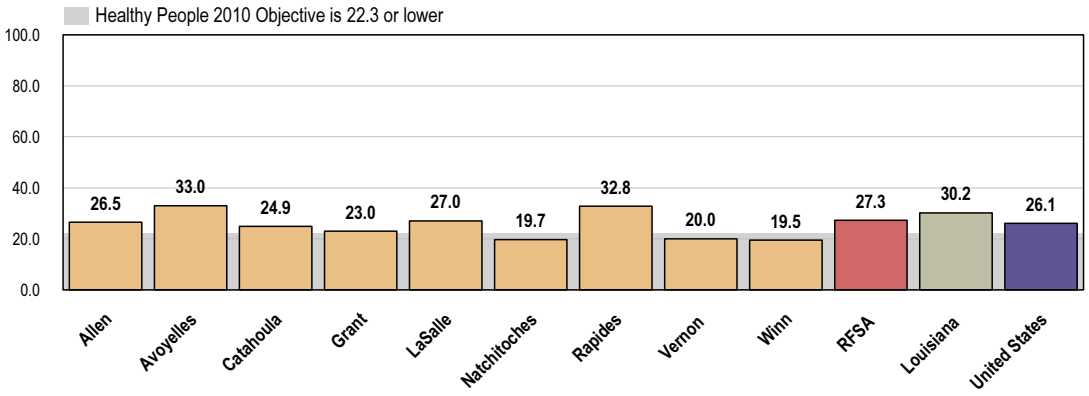
Female Breast Cancer Deaths

Between 2000 and 2002, there was an annual average age-adjusted female breast cancer death rate of 27.3 deaths per 100,000 female population in the RFSA.

- More favorable than the state rate (30.2).
- Above the national rate of 26.1 per 100,000 females.
- Fails to satisfy the related Healthy People 2010 objective of 22.3 or lower.
- Higher in Avoyelles and Rapides parishes.

Age-Adjusted Mortality: Female Breast Cancer

(By Parish; 2000-2002 Deaths Per 100,000 Female Population)



Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

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

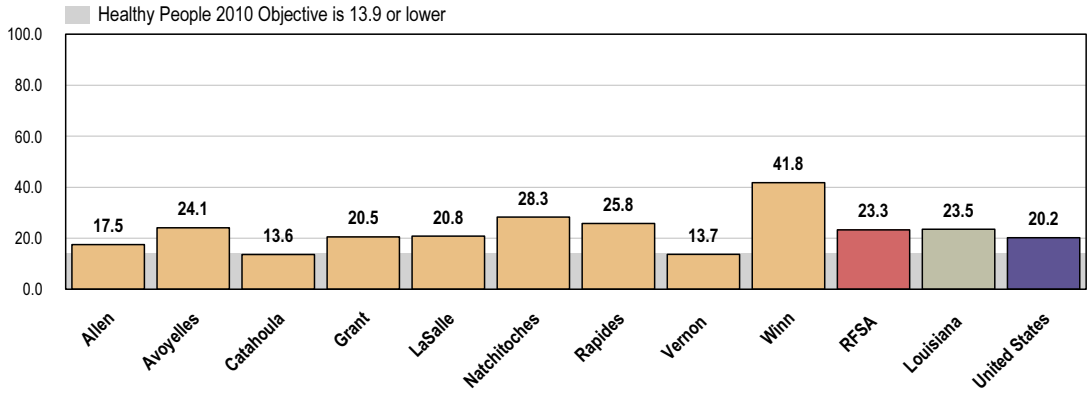
Colorectal Cancer Deaths

Between 2000 and 2002, there was an annual average age-adjusted colorectal cancer death rate of 23.3 deaths per 100,000 population in the RFSA.

- Nearly identical to the 23.5 reported across Louisiana.
- Higher than the U.S. rate (20.2) for the same time period.
- Fails to satisfy the related Healthy People 2010 objective of 13.9 or lower.
- Ranges from 13.7 in Vernon Parish to 41.8 in Winn Parish.

Age-Adjusted Mortality: Colorectal Cancer

(By Parish; 2000-2002 Deaths Per 100,000 Population)



Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

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

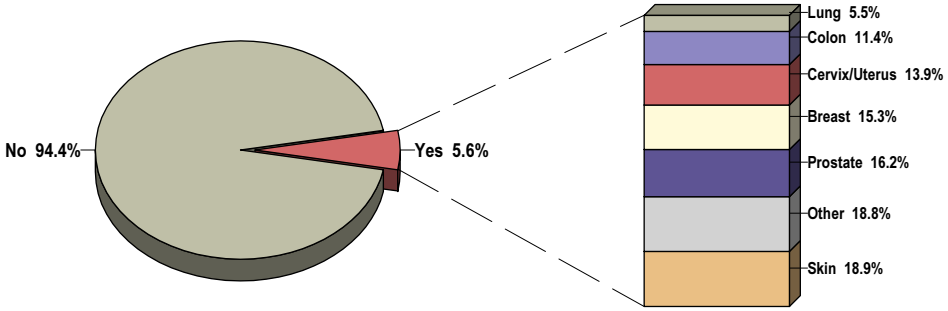
Prevalence Of Cancer

A total of 5.6% of surveyed adults report having been diagnosed with cancer.

- Represents nearly 14,500 RFSA adults.
- Most common types of cancers reported include skin, prostate, breast, and cervix/uterus.

Prevalence Of Cancer

(Rapides Foundation Service Area, 2005)

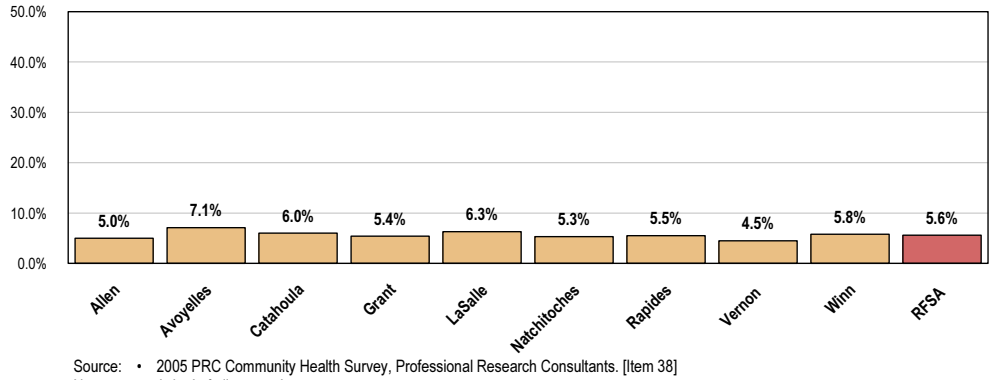


Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Items 38, 39]
Note: • Asked of all respondents.

- Relatively uniform when viewed by parish.

Prevalence Of Cancer

(By Parish, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 38]
Note: • Asked of all respondents.

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

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

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

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

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup as part of a routine 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 parish were measured in the survey relative to four cancers: 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

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

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

– American Cancer Society

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

PSA Testing And/Or Digital Rectal Examination

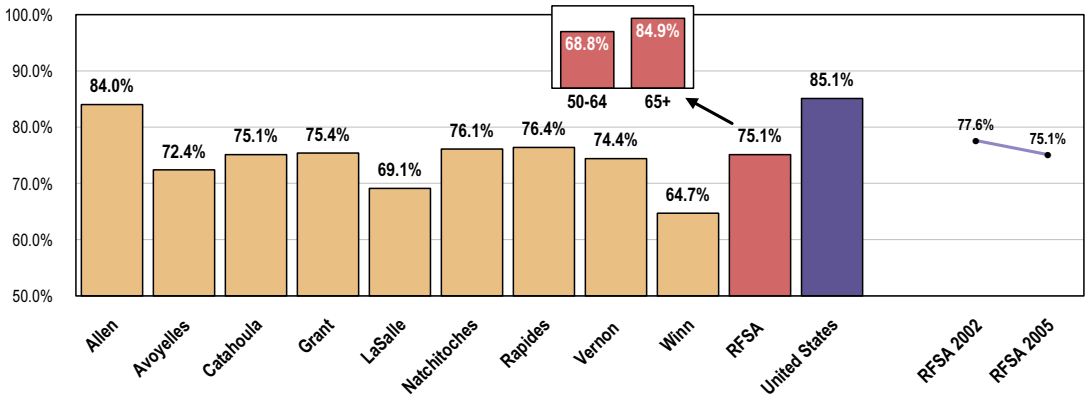
75.1% of surveyed men aged 50 and older had a PSA (prostate-specific antigen) test and/or a digital rectal exam to check for prostate cancer within the past two years.

- Less favorable than the 85.1% reported among men 50+ across the nation.
- Ranges from 64.7% in Winn Parish to 84.0% in Allen Parish.
- Higher (84.9%) among males aged 65 and older.

TREND: This year's finding is statistically unchanged from 2002.

Have Had A Prostate-Specific Antigen (PSA) Test And/Or A Digital Rectal Exam In Past Two Years

(Among Men Aged 50 And Older; By Parish And Age; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 158]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Reflects male respondents aged 50 and older.
• State data not available.

Female Breast Cancer Screening

Screenings for female breast cancer are recommended as outlined below:

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

– American Cancer Society

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

Mammography

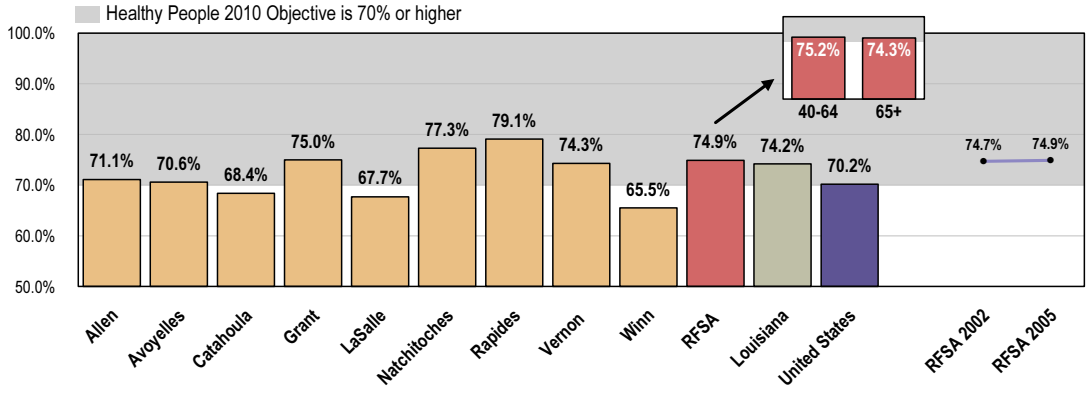
74.9% of women aged 40 and older have had a mammogram within the past two years.

- Similar to the national prevalence of 70.2%.
- Satisfies the Healthy People 2010 target (70% or higher).
- Ranges from 65.5% in Winn Parish to 79.1% in Rapides Parish.

TREND: This year's proportion is not statistically different from 2002 data.

Have Had A Mammogram In The Past Two Years

(Among Women Aged 40 And Older; By Parish And Age; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 156]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-13]

Note:
- Reflects women aged 40 and over.

Cervical Cancer Screenings

Screenings for cervical cancer are recommended as outlined below:

- All women should begin cervical cancer screening about 3 years after they begin having vaginal intercourse, but no later than when they are 21 years old. Screening should be done every year with the regular Pap test or every 2 years using the newer liquid-based Pap test.
- Beginning at age 30, women who have had 3 normal Pap test results in a row may get screened every 2 to 3 years with either the conventional (regular) or liquid-based Pap test. Women who have certain risk factors such as diethylstilbestrol (DES) exposure before birth, HIV infection, or a weakened immune system due to organ transplant, chemotherapy, or chronic steroid use should continue to be screened annually.
- Another reasonable option for women over 30 is to get screened every 3 years (but not more frequently) with either the conventional or liquid-based Pap test, *plus* the HPV DNA test.
- Women 70 years of age or older who have had 3 or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system should continue to have screening as long as they are in good health.
- Women who have had a total hysterectomy (with removal of the uterus and cervix) may also choose to stop having cervical cancer screening, unless the surgery was done as a treatment for cervical cancer or precancer.

– American Cancer Society

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

Pap Smear Testing

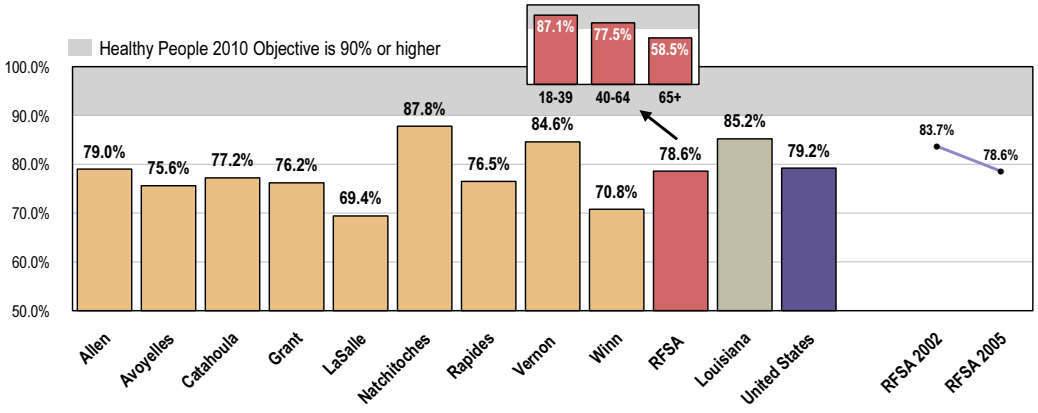
78.6% of women aged 18 and older have had a Pap smear within the past three years.

- Less favorable than the state proportion (85.2%).
- Similar to the 79.2% reported nationwide.
- Fails to satisfy the Healthy People 2010 target (90% or higher).

TREND: The current proportion marks a *statistically significant decrease* from 2002.

Have Had A Pap Smear Within The Past Three Years

(Among Women Aged 18 And Older; By Parish And Age; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 85]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-11]

Note:
- Asked of all female respondents.

Colorectal Cancer Screenings

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

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

*For FOBT, the take-home multiple sample method should be used.
**The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.

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

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

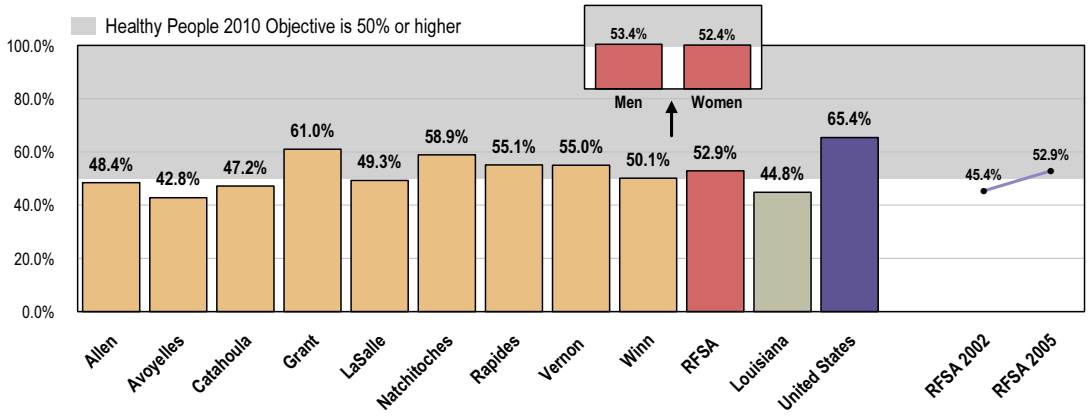
Sigmoidoscopy/Colonoscopy

52.9% of RFSA adults aged 50 and older have had a sigmoidoscopy (or colonoscopy) at some point in their lives.

- Higher than the 44.8% reported across Louisiana.
- Much less favorable than the U.S. prevalence of 65.4%.
- Satisfies the Healthy People 2010 target (50% or higher).
- Includes 53.4% of RFSA men 50+ and 52.4% of RFSA women 50+.
- Ranges from 42.8% in Avoyelles Parish to 61.0% in Grant Parish.

TREND: Marks a *statistically significant increase* from the 45.4% reported in the RFSA in 2002.

Have Ever Had A Sigmoidoscopy/Colonoscopy Examination
(Among Persons Aged 50 And Older; By Parish And Gender; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 160]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-12b]

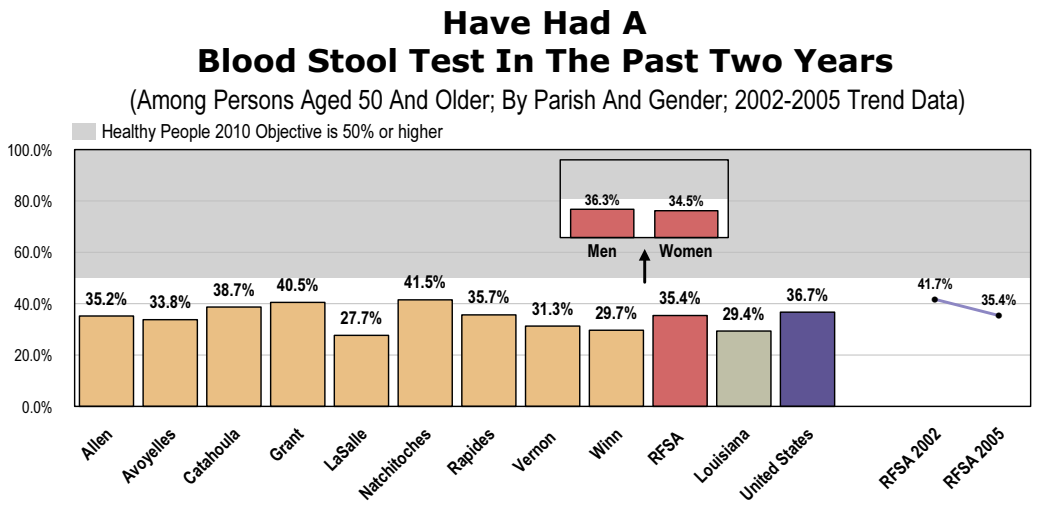
Note:
- Asked of all respondents aged 50 or over.

Blood Stool Testing

35.4% of surveyed adults aged 50 and older have had a blood stool test (a.k.a. fecal occult blood test) within the past two years.

- More favorable than the 29.4% reported across Louisiana.
- Comparable to the 36.7% found nationwide.
- Fails to satisfy the Healthy People 2010 target (50% or higher).
- Includes 36.3% of men 50+ and 34.5% of women 50+.

TREND: Currently *significantly lower* than the 41.7% recorded in 2002.



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 161]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-12b]

Note:
- Asked of all respondents aged 50 or over.

RESPIRATORY DISEASE

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

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

- Inflammation of the airways is the common finding in all asthma patients. Recent studies indicate that this inflammation is virtually always causative in the asthmatic condition. This inflammation is produced by allergy, viral respiratory infections, and airborne irritants among others. Childhood asthma is a disorder with genetic predispositions and a strong allergic component. Approximately 75% to 80% of children with asthma have significant allergies.

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

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

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

Age-Adjusted Respiratory Disease Deaths

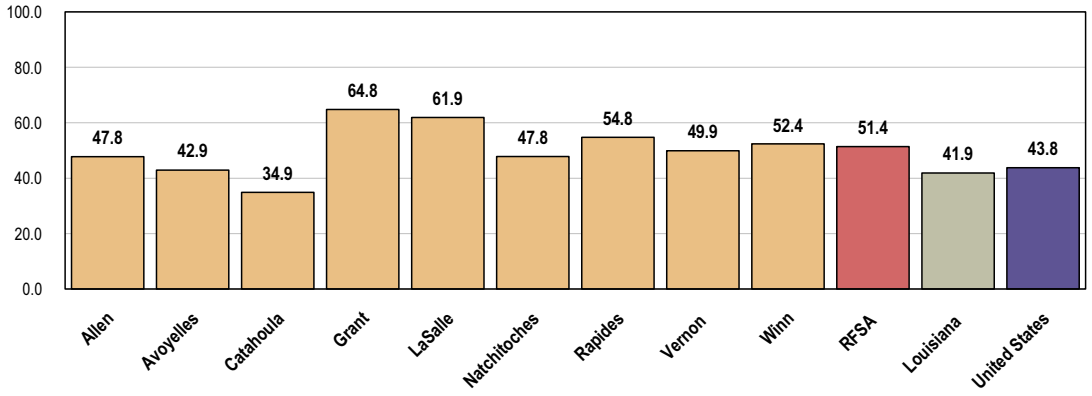
Chronic Lower Respiratory Disease (CLRD) Deaths

Between 2000 and 2002, there was an annual average age-adjusted CLRD death rate of 51.4 deaths per 100,000 population in the RFSA.

- Less favorable than the 41.9 rate reported statewide and the 43.8 nationwide.
- Ranges from 34.9 in Catahoula Parish to 64.8 in Grant Parish.

Age-Adjusted Mortality: CLRD

(By Parish; 2000-2002 Deaths Per 100,000 Population)



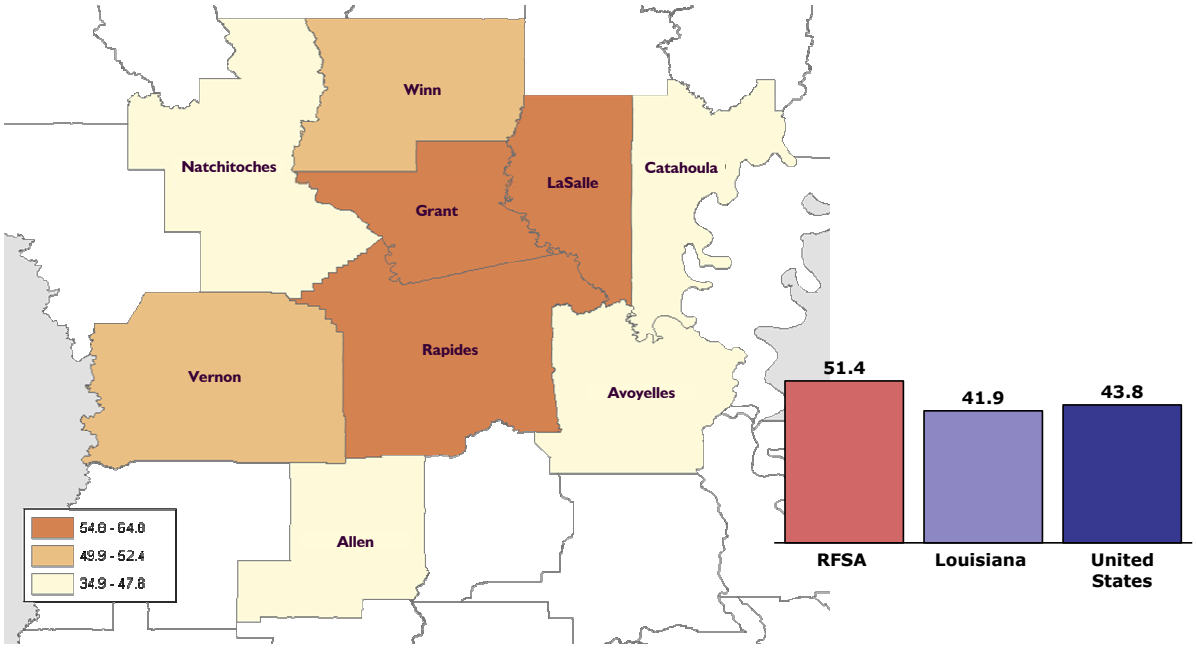
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Parish, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
• CLRD is "chronic lower respiratory disease".

The highest CLRD mortality rates are found in Grant, LaSalle and Rapides parishes.

Age-Adjusted Mortality: CLRD

(By Parish, 2000-2002 Deaths Per 100,000 Population)



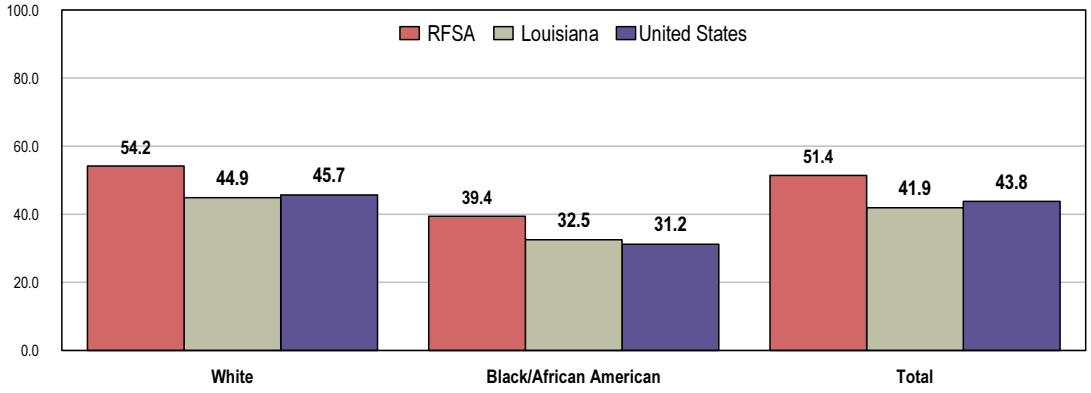
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.

Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Parish, county, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
• CLRD is "chronic lower respiratory disease".

CLRD death rates (age-adjusted) are much higher among Whites (54.2) than Blacks/African Americans (39.4).

Age-Adjusted Mortality: CLRD

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

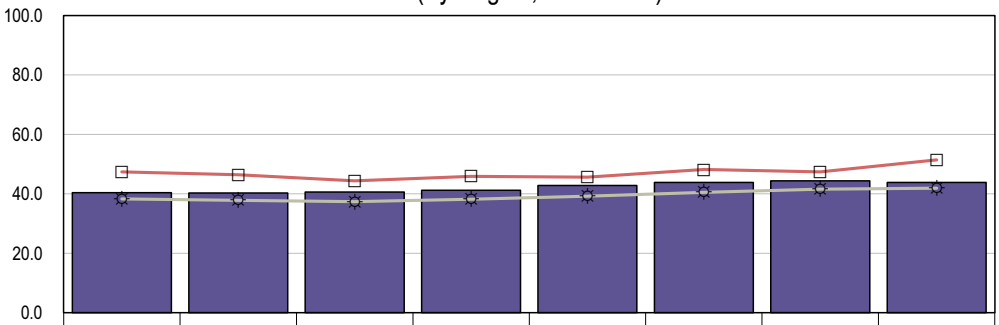
Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Parish, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
• CLRD is "chronic lower respiratory disease".

TREND: Age-adjusted mortality due to CLRD has trended upward in recent years.

- Note: Death rates before and after 1998 are not fully comparable due to changes in the death coding system beginning in 1999.

Age-Adjusted Mortality: CLRD

(By Region, 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	47.4	46.4	44.4	45.9	45.6	48.2	47.4	51.4
Louisiana	38.3	37.8	37.4	38.2	39.2	40.5	41.6	41.9
United States	40.4	40.3	40.6	41.2	42.8	43.8	44.4	43.8

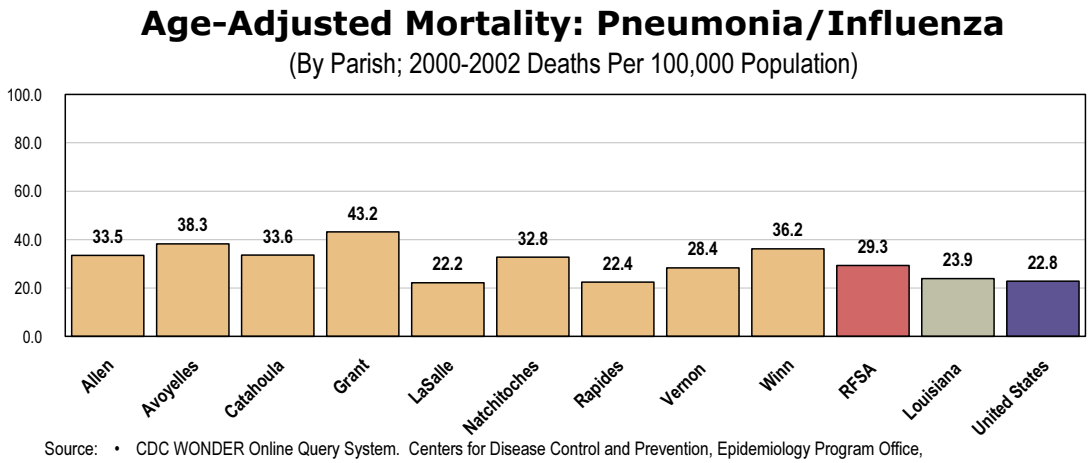
Source: • Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States.
• CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Data for 1999 and subsequent years are not fully comparable to data from 1998 and prior years, due to changes in coding of causes of deaths resulting from the switch from the ninth revision of the International Classification of Diseases (ICD9) to the tenth revision (ICD10).
• State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
• CLRD is "chronic lower respiratory disease".

Pneumonia/Influenza Deaths

Between 2000 and 2002, there was an annual average age-adjusted pneumonia/ influenza death rate of 29.3 deaths per 100,000 population in the RFSA.

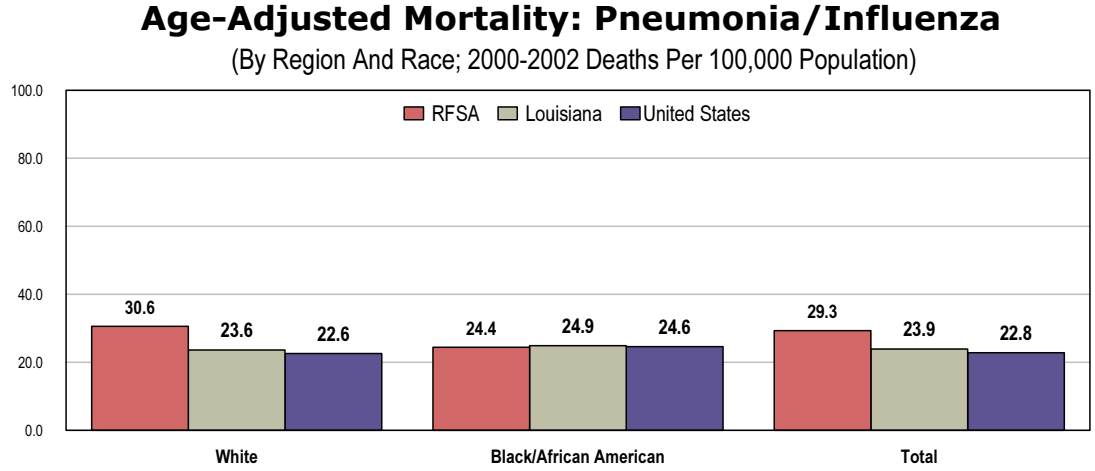
- Less favorable than the rates reported statewide and nationwide.
- Ranges from 22.2 in LaSalle Parish to 43.2 in Grant Parish.



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

- Mortality due to pneumonia/influenza is higher among Whites (30.6) than Blacks/African Americans (24.4) across the RFSA.



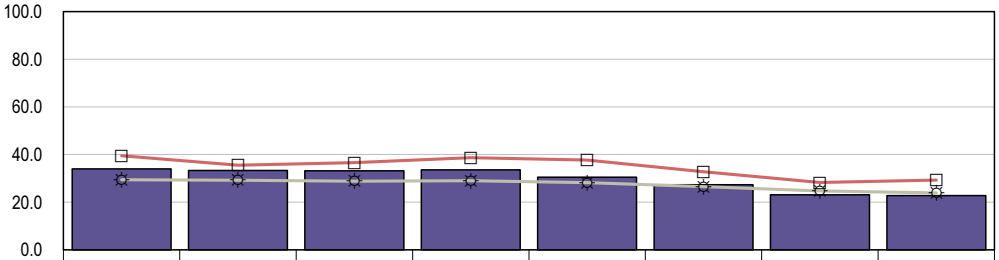
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

TREND: Pneumonia/influenza death rates have trended downward in recent years.

Age-Adjusted Mortality: Pneumonia/Influenza

(By Region, 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	39.5	35.5	36.6	38.7	37.7	32.8	28.3	29.3
Louisiana	29.4	29.2	28.8	29.0	28.2	26.5	24.7	23.9
United States	34.0	33.3	33.2	33.6	30.5	27.3	23.1	22.8

Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

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

Prevalence Of Asthma

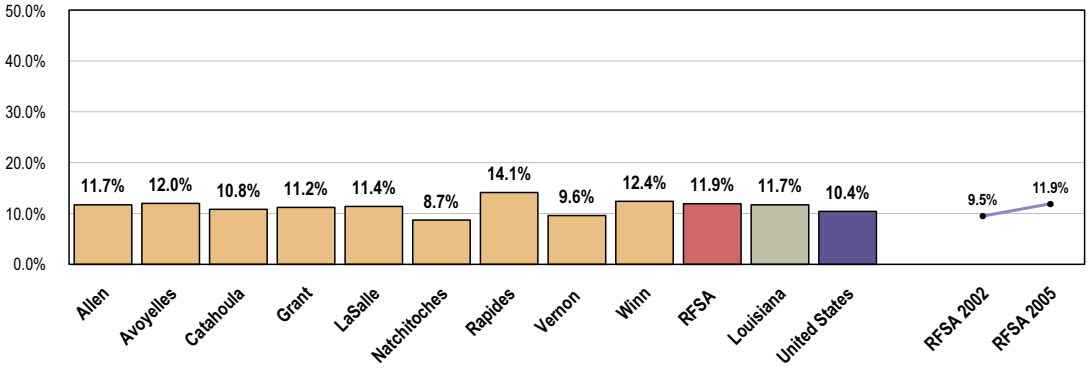
11.9% of RFSA adults report having been diagnosed with asthma.

- Close to the 10.4% reported nationwide.
- Highest (14.1%) in Rapides Parish.

TREND: Marks a *statistically significant increase* from the 9.5% found across the RFSA in 2002.

Prevalence Of Asthma

(By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 41]
• 2005 PRC National Health Survey, Professional Research Consultants.
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.

Note: • Asked of all respondents.

Among respondents having ever been diagnosed with asthma, 67.7% report that they still have this condition.

Asthma In Children

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

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

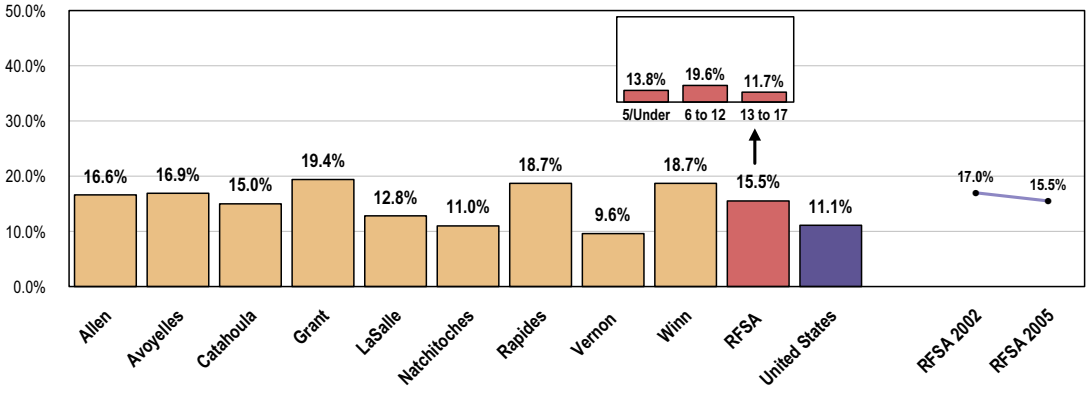
In all, 15.5% of surveyed parents report that their child (aged 0 to 17) has been diagnosed with asthma.

- Less favorable than the 11.1% reported nationwide.
- Ranges from 9.6% in Vernon Parish to 19.4% in Grant Parish.
- Higher (19.6%) among RFSA children between the ages of 6 and 12.

TREND: Has not changed significantly since 2002.

Child Has Asthma

(Among Respondents With Children Aged 0-17; By Parish And Age; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 125]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of respondents with children aged 0-17.
• State data not available.

Prevalence Of Chronic Lung Disease

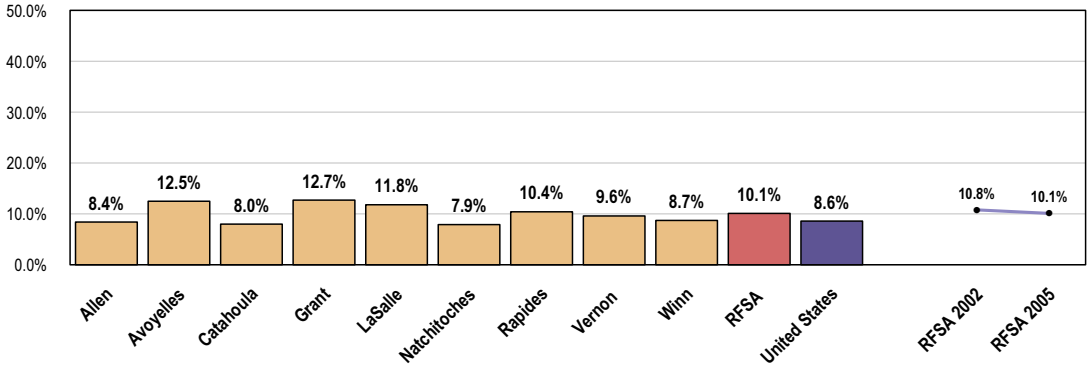
A total of 10.1% of RFSA survey respondents report suffering from chronic lung disease.

- Similar to the 8.6% reported nationwide.
- Ranges from 7.9% in Natchitoches Parish to 12.7% in Grant Parish.

TREND: Statistically unchanged from the 10.8% found in the RFSA in 2002.

Prevalence Of Chronic Lung Disease

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 32]
- 2005 PRC National Health Survey, Professional Research Consultants

Note:
- Asked of all respondents.
- In this case, the term "chronic lung disease" includes bronchitis and emphysema.
- State data not available.

INJURY & VIOLENCE

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

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

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

Unintentional Injury

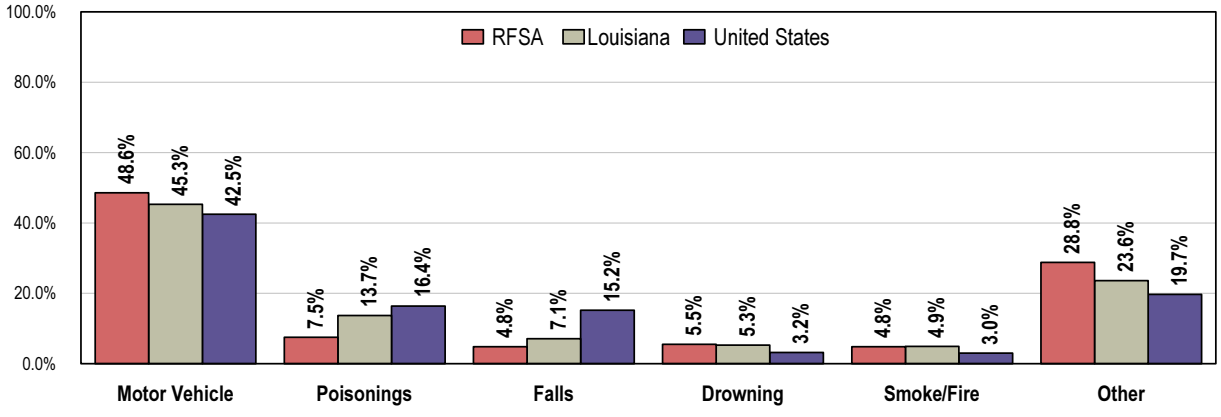
Leading Causes Of Accidental Deaths

Motor vehicle crashes accounted for 48.6% of all accidental deaths in the RFSA in 2002.

- Poisonings (including accidental poisonings, overdoses, and drug interactions), drowning, falls, and smoke/fire are also leading causes of accidental death throughout The Rapides Foundation Service Area.
- "Other" includes a variety of less common causes, such as medical/surgical complications, firearm-related accidental deaths, non-motor vehicle transportation accidents, etc.

Leading Causes Of Accidental Death

(By Region, 2002)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

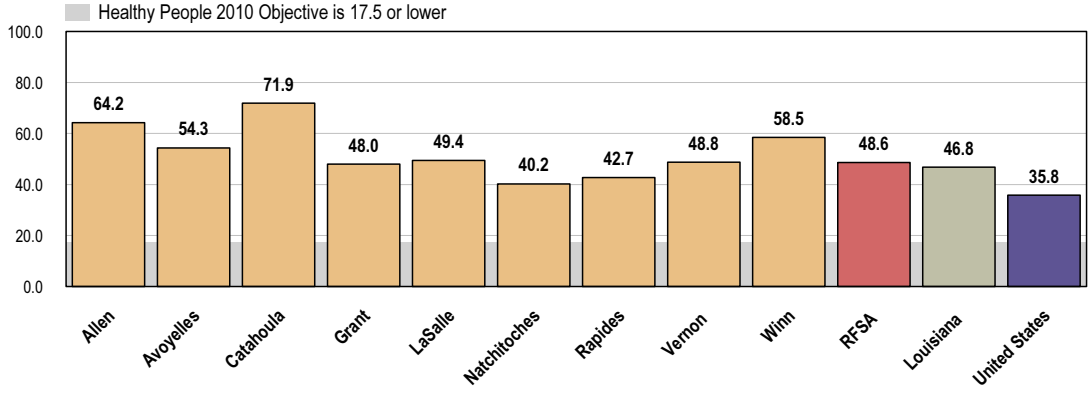
Age-Adjusted Unintentional Injury Deaths

Between 2000 and 2002, there was an annual average age-adjusted unintentional injury death rate of 48.6 deaths per 100,000 population in the RFSA.

- Similar to the 46.8 reported across Louisiana.
- Less favorable than the 35.8 reported nationwide.
- Fails to meet the Healthy People 2010 objective of 17.5 or lower.
- Highest (71.9) in Catahoula Parish.

Age-Adjusted Mortality: Unintentional Injuries

(By Parish; 2000-2002 Deaths Per 100,000 Population)



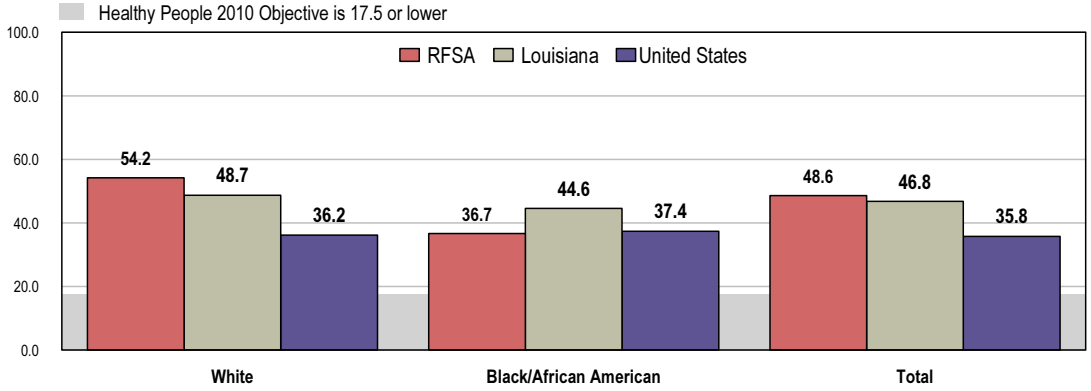
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-13].

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

- Higher among Whites (54.2) than Blacks/African Americans (36.7).

Age-Adjusted Mortality: Unintentional Injuries

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



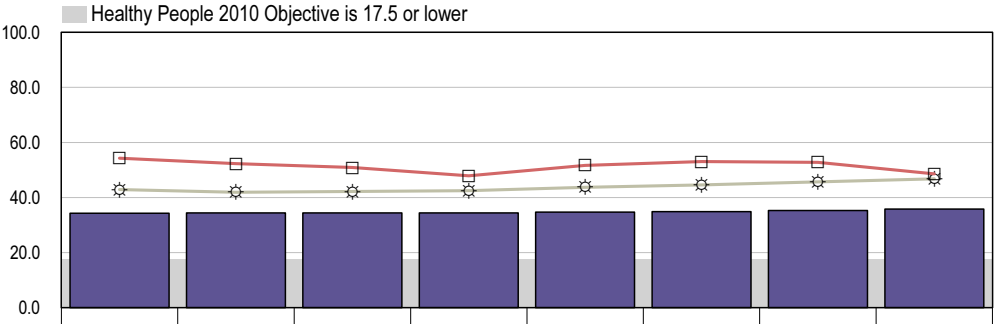
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-13].

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

TREND: Death rates due to unintentional injuries have fluctuated over the past decade, but the latest rate is overall lower than that a decade previously.

Age-Adjusted Mortality: Unintentional Injuries

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	54.3	52.3	50.9	47.9	51.7	53.1	52.8	48.6
Louisiana	42.9	41.9	42.2	42.5	43.7	44.6	45.7	46.8
United States	34.3	34.4	34.4	34.4	34.7	34.9	35.3	35.8

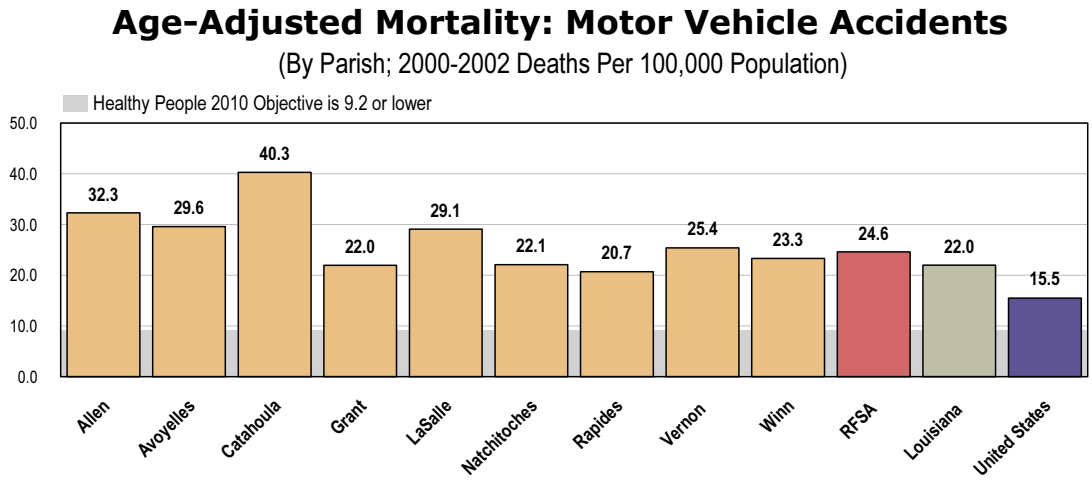
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-13].

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

Age-Adjusted Motor-Vehicle Related Deaths

Between 2000 and 2002, there was an annual average age-adjusted motor vehicle accident death rate of 24.6 deaths per 100,000 population in the RFSA.

- Above the state (22.0) rate.
- Significantly higher than the rate reported nationwide (15.5).
- Fails to meet the Healthy People 2010 objective of 9.2 or lower.
- Ranges from 20.7 in Rapides Parish to 40.3 in Catahoula Parish.



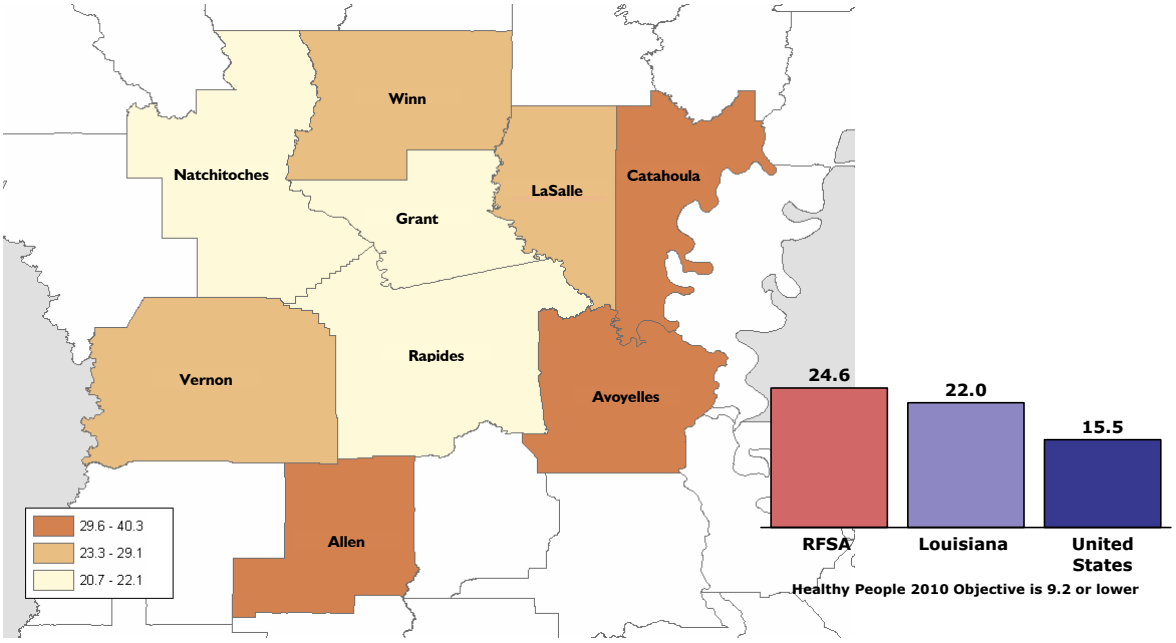
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-15a].

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

The following map further illustrates the higher rates found in Allen, Avoyelles and Catahoula parishes.

Age-Adjusted Mortality: Motor Vehicle Accidents

(By Parish, 2000-2002 Deaths Per 100,000 Population)



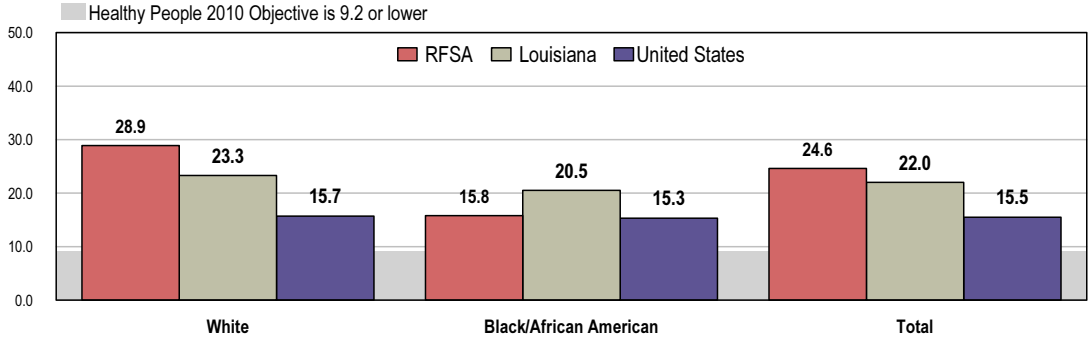
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office,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

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

- Higher among Whites (28.9) than among Blacks/African Americans (15.8).

Age-Adjusted Mortality: Motor Vehicle Accidents

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



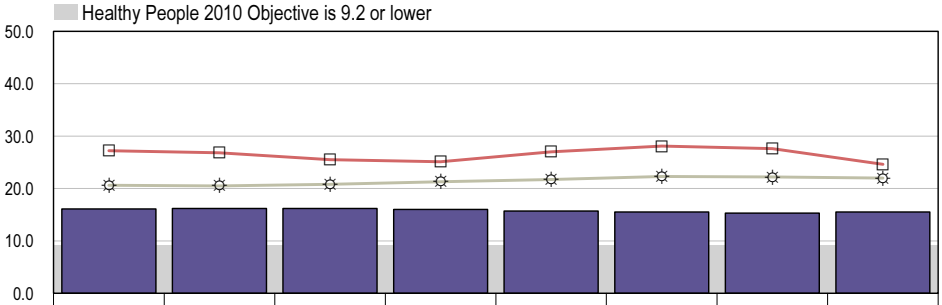
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-15a].

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

TREND: The RFSA motor vehicle accident death rates ranged from 25.1 to 28.1 in recent years. Rates have been stable across Louisiana and the U.S. overall.

Age-Adjusted Mortality: Motor Vehicle Accidents

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	27.2	26.8	25.5	25.1	27.0	28.1	27.6	24.6
Louisiana	20.6	20.5	20.8	21.3	21.7	22.3	22.2	22.0
United States	16.1	16.2	16.2	16.0	15.7	15.5	15.3	15.5

Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-15a].

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

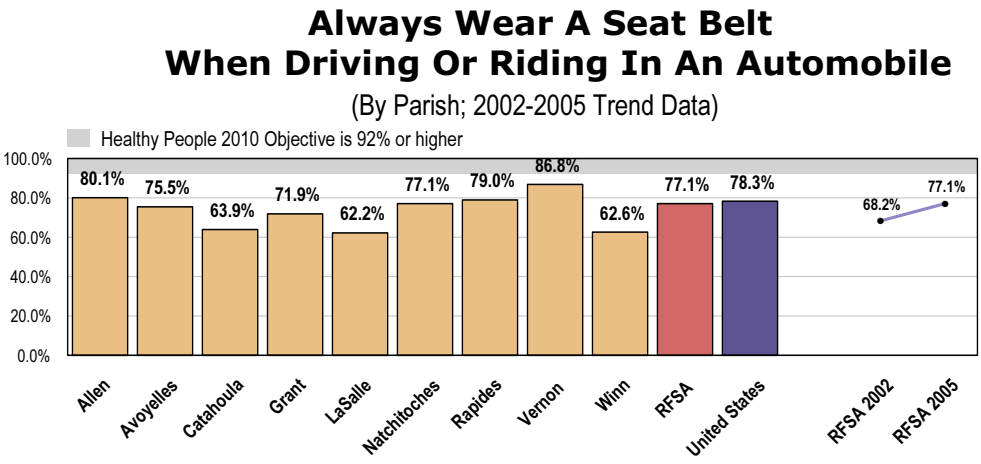
Seat Belt Use

Adults

More than three in four RFSA adults (77.1%) report "always" wearing a seat belt when driving or riding in an automobile.

- Comparable to the national prevalence (78.3%).
- Fails to satisfy the Healthy People 2010 target (92% or higher).
- Ranges from 62.2% in LaSalle Parish to 86.8% in Vernon Parish.

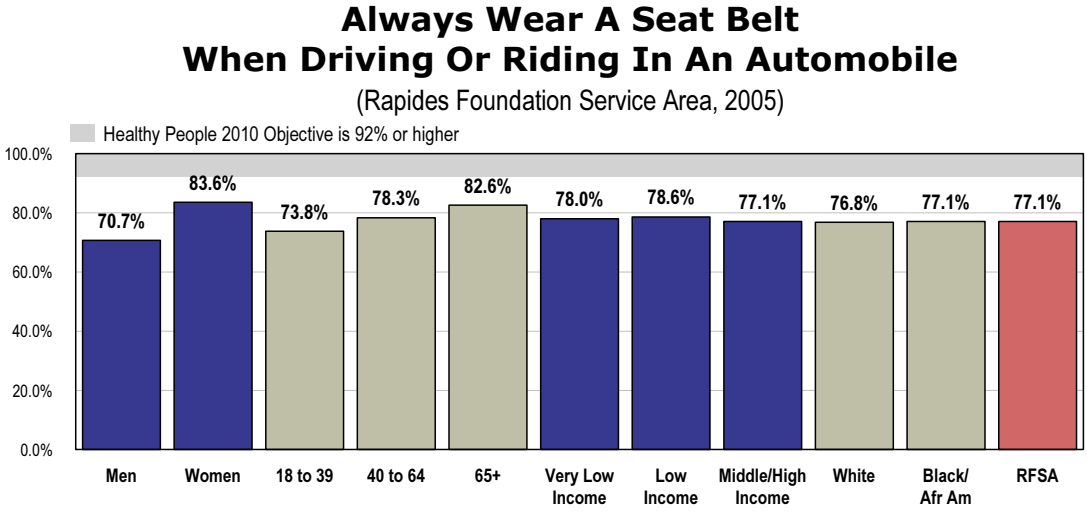
TREND: Marks a *statistically significant increase* from the 68.2% reported in the RFSA in 2002.



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 53]
• 2005 PRC National Health Survey, Professional Research Consultants.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19]
Note: • Asked of all respondents.
• State data not available.

The following chart illustrates differences among key demographic groups. Note:

- Female respondents are more likely to report seat belt use than are male respondents.
- There is a positive correlation of seat belt use with age: 73.8% of young adults (aged 18 to 39) "always" wear a seat belt, compared to 82.6% among those aged 65 and older.



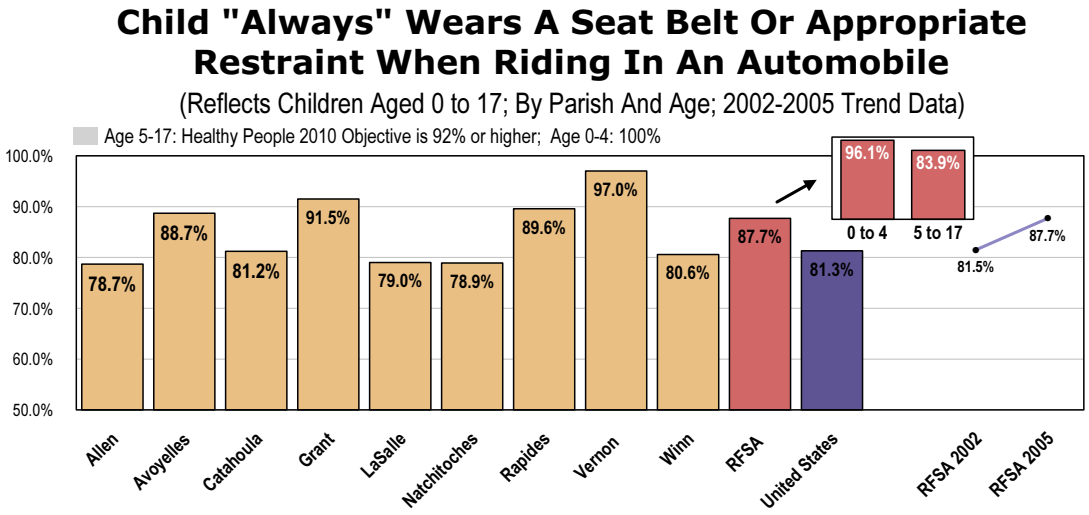
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 53]
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Children

A total of 87.7% of RFSA parents report that their child (aged 0 to 17) "always" wears an appropriate seat belt or child restraint (e.g., safety seat) when riding in an automobile.

- Better than that found nationally (81.3%).
- Fails to satisfy the Healthy People 2010 target for children under 5 (100%) as well as the objective for those aged 5 through 17 (92%).
- Ranges from 78.7% in Allen Parish to 97.0% in Vernon Parish.

TREND: Marks a *statistically significant increase* (in both age categories) since 2002.



Source:
- PRC National Health Surveys, Professional Research Consultants. [Item 129]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19 and 15-20]

Note:
- Reflects respondents with children aged 0 to 17.
- State data not available.

Age-Adjusted Intentional Injury Deaths

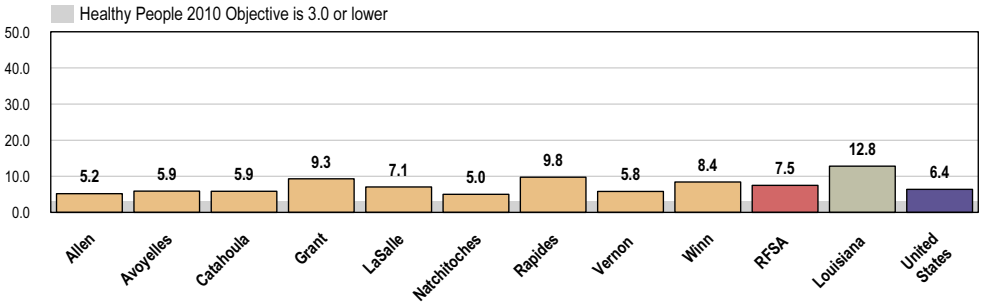
Homicide

Between 2000 and 2002, there was an annual average age-adjusted homicide death rate of 7.5 deaths per 100,000 population in the RFSA.

- More favorable than the state rate of 12.8.
- Just above the 6.4 reported across the nation.
- Fails to satisfy the Healthy People 2010 goal.

Age-Adjusted Mortality: Homicide

(By Parish; 2000-2002 Deaths Per 100,000 Population)



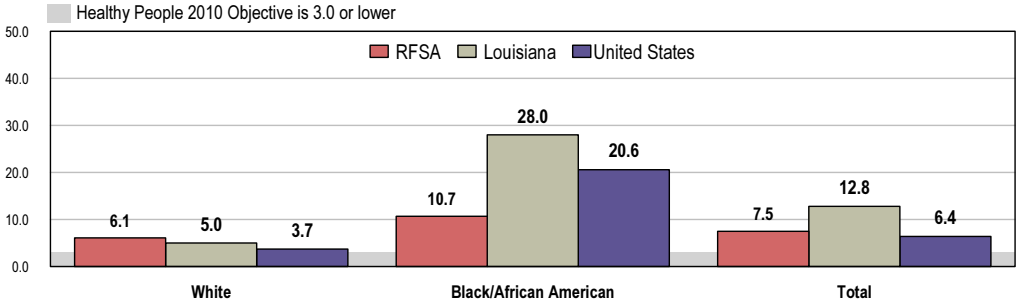
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-32].

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

- Higher among Blacks/African Americans than Whites in the RFSA, although not nearly to the degree found statewide and nationwide.

Age-Adjusted Mortality: Homicide

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



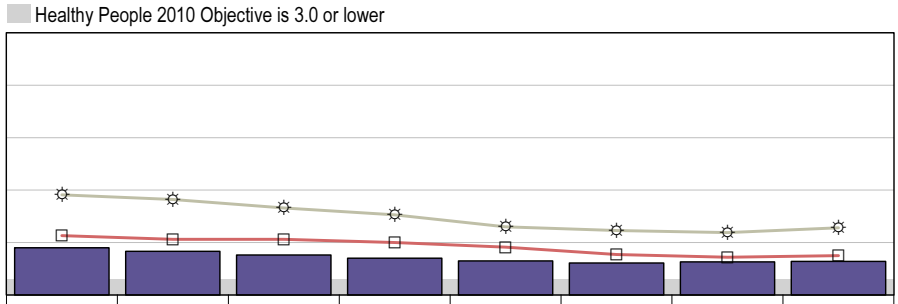
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-32].

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

TREND: Mortality due to homicide has trended downward in recent years.

Age-Adjusted Mortality: Homicide

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	11.3	10.6	10.6	10.0	9.1	7.7	7.2	7.5
Louisiana	19.1	18.2	16.6	15.3	13.0	12.3	11.9	12.8
United States	9.0	8.3	7.6	7.0	6.5	6.1	6.3	6.4

Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 15-32].

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

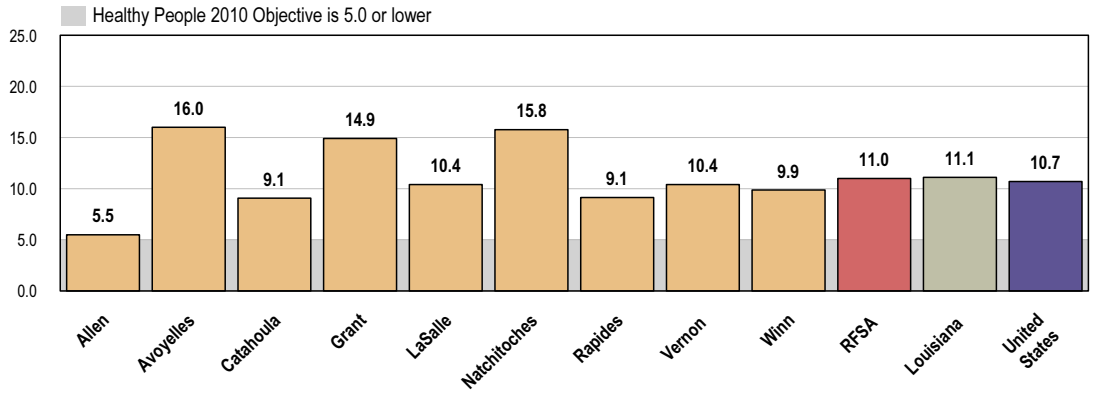
Suicide

Between 2000 and 2002, there was an annual average age-adjusted suicide death rate of 11.0 deaths per 100,000 population in the RFSA.

- Similar to the rates reported statewide and nationwide.
- Fails to satisfy the Healthy People 2010 objective of 5.0 or lower.
- Highest in Avoyelles, Grant, and Natchitoches parishes.

Age-Adjusted Mortality: Suicide

(By Parish; 2000-2002 Deaths Per 100,000 Population)

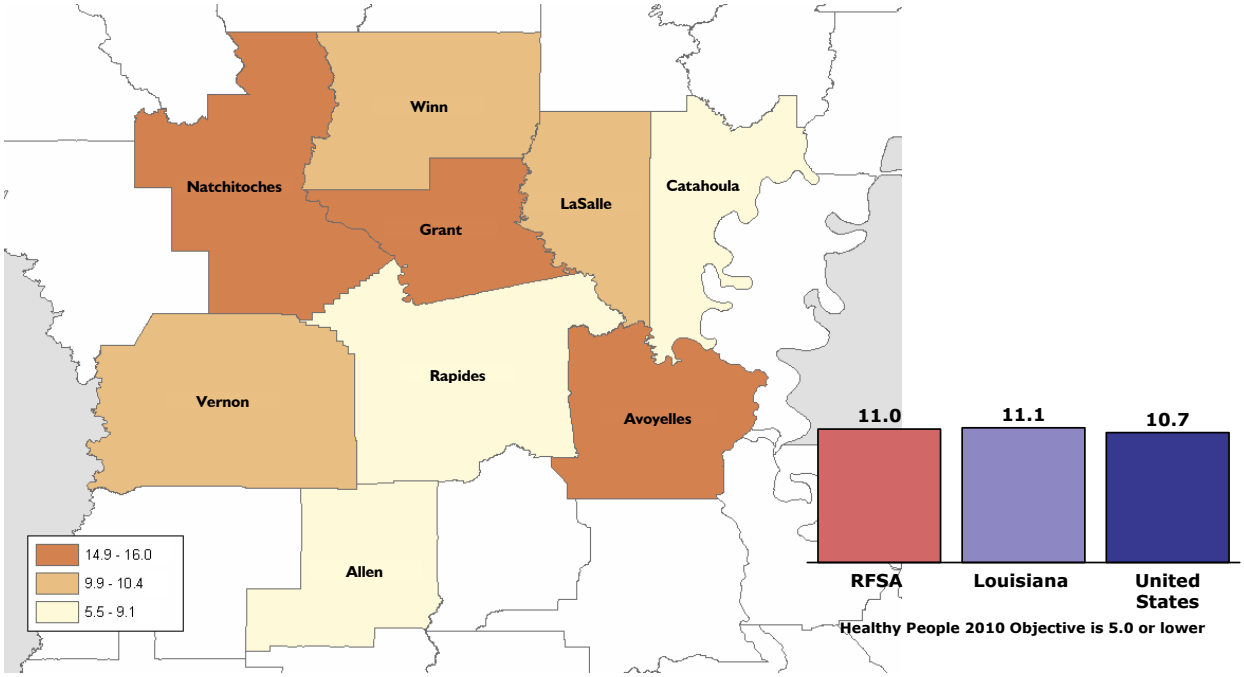


Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 18-1].

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

Age-Adjusted Mortality: Suicide

(By Parish, 2000-2002 Deaths Per 100,000 Population)



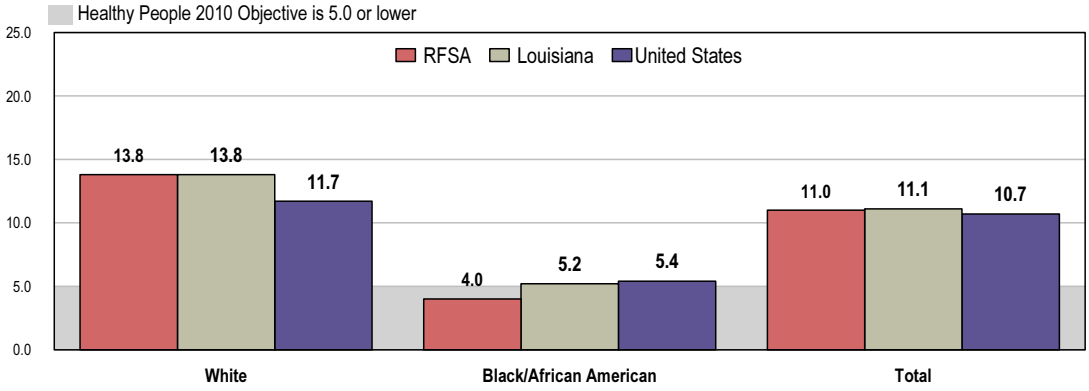
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office,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

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

- Much higher (13.8) among Whites than among Blacks/African Americans (4.0).

Age-Adjusted Mortality: Suicide

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)

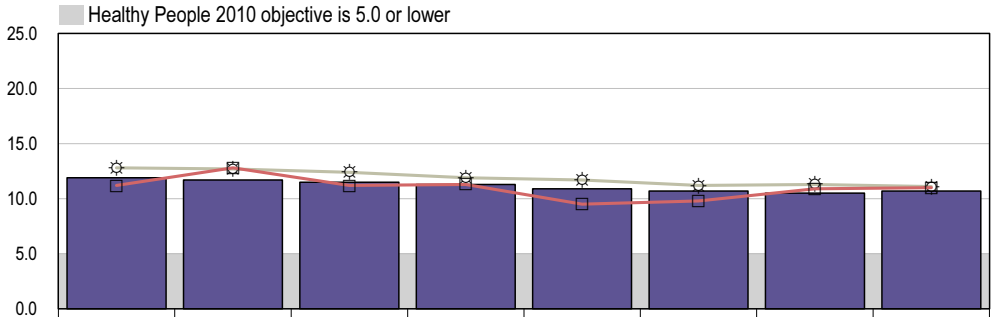


Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 18-1].

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

TREND: Suicide death rates across the parish fluctuated between 9.5 and 12.8 in recent years.

Age-Adjusted Mortality: Suicide
(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	11.2	12.8	11.2	11.3	9.5	9.8	10.9	11.0
Louisiana	12.8	12.7	12.4	11.9	11.7	11.2	11.3	11.1
United States	11.9	11.7	11.5	11.3	10.9	10.7	10.5	10.7

Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 18-1].

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

(See also "Mental Health.")

Violent Crime Rates

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

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

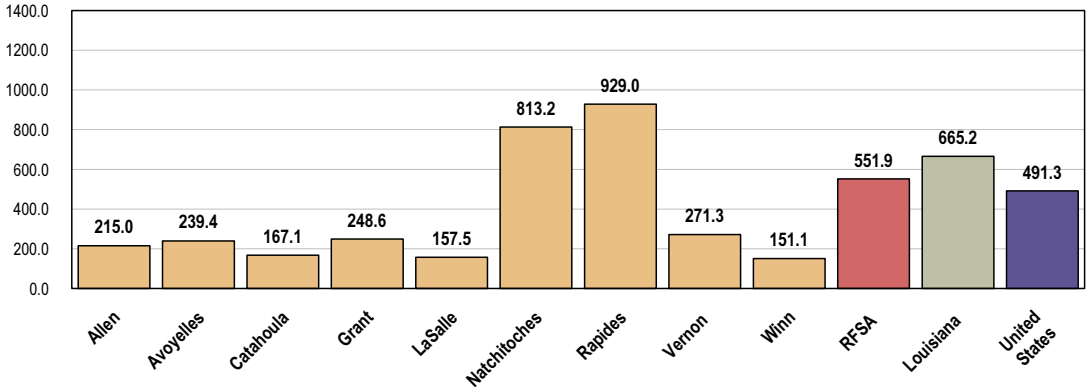
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

The 2001-2003 RFSA annual average violent crime rate (including homicide, forcible rape, robbery and aggravated assault) was 551.9 incidents per 100,000 population.

- More favorable than the 665.2 experienced across Louisiana.
- Higher than the 491.3 reported nationwide for 2001-2003.
- Exceptionally high in Natchitoches Parish (813.2) and Rapides Parish (929.0).

Violent Crime Rates

(Violent Crimes Per 100,000 Population; By Parish, 2001-2003)



Source:
- FBI, Crime in the United States; 2001-2003.
- Louisiana Commission on Law Enforcement.

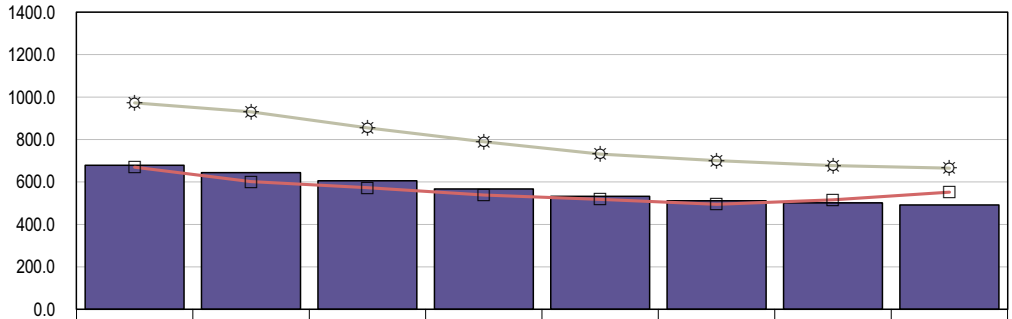
Note:
- Rates are per 100,000 population.
- Includes only agencies reporting. Although uniform crime reporting is mandatory in Louisiana, not all agencies within each parish reported for some or all years.

TREND: The violent crime rate in the RFSA increased between 2000 and 2003, contrary to the downward trend experienced in preceding years.

- It is important to note that, although uniform crime reporting is mandatory in Louisiana, not all agencies within each parish reported for all years.

Violent Crime Rates

(Violent Crimes Per 100,000 Population; By Region, 1994-2003)



	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003
RFSA	669.5	602.1	573.0	538.1	518.0	495.0	515.6	551.9
Louisiana	972.8	930.8	854.8	789.4	731.1	700.3	676.8	665.2
United States	678.2	644.0	605.1	567.2	532.4	511.3	501.8	491.3

Source:
- FBI, Crime in the United States; 1994-2003.
- Louisiana Commission on Law Enforcement.

Note:
- Rates are per 100,000 population.
- Includes only agencies reporting. Although uniform crime reporting is mandatory in Louisiana, not all agencies within each parish reported for some or all years.
- 1997 and 1998 rates exclude Catahoula Parish for which reporting was not available at the time rates were calculated.

Violent Crime Victimization

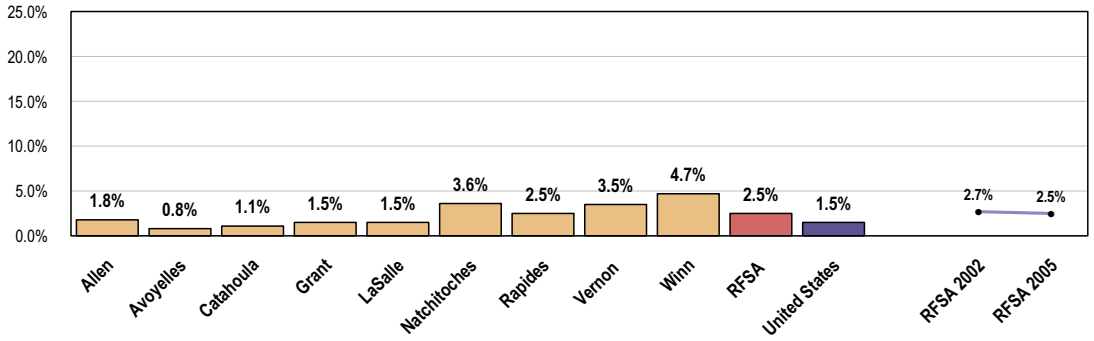
A total of 2.5% of RFSA adults report having been the victim of a violent crime in the past five years.

- Represents approximately 6,500 adults in the RFSA.
- Less favorable than the 1.5% prevalence found nationwide.
- Highest (4.7%) in Winn Parish.

TREND: Statistically unchanged since 2002.

Victim Of A Violent Crime In The Past Five Years

(By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 54]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

Domestic Violence

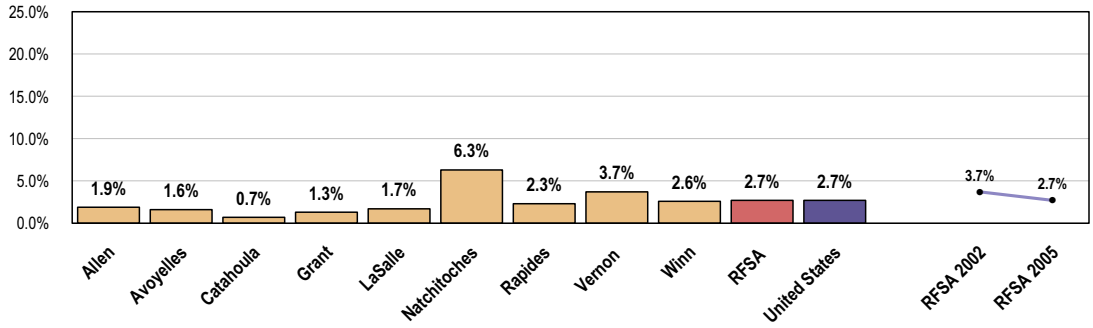
A total of 2.7% of RFSA adults acknowledge being the victim of domestic violence in the past five years.

- Statistically similar to the state and national proportions.
- Highest (6.3%) in Natchitoches Parish.

TREND: Marks a *statistically significant decrease* from the 3.7% reported in 2002.

Victim Of Domestic Violence In The Past Five Years

(By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 55]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

DIABETES

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

- Among U.S. adults, diagnosed diabetes (including gestational diabetes) increased 49% from 1990 to 2000. The largest increase was among people aged 30–39. Type 2 affects 90%–95% of people with diabetes and is linked to obesity and physical inactivity.
- More than 18% of U.S. adults older than age 65 have diabetes.
- Diabetes affects more women than men — in particular, women are prone to gestational diabetes during (and potentially ongoing diabetes after) pregnancy.

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

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

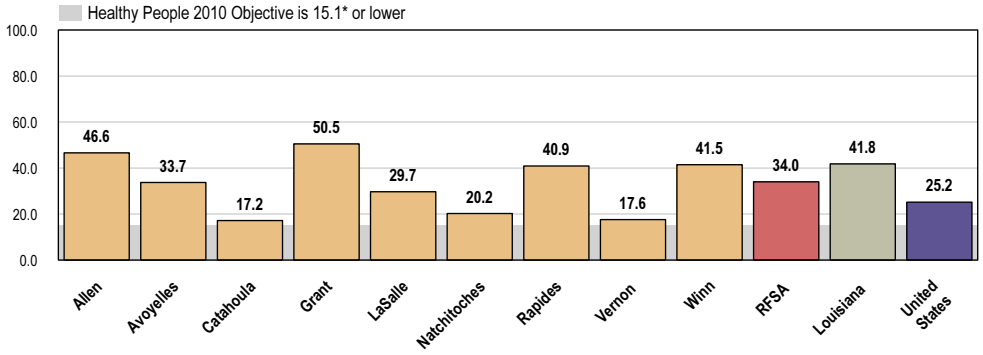
Age-Adjusted Diabetes Deaths

Between 2000 and 2002, there was an annual average age-adjusted diabetes death rate of 34.0 deaths per 100,000 population in the RFSA.

- More favorable than the rate found across the state (41.8).
- Less favorable than the 25.2 mortality rate recorded across the United States.
- Fails to satisfy the Healthy People 2010 objective of 15.1 (adjusted) for diabetes mellitus.

Age-Adjusted Mortality: Diabetes Mellitus

(By Parish; 2000-2002 Deaths Per 100,000 Population)

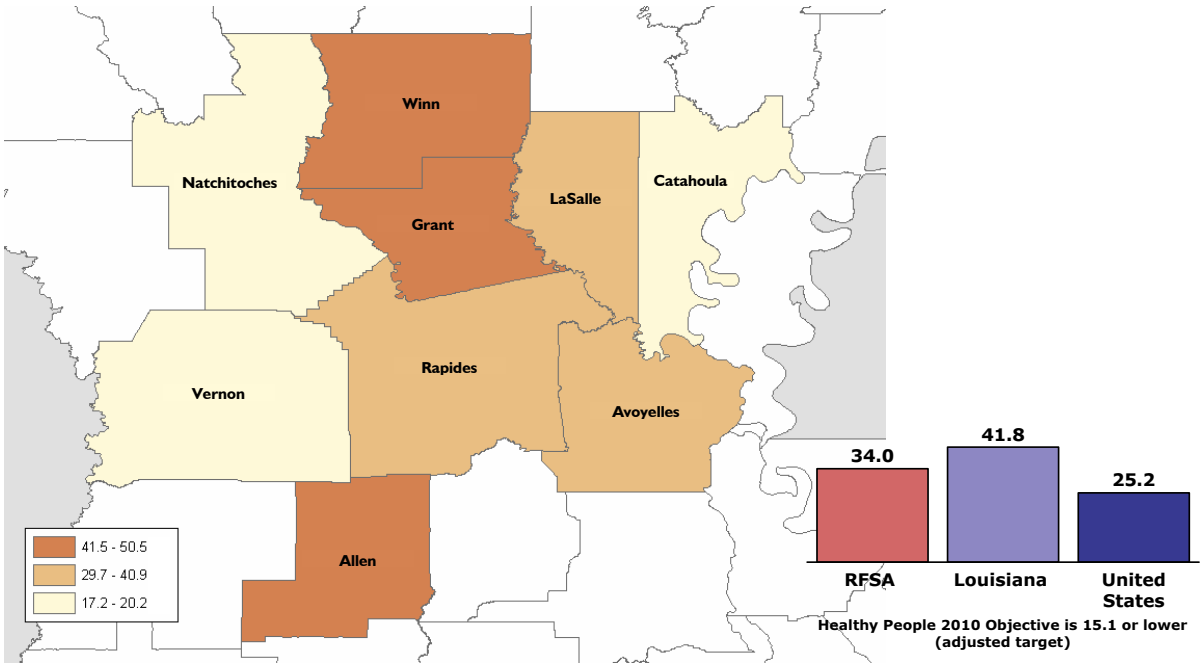


Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 5-5].

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

Age-Adjusted Mortality: Diabetes Mellitus

(By Parish, 2000-2002 Deaths Per 100,000 Population)



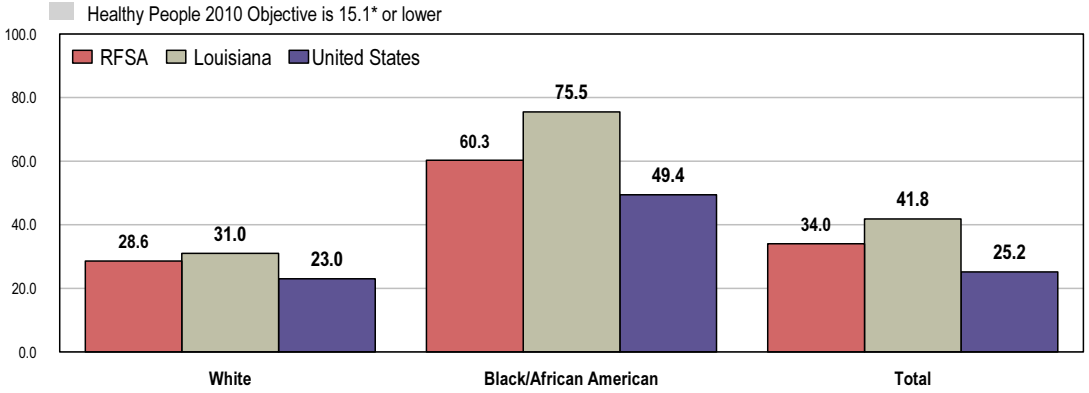
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office,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

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

- Diabetes death rates are twice as high among RFSA Blacks/African Americans (60.3) as among Whites (28.6). This is also the case both statewide and nationwide.

Age-Adjusted Mortality: Diabetes Mellitus

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



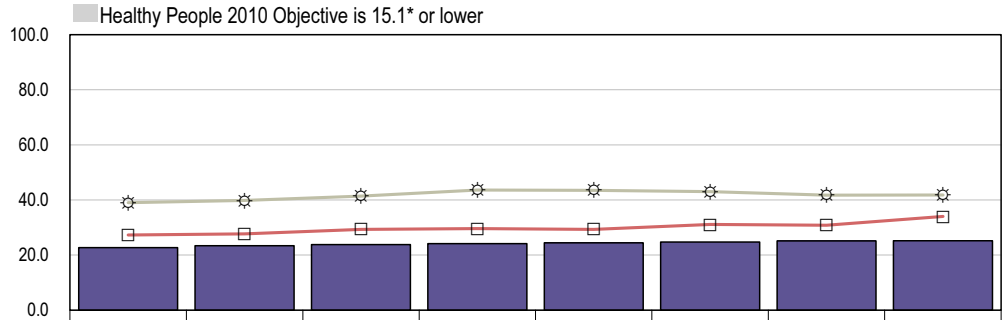
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 5-5].

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
- *The Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

TREND: Diabetes is on an upward trend across the region, mirroring the trend across the U.S. overall.

Age-Adjusted Mortality: Diabetes Mellitus

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	27.3	27.7	29.3	29.6	29.3	31.1	30.8	34.0
Louisiana	39.0	39.8	41.4	43.6	43.5	43.0	41.7	41.8
United States	22.7	23.4	23.8	24.1	24.4	24.7	25.1	25.2

Source:
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 5-5].

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Data for 1999 and subsequent years are not fully comparable to data from 1998 and prior years, due to changes in coding of causes of deaths resulting from the switch from the ninth revision of the International Classification of Diseases (ICD9) to the tenth revision (ICD10).
- State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.
- *The Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence Of Diabetes

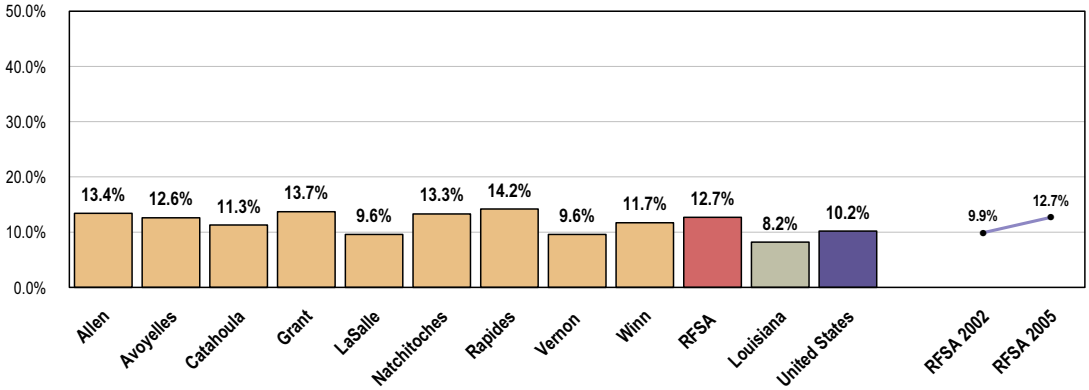
A total of 12.7% of RFSA adults report having been diagnosed with diabetes.

- Less favorable than the proportions recorded across the state and nation overall.

TREND: Marks a *statistically significant increase* since 2002.

Prevalence Of Diabetes

(By Parish; 2002-2005 Trend Data)

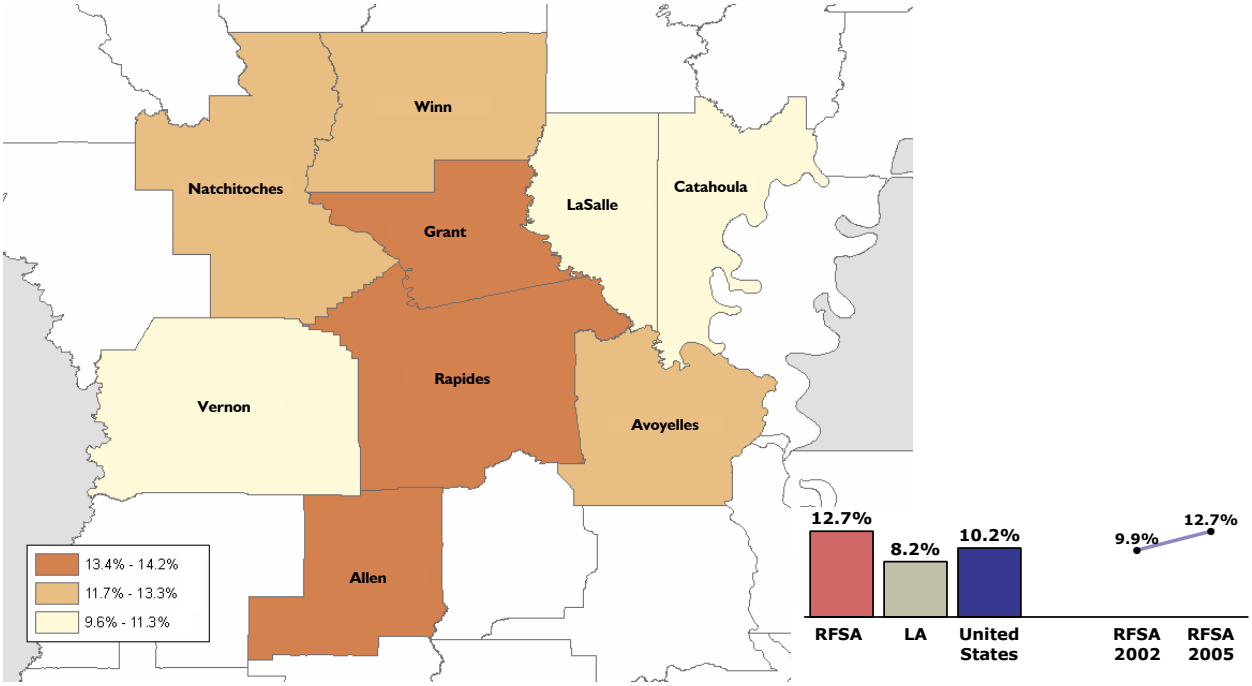


Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 43]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.

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

Prevalence Of Diabetes

(By Parish, 2005)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 43]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.

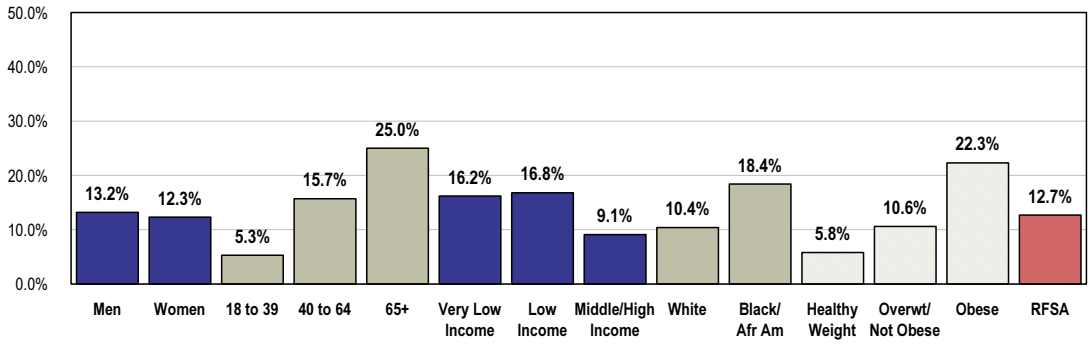
Note:
- Asked of all respondents. Excludes gestational diabetes.

A higher prevalence of diabetes in the RFSA is reported among:

- Adults aged 40 and older.
- Blacks/African Americans.
- Adults with low or very low incomes.
- Note also that diabetes is highly correlated with weight status: in particular, obese adults report a prevalence of diabetes nearly four times that found among persons of healthy weight.

Prevalence Of Diabetes

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 43]

Note:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

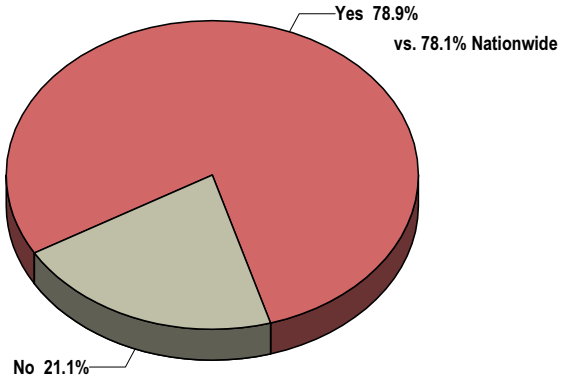
Diabetes Treatment

The majority (78.9%) of adults who have been diagnosed with diabetes are currently taking insulin or other medication for their diabetes.

- Nearly identical to the 78.1% reported nationwide.

Currently Taking Insulin Or Other Medicine For Diabetes

(Rapides Foundation Service Area, 2005; Among Reported Diabetics)



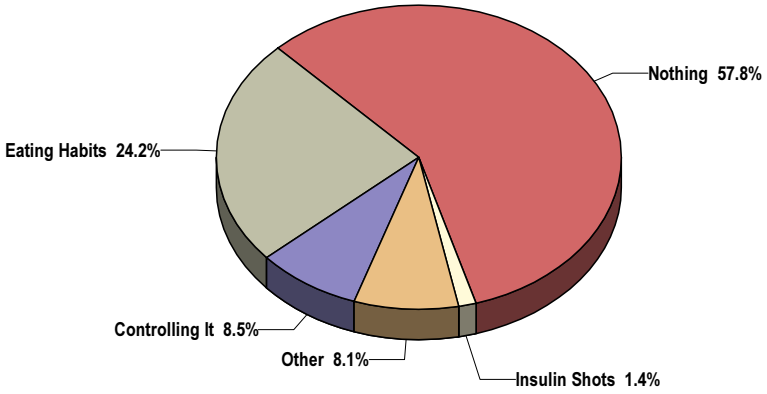
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 44]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of those respondents who have been diagnosed with diabetes.

Among diabetics, 57.8% report <u>not</u> having any problem controlling their blood sugar.

- Examples of some of the problems mentioned among diabetics include changing eating habits and "controlling it."

Problems In Controlling Blood Sugar

(Rapides Foundation Service Area, 2005; Among Reported Diabetics)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 45]
Note: • Asked of those respondents who have been diagnosed with diabetes.

KIDNEY DISEASE

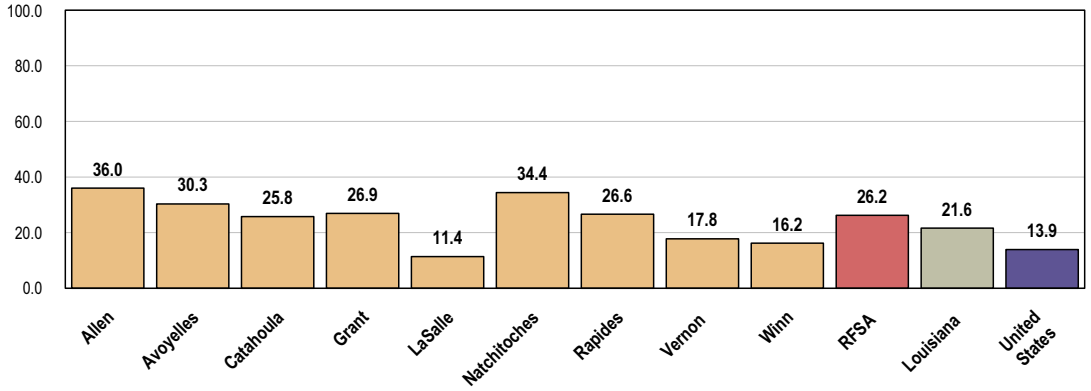
Age-Adjusted Kidney Disease Deaths

Between 2000 and 2002, there was an annual average age-adjusted kidney disease death rate of 26.2 deaths per 100,000 population in the RFSA.

- Less favorable than the statewide rate (21.6).
- Nearly twice the national rate (13.9).
- Ranges from 11.4 in LaSalle Parish to 36.0 in Allen Parish.

Age-Adjusted Mortality: Kidney Disease

(By Parish; 1993-2002)



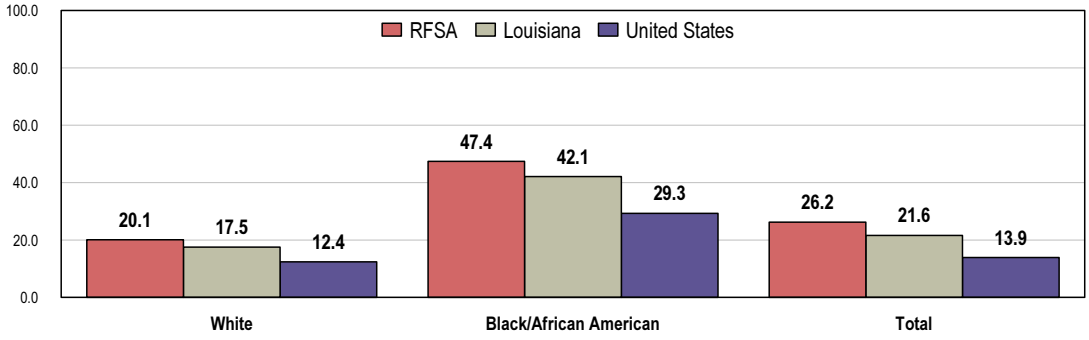
Source:
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Data for 1999 and subsequent years are not fully comparable to data from 1998 and prior years, due to changes in coding of causes of deaths resulting from the switch from the ninth revision of the International Classification of Diseases (ICD9) to the tenth revision (ICD10).
- Parish, state and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

- Note also that kidney disease mortality is much higher among Blacks/African Americans than among Whites for each region shown.

Age-Adjusted Mortality: Kidney Disease

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



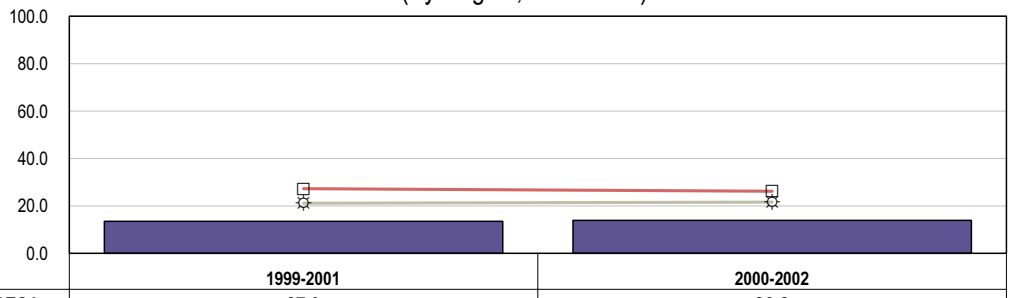
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

TREND: Between the 1999-2001 and 2000-2002 reporting periods, RFSA kidney disease mortality remained stable, as did rates across Louisiana and the U.S. overall.

Age-Adjusted Mortality: Kidney Disease

(By Region; 1993-2002)



	1999-2001	2000-2002
RFSA	27.3	26.2
Louisiana	21.1	21.6
United States	13.5	13.9

Source:
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Data for 1999 and subsequent years are not fully comparable to data from 1998 and prior years, due to changes in coding of causes of deaths resulting from the switch from the ninth revision of the International Classification of Diseases (ICD9) to the tenth revision (ICD10).
- State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

Prevalence Of Kidney Disease

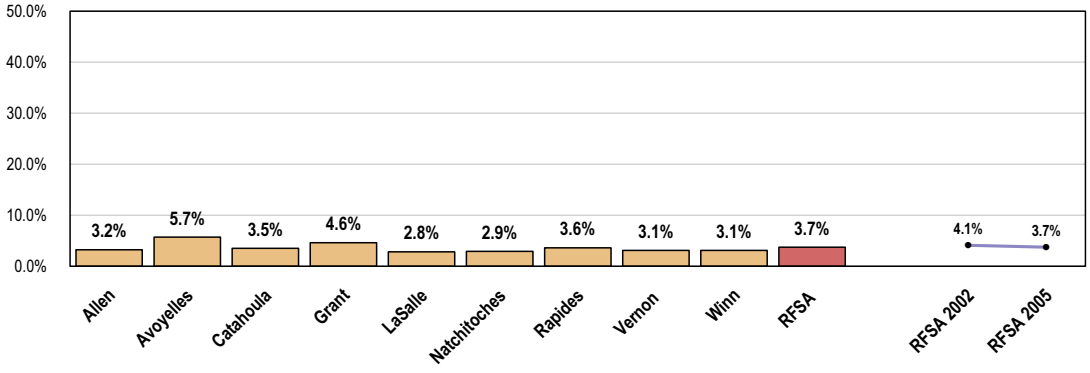
A total of 3.7% of RFSA adults report having kidney disease.

- Represents an estimated 9,572 local adults.
- Highest (5.7%) in Avoyelles Parish.

TREND: The currently reported prevalence is statistically similar to that reported in 2002.

Prevalence Of Kidney Disease

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 40]

Note:
- Asked of all respondents.
- State and national data not available.

ARTHRITIS & RHEUMATISM

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

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

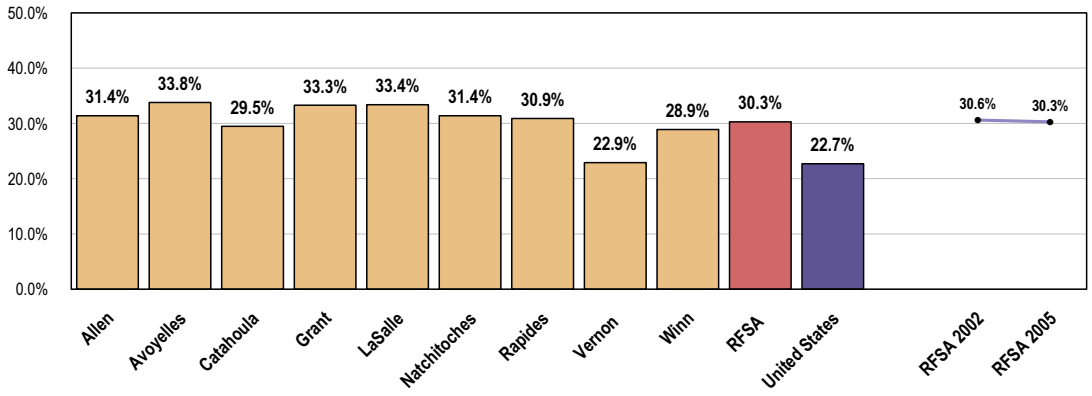
A total of 30.3% of RFSA adults (aged 18 and over) report suffering from arthritis or rheumatism.

- Much higher than the 22.7% reported across the United States.
- Ranges from 22.9% in Vernon Parish to 33.8% in Avoyelles Parish.
- Note: 66.0% of RFSA adults aged 65 and older have arthritis or rheumatism.

TREND: Statistically unchanged from the 30.6% reported in 2002.

Prevalence Of Arthritis/Rheumatism

(By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 35]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

ACTIVITY LIMITATIONS

An estimated 54 million persons in the United States, or nearly 20 percent of the population, currently live with disabilities. The increase in disability among all age groups indicates a growing need for public health programs serving people with disabilities.

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

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

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

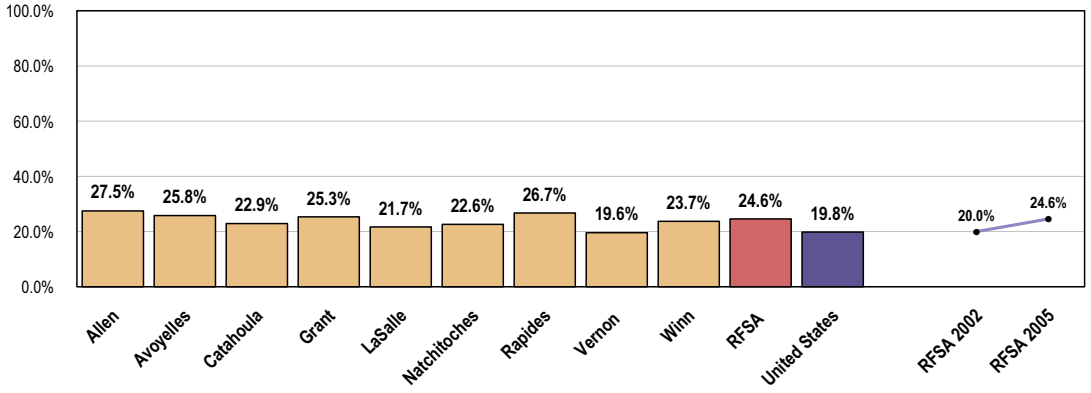
One out of four RFSA adults (24.6%) report that they are limited in some way in some activities due to a physical, mental or emotional problem.

- Represents approximately 63,640 adults in the RFSA.
- Less favorable than the 19.8% reported across the nation.
- Ranges from 19.6% in Vernon Parish to 27.5% in Allen Parish.

TREND: Marks a *statistically significant increase* since 2002.

Limited In Activities In Some Way Due To A Physical, Mental Or Emotional Problem

(By Parish; 2002-2005 Trend Data)



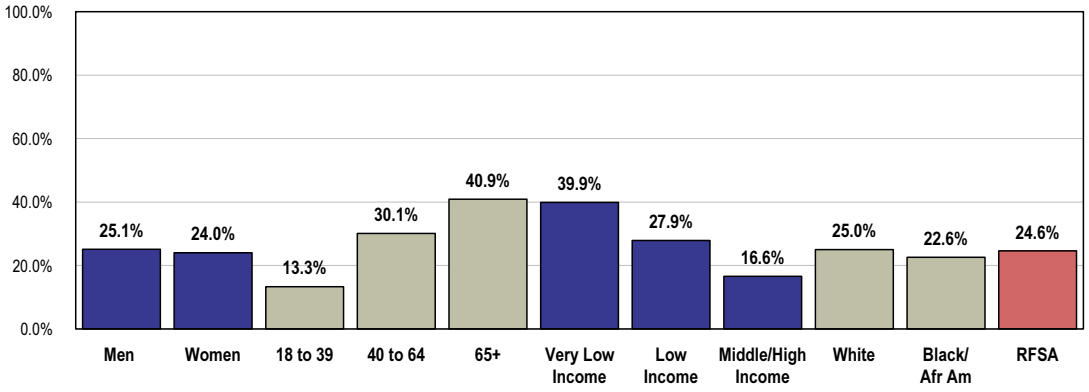
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 106]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

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

- There is a strong correlation with age, with 40.9% of older adults (65+) limited in activities.
- There is a strong negative correlation with income, with 39.9% of very low-income (below poverty) respondents reporting activity limitations.

Limited In Activities In Some Way Due To A Physical, Mental Or Emotional Problem

(Rapides Foundation Service Area, 2005)

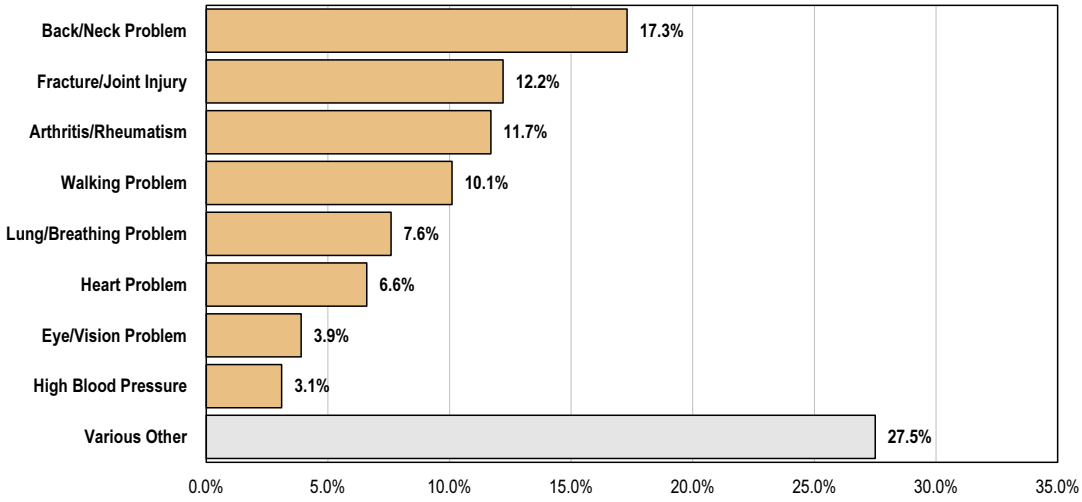


Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 106]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Among persons reporting activity limitations, these are most often attributed to back/neck problems, fractures and joint injuries, or arthritis/rheumatism.

Type Of Problem That Limits Activities

(Among Those Reporting Activity Limitations; Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 107]
Note: • Reflects those respondents who experience activity limitations.

VISION & HEARING

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

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

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

Prevalence Of Vision Problems

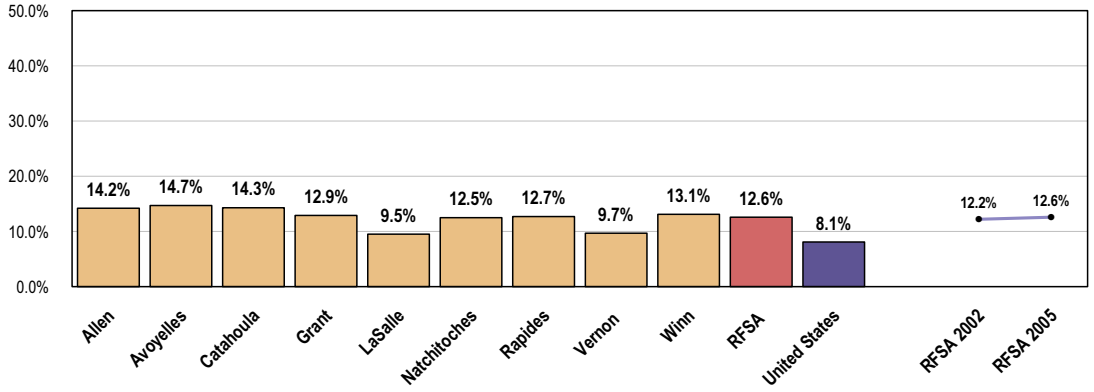
A total of 12.6% of RFSA adults are blind, or have trouble seeing even when wearing corrective lenses.

- Less favorable than the 8.1% prevalence reported nationwide.
- Highest in Allen, Avoyelles, and Catahoula parishes.

TREND: The 2005 proportion is comparable to the 12.2% reported in the RFSA in 2002.

Prevalence Of Vision Problems

(By Parish; 2002-2005 Trend Data)



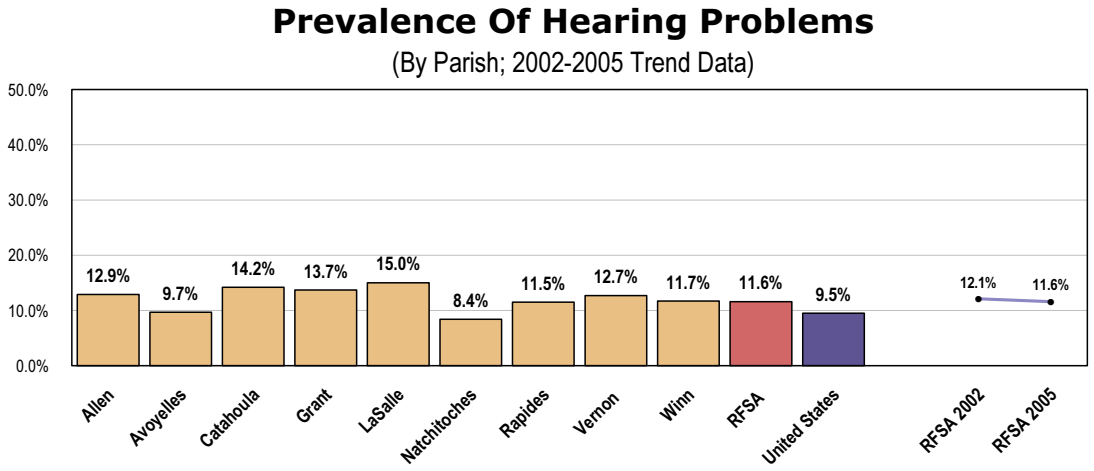
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 33]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

Prevalence Of Hearing Problems

A total of 11.6% of RFSA adults report being deaf or having difficulty hearing.

- Less favorable than the 9.5% reported nationwide.
- Ranges from 8.4% in Natchitoches Parish to 15.0% in LaSalle Parish.
- Note: 23.0% of RFSA adults aged 65 and older have partial or complete hearing loss.

TREND: Statistically unchanged from the 12.1% reported in the RFSA in 2002.



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 34]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

ACTUAL CAUSES OF DEATH

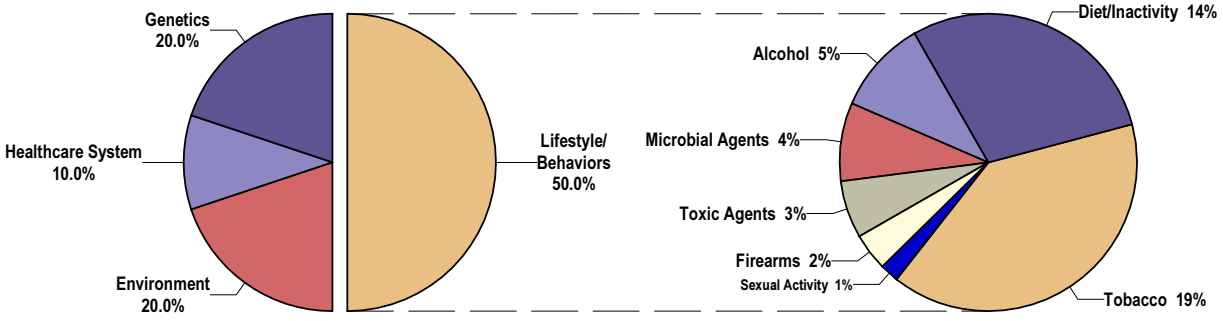
A landmark 1993 study estimated that as many as one-half of all premature deaths in the United States were attributed to social and behavioral factors, and in theory, were preventable.

The most prominent contributors to mortality in the United States in 1990 were **tobacco** (an estimated 400,000 deaths), **poor diet and inactivity** (300,000), **alcohol** (100,000), **microbial agents** (90,000), **toxic agents** (60,000), **firearms** (35,000), **sexual behavior** (30,000), **motor vehicles** (25,000), **and illicit use of drugs** (20,000). 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… **Approximately half of all deaths that occurred among U.S. residents in 1990 could be attributed to the [social and behavioral risk] factors identified**…

There can be no illusions about the difficulty of the challenges in changing the impact these factors have on health status. Of those identified here, the three leading causes of death — tobacco, diet and activity patterns, and alcohol — are rooted in behavioral choices. Behavioral change is motivated not by knowledge alone, but also by a supportive social environment and the availability of facilitative services… The central public health focus for each of these factors must be the possibility for improvement. Change can occur… If the nation is to achieve its full potential for better health, public policy must focus directly and actively on those factors that represent the root determinants of death and disability.

– McGinnis, J. Michael, and William H. Foege. "Actual Causes of Death in the United States." *JAMA*, 270(1993):2207-12.

Factors Contributing To Premature Deaths In The United States



Source: McGinnis, J. Michael, and William H. Foege. "Actual Causes of Death in the United States." JAMA, 270(1993):2207-12.

Further, the following table outlines the relationship that exists among these behavioral factors and leading causes of death, such as cancer and heart disease.

	LEADING CAUSES OF DEATH[1]									
	HEART DISEASE	CANCER	UNINTENTIONAL INJURIES	SUICIDE	LIVER DISEASE	STROKE	DIABETES	COPD	HOMICIDE	HIV
BEHAVIORAL FACTORS	**Tobacco Use** Prevention	**Tobacco Use** Prevention of various cancers				**Tobacco Use** Prevention	**Tobacco Use** Control	**Tobacco Use** Prevention		
	Diet [2] Prevention	**Diet** [2] Prevention of various cancers				**Diet** [2] Prevention	**Diet** [2] Control, Prevention			
	Physical Activity [2] Prevention, Control	**Physical Activity** [2] Prevention of colon cancer		**Physical Activity** [2] Control of depression		**Physical Activity** [2] Prevention	**Physical Activity** [2] Control, Prevention			
	Alcohol Use Can be beneficial at low doses	**Alcohol Use** Prevention of various cancers	**Alcohol Use** Prevention	**Alcohol Use** Prevention	**Alcohol Use** Prevention					
			Firearms Prevention	**Firearms** Prevention					**Firearms** Prevention	
										Sexual Behavior Prevention
			Motor Vehicles Prevention							
	Preventive Medical Care Screening for risk factors such as blood pressure[2] and cholesterol	**Preventive Medical Care** Screening: early detection	**Preventive Medical Care** Anticipatory guidance	**Preventive Medical Care** Control of mental disorders	**Preventive Medical Care** Screening for alcohol abuse	**Preventive Medical Care** Screening for BP; Control	**Preventive Medical Care** Control			**Preventive Medical Care** Screening for STDs; Control

Notes: 1. Leading causes of death are those which are listed on the death certificate.
2. High blood pressure and obesity can be thought of as "intermediary" causes. Both are determined in part by genetics and in part by behavior. Diet and physical activity are important determinants of obesity.

Sources: Amler RW, Dull HB [eds]. Closing the gap: The burden of unnecessary illness. New York: Oxford, 1987; Am J Prev Med 1987;3(5 suppl).

Nutrition

For the nutrition question series, survey respondents were asked about the foods that they ate on the day prior to the interview.

Consumption Of Fruits & Vegetables

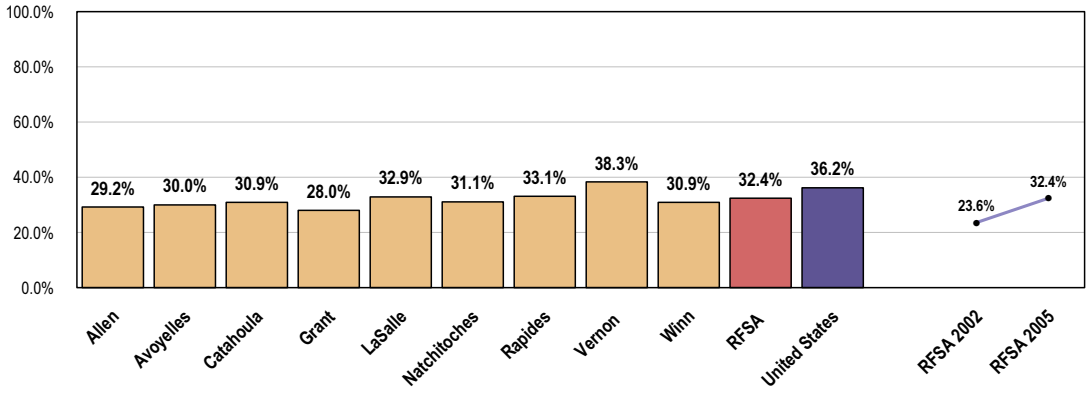
Daily Recommendation

Nearly one in three (32.4%) RFSA adults reports eating five or more servings of fruits and/or vegetables per day.

- Less favorable than the 36.2% reported nationwide.
- **TREND:** This year's proportion marks a *statistically significant increase* from the 23.6% in 2002.

Consume Five Or More Servings Of Fruits/Vegetables Per Day

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 139]
- 2005 PRC National Health Survey, Professional Research Consultants.

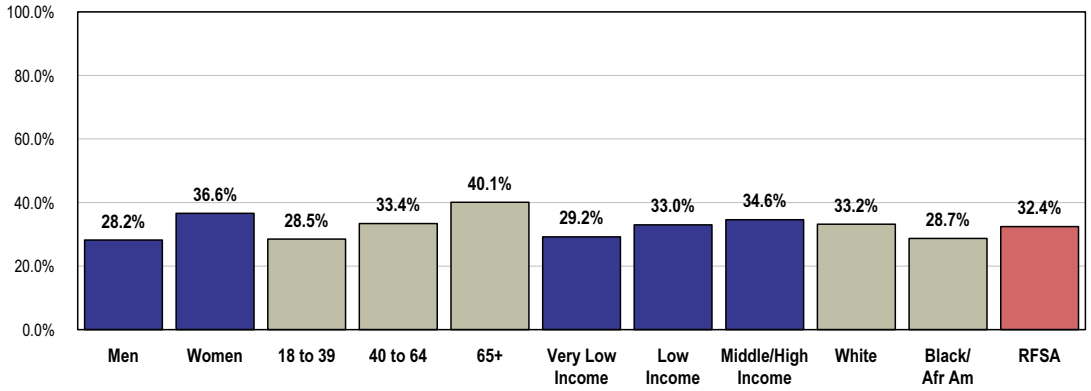
Note:
- Asked of all respondents.
- For this issue, respondents were asked to recall the foods they had eaten on the day prior to the interview.
- State data not available.

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

- Men.
- Persons living at very low incomes.
- Adults under 65.

Consume Five Or More Servings Of Fruits/Vegetables Per Day

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 139]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Fruits

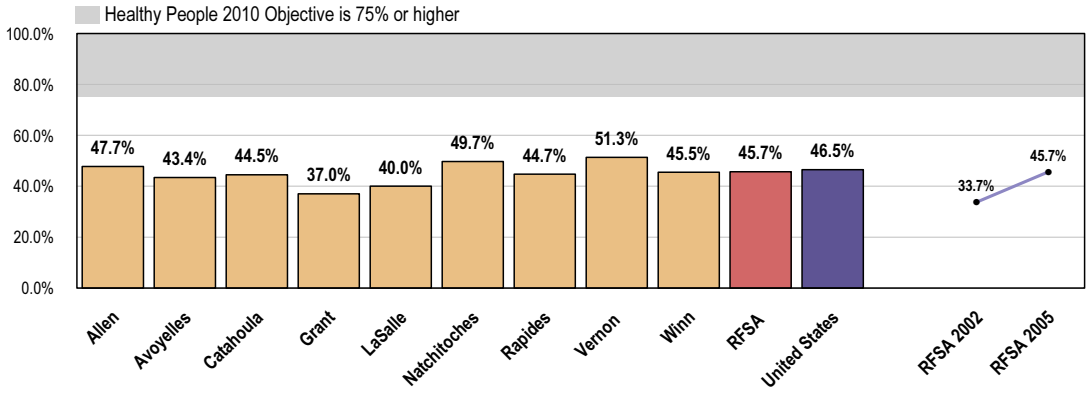
Just under one-half of RFSA residents (45.7%) report eating at least two servings of fruit or fruit juice per day.

- Similar to the 46.5% found nationally.
- Fails to satisfy the Healthy People 2010 target (75% or higher).
- Ranges from 37.0% in Grant Parish to 51.3% in Vernon Parish.

TREND: Marks a *statistically significant increase* since 2002.

Consume Two Or More Servings Of Fruit Or Fruit Juices Per Day

(By Parish; 2002-2005 Trend Data)



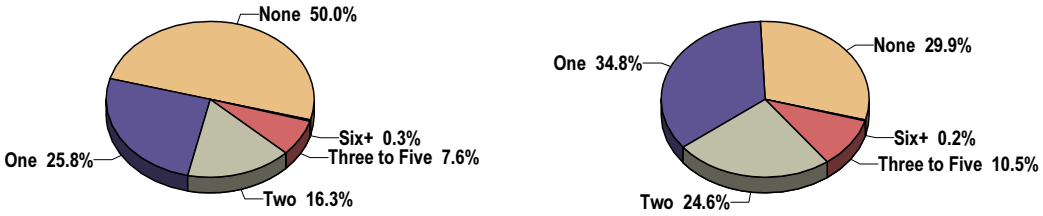
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 90]
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-5]
Note: • Asked of all respondents.
• For this issue, respondents were asked to recall the foods they had eaten on the day prior to the interview.
• State data not available.

Vegetables

One in two RFSA adults (50.0%) do <u>not</u> eat any dark green or orange vegetables on a daily basis.

- Another 25.8% report eating one serving of dark green or orange vegetables daily.
- Survey respondents were more likely to report eating "other vegetables," including potatoes, corn, onions, etc.

Daily Servings Of Vegetables
(Rapides Foundation Service Area, 2005)



Dark Green Or Orange Vegetables
Mean = 0.9 Servings/Day

"Other" Vegetables
Mean = 1.2 Servings/Day

Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 91-92]
Note: • Asked of all respondents.
• For this issue, respondents were asked to recall the foods they had eaten on the day prior to the interview.

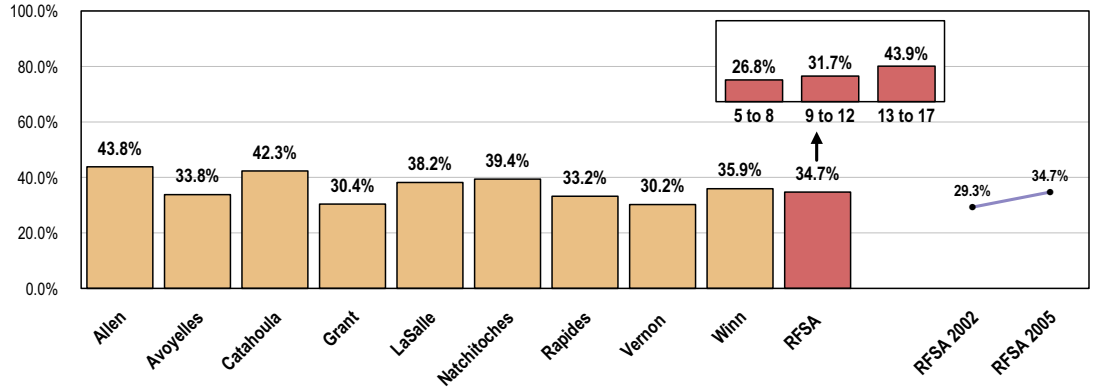
Children's Consumption Of Fast Food

Among RFSA parents of children between the ages of 5 and 17, 34.7% report that their child eats three or more fast food meals per week.

- Ranges from 30.2% in Vernon Parish to 43.8% in Allen Parish.

TREND: Marks a *statistically significant increase* from the 29.3% reported in 2002.

Child Eats Three Or More Fast Food Meals Per Week
(By Parish And Age; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 130]
Note: • Asked of all respondents with children between the ages of 5 and 17 at home.
• State and national data not available.

Body Weight

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

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

Overweight and obesity result from a complex interaction between genes and the environment characterized by long-term energy imbalance due to a sedentary lifestyle, excessive caloric consumption, or both. They develop in a socio-cultural environment characterized by mechanization, sedentary lifestyle, and ready access to abundant food. Attempts to prevent overweight and obesity are difficult to both study and achieve.

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

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI

		BMI (kg/m^2)
Underweight		<18.5
Normal		18.5 – 24.9
Overweight		25.0 – 29.9
Obesity	Obesity Class	
	I	30.0 – 34.9
	II	35.0 – 39.9
Extreme Obesity	III	≥40

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

Healthy Weight

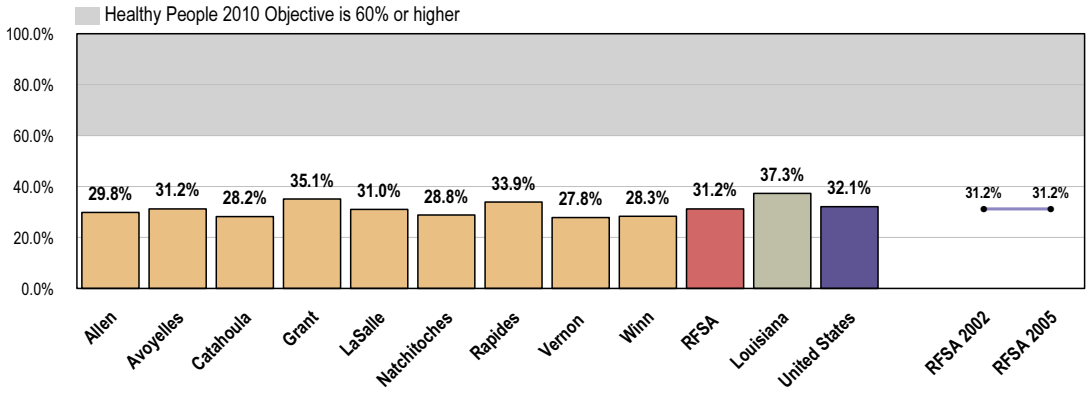
Based on self-reported heights and weights, nearly one-third (31.2%) of RFSA adults are at a healthy weight (neither underweight nor overweight, BMI = 18.5-24.9).

- Less favorable than the 37.3% reported across Louisiana.
- Similar to the 32.1% reported nationwide.
- Far from reaching the Healthy People 2010 target (60% or higher).

TREND: Identical to the 31.2% reported in 2002.

Healthy Weight

(Body Mass Index Between 18.5 And 24.9; By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 135]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 19-1].

Note:
- Based on self-reported height and weight, asked of all respondents.
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

Overweight Status

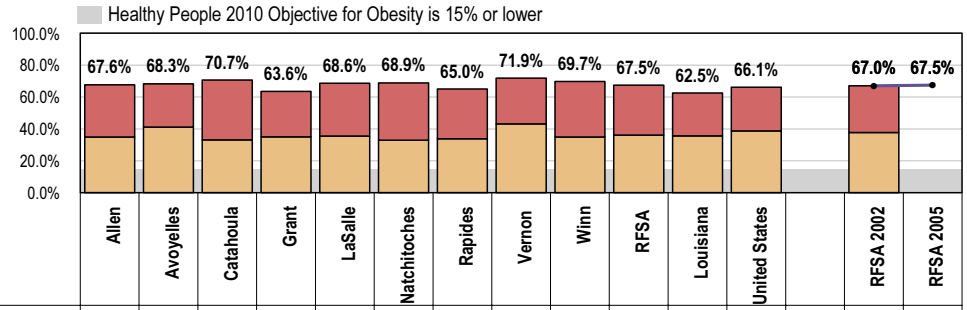
A total of 67.5% of RFSA adults are overweight (BMI ≥ 25), including 31.3% who are obese (BMI ≥ 30).

- Less favorable than the proportion of overweight reported across the state.
- Comparable to the proportion of **overweight** reported throughout the nation (66.1%).
- Fails to satisfy the Healthy People 2010 target for **obesity** (15% or lower).
- Local overweight ranges from 63.6% in Grant Parish to 71.9% in Vernon Parish.

TREND: The RFSA proportion of **obesity** marks a *statistically significant increase* (from 29.2% to 31.3%) since 2002.

Prevalence Of Overweight

(By Parish; 2002-2005 Trend Data)



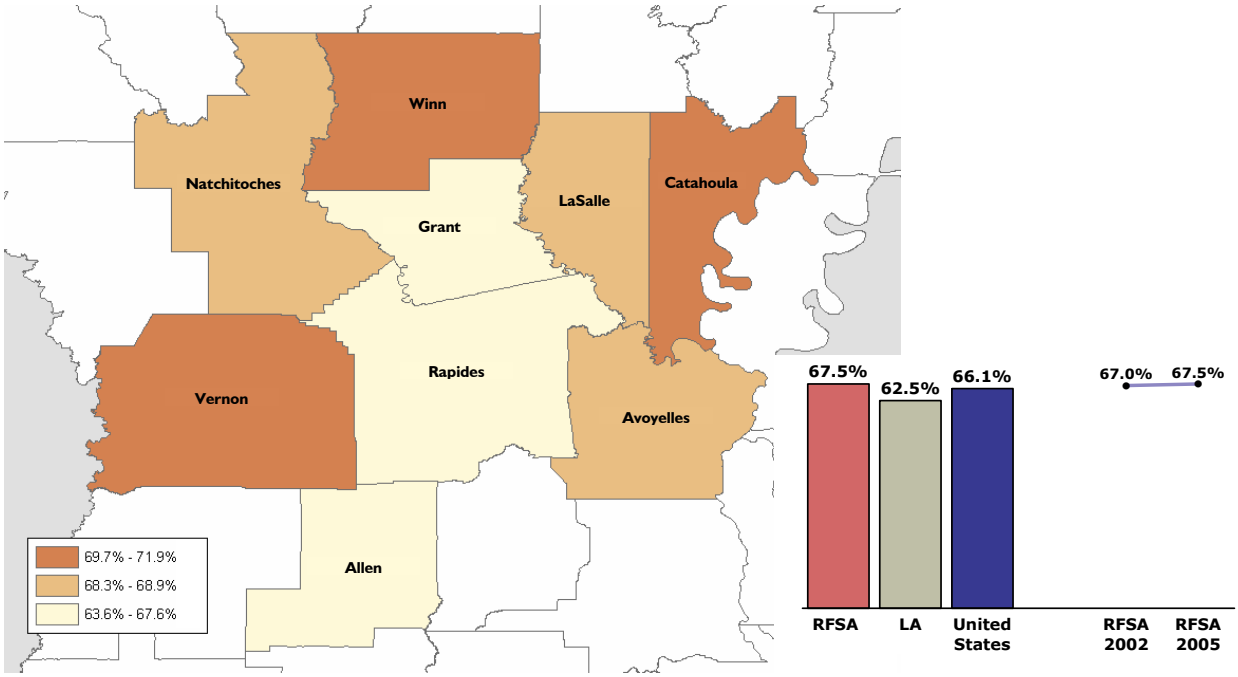
	Allen	Avoyelles	Catahoula	Grant	LaSalle	Natchitoches	Rapides	Vernon	Winn	RFSA	Louisiana	United States	RFSA 2002	RFSA 2005
Total Overweight													67.0%	67.5%
Obese	32.7%	27.2%	37.5%	28.5%	33.1%	36.0%	31.2%	28.7%	34.7%	31.3%	26.9%	27.3%	29.2%	31.3%
Overweight, Not Obese	34.9%	41.1%	33.2%	35.1%	35.5%	32.9%	33.8%	43.2%	35.0%	36.2%	35.6%	38.8%	37.8%	36.2%

Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 135]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-2]

Note:
- Based on self-reported height and weight, asked of all respondents.
- The definition of 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.

Prevalence Of Overweight

(By Parish, 2005)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 135]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-2]

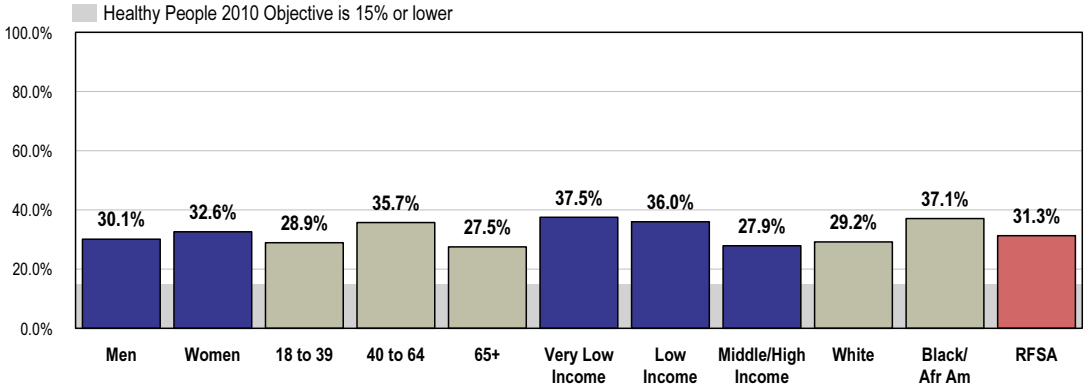
Note:
- Based on self-reported height and weight, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater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

The following chart further examines parish obesity by various demographic characteristics. As shown, the following groups are more likely to be obese:

- Adults aged 40 through 64.
- Those in the lower income categories.
- Blacks/African Americans.

Prevalence Of Obesity

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 135]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-2]

Note:
- Based on self-reported height and weight, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Health Professional Advice About Weight

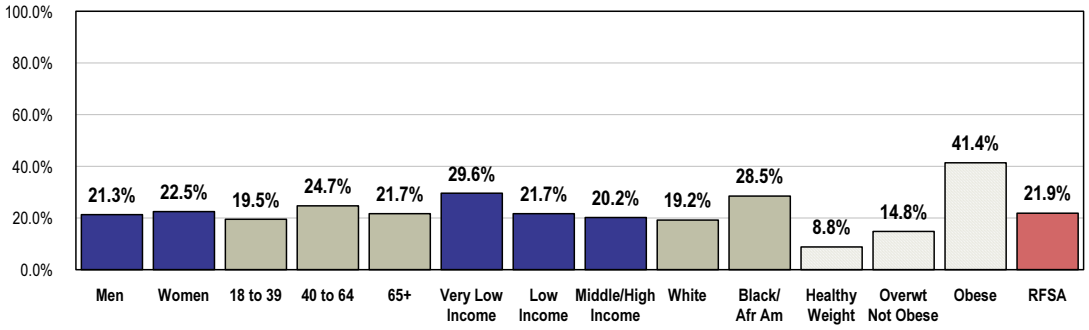
A total of 21.9% of RFSA adults report that their physician, nurse or other health professional has given them advice in the past year about their weight.

The following groups are more likely to have received advice about weight in the past year:

- Obese adults.
- Those aged 40 to 64.
- Adults in the lowest income breakout.
- Blacks/African Americans.

Have Received Advice About Weight In The Past Year From A Physician, Nurse Or Other Health Professional

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 101]
Note: • Asked of all respondents.
• State and national data not available.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Weight Control

Many diseases are associated with overweight and obesity. Persons who are overweight or obese are at increased risk for high blood pressure, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and some types of cancer. The health outcomes related to these diseases, however, often can be improved through weight loss or, at a minimum, no further weight gain. Total costs (medical costs and lost productivity) attributable to obesity alone amounted to an estimated $99 billion in 1995.

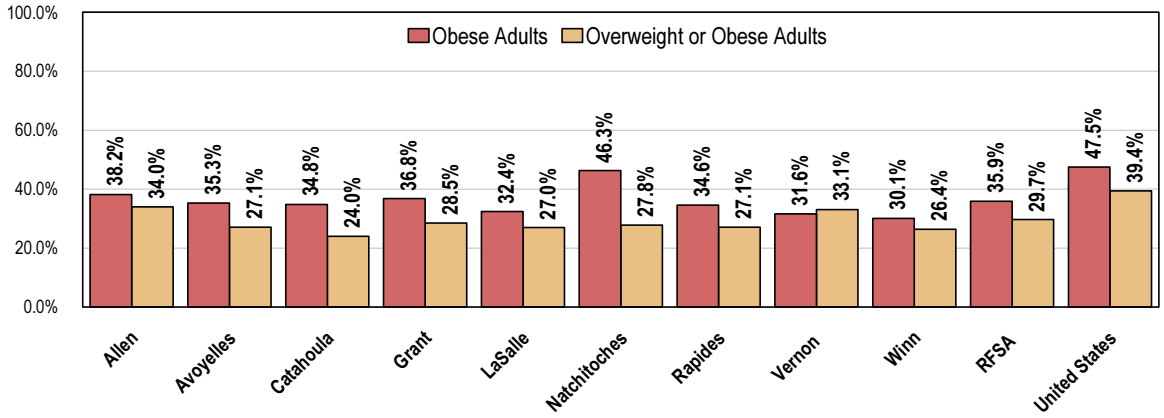
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

29.7% of RFSA adults who are overweight say that they are both modifying their diet and increasing their physical activity in order to lose weight.

- Lower than the 39.4% reported nationally.
- Among obese RFSA adults: 35.9% are trying to lose weight through a combination of diet and exercise, lower than the nationwide proportion.

Trying To Lose Weight By Both Modifying Diet And Increasing Physical Activity

(Among Respondents Who Are Overweight; By Weight Status; By Parish, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 136]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Reflects responses among overweight respondents (categories are not mutually exclusive).

Relationship Of Overweight With Other Health Issues

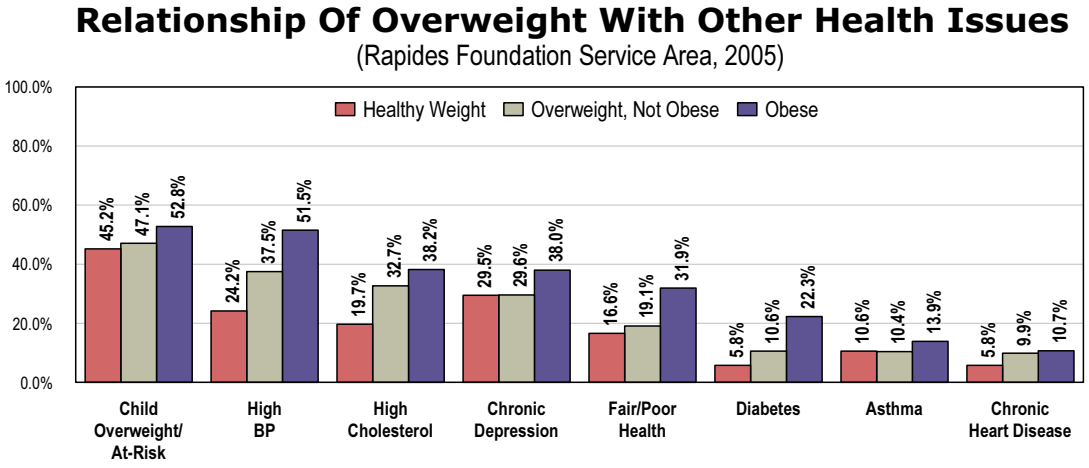
The correlation between overweight and various health issues cannot be disputed.

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

These include:

- Hypertension (high blood pressure).
- High cholesterol.
- Chronic depression.
- "Fair" or "poor" physical health.
- Diabetes.
- Asthma.
- Chronic heart disease.

Overweight/obese parents also appear to be more likely to have children who are overweight or at-risk for overweight.



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Items 16,36,41,43,46,50,103,138,166]
Note: • Reflects responses among the total sample of respondents, segmented by their bodyweight category (categories are mutually exclusive).

Child Overweight

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

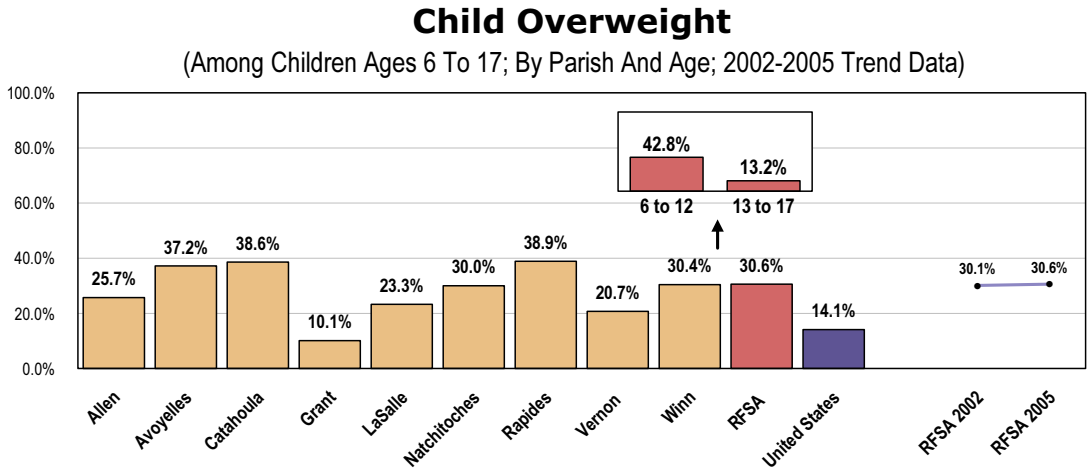
Underweight..... <5th percentile
At Risk of Overweight..... 85th to 95th percentile
Overweight..... ≥ 95th percentile

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

A total of 30.6% of RFSA children aged 6 to 17 are overweight, based on heights/weights reported by surveyed parents.

- More than twice the national prevalence for child overweight (14.1%).
- Ranges from 10.1% in Grant Parish to 38.9% in Rapides Parish.

TREND: Statistically unchanged from the 30.1% reported in the RFSA in 2002.



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 166]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents with children aged 6 to 17 at home.
• Overweight among children is estimated based on children's' Body Mass Index status above the 95th percentile of U.S. growth charts by gender and age.
• State data not available.

PHYSICAL ACTIVITY & FITNESS

The 1990s brought a historic new perspective to exercise, fitness, and physical activity by shifting the focus from intensive vigorous exercise to a broader range of health-enhancing physical activities. Research has demonstrated that virtually all individuals will benefit from regular physical activity. A Surgeon General's report on physical activity and health concluded that moderate physical activity can reduce substantially the risk of developing or dying from heart disease, diabetes, colon cancer, and high blood pressure. Physical activity also may protect against lower back pain and some forms of cancer (for example, breast cancer), but the evidence is not yet conclusive.

On average, physically active people outlive those who are inactive. Regular physical activity also helps to maintain the functional independence of older adults and enhances the quality of life for people of all ages.

The role of physical activity in preventing coronary heart disease (CHD) is of particular importance, given that CHD is the leading cause of death and disability in the United States. Physically inactive people are almost twice as likely to develop CHD as persons who engage in regular physical activity. The risk posed by physical inactivity is almost as high as several well-known CHD risk factors, such as cigarette smoking, high blood pressure, and high blood cholesterol. Physical inactivity, though, is more prevalent than any one of these other risk factors. People with other risk factors for CHD, such as obesity and high blood pressure, may particularly benefit from physical activity.

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

Work-Related & Leisure-Time Physical Activity

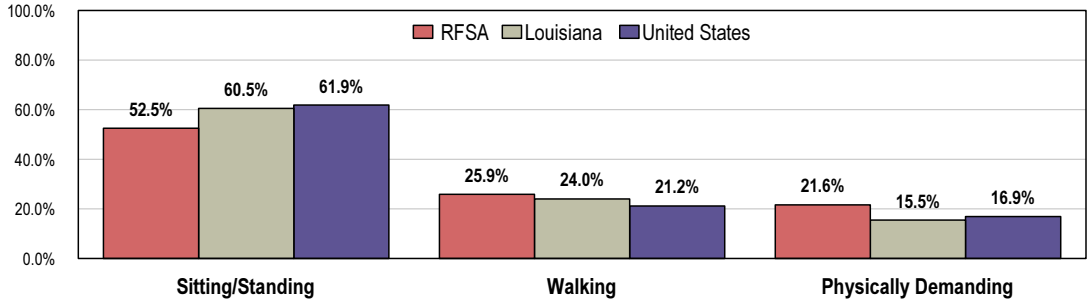
Level Of Activity at Work

More than one-half of employed RFSA respondents report low levels of physical activity at work.

- 52.5% of employed respondents report that their job entails mostly sitting or standing.
- Others report that they mostly walk (25.9%) or perform physically demanding work (21.6%).
- Note that adults in the RFSA are more likely than those across the nation to be physically active at work.

Primary Level Of Physical Activity At Work

(Among Employed Respondents; By Region, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2003 Louisiana data.
- 2005 PRC National Health Survey, Professional Research Consultants.

Note:
- Asked of all employed respondents.

Leisure-Time Physical Activity

To address physical activity during leisure time (outside of regular work duties), respondents were asked: *"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"*

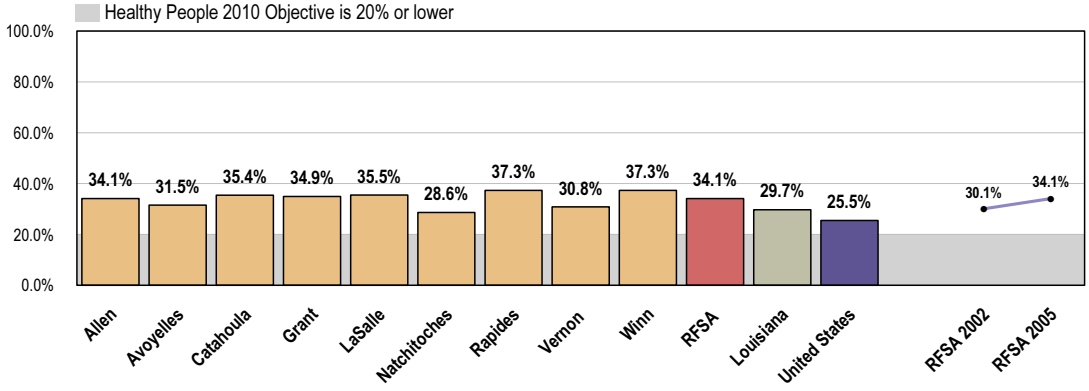
A total of one in three (34.1%) RFSA adults report no leisure-time physical activity in the past month.

- Less favorable than the 25.5% reported across the nation.
- Ranges from 28.6% in Natchitoches Parish to 37.3% in Rapides and Winn parishes.

TREND: Marks a *statistically significant increase* from the 30.1% reported in 2002.

No Leisure-Time Physical Activity In The Past Month

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 94]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-1]

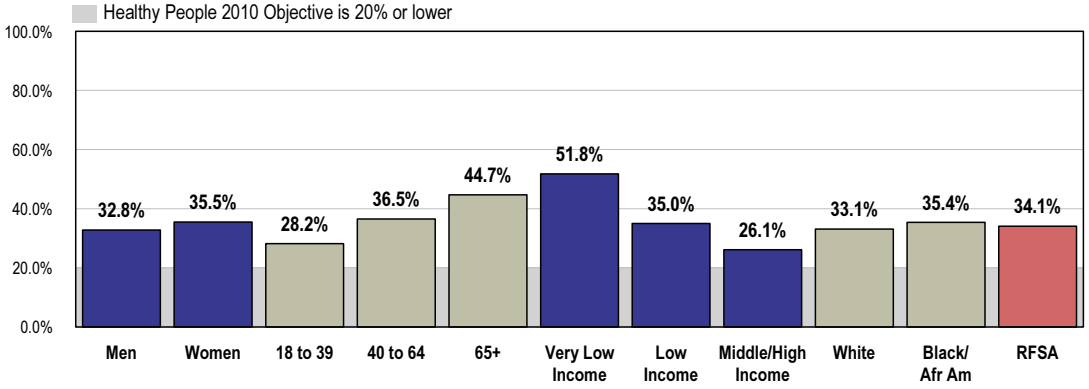
Note:
- Asked of all respondents.
- The Healthy People 2010 goal is to decrease to at most 20% the proportion of people who engage in no leisure-time physical activity.
- State data not available.

A lack of leisure-time physical activity is more prevalent among respondents with the following demographic characteristics:

- Adults aged 65 and over.
- Those living at very low incomes.

No Leisure-Time Physical Activity In Past Month

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 94]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-1]

Note:
- Asked of all respondents.
- The Healthy People 2010 goal is to decrease to at most 20% the proportion of people who engage in no leisure-time physical activity.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Activity Levels

Effects Of Physical Inactivity And Unhealthy Diets

- Poor diet and physical inactivity lead to 300,000 deaths each year—second only to tobacco use.
- People who are overweight or obese increase their risk for heart disease, diabetes, high blood pressure, arthritis-related disabilities, and some cancers.
- Not getting an adequate amount of exercise is associated with needing more medication, visiting a physician more often, and being hospitalized more often.

Costs

- The direct medical cost associated with physical inactivity was $29 billion in 1987 and nearly $76.6 billion in 2000.
- The annual cost of obesity in the United States is about $100 billion.

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

Moderate Physical Activity

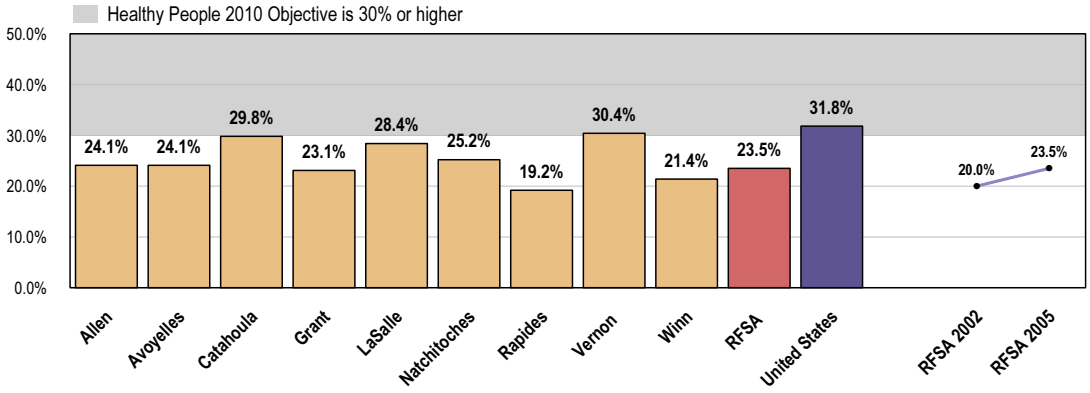
In the past month, just under one in four (23.5%) RFSA adults regularly participated in moderate physical activity.

- Much lower than to the U.S. prevalence (31.8%).
- Ranges from 19.2% in Rapides Parish to 30.4% in Vernon Parish.

TREND: Marks a *statistically significant increase* from the 20.0% reported in 2002.

Moderate Physical Activity

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 138]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-2]

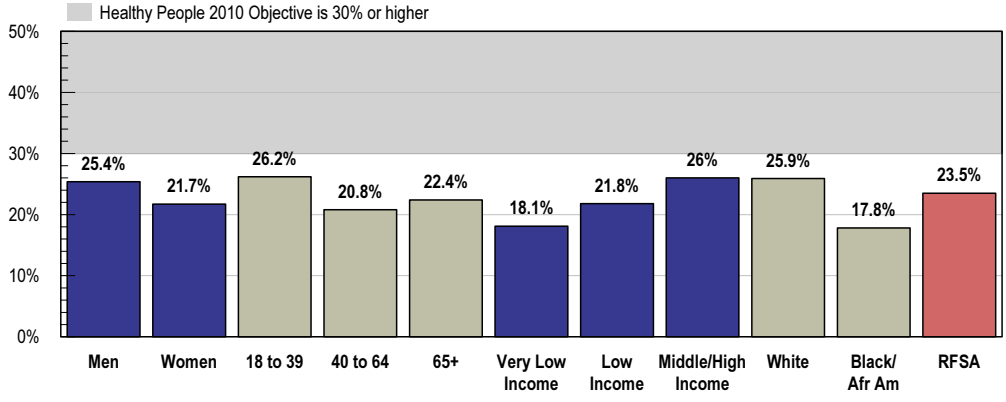
Note:
- Asked of all respondents.
- Takes part in "light/moderate physical activity" (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time.
- The Healthy People 2010 goal is to increase to at least 30% the proportion of people who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.
- State data not available.

Adults less likely to regularly participate in moderate physical activity include the following:

- Women.
- Those aged 40 and older.
- Adults living at lower income levels.
- Blacks/African Americans.

Moderate Physical Activity

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 138]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-2]

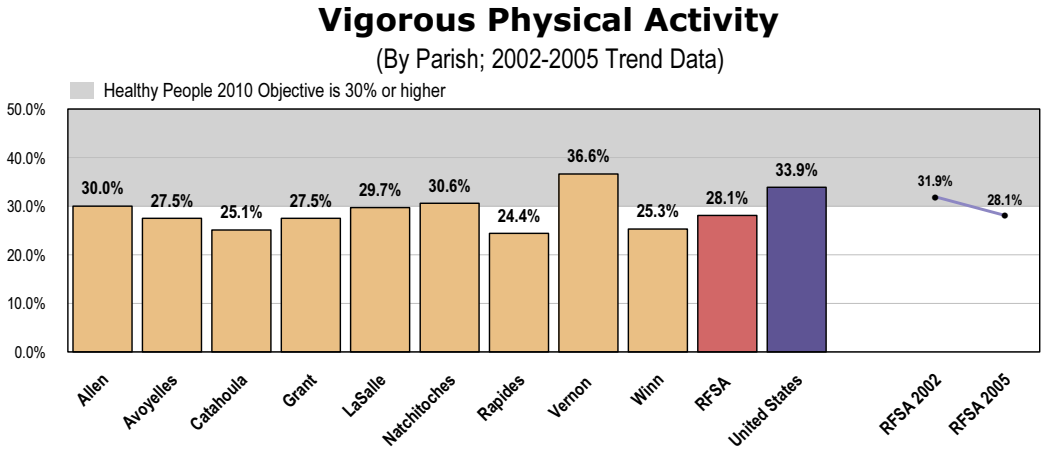
Note:
- Asked of all respondents.
- Takes part in "light/moderate physical activity" (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time.
- The Healthy People 2010 goal is to increase to at least 30% the proportion of people who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Vigorous Physical Activity

In the past month, 28.1% of RFSA adults regularly participated in vigorous physical activity (causing heavy sweating or large increases in breathing or heart rate).

- Less favorable than the 33.9% reported across the country.
- Fails to satisfy the 30% objective established by Healthy People 2010.
- Ranges from 24.4% in Rapides Parish to 36.6% in Vernon Parish.

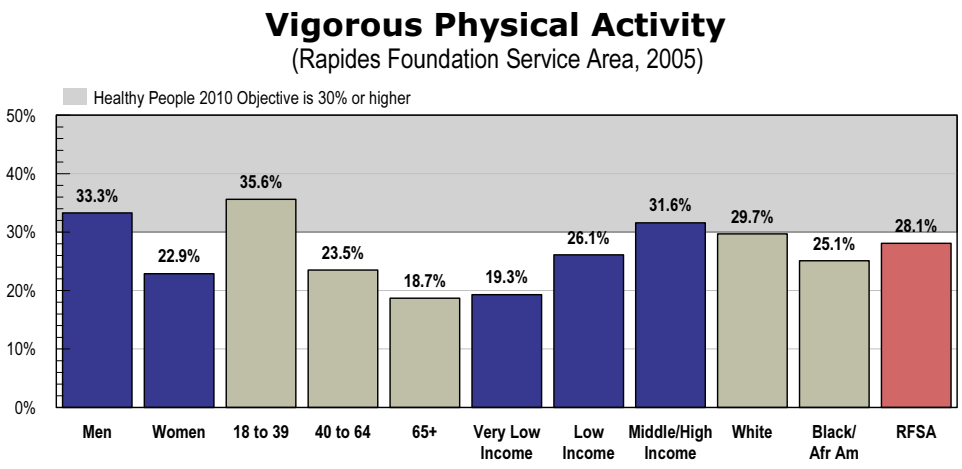
TREND: Marks a *statistically significant decrease* since 2002.



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 137]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-3]

Note:
- Asked of all respondents.
- Takes part in "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 Healthy People 2010 goal is to increase to at least 30% the proportion of people who engage regularly, preferably 3 times or more weekly, in vigorous physical activity for at least 20 minutes per exercise session.
- State data not available.

Note the following demographic breakout for regular participation in vigorous physical activity.



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 137]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-3]

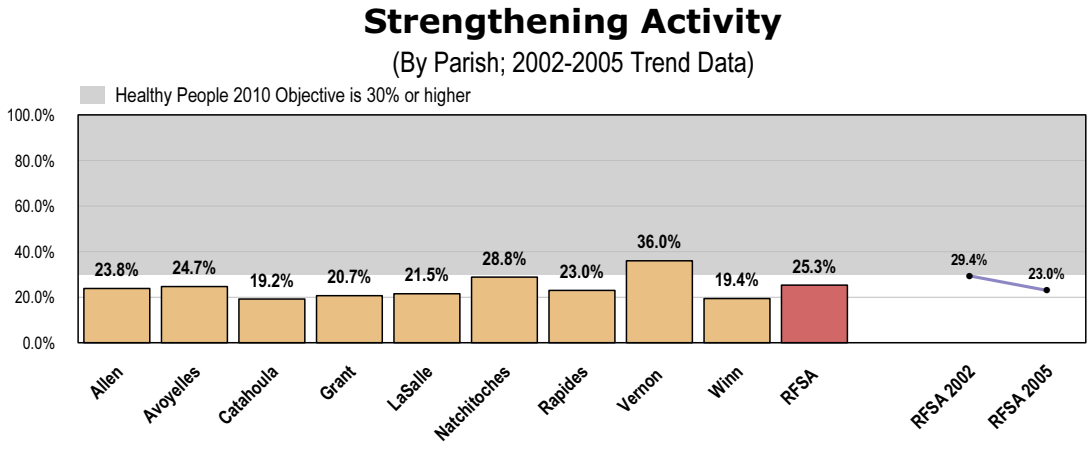
Note:
- Asked of all respondents.
- Takes part in "vigorous physical activity" (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.
- The Healthy People 2010 goal is to increase to at least 30% the proportion of people who engage regularly, preferably 3 times or more weekly, in vigorous physical activity for at least 20 minutes per exercise session.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Strengthening Activity

In the past month, 25.3% of RFSA adults regularly participated in strengthening activities at least twice weekly (activities designed to strengthen muscles, such as lifting weights or doing calisthenics).

- Highest (36.0%) in Vernon Parish.

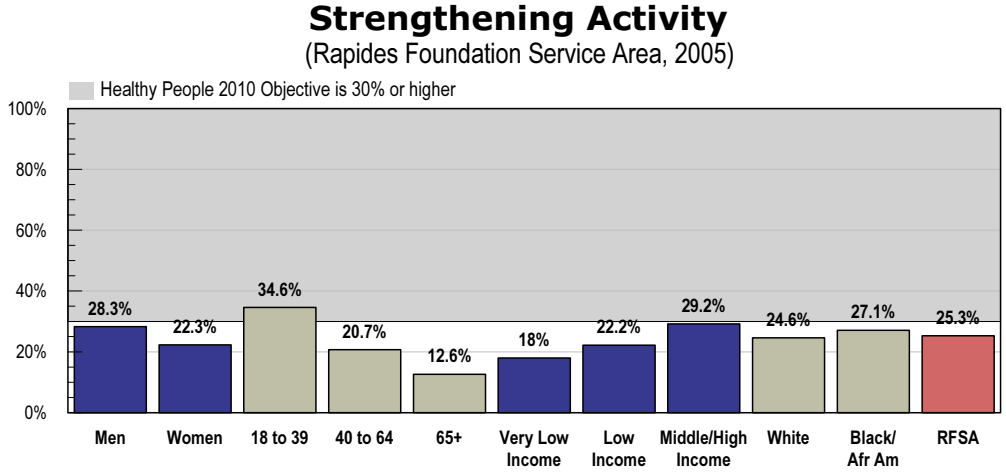
TREND: Marks a *statistically significant decrease* in strengthening activity since 2002.



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 97]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-4]

Note:
- Asked of all respondents.
- Takes part in "strengthening activity" (activities that are specifically designed to strengthen muscles, such as lifting weights or doing calisthenics) at least twice weekly.
- The Healthy People 2010 goal is to increase to at least 30% the proportion of people who perform physical activities which enhance and maintain muscular strength and endurance.
- State and national data not available.

- RFSA adults who currently meet the related Healthy People 2010 objective are those aged 18 to 39 and adults living in the highest income breakout.



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 97]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-4]

Note:
- Asked of all respondents.
- Takes part in "strengthening activity" (activities that are specifically designed to strengthen muscles, such as lifting weights or doing calisthenics) at least twice weekly.
- The Healthy People 2010 goal is to increase to at least 30% the proportion of people who perform physical activities which enhance and maintain muscular strength and endurance.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Physical Activity Among Children

Participation In Physical Activity

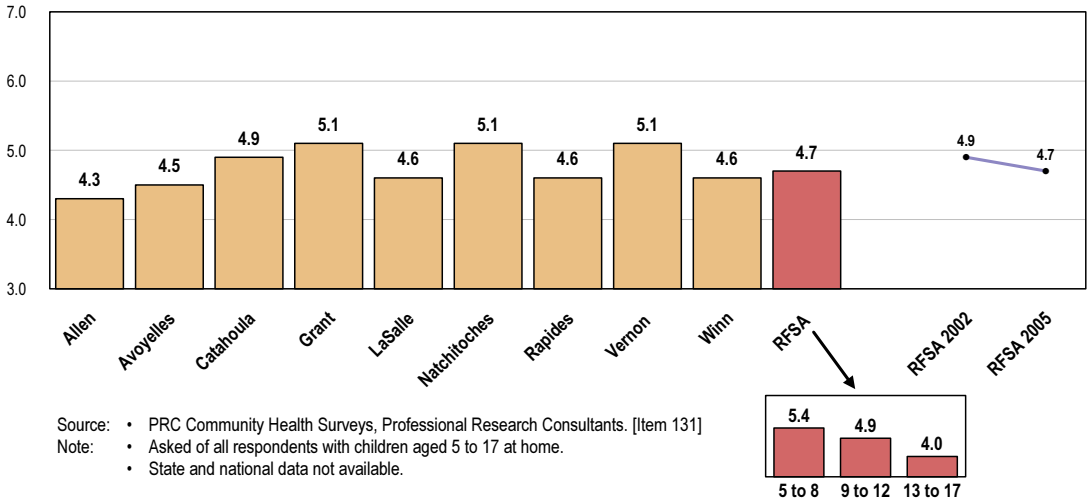
RFSA children aged 5 through 17 average 4.7 days per week in or when they participate in physical activity lasting 20 minutes or more.

- Ranges from 4.3 in Allen Parish to 5.1 in Grant, Natchitoches, and Vernon parishes.

TREND: The proportion of RFSA children who exercise five or more days weekly for at least 20 minutes each time has undergone a *statistically significant decrease* since 2002.

Average Days Per Week In Which Child Participates In Physical Activity Lasting 20+ Minutes

(By Parish And Age; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 131]
Note: • Asked of all respondents with children aged 5 to 17 at home.
• State and national data not available.

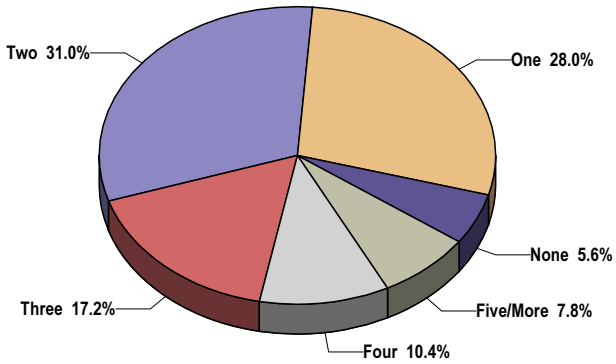
Television Viewing

More than one-third of RFSA parents indicate that their child watches three or more hours of television on a typical school day.

- This includes 17.2% who indicate their child watches **three hours**, 10.4% who report that their child watches **four hours** of television, and 7.8% whose child watches television **five or more hours** on a typical school day.

Hours Child Watches Television On A Typical School Day

(Rapides Foundation Service Area, 2005)



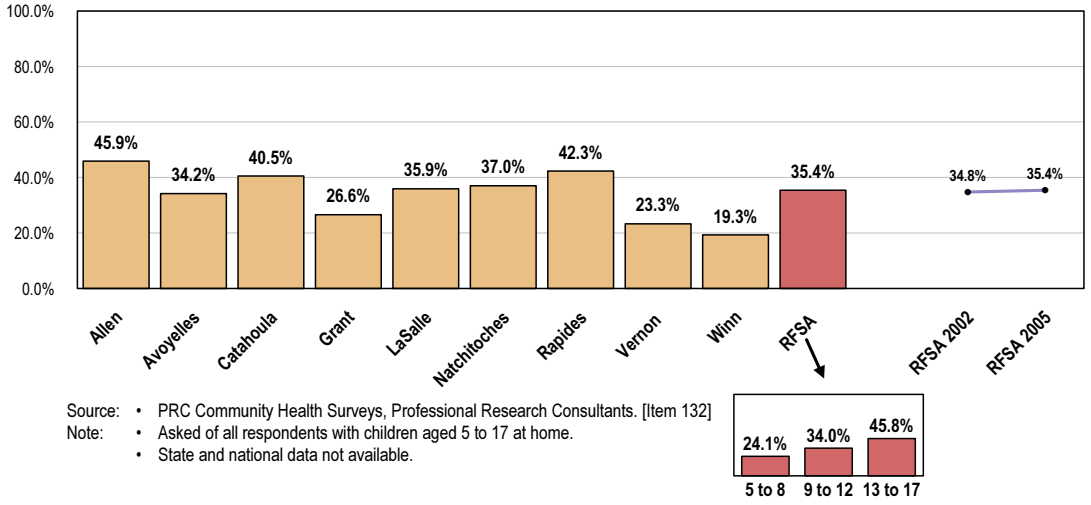
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 132]
Note: • Asked of all respondents with children under 18 at home.

- Ranges from 19.3% in Winn Parish to 45.9% in Allen Parish.
- Increases steadily with the child's age.

TREND: Statistically similar to 2002 findings.

Child Watches Three Or More Hours Of Television On A Typical School Day

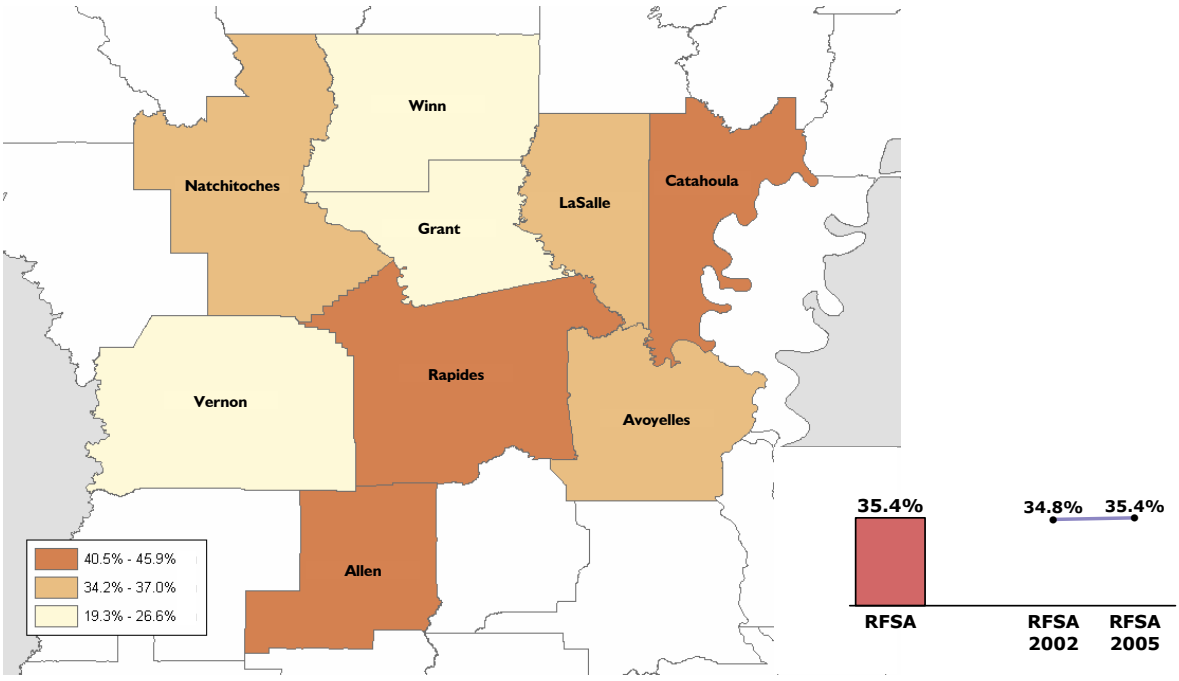
(By Parish And Age; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 132]
Note: • Asked of all respondents with children aged 5 to 17 at home.
• State and national data not available.

Child Watches Three Or More Hours Of Television On A Typical School Day

(Children Age 5 to 17 Years; By Parish, 2005)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 132]
Note: • Asked of all respondents with children aged 5 to 17 at home.

SUBSTANCE ABUSE

Substance abuse and its related problems are among society's most pervasive health and social concerns. Each year, about 100,000 deaths in the United States are related to alcohol consumption. Illicit drug abuse and related acquired immunodeficiency syndrome (AIDS) deaths account for at least another 12,000 deaths. In 1995, the economic cost of alcohol and drug abuse was $276 billion. This represents more than $1,000 for every man, woman, and child in the United States to cover the costs of healthcare, motor vehicle crashes, crime, lost productivity, and other adverse outcomes of alcohol and drug abuse.

A substantial proportion of the population drinks alcohol… Alcohol use and alcohol-related problems also are common among adolescents. Excessive drinking has consequences for virtually every part of the body. The wide range of alcohol-induced disorders is due (among other factors) to differences in the amount, duration, and patterns of alcohol consumption, as well as differences in genetic vulnerability to particular alcohol-related consequences… Alcohol use has been linked with a substantial proportion of injuries and deaths from motor vehicle crashes, falls, fires, and drownings. It also is a factor in homicide, suicide, marital violence, and child abuse and has been associated with high-risk sexual behavior…

Illegal use of drugs, such as heroin, marijuana, cocaine, and methamphetamine, is associated with other serious consequences, including injury, illness, disability, and death, as well as crime, domestic violence, and lost workplace productivity. Drug users and persons with whom they have sexual contact run high risks of contracting gonorrhea, syphilis, hepatitis, tuberculosis, and human immunodeficiency virus (HIV). The relationship between injection drug use and HIV/AIDS transmission is well known. Injection drug use also is associated with hepatitis B and C infections… Long-term consequences, such as chronic depression, sexual dysfunction, and psychosis, may result from drug use.

Although there has been a long-term drop in overall use, many people in the United States still use illicit drugs… Drug use among adolescents aged 12 to 17 years doubled between 1992 and 1997… Drug and alcohol use by youth also is associated with other forms of unhealthy and unproductive behavior, including delinquency and high-risk sexual activity.

The stigma attached to substance abuse increases the severity of the problem. The hiding of substance abuse, for example, can prevent persons from seeking and continuing treatment and from having a productive attitude toward treatment. Compounding the problem is the gap between the number of available treatment slots and the number of persons seeking treatment for illicit drug use or problem alcohol use.

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

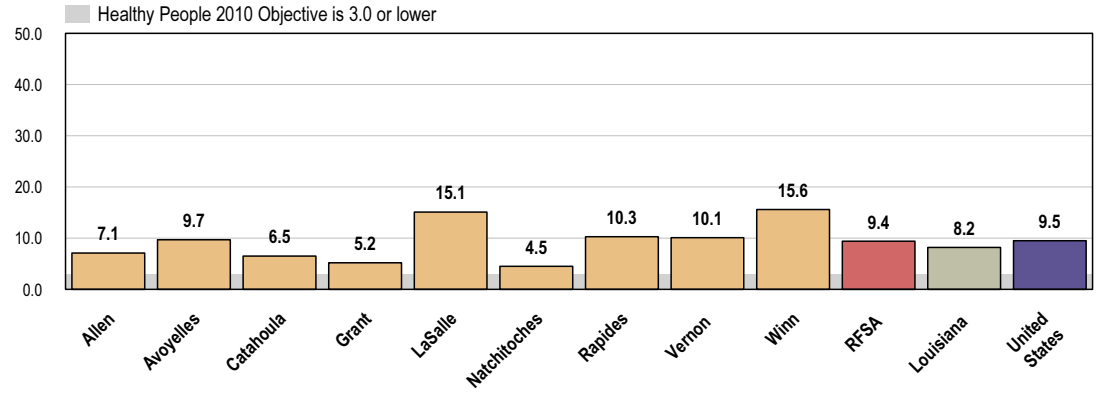
Age-Adjusted Cirrhosis Deaths

Between 2000 and 2002, there was an annual average age-adjusted cirrhosis/liver disease death rate of 9.4 deaths per 100,000 population in the RFSA.

- Comparable to the 9.5 per 100,000 national rate.
- Fails to satisfy the Healthy People 2010 objective of 3.0 or lower.
- Highest in LaSalle and Winn parishes.

Age-Adjusted Mortality: Cirrhosis/Liver Disease

(By Parish; 2000-2002 Deaths Per 100,000 Population)



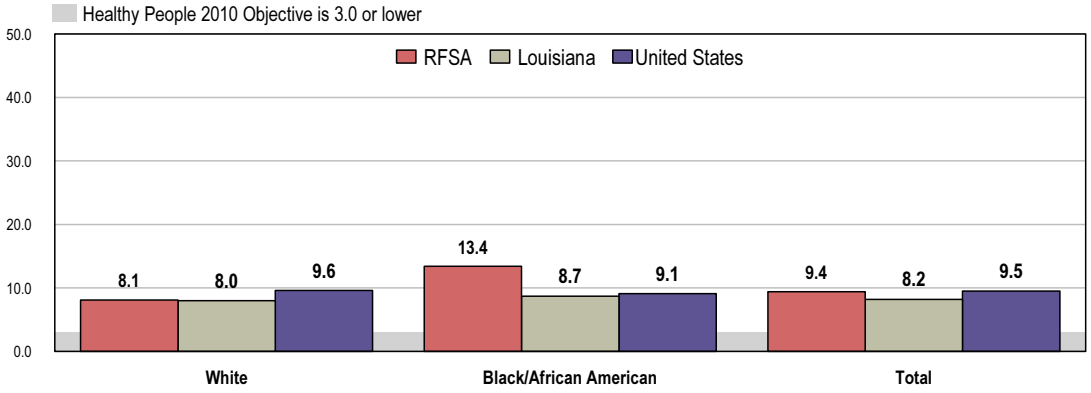
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 26-2].

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

- In the RFSA, the cirrhosis/liver disease death rate is higher among Blacks/African Americans (13.4) than among Whites (8.1).

Age-Adjusted Mortality: Cirrhosis/Liver Disease

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



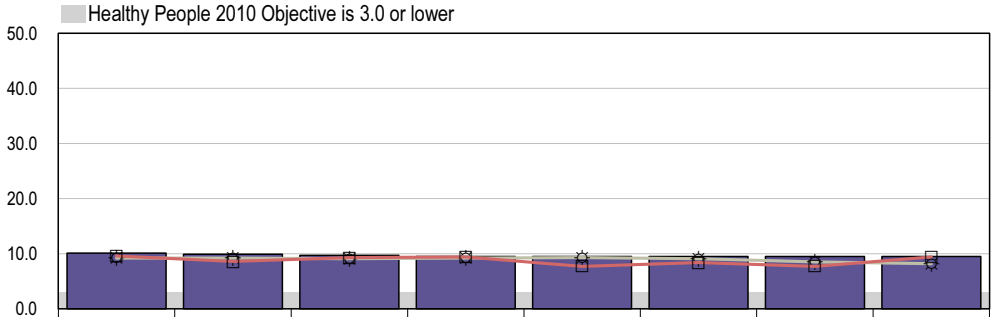
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 26-2].

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

TREND: Age-adjusted cirrhosis/liver disease mortality rates in the RFSA remained fairly stable over the past decade; this was also the case across Louisiana and the U.S. overall.

Age-Adjusted Mortality: Cirrhosis/Liver Disease

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	9.6	8.6	9.3	9.4	7.7	8.4	7.7	9.4
Louisiana	9.2	9.2	9.1	9.2	9.3	9.1	8.5	8.2
United States	10.1	9.9	9.7	9.5	9.5	9.5	9.5	9.5

Source:
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000 [Objective 26-2].

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Data for 1999 and subsequent years are not fully comparable to data from 1998 and prior years, due to changes in coding of causes of deaths resulting from the switch from the ninth revision of the International Classification of Diseases (ICD9) to the tenth revision (ICD10).
- State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

Alcohol Use

Current Drinkers

Current drinkers include survey respondents reporting one or more drinks of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is defined as one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail or one shot of liquor.

In the RFSA, 39.2% of adults are current drinkers.

- Lower than the 58.0% reported across the United States.

High-Risk Alcohol Use

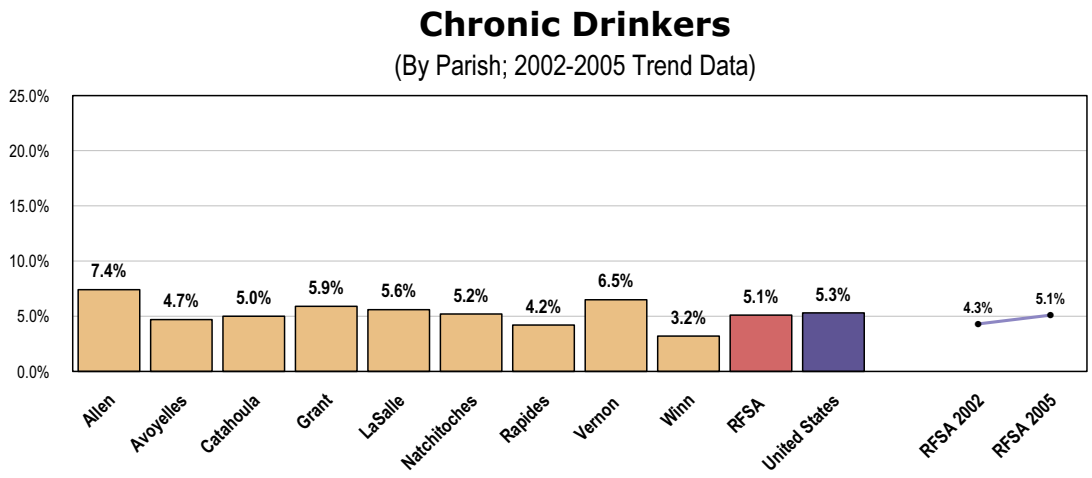
Chronic Drinking

Chronic drinkers include respondents reporting 60 or more drinks of alcohol in the month preceding the interview (an average of two or more per day).

5.1% of RFSA adults report an average of two or more drinks of alcohol per day in the past month.

- Similar to the 5.3% reported nationwide.
- Ranges from 3.2% in Winn Parish to 7.4% in Allen Parish.

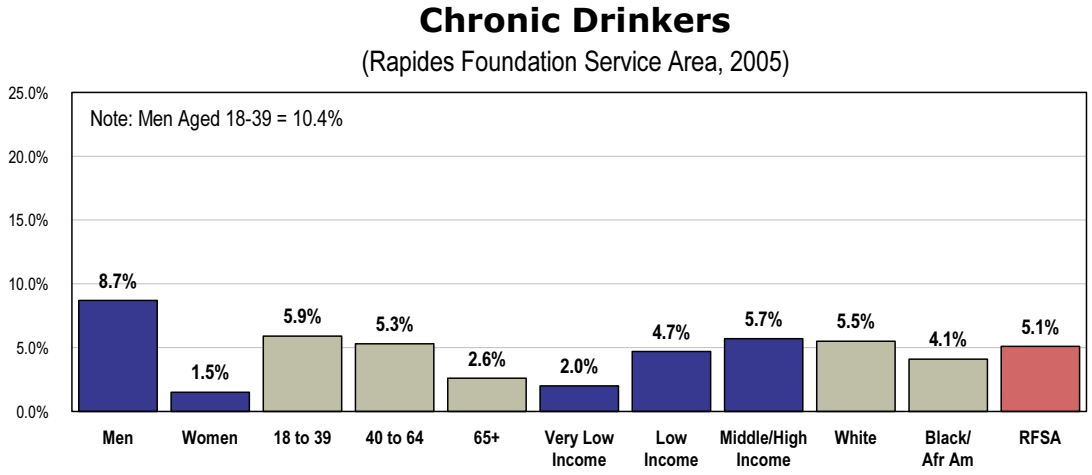
TREND: Statistically unchanged from the 4.3% reported in 2002.



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 144]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Reflects the total sample of respondents.
• Chronic drinkers are defined as those who have had at least 60 drinks of alcoholic beverages during the past month.
• State data not available.

Chronic drinking is more prevalent in the RFSA among:

- Men (especially men aged 18 through 39).
- Adults under 65.
- Persons living at the higher income levels.



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 144]
Note: • Reflects the total sample of respondents.
• Chronic drinkers are defined as those who have had at least 60 drinks of alcoholic beverages during the past month.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

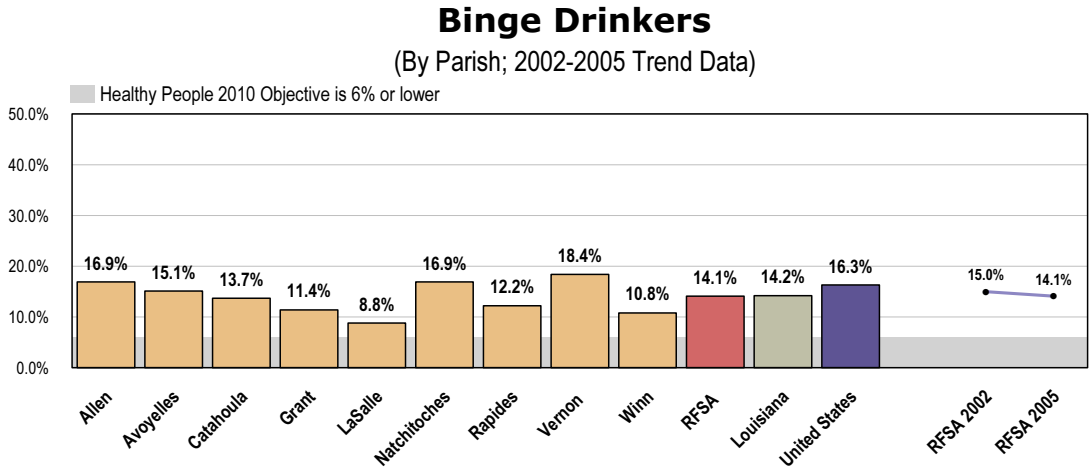
Binge Drinking

Binge drinkers are respondents who report that there was one or more times in the past month when they drank five or more drinks on a single occasion.

14.1% of RFSA adults are binge drinkers.

- Similar to the state proportion.
- Comparable to the 16.3% reported across the U.S.
- Fails to satisfy the Healthy People 2010 target (6% or lower).
- Ranges from 8.8% in LaSalle Parish to 18.4% in Vernon Parish.

TREND: Statistically unchanged from the 15.0% reported in 2002.



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 145]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-11c]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.

Note:
- Reflects the total sample of respondents.
- Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once in the past month.

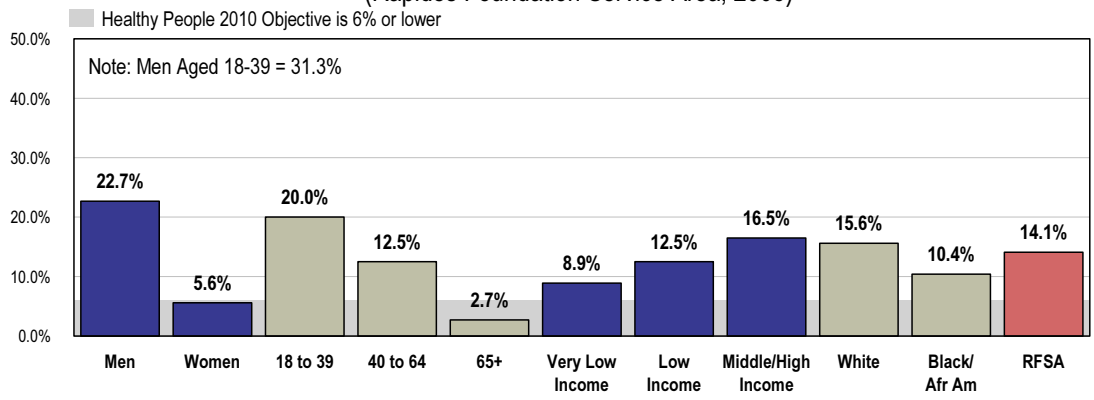
Note that binge drinking is more prevalent among:

- Men (particularly men aged 18 to 39).
- Adults under 65.
- Those in the middle/high income category.
- Whites.

Women and adults aged 65 and older satisfy the Healthy People 2010 target.

Binge Drinkers

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 145]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-11c]

Note:
- Reflects the total sample of respondents.
- Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once during the past month.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Drinking & Driving

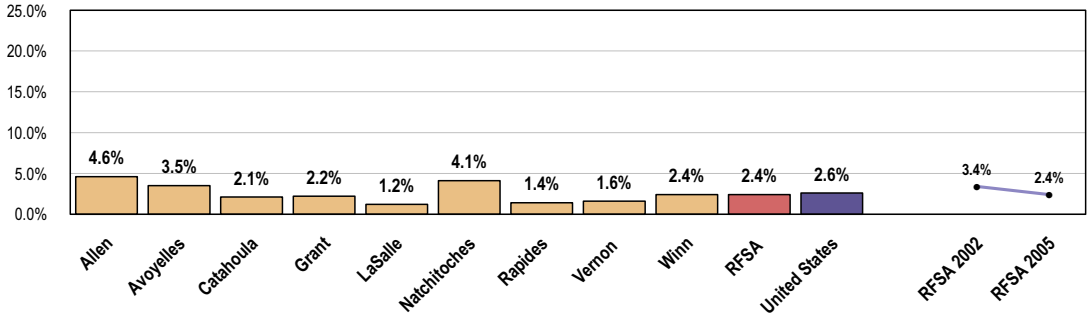
A total of 2.4% of parish adults acknowledge having driven a vehicle in the past month after they had perhaps too much alcohol to drink.

- Statistically similar to the 2.6% reported nationwide.
- Based on current population estimates, this figure represents approximately 6,209 drunk drivers on RFSA streets during the past month (an average of 207 per day).

TREND: Marks a *statistically significant decrease* in self-reported drunk driving since 2002.

Have Driven In The Past Month After Perhaps Having Too Much to Drink

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 65]
- 2005 PRC National Health Survey, Professional Research Consultants.

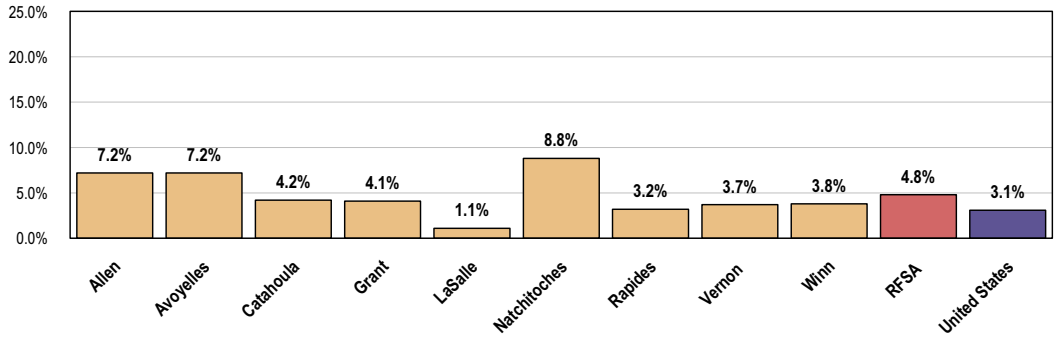
Note:
- Asked of all respondents.
- State data not available.

A total of 4.8% of RFSA adults acknowledge having ridden with someone in the past month after the driver had perhaps too much to drink.

- Less favorable than the 3.1% reported nationwide.
- Particularly high in Allen, Avoyelles, and Natchitoches parishes.

Have Ridden In The Past Month With A Driver Who Had Too Much To Drink

(By Parish, 2005)



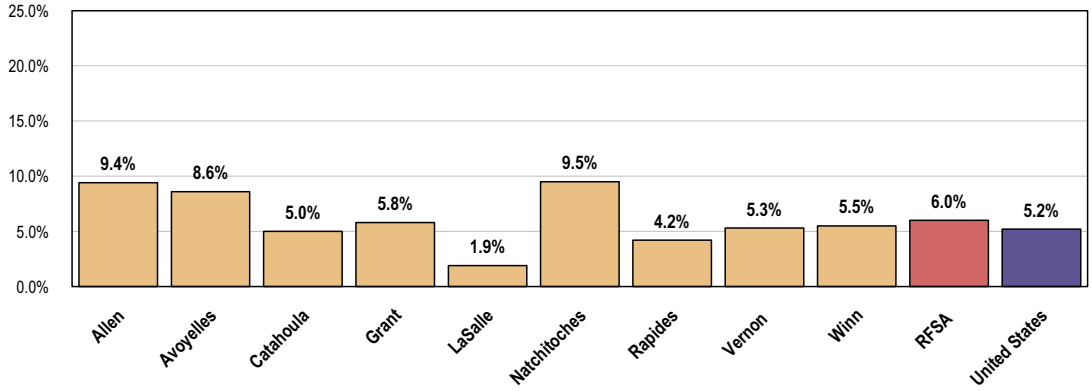
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 66]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

In all, 6.0% of RFSA adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- Statistically similar to benchmark data.
- Ranges from 1.9% in LaSalle Parish to 9.5% in Natchitoches.

Have Driven Drunk In The Past Month OR Ridden With A Driver Who Had Too Much To Drink

(By Parish, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 167]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

Illicit Drug Use

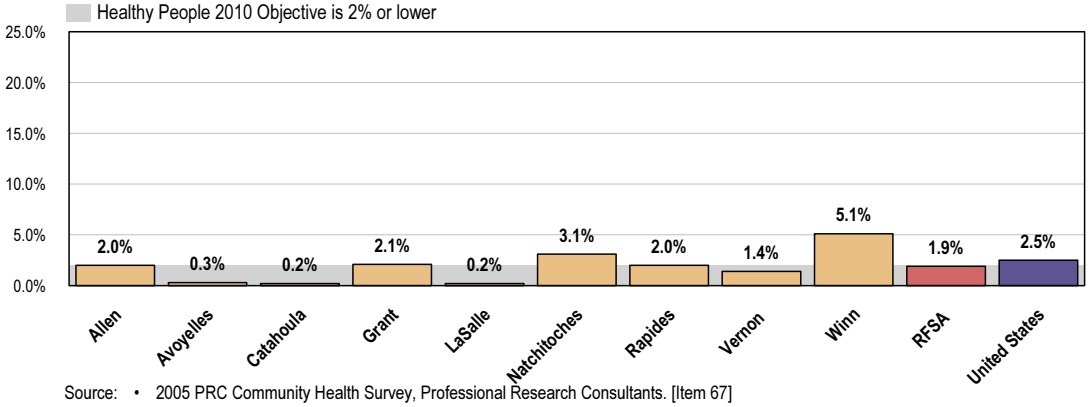
For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Just 1.9% of RFSA adults acknowledge using an illicit drug in the past month.

- Similar to the 2.5% found nationwide.
- Satisfies the Healthy People 2010 target (2% or lower).
- Ranges from 0.2% in Catahoula and LaSalle parishes to 5.1% in Winn Parish.

Illicit Drug Use In The Past Month

(By Parish, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 67]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-10c]

Note:
- Asked of all respondents.
- In this case, the term "illicit drug use" includes use of an illegal drug and/or use of a prescription drug without a physician's orders.
- State data not available.

Alcohol & Drug Treatment

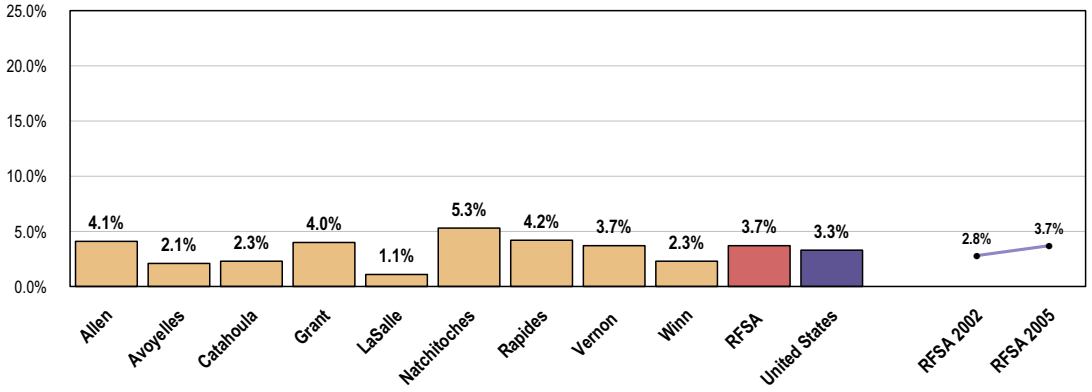
Among parish respondents, 3.7% have sought professional help for an alcohol- or drug-related problem.

- Similar to the national prevalence (3.3%).
- Ranges from 1.1% in LaSalle Parish to 5.3% in Natchitoches Parish.

TREND: Marks a *statistically significant increase* from the 2.8% reported in 2002.

Have Ever Sought Professional Help For An Alcohol- Or Drug-Related Problem

(By Parish; 2002-2005 Trend Data)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 68 by 145]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• State data not available.

TOBACCO USE

Cigarette smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth, and bladder), and chronic lung disease. Cigarette smoking also contributes to cancer of the pancreas, kidney, and cervix. Smoking during pregnancy causes spontaneous abortions, low birth weight, and sudden infant death syndrome. Other forms of tobacco are not safe alternatives to smoking cigarettes.

Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States [about 20% of all deaths]… If current tobacco use patterns persist in the United States, an estimated 5 million persons under age 18 years will die prematurely from a smoking-related disease. Direct medical costs related to smoking total at least $50 billion per year [other sources estimate more than $75 billion in 1998, about 8% of the personal healthcare expenditures in the U.S.]; direct medical costs related to smoking during pregnancy are approximately $1.4 billion per year.

Evidence is accumulating that shows maternal tobacco use is associated with mental retardation and birth defects such as oral clefts. Exposure to secondhand smoke also has serious health effects. Researchers have identified more than 4,000 chemicals in tobacco smoke; of these, at least 43 cause cancer in humans and animals. Each year, because of exposure to secondhand smoke, an estimated 3,000 nonsmokers die of lung cancer, and 150,000 to 300,000 infants and children under age 18 months experience lower respiratory tract infections.

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

(For lung cancer prevalence, see "Cancer;" for prevalence of other lung diseases, see "Respiratory Disease.")

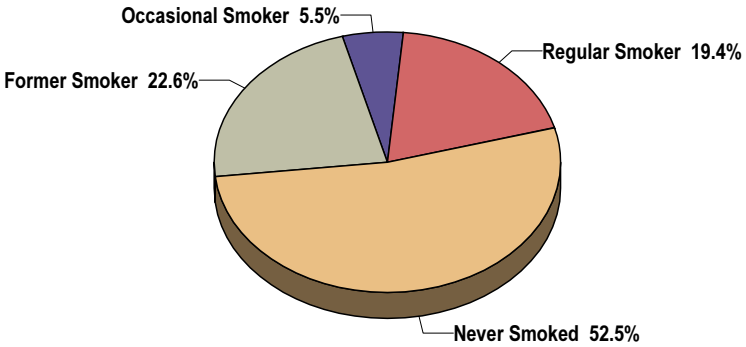
Cigarette Smoking

Cigarette Smoking Prevalence

One in four RFSA adults (24.9%) currently smokes cigarettes, either regularly (every day) or occasionally (on some days).

- Another 22.6% of RFSA adults are former smokers (those who have smoked 100 or more cigarettes in their lives, but do not currently smoke).
- More than one-half (52.5%) have never smoked.

Cigarette Smoking Prevalence
(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 140]
Note: • Asked of all respondents.

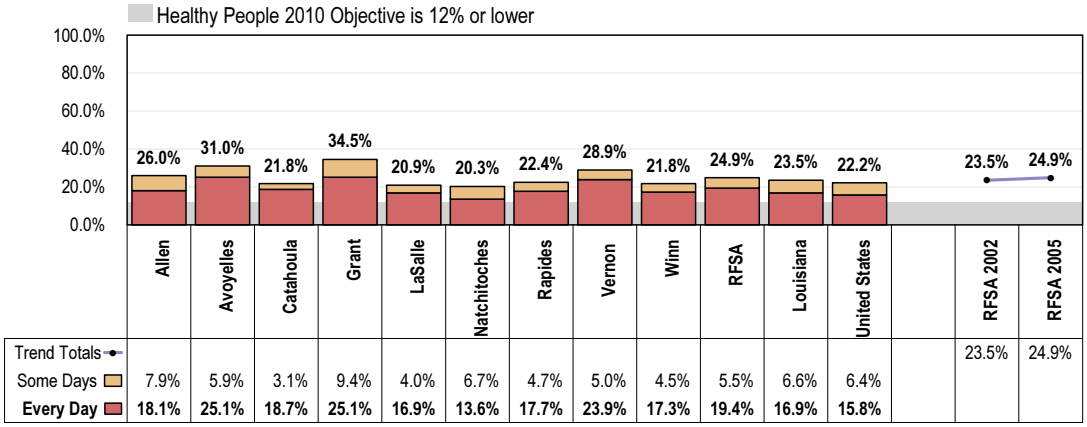
Current smoking prevalence in the RFSA (24.9%) is:

- Similar to that recorded statewide (23.5%) and across the U.S. (22.2%).
- Much higher than the Healthy People 2010 target of 12% or lower.
- Ranges from 20.3% in Natchitoches Parish to 34.5% in Grant Parish.

TREND: Current smoking levels in the RFSA remain relatively unchanged from the 23.5% reported in 2002.

Current Smokers

(By Parish; 2002-2005 Trend Data)



	Allen	Avoyelles	Catahoula	Grant	LaSalle	Natchitoches	Rapides	Vernon	Winn	RFSA	Louisiana	United States	RFSA 2002	RFSA 2005
Trend Totals													23.5%	24.9%
Some Days	7.9%	5.9%	3.1%	9.4%	4.0%	6.7%	4.7%	5.0%	4.5%	5.5%	6.6%	6.4%		
Every Day	**18.1%**	**25.1%**	**18.7%**	**25.1%**	**16.9%**	**13.6%**	**17.7%**	**23.9%**	**17.3%**	**19.4%**	**16.9%**	**15.8%**		

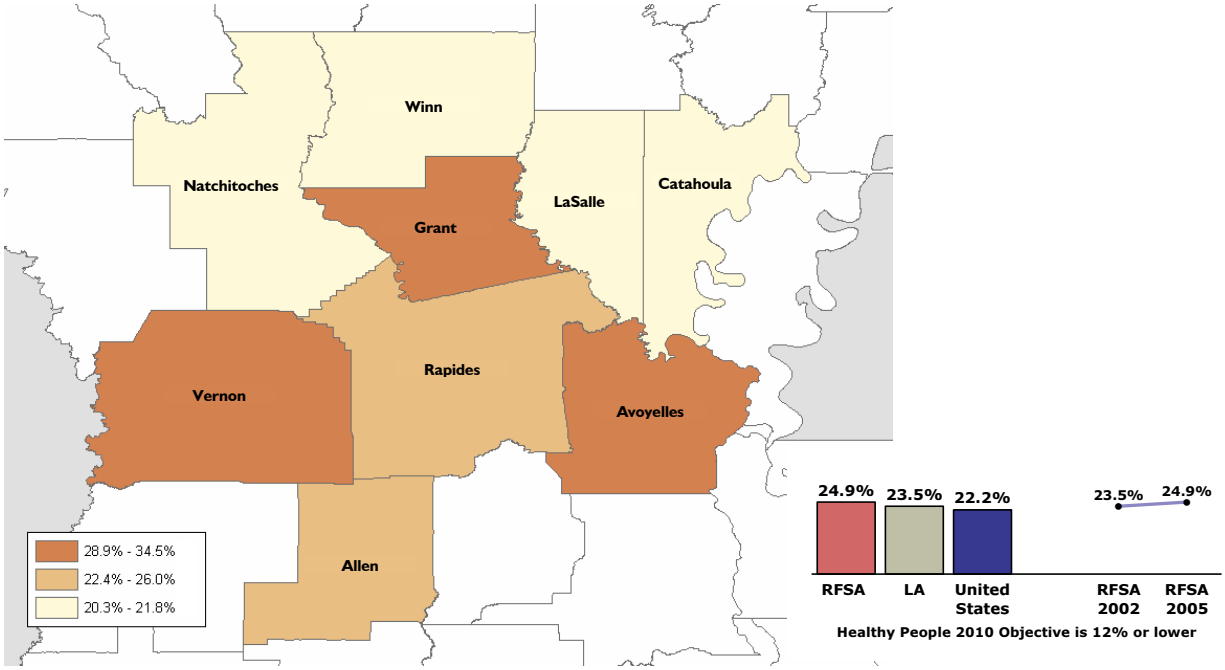
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 140]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-1a]

Note:
- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

As shown in the following map, smoking rates are highest in Avoyelles, Grant and Vernon parishes.

Current Smokers

(By Parish, 2005)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 140]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-1a]

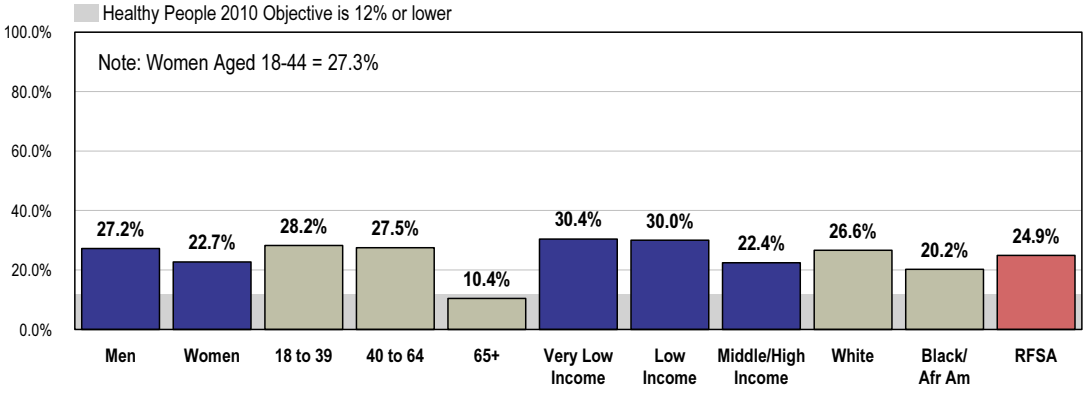
Note:
- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

The following chart looks at current smoking prevalence by various demographic characteristics. As shown, cigarette smoking is more prevalent among:

- Men.
- Adults under the age of 65. (Of the groups outlined, only adults aged 65+ currently satisfy the Healthy People 2010 objective.)
- Persons living at very low/low incomes.
- Whites.

Current Smokers

(Rapides Foundation Service Area, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Items 140,141]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-1a]

Note:
- Asked of all respondents.
- Includes those who smoke everyday or on some days.
- Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Note also that 27.3% 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.

Smoking Cessation

Health Advice About Smoking Cessation

Among current smokers, more than 6 in 10 (61.0%) report that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Comparable to the 66.2% reported nationwide.

Smoking Cessation Attempts

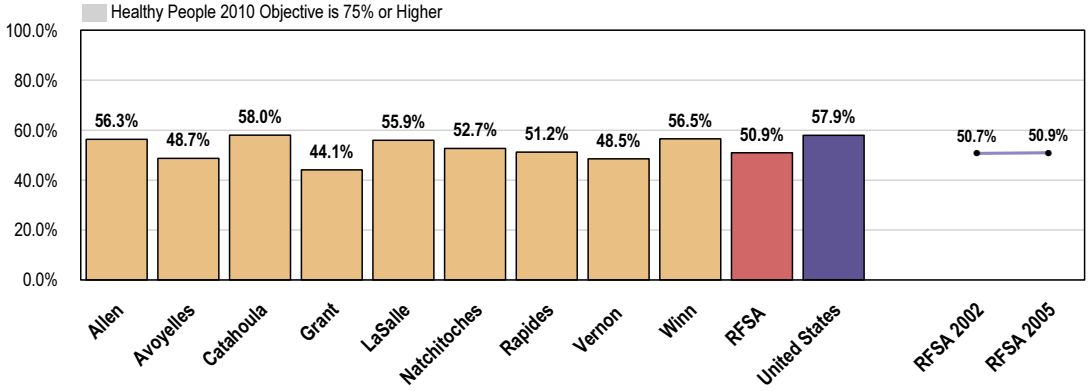
One-half (50.9%) of RFSA everyday smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Statistically similar to the 57.9% reported nationwide.
- Fails to satisfy the Healthy People 2010 target (75% or higher).
- Ranges from 44.1% in Grant Parish to 58.0% in Catahoula Parish.

TREND: Statistically similar to the 50.7% reported in 2002.

Have Stopped Smoking For One Day Or Longer In The Past Year In An Attempt To Quit Smoking

(Among Adults Who Smoke Cigarettes Every Day; By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 58]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-5]

Note:
- Asked of regular (everyday) smokers.
- State data not available.

Environmental Tobacco Smoke

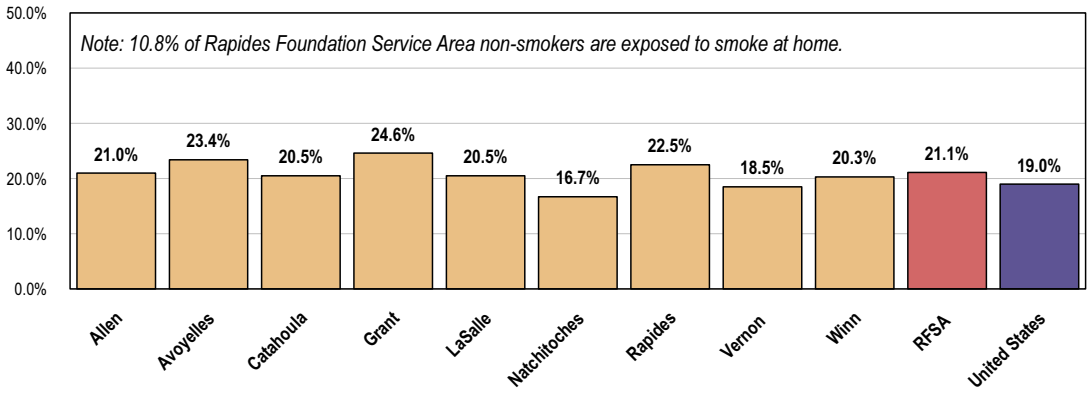
One in five RFSA adults (21.1%) reports that a member of their household has smoked cigarettes in the home in the past month an average of four or more times per week.

- Similar to the 19.0% prevalence reported across the nation.
- Highest (24.6%) in Grant Parish.

Note that 10.8% of RFSA non-smokers are exposed to cigarette smoke at home.

Member Of Household Smokes At Home

(By Parish, 2005)



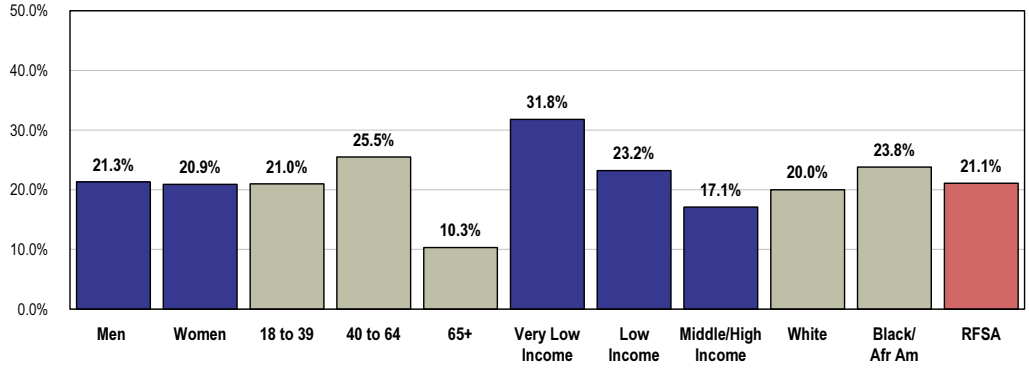
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 60,148]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• "Smokes at home" refers to someone smoking cigarettes, cigars or a pipe in the home an average of four or more times per week in the past month.
• State data not available.

Respondents more likely to report living with a smoker in the home are:

- Persons living at very low incomes.
- Adults under 65.

Member Of Household Smokes At Home

(Rapides Foundation Service Area, 2005)



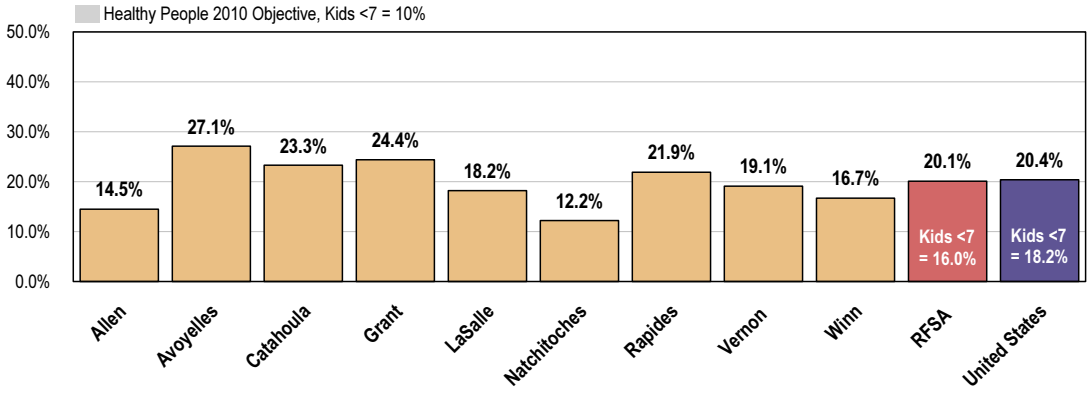
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 60]
Note: • Reflects the total sample of respondents.
• "Smokes at home" refers to someone smoking cigarettes, cigars or a pipe in the home an average of four or more times per week in the past month.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

20.1% of RFSA households with children have someone who smokes cigarettes in the home.

- Comparable to the 20.4% reported nationally.
- Ranges from 12.2% in Natchitoches Parish to 27.1% in Avoyelles Parish.
- The prevalence is 16.0% among households with kids under age 7, which is statistically comparable to the 2010 goal (10% or lower for households with kids under 7 years old).

Percentage Of Households With Children In Which Someone Smokes In The Home

(Among Households With Children Under 18; By Parish, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 147]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-9]

Note:
- Reflects respondents with children aged 0 to 17 years old.
- "Smokes at home" refers to someone smoking cigarettes, cigars or a pipe in the home an average of four or more times per week in the past month.
- State data not available.

Other Tobacco Use

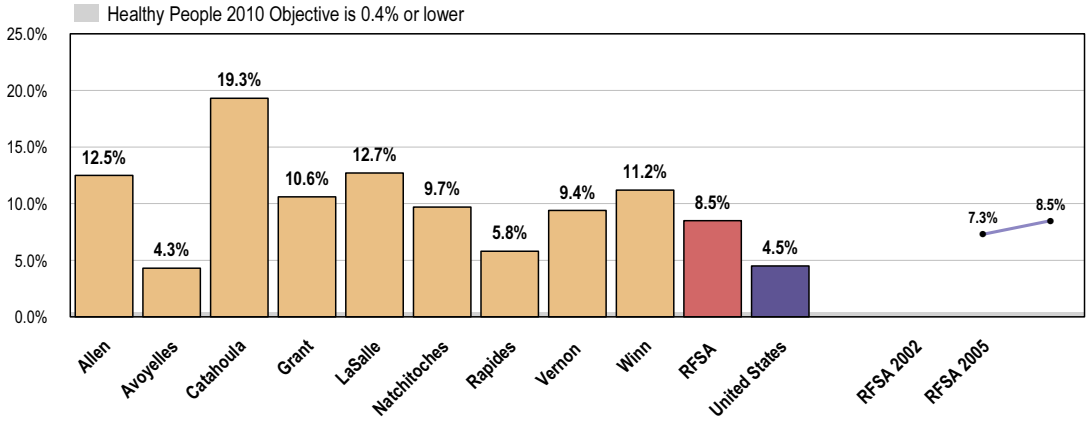
A total of 8.5% of RFSA adults currently use smokeless tobacco (e.g., chewing tobacco or snuff) every day or on some days.

- Nearly twice the 4.5% reported across the U.S.
- Fails to satisfy the Healthy People 2010 target (2% or lower).
- Particularly high (19.3%) in Catahoula Parish.

TREND: Marks a *statistically significant increase* from the 7.3% reported in 2002.

Use Of Smokeless Tobacco

(By Parish; 2002-2005 Trend Data)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 61]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-1b and 27-1c]

Note:
- Asked of all respondents.
- Includes respondents who use chewing tobacco/snuff every day or on some days.
- State data not available.

PHYSICAL HEALTH STATUS

Self-Reported Health Status

The initial inquiry of the *2005 PRC Community Health Survey* asked respondents the following: *"Would you say that in general your health is: excellent, very good, good, fair or poor?"*

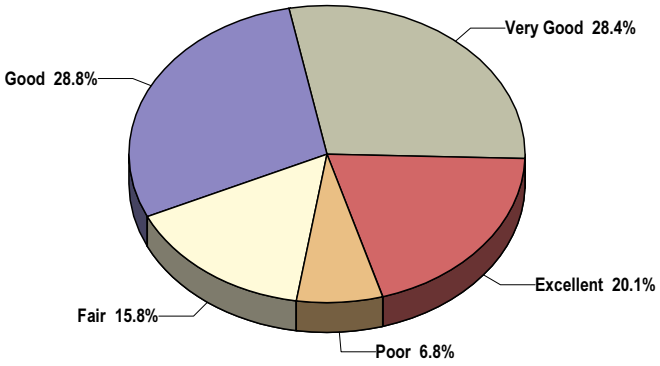
While most survey respondents rate their overall health as "excellent" or "very good," 22.6% rate it as "fair" or "poor."

- Note the 18.8% reported statewide.
- Less favorable than the 18.6% reported nationwide.
- Ranges from 17.6% in Vernon Parish to 26.6% in Catahoula Parish.

TREND: The 2005 proportion of community members reporting "fair/poor" overall health marks a *statistically significant increase* from that reported in 2002 (20.0%).

Self-Reported Health Status

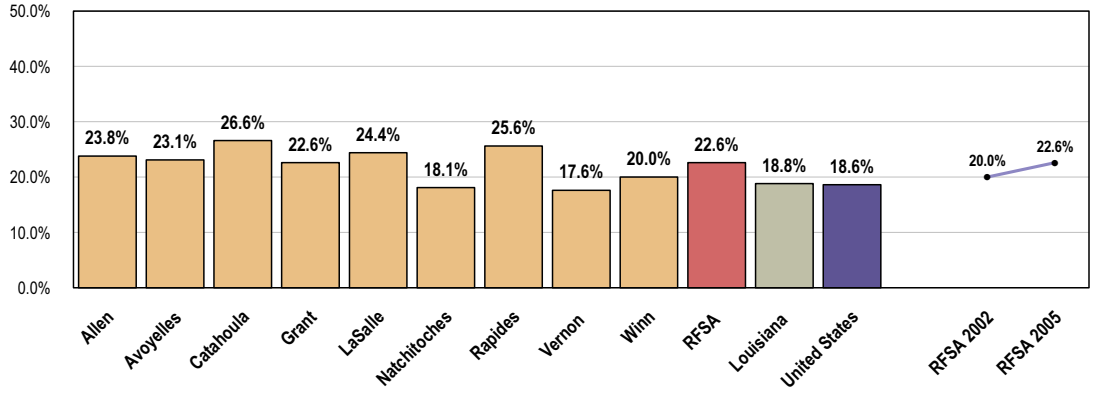
(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 16]
Note: • Asked of all respondents.

Experience "Fair" Or "Poor" Overall Health

(By Parish; 2002-2005 Trend Data)

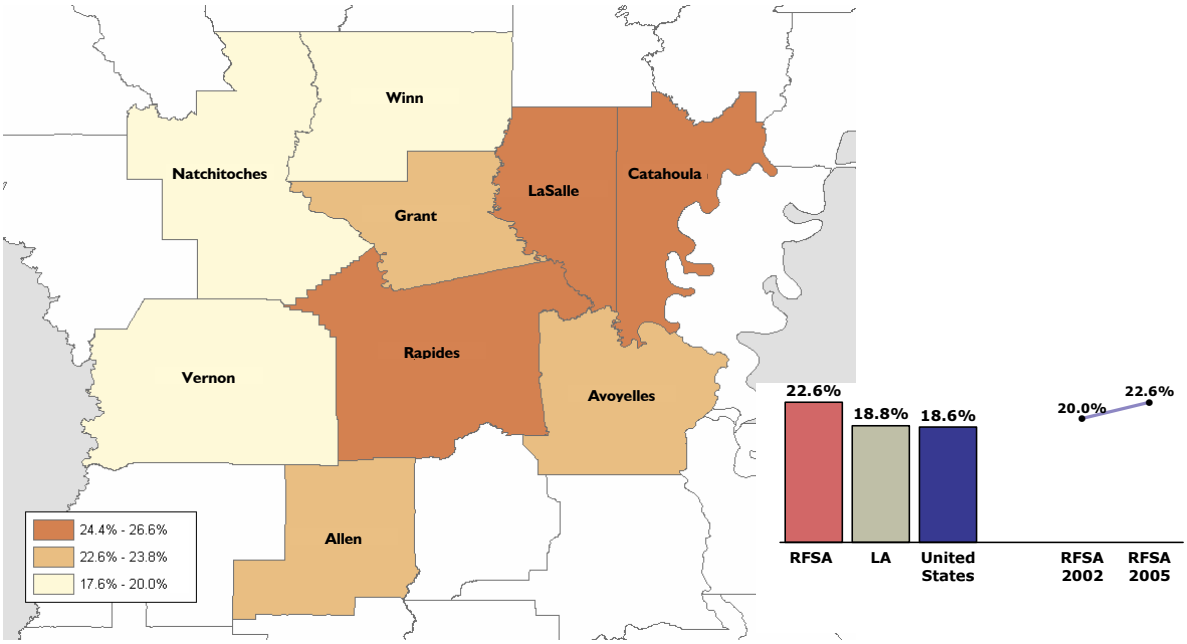


Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 16]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

"Fair/poor" health status responses are higher in Catahoula, LaSalle and Rapides parishes.

Experience "Fair" Or "Poor" Overall Health

(By Parish, 2005)



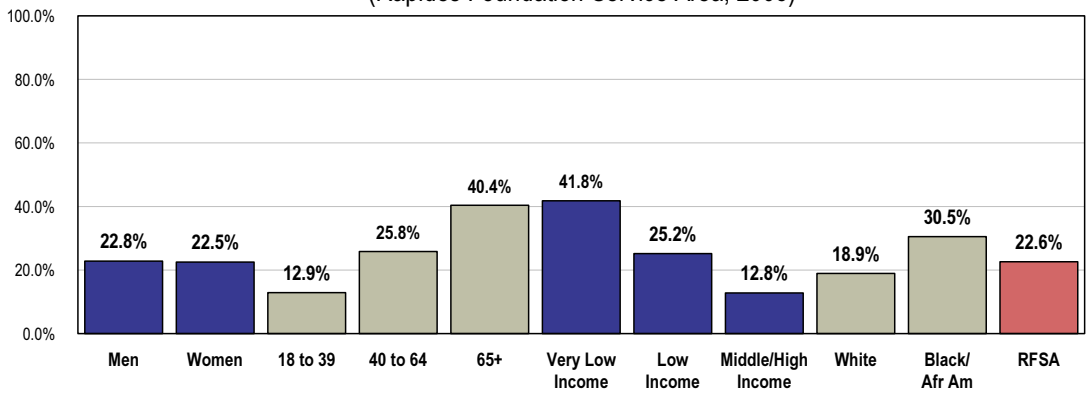
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 16]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

The following chart further examines self-reported health status by demographic characteristics.

- As might be expected, indications of "fair" or "poor" health increase with age; that is, older residents much more often report their health as "fair" or "poor."
- There is a very strong negative correlation with income — persons living at a very low income level give a much higher indication of "fair/poor" health.
- Across the RFSA, low levels of overall health are much more prevalent among Blacks/ African Americans than among Whites.

Experience "Fair" Or "Poor" Overall Health

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 16]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

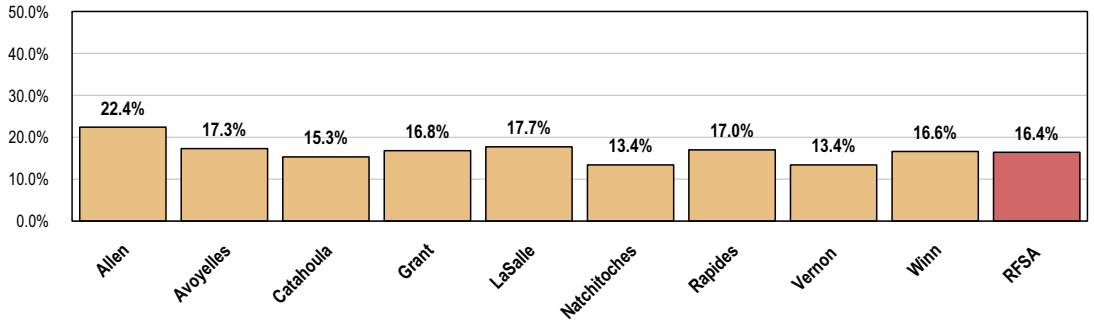
Days Of Poor Physical/Mental Health

While a majority of RFSA adults reports no days on which poor physical or mental health prevented their usual activities in the past month, 16.4% report experiencing 4+ days in the past month when their poor physical/mental health prevented their usual activities.

- Highest (22.4%) in Allen Parish.

Experience Four Or More Days In The Past Month When Poor Physical Or Mental Health Prevented Usual Activities

(By Parish, 2005)



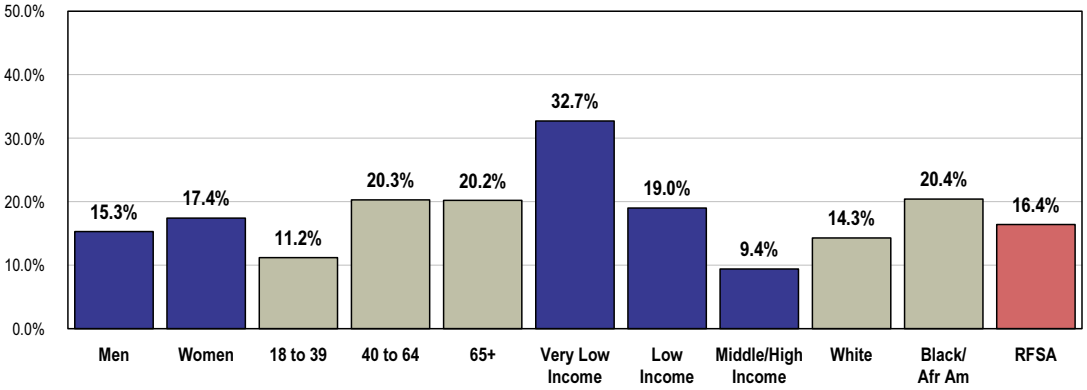
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 17]
• 2005 PRC National Health Survey, Professional Research Consultants, Inc.
Note: • Asked of all respondents.

Among RFSA respondents, the following were more likely to indicate that health limited their usual activities:

- Adults aged 40 and older.
- Those at lower income levels.
- Blacks/African Americans.

Experienced Four Or More Days In The Past Month When Poor Physical Or Mental Health Prevented Usual Activities

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 17]
• 2005 PRC National Health Survey, Professional Research Consultants, Inc.
Note: • Asked of all respondents.
• State and national data not available.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

MENTAL HEALTH & MENTAL DISORDERS

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

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

- Mental disorders occur across the lifespan, affecting persons of all racial and ethnic groups, both genders, and all educational and socioeconomic groups…
- Modern treatments for mental disorders are highly effective, with a variety of treatment options available for most disorders…[however], the majority of persons with mental disorders do not receive mental health services.
- The co-occurrence of addictive disorders among persons with mental disorders is gaining increasing attention from mental health professionals…Having both mental and addictive disorders…is a particularly significant clinical treatment issue, complicating treatment for each disorder…
- There is increasing awareness and concern in the public health sector regarding the impact of stress, its prevention and treatment, and the need for enhanced coping skills…
- Evidence that mental disorders are legitimate and highly responsive to appropriate treatment promises to be a potent antidote to stigma. Stigma creates barriers to providing and receiving competent and effective mental health treatment and can lead to inappropriate treatment, unemployment, and homelessness.
- In later life, the majority of people aged 65 years and older cope constructively with the changes associated with aging and maintain mental health, yet an estimated 25% of older people experience specific mental disorders, such as depression, anxiety, substance abuse, and dementia, that are not part of normal aging. Alzheimer's disease strikes 8% to 15% of people over age 65 years, with the number of cases in the population doubling every 5 years of age after age 60 years. Alzheimer's disease is thought to be responsible for 60% to 70% of all cases of dementia and is one of the leading causes of nursing home placements.

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

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

Mental Health Status

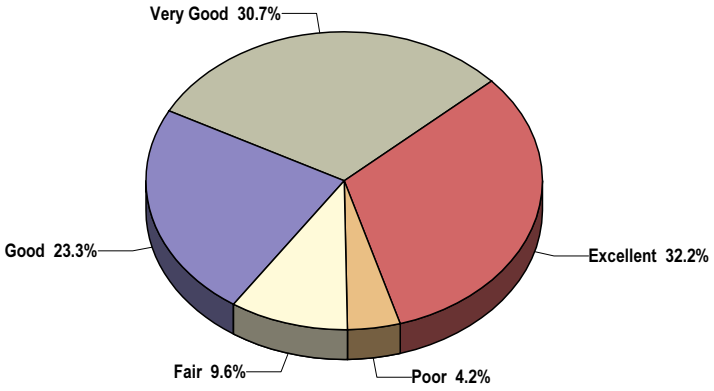
Self-Reported Mental Health Status

When asked to evaluate their own mental health status, more than 6 in 10 RFSA respondents (62.9%) said "excellent" or "very good." In contrast, 13.8% rated it as "fair" or "poor."

- Similar to nationwide findings (11.7% "fair/poor").

Self-Reported Mental Health Status

(Rapides Foundation Service Area, 2005)

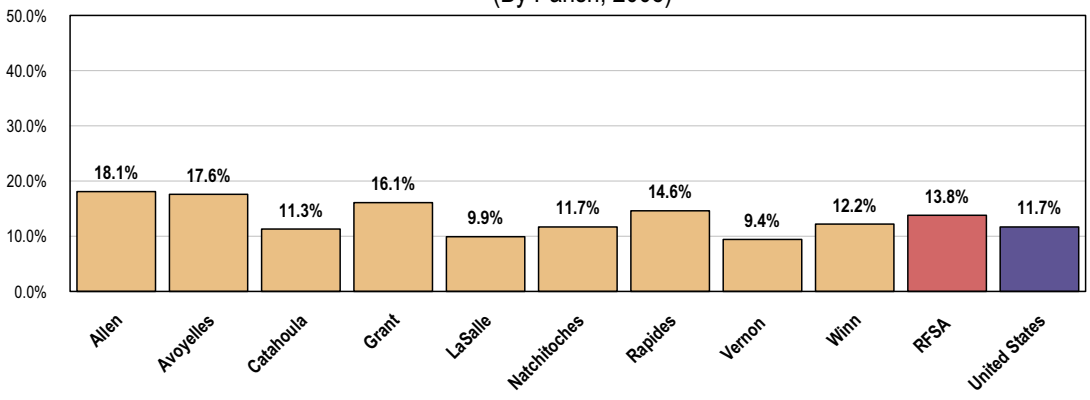


Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 102]
Note: • Asked of all respondents.
• In this case, the term "mental health" refers to stress, depression, and problems with emotions.

- Highest in Allen and Avoyelles parishes.

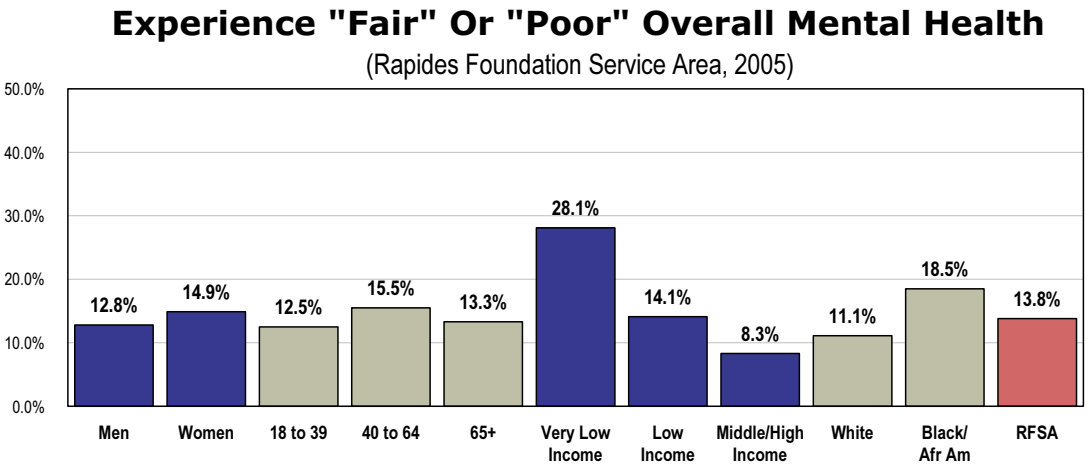
Experience "Fair" Or "Poor" Overall Mental Health

(By Parish, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 102]
Note: • Asked of all respondents.

- The proportion of RFSA adults reporting "fair/poor" mental health is highest among adults living at the lowest income level (28.1%).
- Blacks/African Americans are also more likely to report unfavorable levels of mental health status.



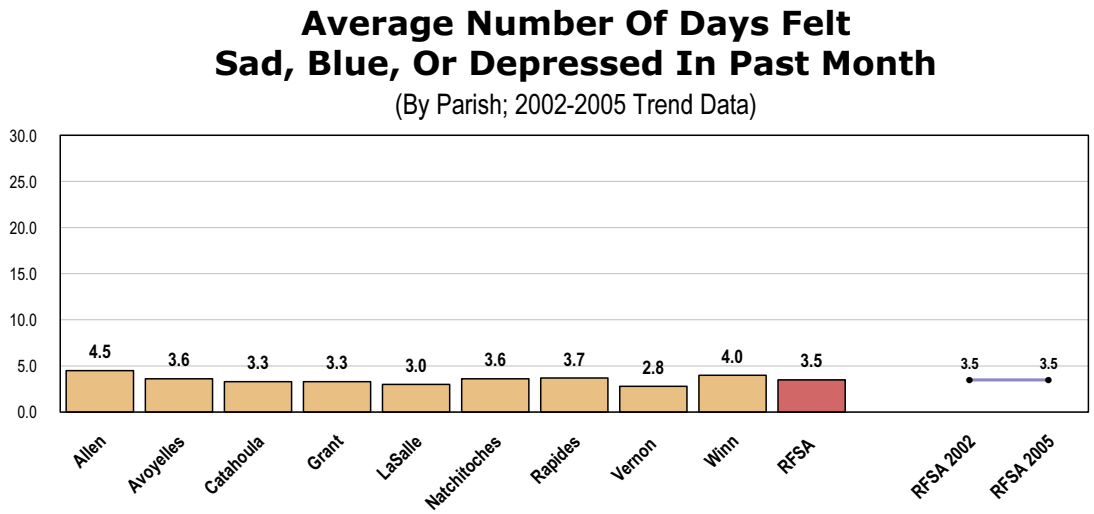
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 102]
Note: • Asked of all respondents.
• State and national data not available.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Days Of Feeling Sad, Blue Or Depressed

RFSA adults average 3.5 days per month when they were sad, blue, or depressed.

- Ranges from 2.8 in Vernon Parish to 4.5 in Allen Parish.

TREND: The 2005 average is identical to the average reported in 2002.

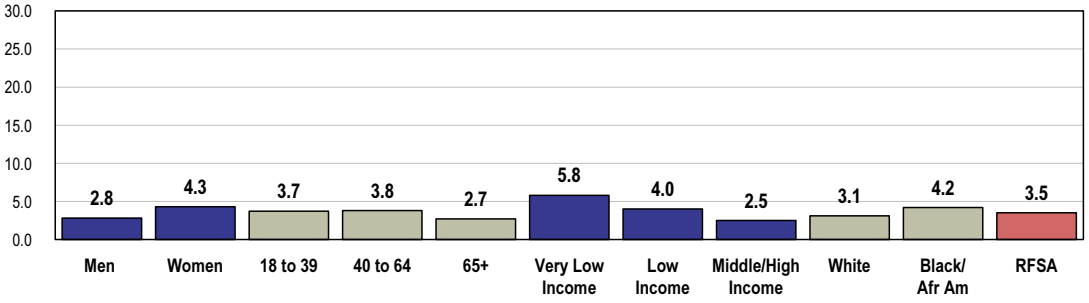


Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 104]
Note: • Asked of all respondents.
• State and national data not available.

- Highest among those in the lowest income breakout.

Average Number Of Days Felt Sad, Blue, Or Depressed In Past Month

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 104]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Chronic Depression

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

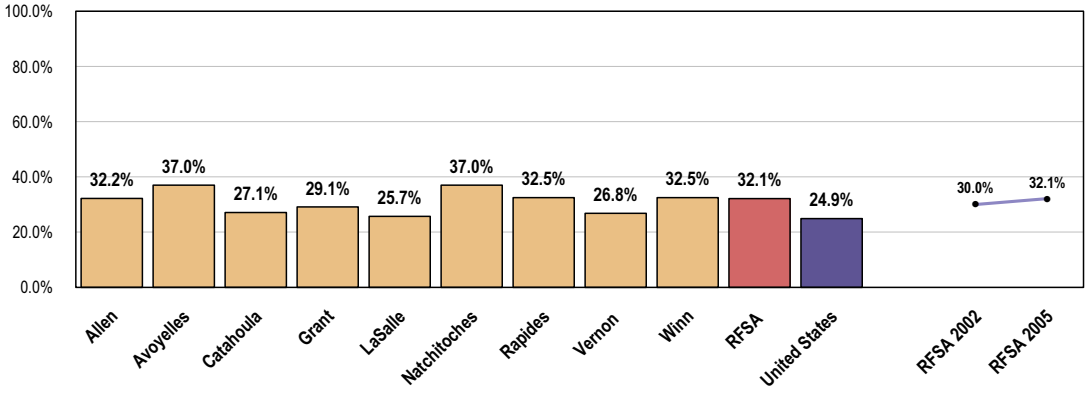
Nearly one in three RFSA adults (32.1%) reports that they have had two or more <u>years</u> in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes.

- Less favorable than the 24.9% reported nationwide.
- This represents an estimated 83,000 adults across the service area who have faced or are facing prolonged bouts with depression.
- Ranges from 25.7% in LaSalle Parish to 37.0% in Avoyelles and Natchitoches parishes.

TREND: Marks a *statistically significant increase* from the 30.0% reported in 2002.

Have Experienced Chronic Depression

(By Parish; 2002-2005 Trend Data)

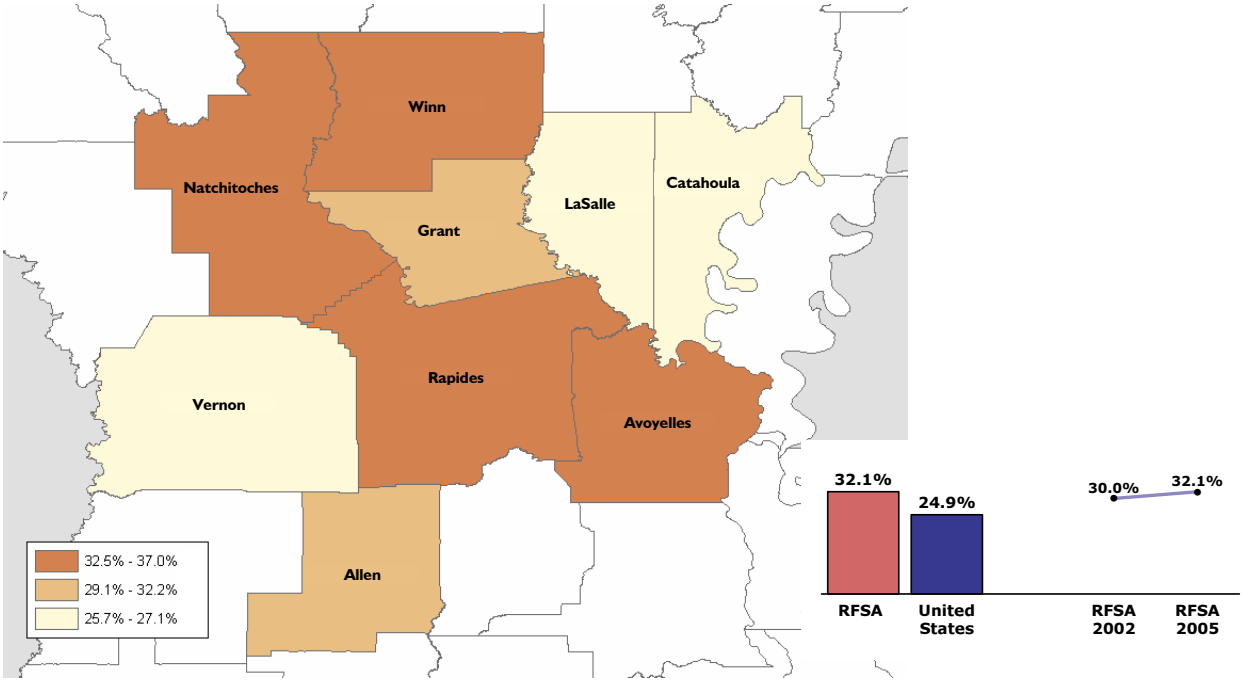


Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 103]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• In this case, the term "chronic depression" refers to periods of self-reported depression lasting two years or longer.
• State data not available.

Note the following map.

Have Experienced Chronic Depression

(By Parish, 2005)



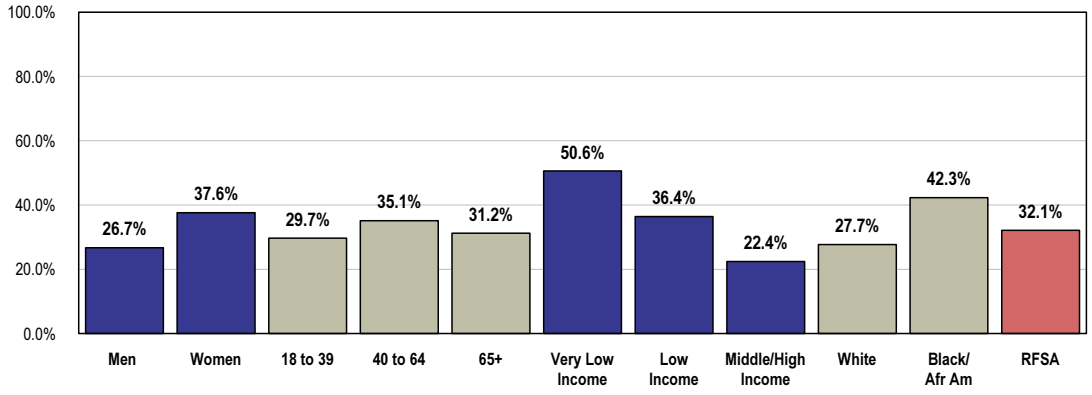
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 103]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.
• In this case, the term "chronic depression" refers to periods of self-reported depression lasting two years or longer.

The following chart illustrates differences found among key demographic groups. Note that self-reported prevalence of chronic depression is considerably higher among:

- Women.
- Persons living at very low incomes.
- Blacks/African Americans.

Have Experienced Chronic Depression

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 103]
Note: • Asked of all respondents.
• In this case, the term "chronic depression" refers to periods of self-reported depression lasting two years or longer.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Mental Health Treatment

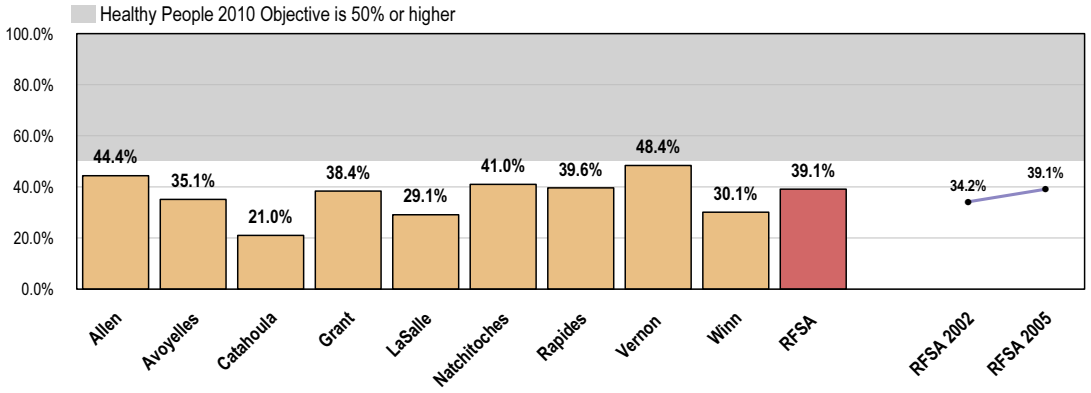
Among RFSA adults reporting chronic depression, 39.1% acknowledge that they have sought professional help for a mental or emotional problem at some point in their lives.

- The Healthy People 2010 Objective is that 50% or more of those experiencing depression will seek professional help.
- Ranges from 21.0% in Catahoula Parish to 48.4% in Vernon Parish.

▦ Marks a *statistically significant increase* since 2002.

Have Sought Professional Help For A Mental Or Emotional Problem

(Among Respondents With Recognized Depression; By Parish, 2005)



Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 151]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 18-9b]

Note:
- Among respondents who have experienced two or more years of depression at some point in their lives.
- State and national data not available.

(Related Issue: see also "Substance Abuse.")

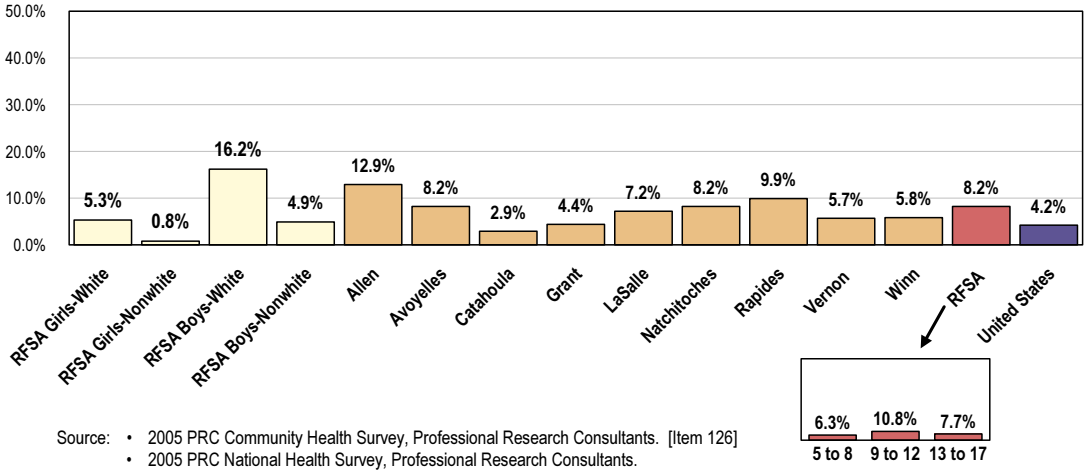
Children & Attention-Deficit/Hyperactivity Disorder

A total of 8.2% of parents in the RFSA report that their school-aged child takes medication for attention-deficit disorder or attention-deficit/hyperactivity disorder (ADD/ADHD).

- Less favorable than the nationwide percentage (4.2%).
- Ranges from 2.9% among Catahoula Parish children to 12.9% in Allen Parish.
- Dramatically higher among boys than girls, and among Whites than Nonwhites.

Child Takes Medication For ADD/ADHD

(By Parish And Age, 2005; Among Parents Of Children Age 5 To 17)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 126]
- 2005 PRC National Health Survey, Professional Research Consultants.

Note:
- Asked of all respondents with children aged 5 through 17 at home.
- "ADD/ADHD" refers to "Attention-Deficit Disorder/Attention-Deficit/Hyperactivity Disorder."
- State data not available.

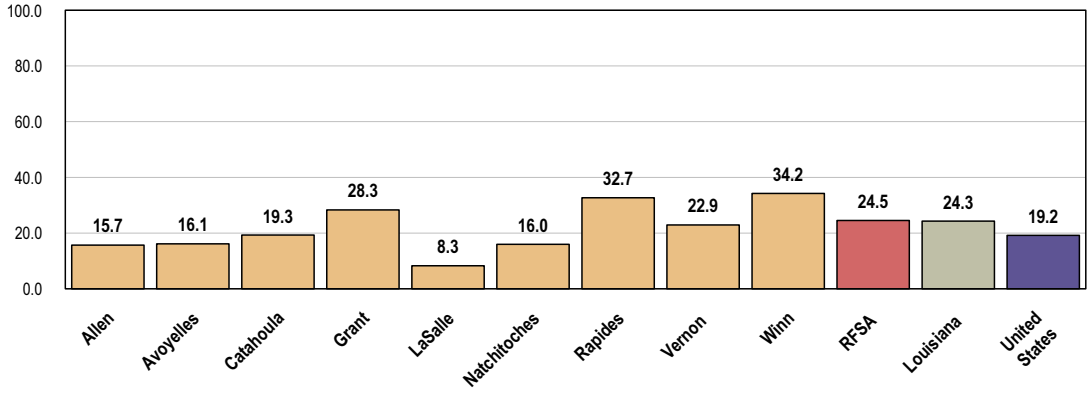
Age-Adjusted Alzheimer's Disease Deaths

Between 2000 and 2002, there was an annual average age-adjusted Alzheimer's disease death rate of 24.5 deaths per 100,000 population in the RFSA.

- The RFSA rate is comparable to the 24.3 reported statewide but higher than the 19.2 across the nation.
- Ranges from 8.3 in LaSalle Parish to 34.2 in Winn Parish.

Age-Adjusted Mortality: Alzheimer's Disease

(By Parish; 2000-2002 Deaths Per 100,000 Population)



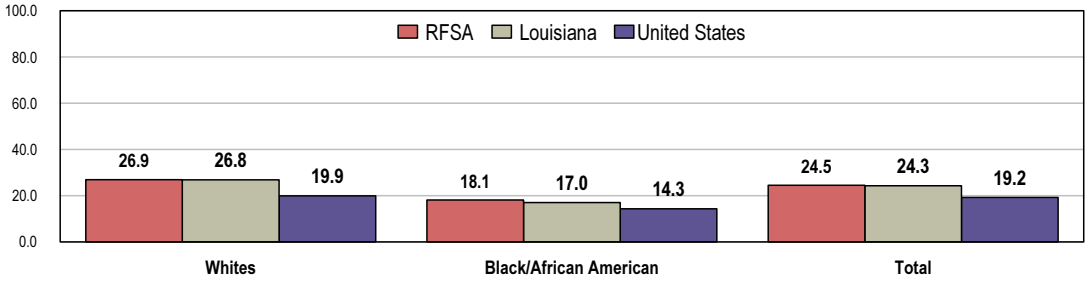
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

- Whites experience much higher rates in the RFSA, while rates among Blacks/African Americans are lower; this is true both statewide and nationwide.

Age-Adjusted Mortality: Alzheimer's Disease

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



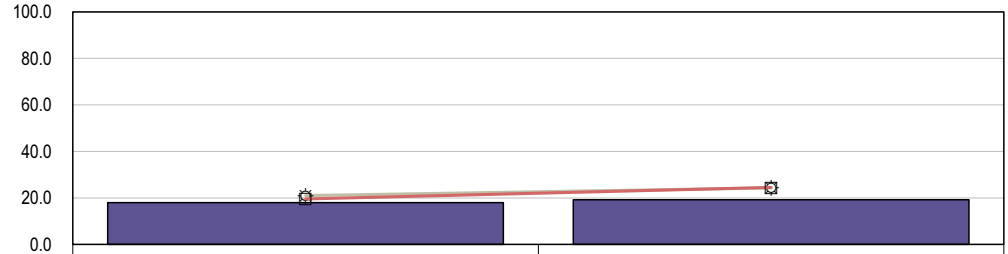
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

TREND: Between 1999 and 2002, the reported RFSA age-adjusted mortality rate due to Alzheimer's disease increased from 19.6 to 24.5 (this increase may be at least partly related to improvement in reporting of the disease). This increase was more pronounced in the RFSA and in Louisiana when compared national rates.

Age-Adjusted Mortality: Alzheimer's Disease

(By Region; 1993-2002)



	1999-2001	2000-2002
RFSA	19.6	24.5
Louisiana	21.0	24.3
United States	18.0	19.2

Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.

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

MATERNAL, INFANT & CHILD HEALTH

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

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

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

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

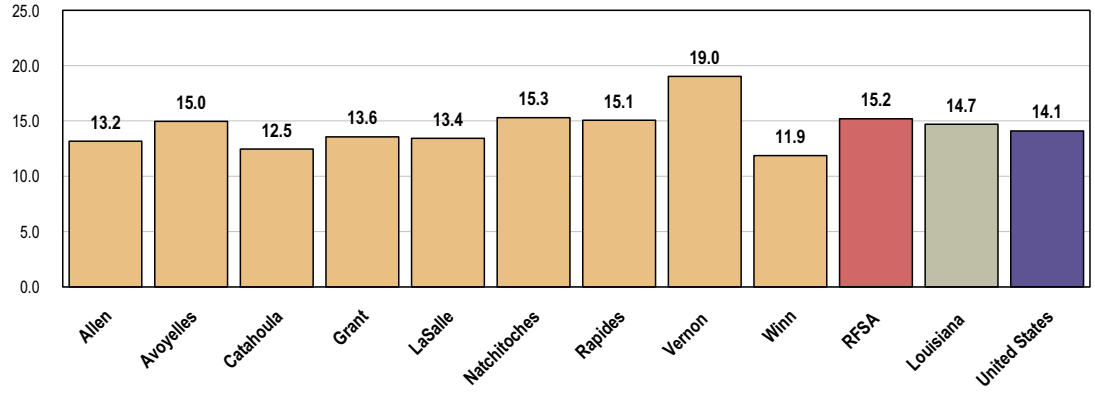
Birth Rate

Between 2000-2002, the annual average RFSA birth rate was 15.2 births per 100,000 population.

- Higher than the Louisiana rate (14.7).
- Above the U.S. rate (14.1).
- Highest (19.0) in Vernon Parish.

Birth Rate

(By Parish; Births Per 1,000 Population; 2000-2002)

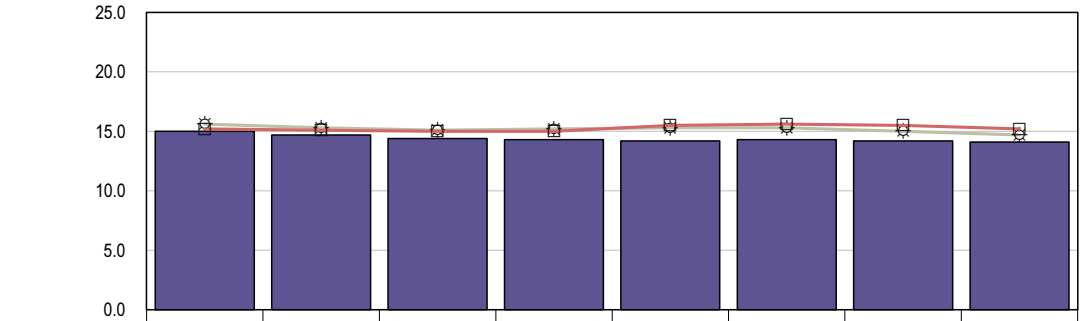


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are rates of births per 1,000 population.

TREND: Between 1993 and 2002, the RFSA birth rate remained fairly stable. The U.S. birth rate during this time decreased slightly.

Birth Rate

(By Region; Births Per 1,000 Population; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	15.2	15.1	15.0	15.0	15.5	15.6	15.5	15.2
Louisiana	15.6	15.3	15.1	15.2	15.3	15.3	15.0	14.7
United States	15.0	14.7	14.4	14.3	14.2	14.3	14.2	14.1

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are rates of births per 1,000 population.

Adequacy Of Prenatal Care

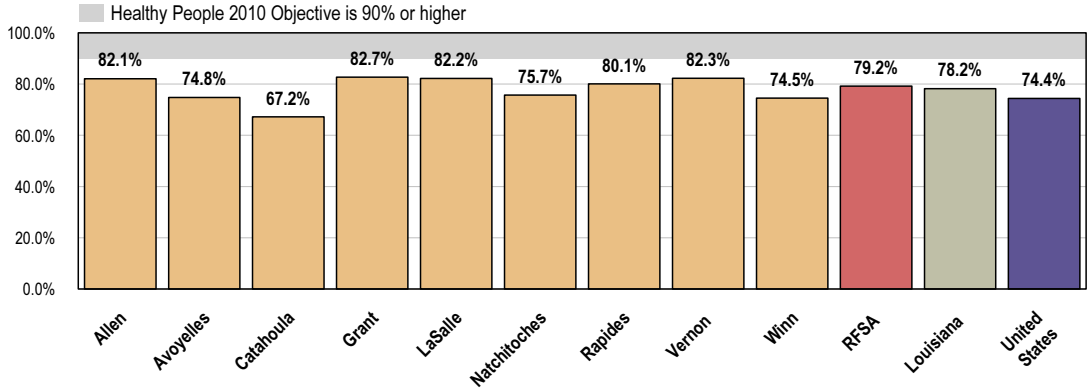
Early and continuous prenatal care is the best assurance of infant health. The related Healthy People 2010 objective strives for 90% of pregnant women to receive early and adequate prenatal care.

Between 2000-2002, 79.2% of RFSA women giving birth received at least adequate prenatal care during their pregnancy.

- Similar to the 78.2% reported across the state.
- Higher than the 74.4% of mothers nationwide who had received adequate prenatal care. (Note that national data shown below uses a slightly different index to measure adequacy of prenatal care.)
- Fails to meet the Healthy People 2010 objective (90% or better).
- Lowest (67.2%) in Catahoula Parish.

Mothers Receiving At Least Adequate Prenatal Care

(By Parish; Percentage Of Live Births, 2000-2002)



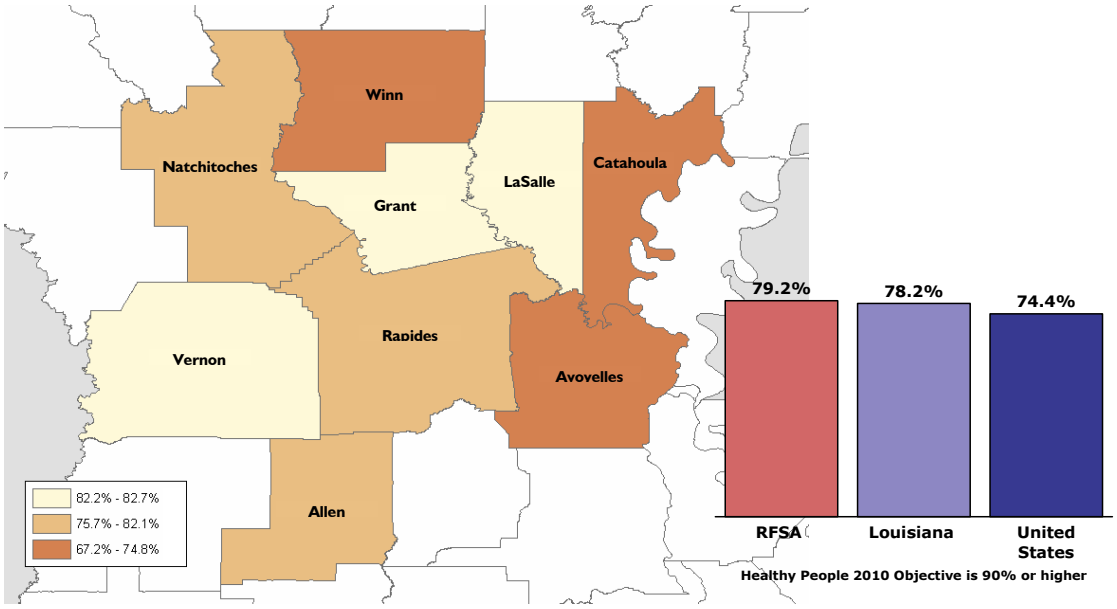
Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-6].

Note:
- Numbers are a percentage of all live births within each population.
- Adequate prenatal care is measured by the modified Kessner Index, which defines prenatal care as adequate if the first prenatal visit occurred in the first trimester of pregnancy and if the total number of visits was appropriate to the gestational age of the baby at birth.

Note the following map.

Mothers Receiving At Least Adequate Prenatal Care

(By Parish, 2000-2002)



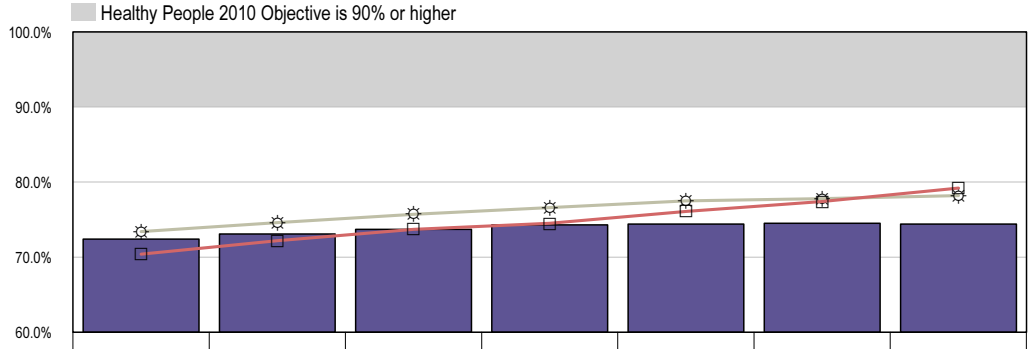
Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-6].

Note:
- Numbers are a percentage of all live births within each population.
- Adequate prenatal care is measured by the modified Kessner Index, which defines prenatal care as adequate if the first prenatal visit occurred in the first trimester of pregnancy and if the total number of visits was appropriate to the gestational age of the baby at birth.

TREND: The percentage of mothers receiving adequate prenatal care has *improved* steadily over the past decade.

Mothers Receiving At Least Adequate Prenatal Care

(By Region; Percentage Of Live Births,1993-2002)



	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	70.4%	72.2%	73.7%	74.5%	76.1%	77.4%	79.2%
Louisiana	73.4%	74.6%	75.7%	76.6%	77.5%	77.8%	78.2%
United States	72.4%	73.1%	73.7%	74.3%	74.4%	74.5%	74.4%

Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-6].

Note:
- Numbers are a percentage of all live births within each population.
- For Louisiana data, "adequate prenatal care" is measured by a modified Kessner Index, which defines prenatal care as adequate if the first prenatal visit occurred in the first trimester of pregnancy and if the total number of visits was appropriate to the gestational age of the baby at birth.
- For U.S. data, the Adequacy of Prenatal Care Utilization (APNCU) index is used. Both indices agree in their definition of "adequate" up to 36 weeks gestation; for pregnancies going past 36 weeks gestation, the APNCU requires an additional visit per week whereas the Kessner Index does not.

Birth Outcomes

Low-Weight Births

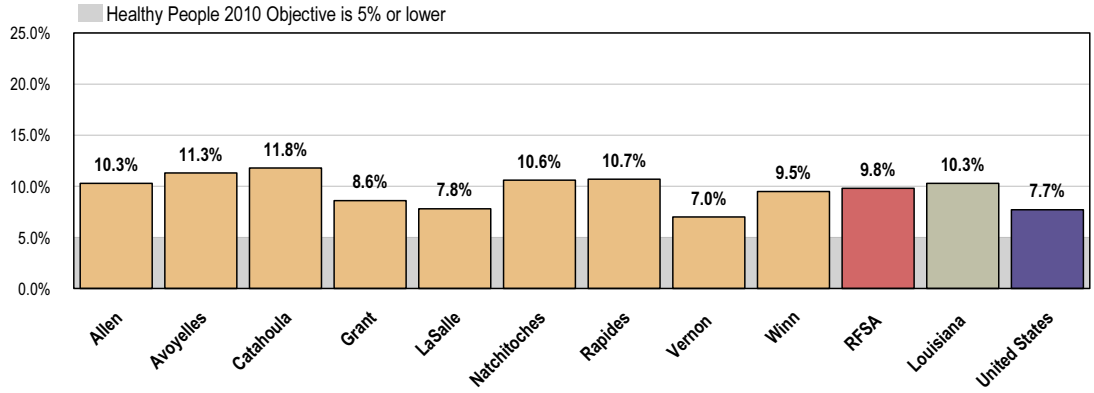
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

9.8% of RFSA births between 2000-2002 were of low birthweight.

- Comparable to the percentage recorded across the state.
- Higher than the 7.7% percentage reported nationwide.
- Nearly twice the Healthy People 2010 target (5% or lower).
- Ranges from 7.0% in Vernon Parish to 11.8% in Catahoula Parish.

Low-Weight Births

(By Parish; Percentage Of Live Births, 2000-2002)



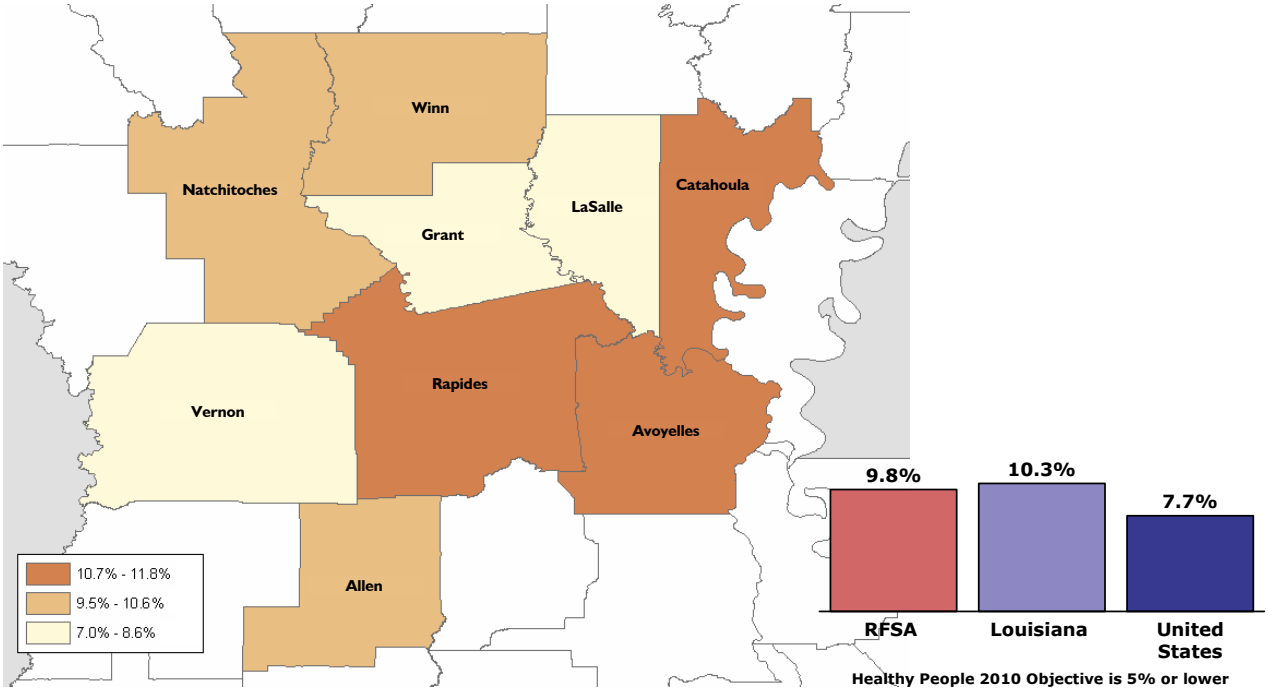
Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.

Note:
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-10].
- Numbers are a percentage of all live births within each population.

Low-weight births are most prevalent in Avoyelles, Catahoula and Rapides parishes.

Low-Weight Births

(By Parish; 2000-2002 Percentage Of Live Births)



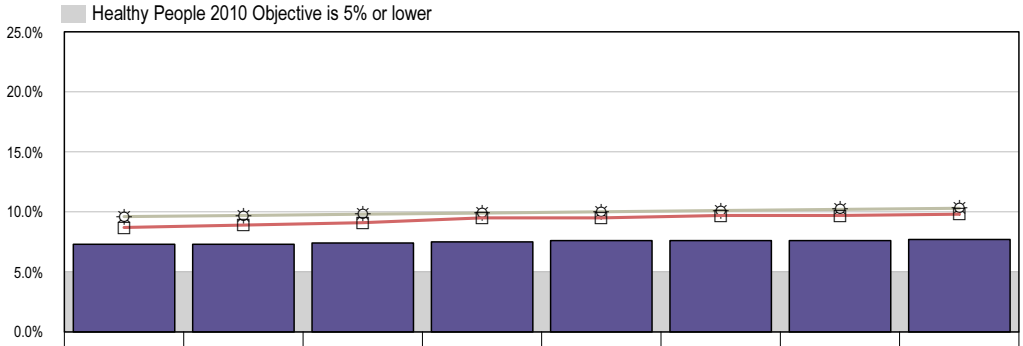
Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.

Note:
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-10].
- Numbers are a percentage of all live births within each population.

TREND: The percentage of low-weight births across the RFSA increased over the past decade, similar to state and national trends.

Low-Weight Birth Trends

(By Region; Percentage Of Live Births,1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	8.7%	8.9%	9.1%	9.5%	9.5%	9.7%	9.7%	9.8%
Louisiana	9.6%	9.7%	9.8%	9.9%	10.0%	10.1%	10.2%	10.3%
United States	7.3%	7.3%	7.4%	7.5%	7.6%	7.6%	7.6%	7.7%

Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.

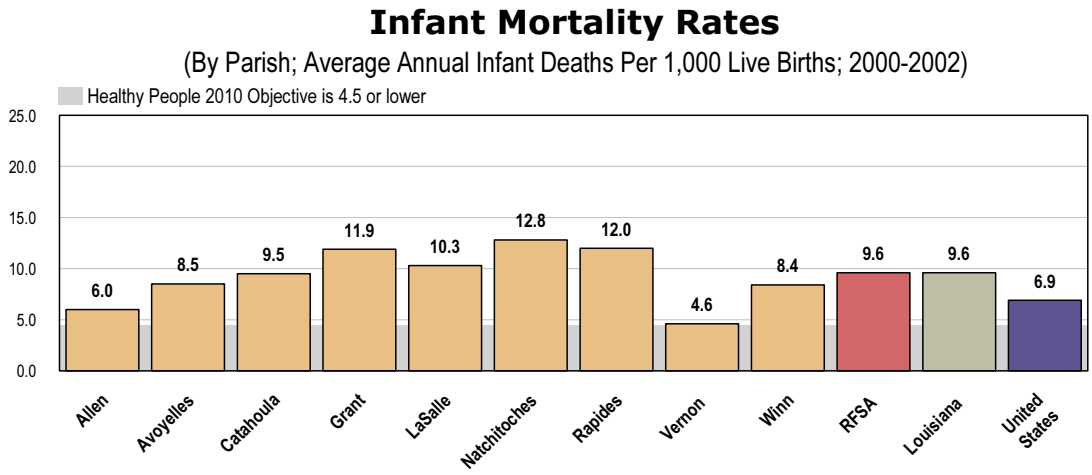
Note:
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-10].
- Numbers are a percentage of all live births within each population.

Infant Mortality

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

Between 2000 and 2002, there were 9.6 infant deaths per 1,000 live births in the RFSA.

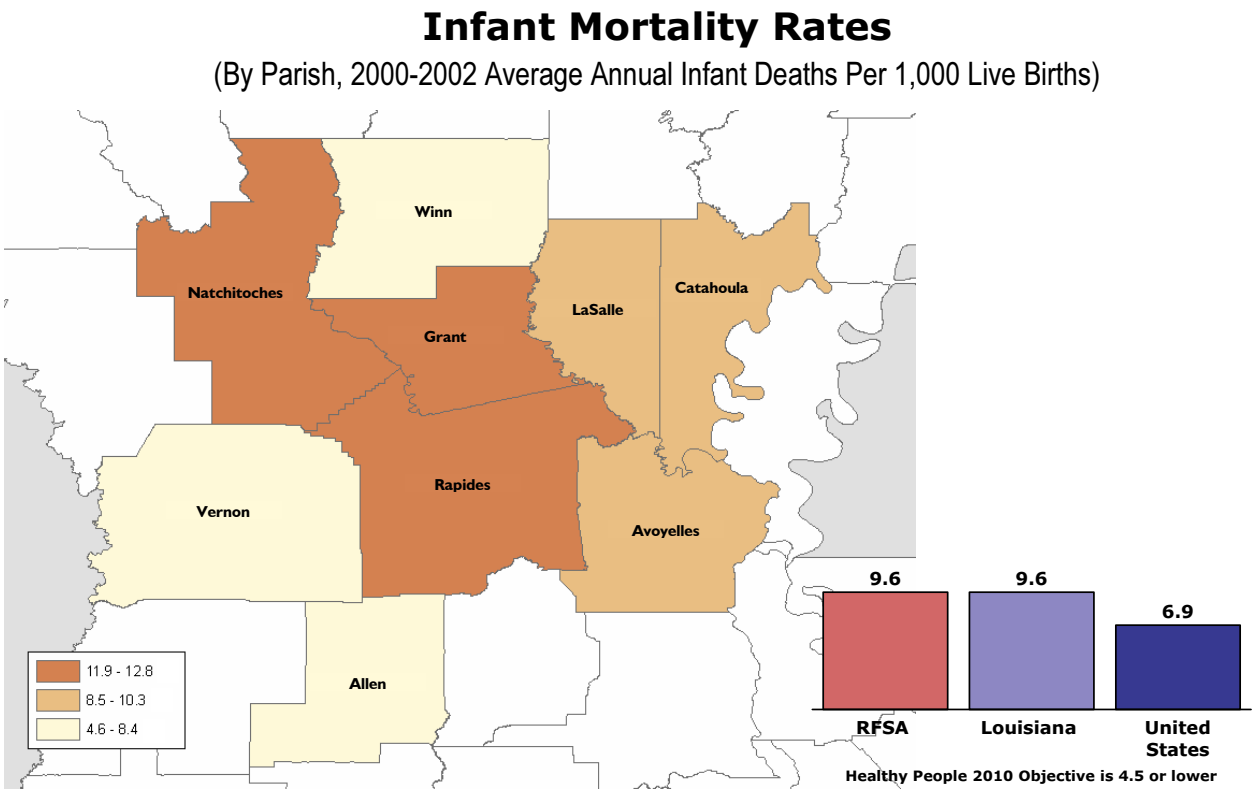
- Identical to the rate reported in Louisiana.
- Less favorable than the 6.9 infant mortality rate recorded across the nation.
- Fails to satisfy the Healthy People 2010 target (4.5 or fewer per 1,000 live births).
- Ranges from 4.6 in Vernon Parish to 12.8 in Natchitoches Parish.



Source:
- Louisiana Department of Health and Hospitals.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-1].

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

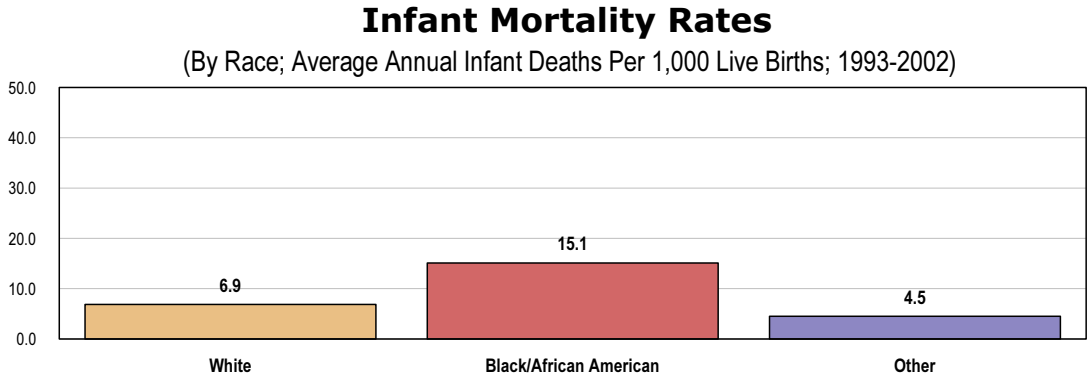
Note the following map of infant mortality rates in the RFSA.



Source:
- Louisiana Department of Health and Hospitals.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office,Division of Public Health Surveillance and Informatics.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-1].

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

- Infant mortality rates are more than twice as high among Blacks/African Americans as among Whites in the RFSA.



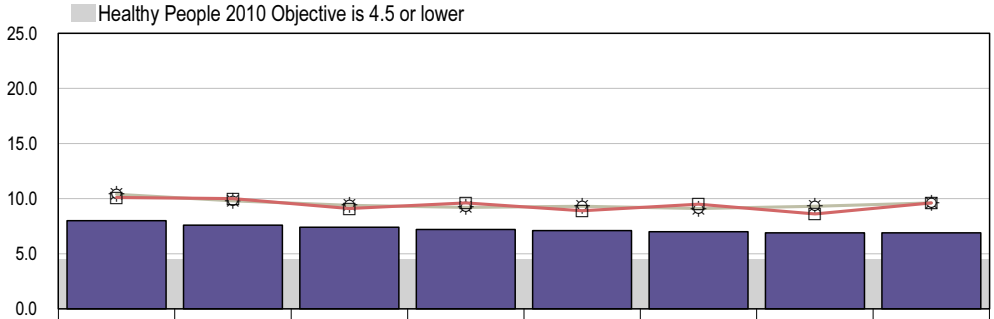
Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2005.

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

TREND: Regionally, infant mortality rates declined slightly over the past decade. This was also the case both statewide and nationwide.

Infant Mortality Rates

(By Region; Average Annual Infant Deaths Per 1,000 Live Births; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	10.1	10.0	9.1	9.6	8.9	9.5	8.6	9.6
Louisiana	10.4	9.8	9.4	9.2	9.3	9.1	9.3	9.6
United States	8.0	7.6	7.4	7.2	7.1	7.0	6.9	6.9

Source:
- Louisiana Department of Health and Hospitals.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objecitve 16-1].

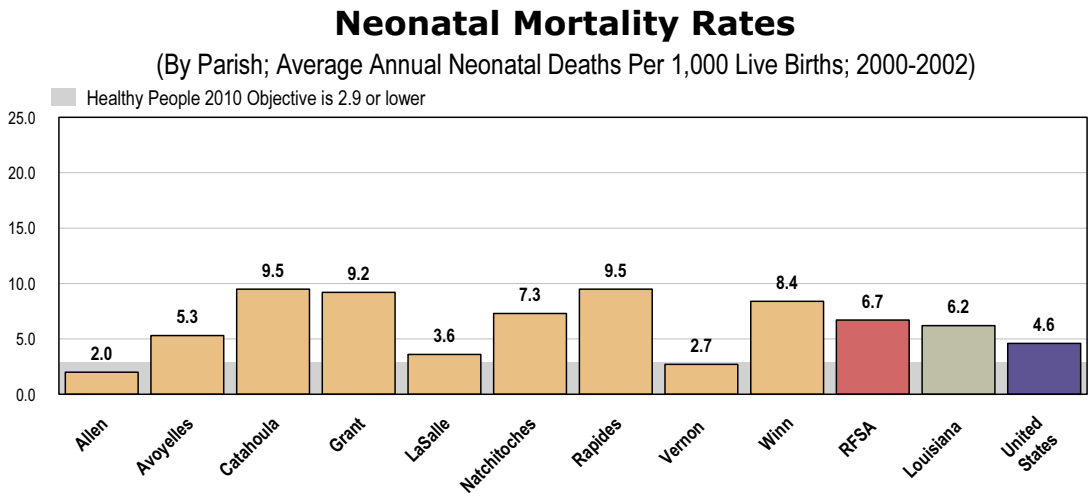
Note:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Neonatal Mortality

Neonatal mortality rates reflect deaths of children within the first 28 days of life per 1,000 live births.

Between 2000 and 2002, the RFSA experienced an annual average of 6.7 neonatal deaths per 1,000 live births.

- Less favorable than the state and national neonatal mortality rates.
- Fails to satisfy the Healthy People 2010 objective of 2.9 or lower.
- Ranges from 2.0 in Allen Parish (meeting the 2010 goal) to 9.5 in Catahoula and Rapides parishes.



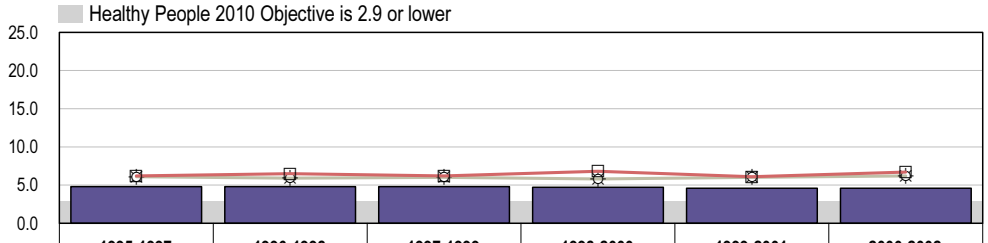
Source:
- Louisiana Department of Health and Hospitals.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-1].

Note:
- Rates are three-year averages of deaths of children within the first 28 days of life per 1,000 live births.

TREND: Since 1995, the RFSA neonatal mortality rate has ranged from 6.1 to 6.8; state and national trends are stable.

Neonatal Mortality Rates

(By Region; Average Annual Neonatal Deaths Per 1,000 Live Births; 1995-2002)



	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	6.2	6.5	6.2	6.8	6.1	6.7
Louisiana	6.1	5.9	6.0	5.8	6.0	6.2
United States	4.8	4.8	4.8	4.7	4.6	4.6

Source:
- Louisiana Department of Health and Hospitals.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 1601].

Note:
- Rates are three-year averages of deaths of children within the first 28 days of life per 1,000 live births.

FAMILY PLANNING

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

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

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

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

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

Births To Unwed Mothers

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

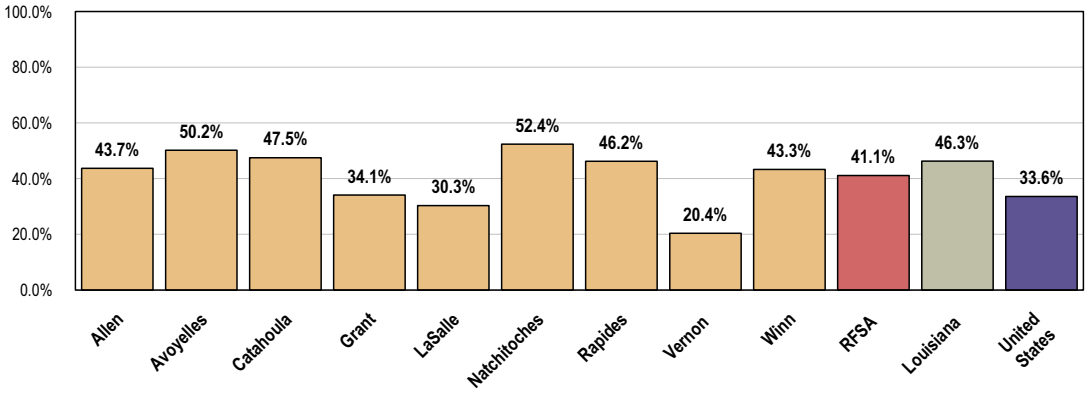
Because it is impossible to measure the true incidence of unintended pregnancy in the U.S., the following indicator looks at births occurring among unmarried mothers as a proxy measure for pregnancies that are not intended (knowing that this is not always the case).

A total of 41.1% of women giving birth in the RFSA between 2000 and 2002 were unmarried.

- Lower than the 46.3% found across Louisiana.
- Higher than the 33.6% reported nationwide.
- Ranges from 20.4% in Vernon Parish to over one-half (52.4%) in Natchitoches Parish.

Percentage Of Births To Unwed Mothers

(By Parish; Percentage Of Live Births, 2000-2002)

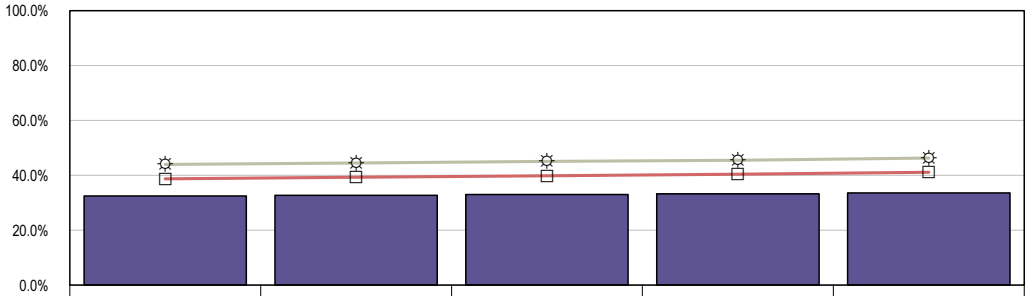


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are a percentage of all live births within each population.

TREND: In recent years, the percentage of births to unwed mothers increased within each of the regions shown.

Percentage Of Births To Unwed Mothers

(By Region; Percentage Of Live Births, 1996-2002)



	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	38.7%	39.3%	39.8%	40.4%	41.1%
Louisiana	44.0%	44.5%	45.1%	45.5%	46.3%
United States	32.5%	32.7%	33.0%	33.2%	33.6%

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are a percentage of all live births within each population.

Births To Teenage Mothers

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

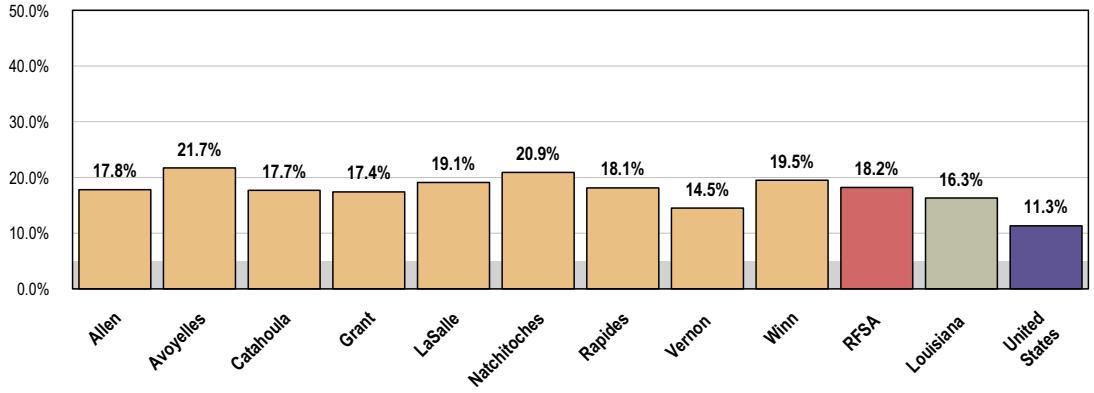
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Between 2000-2002, 18.2% of RFSA births were to mothers between the ages of 10 and 19 years old.

- Higher than the 16.3% reported across the State of Louisiana.
- Much higher than the 11.3% reported across the United States.
- Ranges from 14.5% in Vernon Parish to 21.7% in Avoyelles Parish.

Percentage Of Births To Mothers Under 20

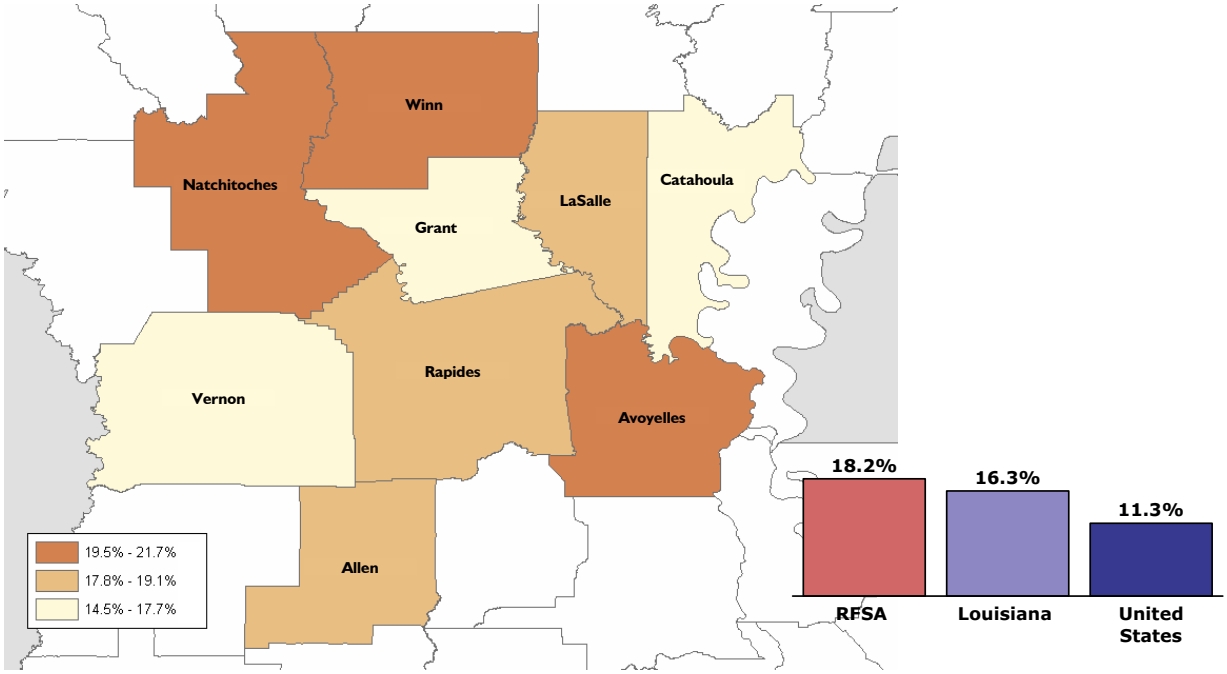
(By Parish; Percentage Of Live Births,2000-2002)



Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are a percentage of all live births within each population.

Percentage Of Births To Mothers Under 20

(By Parish, 2000-2002 Percentage Of Live Births)

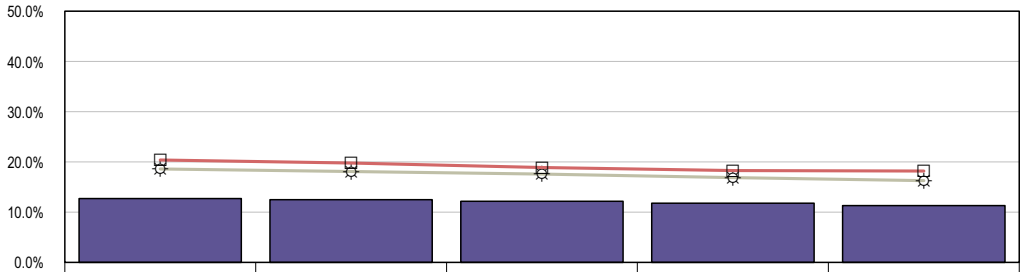


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are a percentage of all live births within each population.

TREND: The percentages of births to mothers under age 20 have decreased in the RFSA, as they have both statewide and nationwide.

Percentage Of Births To Mothers Under 20

(By Region; Percentage Of Live Births,1996-2002)



	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	20.4%	19.8%	18.9%	18.3%	18.2%
Louisiana	18.6%	18.1%	17.6%	16.9%	16.3%
United States	12.7%	12.5%	12.2%	11.8%	11.3%

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are a percentage of all live births within each population.

IMMUNIZATION

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

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

Vaccine-Preventable Diseases

Between 2001-2003, there were no reported cases of measles, mumps, or rubella in the RFSA.

- The Healthy People 2010 goal for measles, mumps, and rubella is 0 cases.
- Across the RFSA, the pertussis rate for 2001-2003 was 0.1 per 100,000 people.

Reported Case Rates For Vaccine-Preventable Diseases

(By Region, 2001-2003)

	RFSA	LA	US	HP2010
Measles	0.0	0.0	0.0	0.0
Mumps	0.0	0.0	0.1	0.0
Rubella	0.0	0.0	0.0	0.0
Pertussis	0.1	0.2	3.4	n/a

Source:
- Louisiana Department of Health and Hospitals, 2001-2003 data.
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

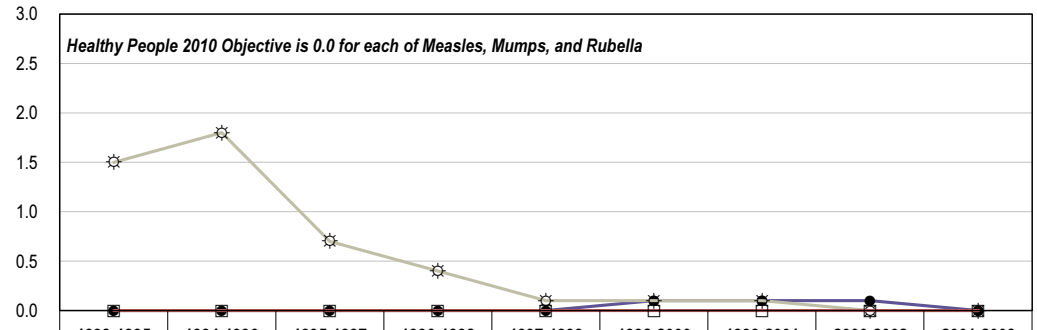
Note:
- United States measles cases only include those infected while in the United States.

Measles, Mumps & Rubella

TREND: Note the lack of measles cases across the RFSA during this time.

Select Vaccine-Preventable Disease Rates

(Cases Per 100,000 Population; Rapides Foundation Service Area, 1993-2003)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003
Measles	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mumps	1.5	1.8	0.7	0.4	0.1	0.1	0.1	0.0	0.0
Rubella	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.0

Source: • Louisiana Department of Health and Hospitals.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-9]

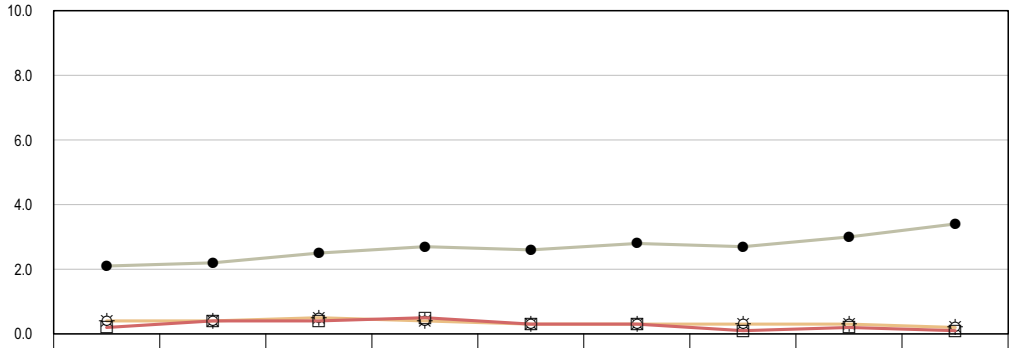
Note: • Rates are per 100,000 population.

Pertussis

TREND: Pertussis rates across the RFSA were quite low in recent years, comparing to much higher, and growing, rates across the nation.

Pertussis Incidence

(Cases Per 100,000 Population; 1993-2003)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003
RFSA	0.2	0.4	0.4	0.5	0.3	0.3	0.1	0.2	0.1
Louisiana	0.4	0.4	0.5	0.4	0.3	0.3	0.3	0.3	0.2
United States	2.1	2.2	2.5	2.7	2.6	2.8	2.7	3.0	3.4

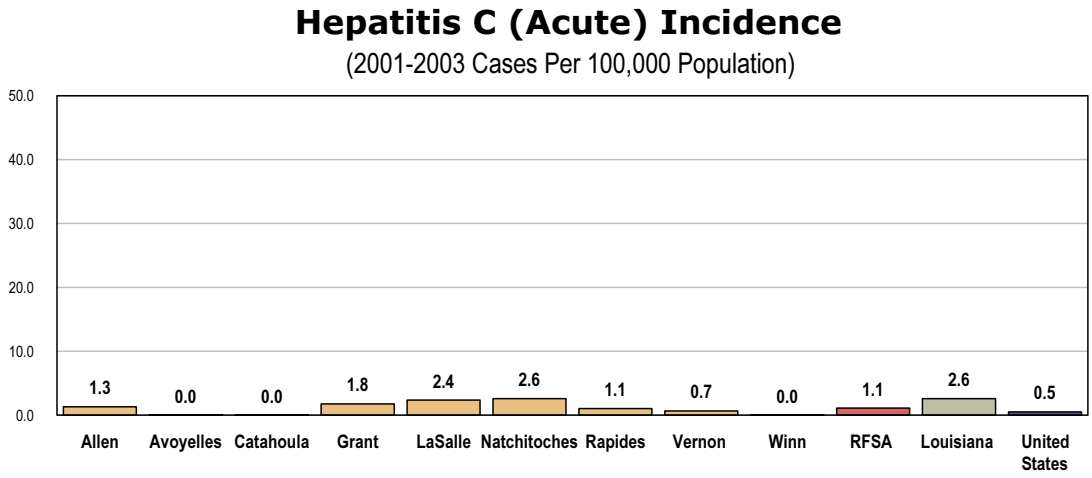
Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.

Notes: • Rates are per 100,000 population.

Acute Hepatitis C

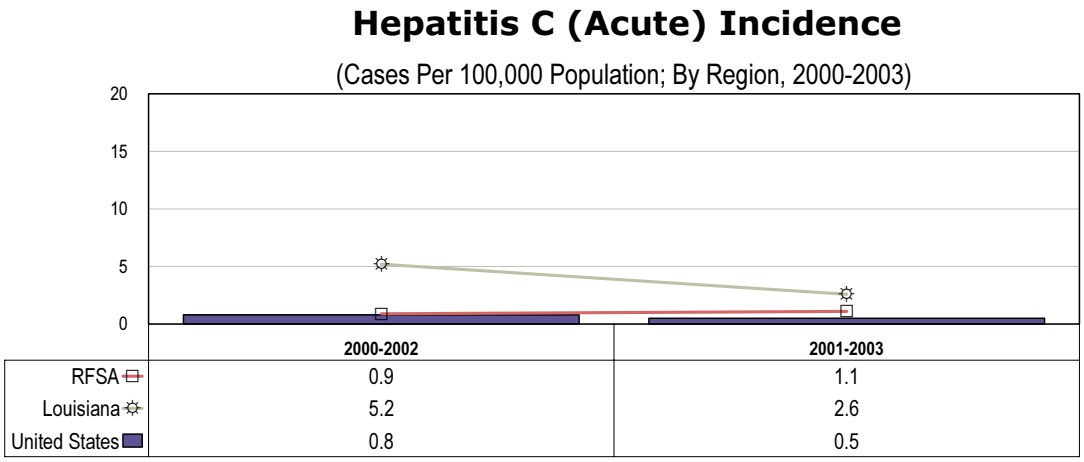
Between 2001 and 2003, there was an annual average of 1.1 acute hepatitis C cases per 100,000 population reported in the RFSA.

- Lower than the 2.6 found statewide.
- Above the national incidence rate (0.5).
- Highest (2.6) in Natchitoches Parish.



Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are per 100,000 population.

TREND: Hepatitis C incidence increased slightly in the RFSA between 2000 and 2003, while state and national rates declined.



Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are per 100,000 population.

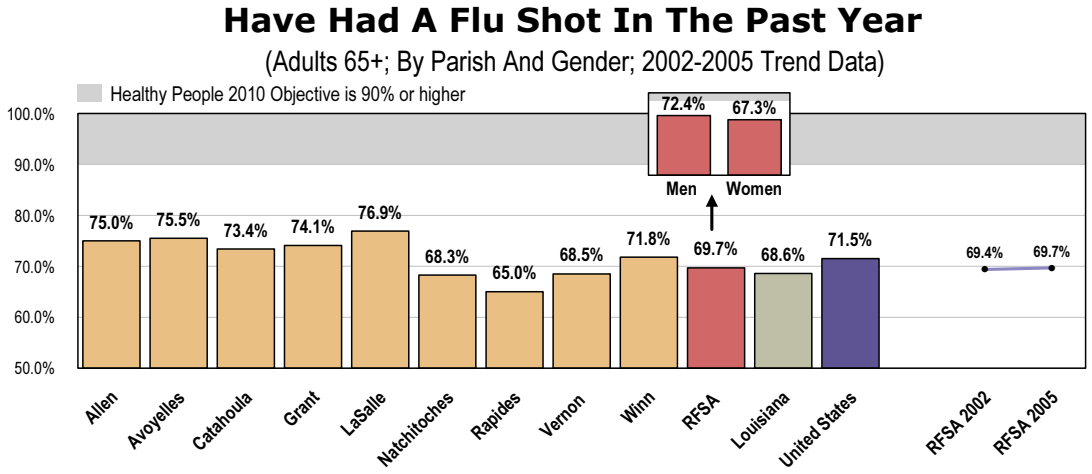
Influenza/Pneumonia Vaccination

Influenza

A total of 7 in 10 RFSA adults aged 65 and older (69.7%) received a flu shot within the past year.

- Similar to the 68.6% found across Louisiana.
- Statistically similar to national findings (71.5%).
- Fails to satisfy the Healthy People 2010 target (90% or higher).

TREND: The 2005 finding is comparable to that reported in 2002 among older adults in the RFSA.



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 162]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29c]

Note:
- Asked of all respondents aged 65 and older.

High-Risk Adults Aged 18 to 64

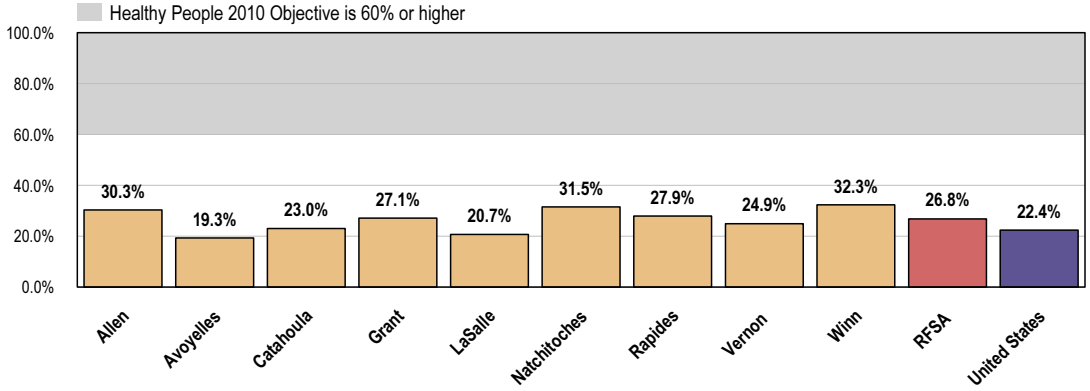
In this instance, "high-risk" includes adults aged 18 to 64 who report having been diagnosed with heart disease, diabetes or respiratory disease.

In the RFSA, 26.8% of high-risk adults aged 18 to 64 received a flu shot within the past year.

- Statistically similar to the 22.4% found nationwide.
- Fails to satisfy the Healthy People 2010 target (60% or higher).
- Highest (32.3%) in Winn Parish.

Have Had A Flu Shot In The Past Year

(High-Risk Adults Aged 18-64; By Parish, 2005)



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 168]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29c]

Note:
- "High-Risk" includes adults aged 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- State data not available.

Pneumonia

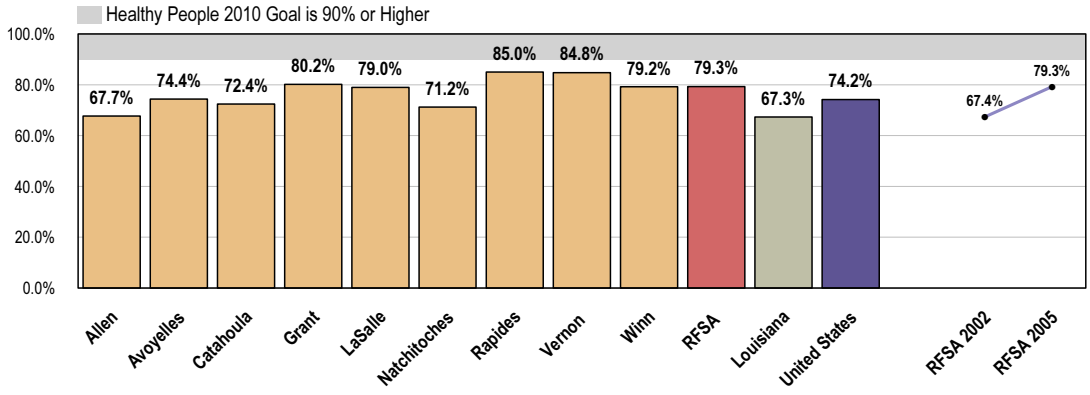
A majority (79.3%) of RFSA adults aged 65 and older have received a pneumonia vaccination at some point in their lives.

- More favorable than the 67.3% reported across Louisiana.
- Comparable to the 74.2% reported across the United States.
- Fails to satisfy the Healthy People 2010 target (90% or higher).
- Ranges from 67.7% in Allen Parish to 85.0% in Rapides Parish.

TREND: Marks a *statistically significant increase* over the 67.4% reported in 2002.

Have Ever Had A Pneumonia Vaccination

(Adults 65+; By Parish; 2002-2005 Trend Data)



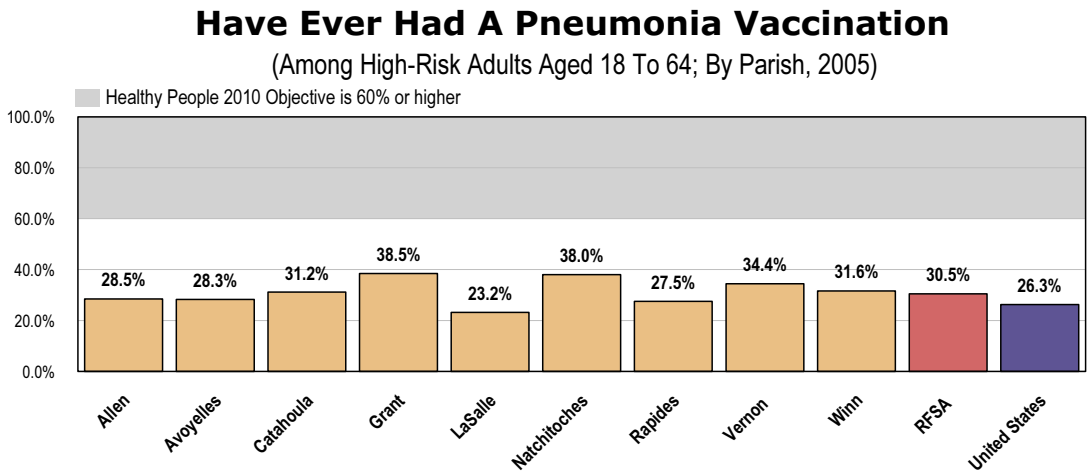
Source:
- PRC Community Health Surveys, Professional Research Consultants. [Item 163]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2004 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29b]

Note:
- Reflects respondents aged 65 and older.

High-Risk Adults Aged 18 to 64

In the RFSA, just over 3 in 10 (30.5%) high-risk adults aged 18 to 64 have received a pneumonia vaccination at some point in their lives.

- Similar to the national prevalence (26.3%).
- Fails to satisfy the Healthy People 2010 target (60% or higher).
- Ranges from 23.2% in LaSalle Parish to 38.5% in Grant Parish.



Source:
- 2005 PRC Community Health Survey, Professional Research Consultants. [Item 169]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29d]

Note:
- "High-Risk" includes adults aged 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- State data not available.

TUBERCULOSIS

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

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

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

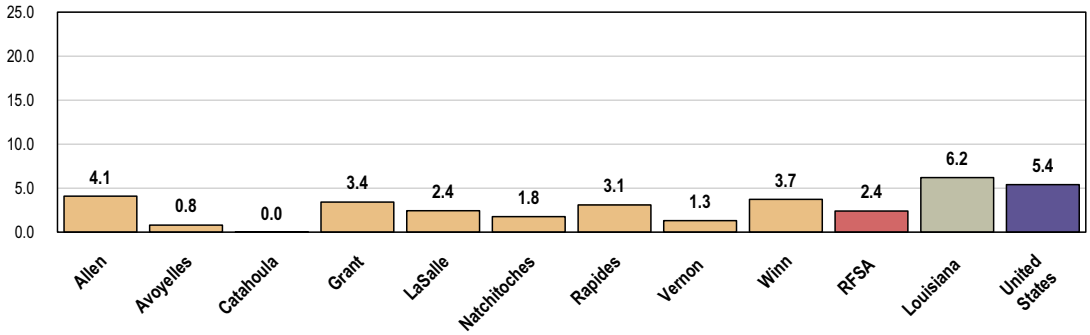
— Ending Neglect: The Elimination Of Tuberculosis In The United States. National Academy of Sciences, Institute of Medicine. Funded by the Centers for Disease Control and Prevention. 2000.

Between 2001-2003, there was an annual average of 2.4 reported cases of tuberculosis per 100,000 population in the RFSA.

- More favorable than the 6.2 reported statewide as well as the 5.4 reported nationally.
- Highest (4.1) in Allen Parish.

Tuberculosis Incidence

(By Parish; Cases Per 100,000 Population; 2001-2003)

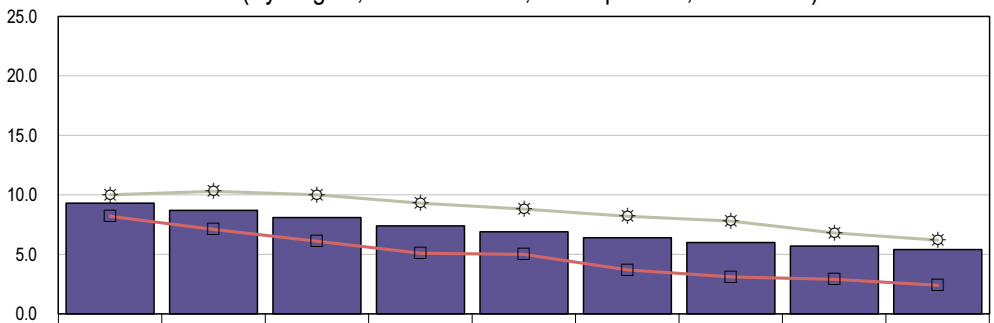


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.

TREND: RFSA tuberculosis incidence rates have declined considerably over the past decade.

Tuberculosis Incidence

(By Region; Cases Per 100,000 Population; 1993-2003)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003
RFSA	8.2	7.1	6.1	5.1	5.0	3.7	3.1	2.9	2.4
Louisiana	10.0	10.3	10.0	9.3	8.8	8.2	7.8	6.8	6.2
United States	9.3	8.7	8.1	7.4	6.9	6.4	6.0	5.7	5.4

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.

ENTERIC DISEASES

Enteric diseases are gastrointestinal illnesses caused by bacteria, parasites or viruses. Transmission from person to person is via hand-to-mouth. They include such known and lesser-known diseases as hepatitis A, shigellosis, salmonellosis and campylobacteriosis.

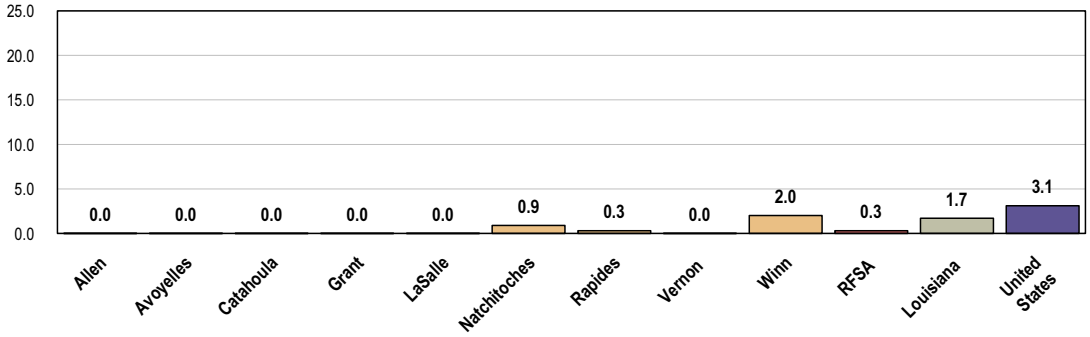
Acute Hepatitis A

Between 2001-2003, there were 0.3 cases of acute hepatitis A per 100,000 population across the RFSA.

- More favorable than the 1.7 reported statewide and the 3.1 reported nationally.
- Highest (2.0) in Winn Parish.

Hepatitis A (Acute) Incidence

(By Parish; Cases Per 100,000 Population; 2001-2003)

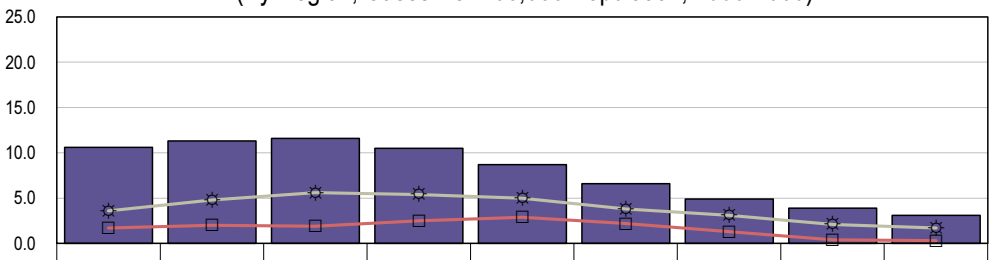


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.

TREND: In recent years, the RFSA hepatitis A rate has decreased considerably.

Hepatitis A (Acute) Incidence

(By Region; Cases Per 100,000 Population; 1993-2003)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003
RFSA	1.7	2.0	1.9	2.5	2.9	2.2	1.3	0.4	0.3
Louisiana	3.6	4.8	5.6	5.4	5.0	3.8	3.1	2.1	1.7
United States	10.6	11.3	11.6	10.5	8.7	6.6	4.9	3.9	3.1

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.

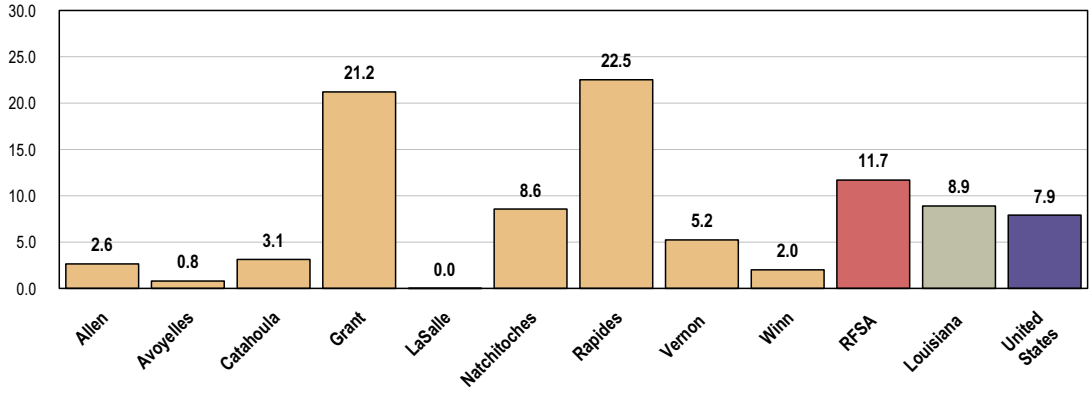
Shigellosis

Between 2001-2003, there was an annual average of 11.7 reported cases of shigellosis per 100,000 population in the RFSA.

- Higher than state and national rates.
- Dramatically higher in Grant and Rapides parishes.

Shigellosis Incidence

(By Parish; Cases Per 100,000 Population; 2001-2003)

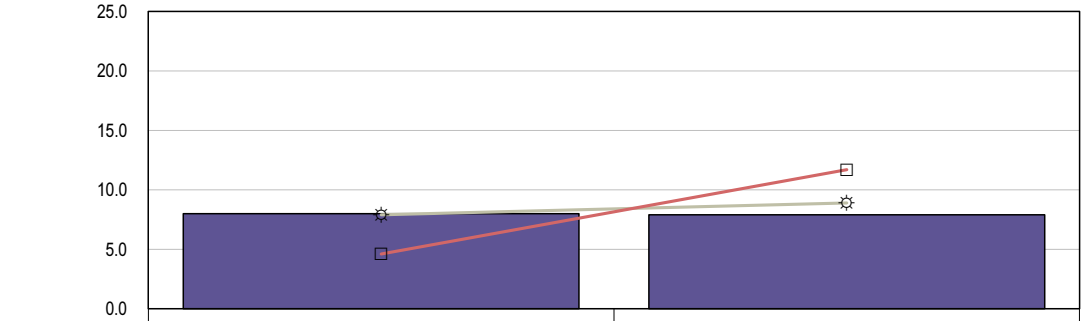


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.

TREND: The rate across RFSA increased from 4.6 to 11.7 between 2000-2002 and 2001-2003. The changes occurring both statewide and nationwide were much less dramatic.

Shigellosis Incidence

(By Region; Cases Per 100,000 Population; 2000-2003)



	2000-2002	2001-2003
RFSA	4.6	11.7
Louisiana	7.9	8.9
United States	8.0	7.9

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.

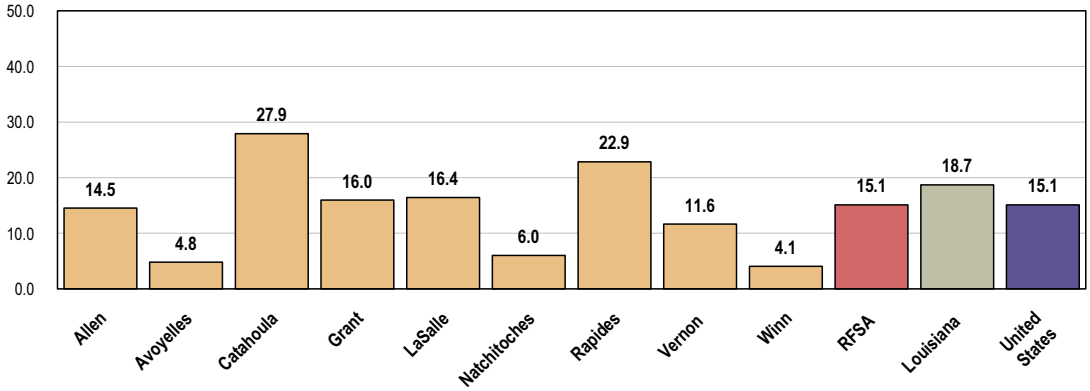
Salmonellosis

Between 2001-2003, there was an annual average of 15.1 reported cases of salmonellosis per 100,000 population in the RFSA.

- Lower than the 18.7 across Louisiana.
- Identical to the national prevalence.
- Ranges from 4.1 in Winn Parish to 27.9 in Catahoula Parish.

Salmonellosis Incidence

(By Parish; Cases Per 100,000 Population; 2001-2003)



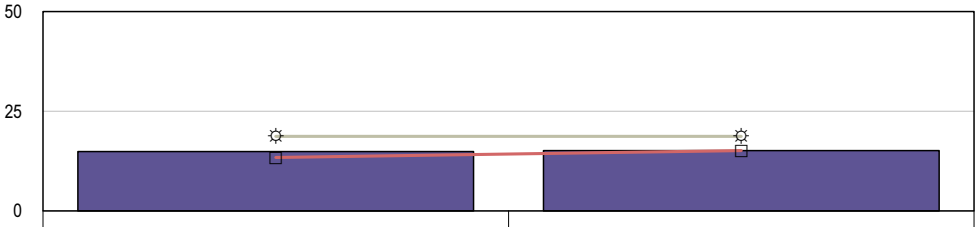
Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.

Note:
- Rates are cases per 100,000 population.
- Excludes typhoid fever.

TREND: The RFSA 2001-2003 reporting period had a slightly higher salmonellosis incidence rate compared to the 2000-2002 reporting period. Rates remained stable across the other regions during this time period.

Salmonellosis Incidence

(By Region; Cases Per 100,000 Population; 2000-2003)



	2000-2002	2001-2003
RFSA	13.4	15.1
Louisiana	18.7	18.7
United States	14.9	15.1

Source:
- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.

Note:
- Rates are cases per 100,000 population.
- Excludes typhoid fever.

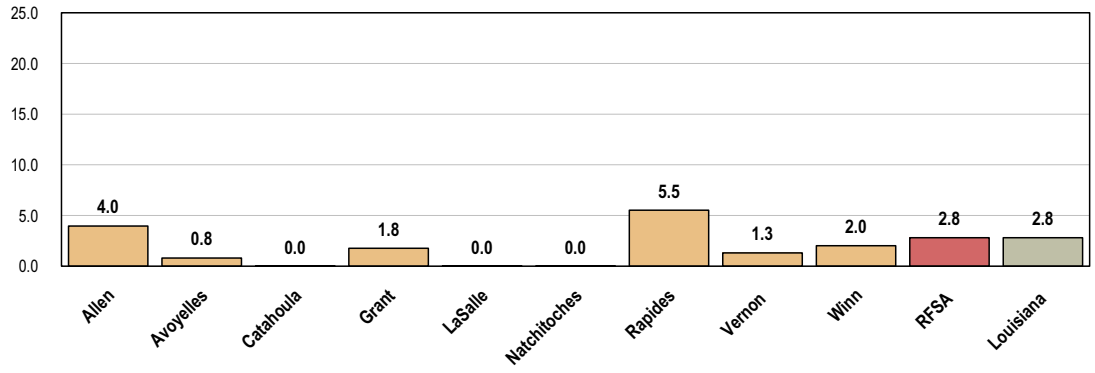
Campylobacteriosis

Between 2001-2003, the annual average campylobacteriosis incidence rate in the RFSA was 2.8 per 100,000 population.

- Identical to the state incidence rate.
- Highest (5.5) in Rapides Parish.

Campylobacteriosis Incidence

(By Parish; Cases Per 100,000 Population; 2001-2003)

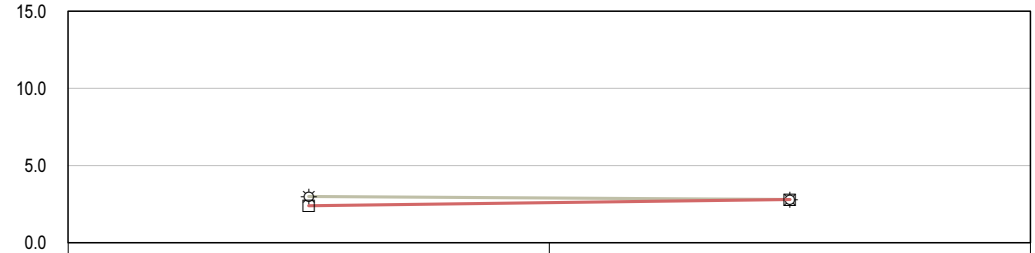


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.
• National data not available.

TREND: The RFSA 2001-2003 incidence rate was comparable to the 2000-2002 reporting period.

Campylobacteriosis Incidence

(By Region; Cases Per 100,000 Population; 2000-2003)



	2000-2002	2001-2003
RFSA	2.4	2.8
Louisiana	3.0	2.8

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
Note: • Rates are cases per 100,000 population.
• National data not available.

HIV/AIDS

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

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

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

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

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

- Because of the long period of time from initial HIV infection to AIDS and because highly active antiretroviral therapy (HAART) has slowed the progression to AIDS, new cases of AIDS no longer provide accurate information about the current HIV epidemic in the United States.

- Because of a lack of awareness of HIV serostatus as well as delays in accessing counseling, testing, and care services by individuals who may be infected or are at risk of infection, some populations do not perceive themselves to be at risk. As a result, some HIV-infected persons are not identified and provided care until late in the course of their infection.

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

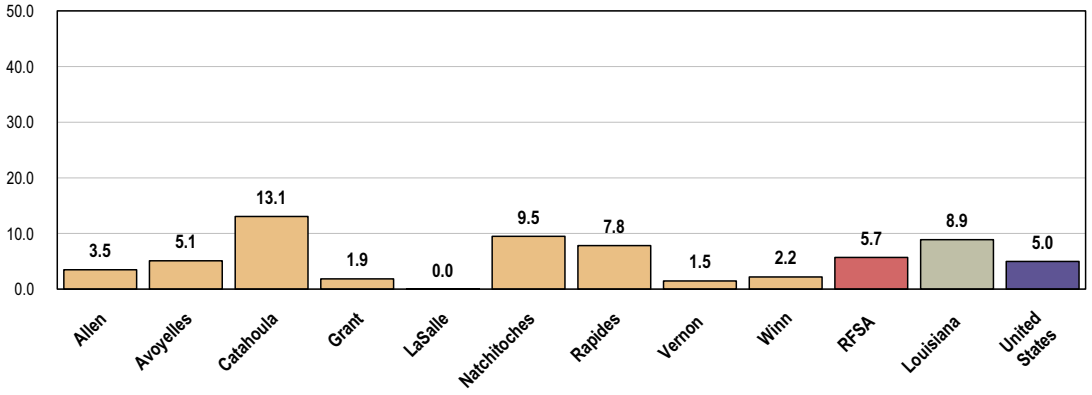
Age-Adjusted Mortality

Between 2000 and 2002, there was an annual average age-adjusted HIV/AIDS death rate of 5.7 deaths per 100,000 population in the RFSA.

- Well below the statewide rate (8.9).
- Just above the 5.0 recorded across the nation.
- Ranges from 0.0 in LaSalle Parish to 13.1 in Catahoula Parish.

Age-Adjusted Mortality: HIV/AIDS

(By Parish; 2000-2002 Deaths Per 100,000 Population)



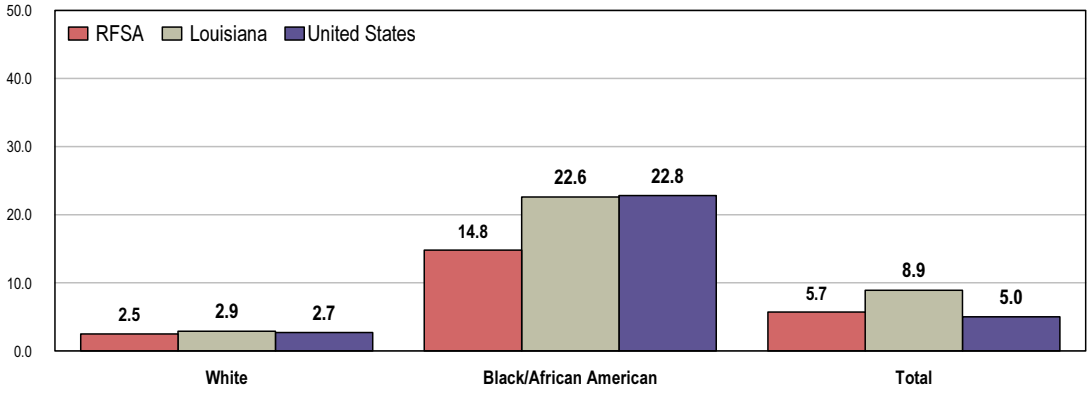
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

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

- Higher among the RFSA Black/African American population (14.8 per 100,000) than among Whites (2.5), mirroring state and national findings.

Age-Adjusted Mortality: HIV/AIDS

(By Region And Race; 2000-2002 Deaths Per 100,000 Population)



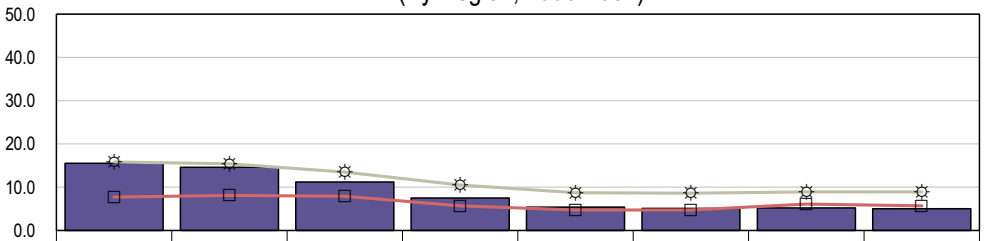
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

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

TREND: The RFSA age-adjusted HIV/AIDS mortality has decreased in recent years, although not as dramatically as the decreases noted across Louisiana and the United States.

Age-Adjusted Mortality: HIV/AIDS

(By Region; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	7.7	8.1	7.9	5.7	4.7	4.7	6.1	5.7
Louisiana	15.8	15.4	13.5	10.5	8.7	8.6	8.9	8.9
United States	15.5	14.6	11.2	7.5	5.4	5.1	5.2	5.0

Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2005.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, November 2000.

Note:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Data for 1999 and subsequent years are not fully comparable to data from 1998 and prior years, due to changes in coding of causes of deaths resulting from the switch from the ninth revision of the International Classification of Diseases (ICD9) to the tenth revision (ICD10).
- State and national data are simple three-year averages, the RFSA three-year averages are weighted by population.

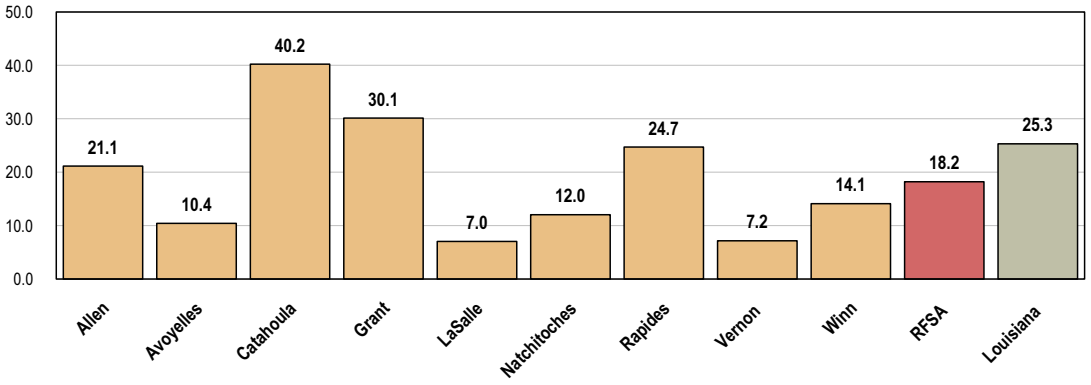
HIV/AIDS Incidence

Between 2001-2003, the annual average RFSA rate of new HIV/AIDS cases was 18.2 per 100,000 population.

- Significantly lower than the statewide rate (25.3).
- Particularly high (40.2) in Catahoula Parish.

HIV/AIDS Case Rates

(2001-2003 Cases Per 100,000 Population)

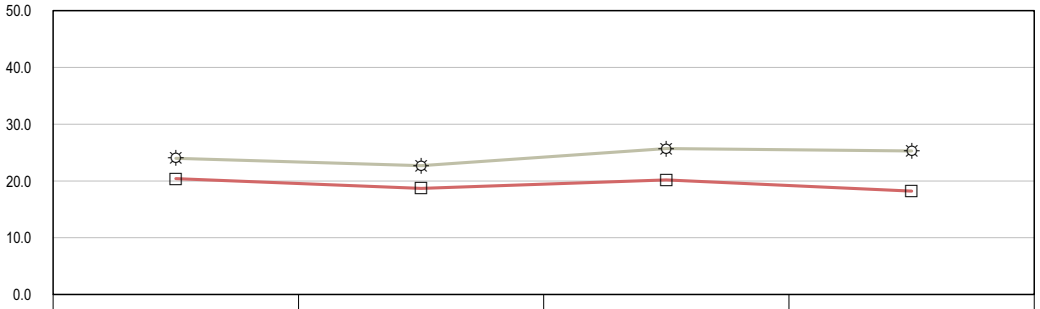


Source: • Louisiana Department of Health and Hospitals.
Note: • Rates are cases per 100,000 population.
• National data not available.

TREND: Between the 1998-2000 and 2001-2003 reporting periods, the regional HIV/AIDS incidence ranged from 20.4 to 18.2.

HIV/AIDS Case Rates

(1998-2003 Cases Per 100,000 Population)



	1998-2000	1999-2001	2000-2002	2001-2003
RFSA	20.4	18.7	20.2	18.2
Louisiana	24.0	22.7	25.7	25.3

Source: • Louisiana Department of Health and Hospitals.
Note: • Represents estimated number of cases per 100,000 population.
• National data not available.

SEXUALLY TRANSMITTED DISEASES

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

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

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

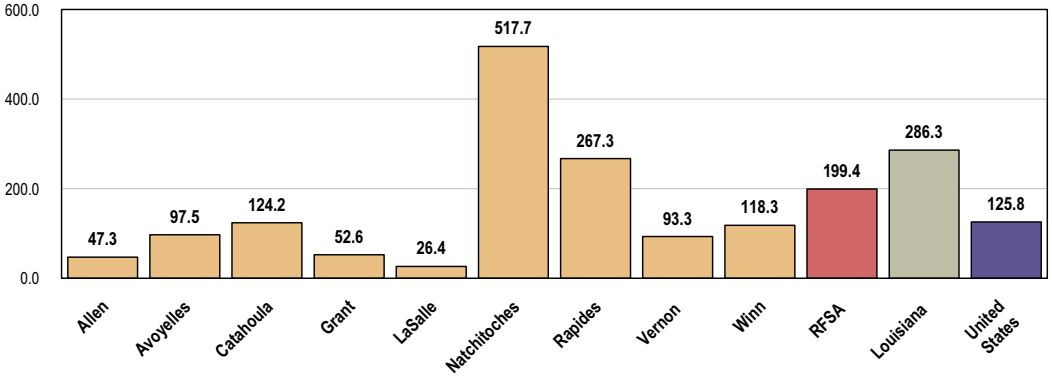
Gonorrhea

Between 2000-2002, the RFSA reported an annual average of 199.4 cases of gonorrhea per 100,000 population.

- Much lower than the 286.3 reported throughout Louisiana.
- Higher than the 125.8 reported nationwide.
- Highest (517.7) in Natchitoches Parish.

Gonorrhea Incidence

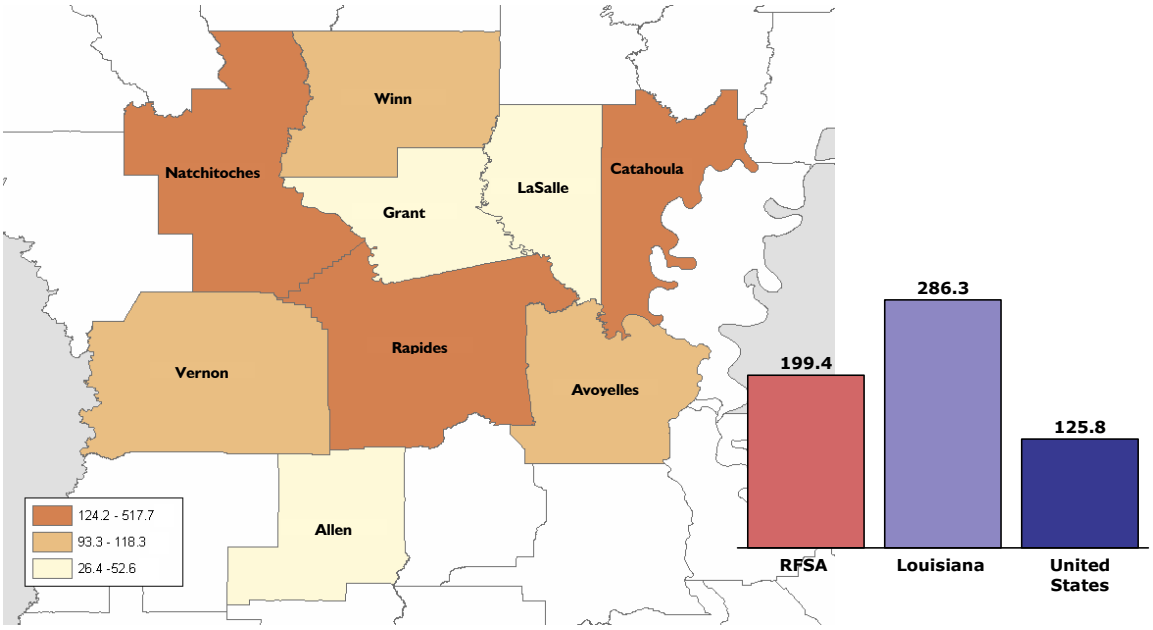
(By Parish; Cases Per 100,000 Population; 2000-2002)



Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

Gonorrhea Incidence

(By Parish; Cases Per 100,000 Population; 2000-2002)

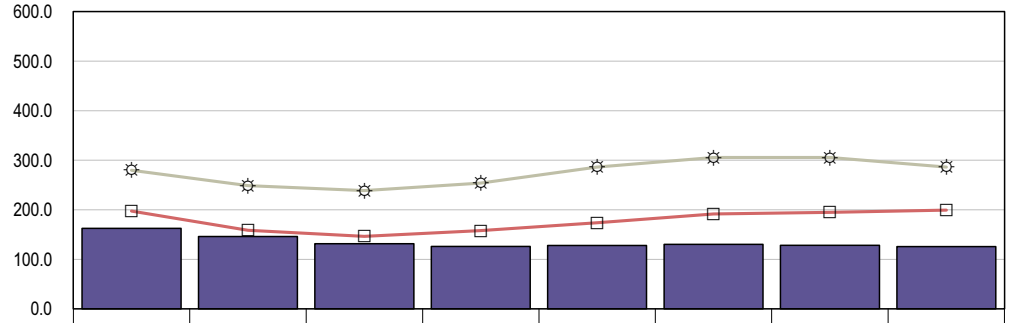


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

TREND: Gonorrhea incidence in the RFSA decreased in the late 1990s but has since increased.

Gonorrhea Incidence

(By Region; Cases Per 100,000 Population; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	197.4	158.6	146.3	157.9	173.9	191.6	194.8	199.4
Louisiana	279.8	248.7	238.6	254.0	286.3	305.7	305.7	286.3
United States	162.4	146.1	131.5	126.0	128.1	130.3	128.3	125.8

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

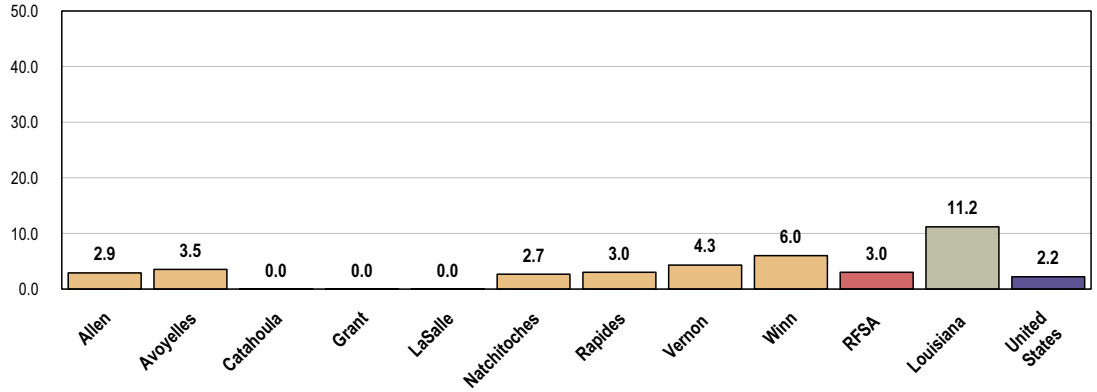
Syphilis

Between 2000-2002, the RFSA reported an annual average of 3.0 cases of primary-stage/secondary-stage syphilis (as characterized by progression of symptoms) per 100,000 population.

- Much lower than the statewide rate (11.2).
- Just above the 2.2 incidence rate reported nationwide.
- Highest (6.0) in Winn Parish.

Primary/Secondary Syphilis Incidence

(By Parish; Cases Per 100,000 Population; 2000-2002)

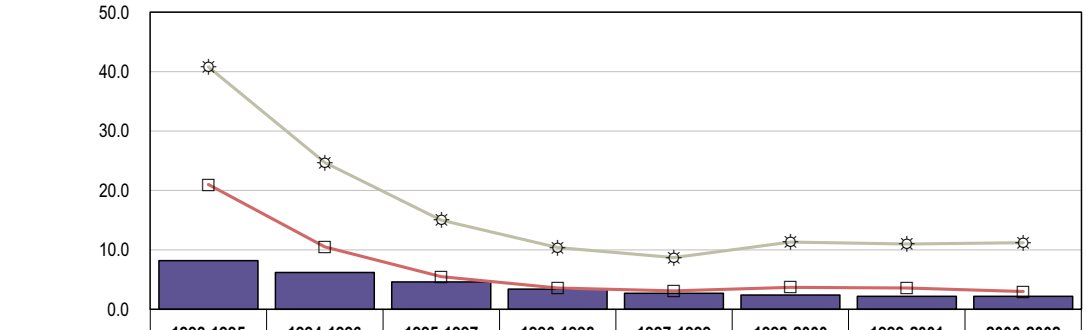


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

TREND: After a sharp decline in the early 1990s, primary/secondary syphilis incidence rates remained fairly stable over the past several reporting periods.

Primary/Secondary Syphilis Incidence

(By Region; Cases Per 100,000 Population; 1993-2002)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	21.0	10.5	5.5	3.6	3.1	3.7	3.6	3.0
Louisiana	40.8	24.7	15.0	10.4	8.7	11.3	11.0	11.2
United States	8.2	6.2	4.6	3.4	2.7	2.4	2.2	2.2

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

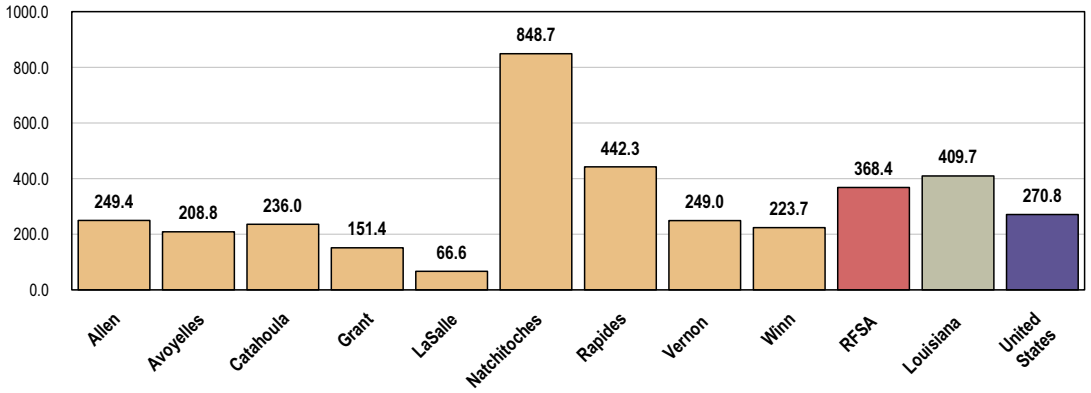
Chlamydia

Between 2000-2002, RFSA reported an annual average of 368.4 cases of chlamydia per 100,000 population.

- Lower than the 409.7 reported across Louisiana.
- Higher than the national incidence rate of 270.8.
- Exceptionally high (848.7) in Natchitoches Parish.

Chlamydia Incidence

(By Parish; Cases Per 100,000 Population; 2000-2002)

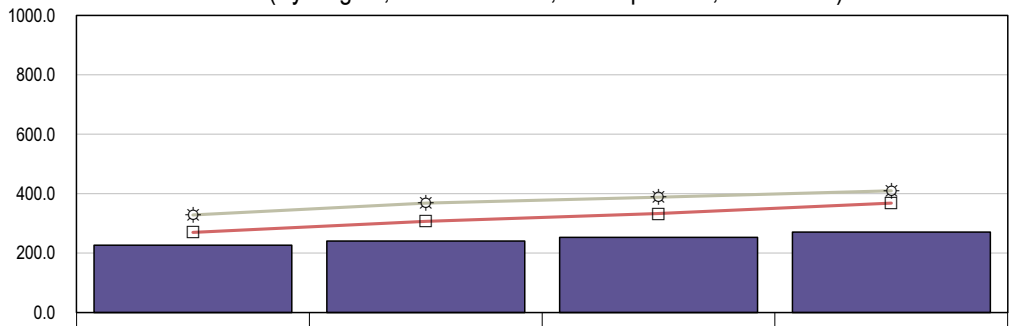


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

TREND: Chlamydia incidence is on the rise in the RFSA, as it is regionally, statewide and nationwide.

Chlamydia Incidence

(By Region; Cases Per 100,000 Population; 1997-2002)



	1997-1999	1998-2000	1999-2001	2000-2002
RFSA	269.5	306.9	332.9	368.4
Louisiana	328.3	368.3	388.3	409.7
United States	226.5	240.4	253.0	270.8

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

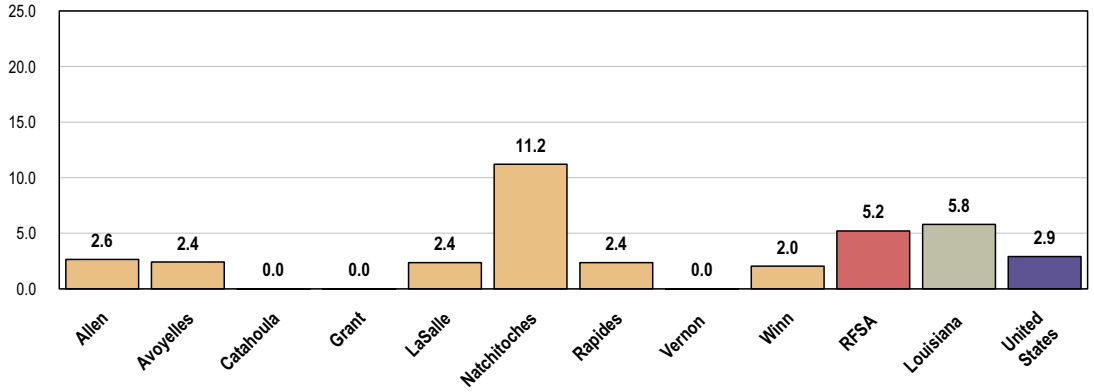
Acute Hepatitis B

In the RFSA, the acute hepatitis B case rate was 5.2 between 2001 and 2003.

- Just below the 5.8 reported across Louisiana.
- Above the 2.9 incidence rate reported nationwide.
- Highest (11.2) in Natchitoches Parish.

Hepatitis B (Acute) Incidence

(By Parish; Cases Per 100,000 Population; 2001-2003)

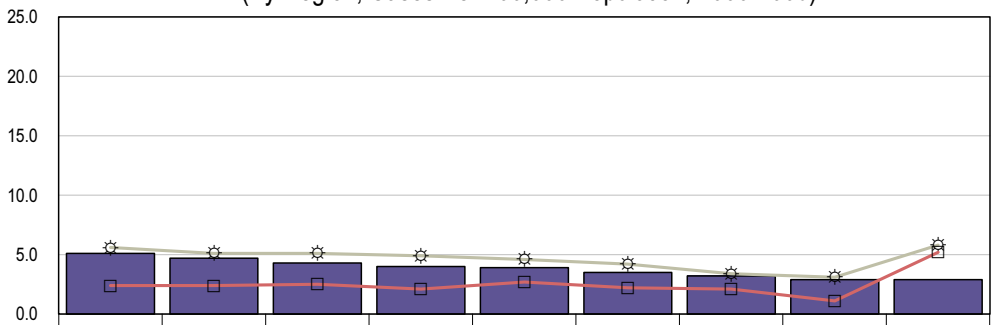


Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

TREND: Hepatitis B cases were stable in the RFSA for much of the past decade, despite the spike between 2000 and 2003.

Hepatitis B (Acute) Incidence

(By Region; Cases Per 100,000 Population; 2000-2003)



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003
RFSA	2.4	2.4	2.5	2.1	2.7	2.2	2.1	1.1	5.2
Louisiana	5.6	5.1	5.1	4.9	4.6	4.2	3.4	3.1	5.8
United States	5.1	4.7	4.3	4.0	3.9	3.5	3.2	2.9	2.9

Source: • Louisiana Department of Health and Hospitals.
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
Note: • Rates are cases per 100,000 population.

HOUSING CONDITIONS

Type Of Dwelling

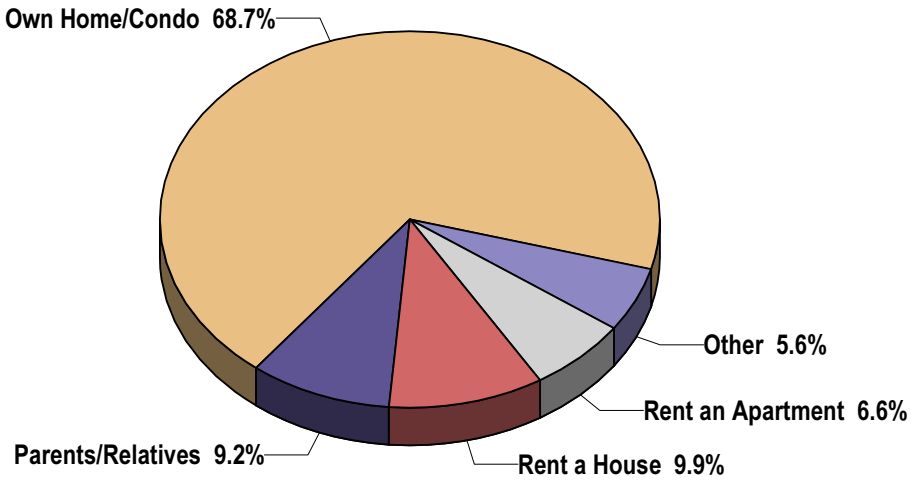
More than two in three RFSA residents (68.7%) currently own their home or condominium.

TREND: Nearly identical to the 68.3% reported across the RFSA in 2002.

Another 16.5% of RFSA adults **rent a house or apartment**, and 16.5% **live with parents or other relatives**.

Type Of Dwelling

(Rapides Foundation Service Area, 2005)



Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 116]
Note: • Asked of all respondents.

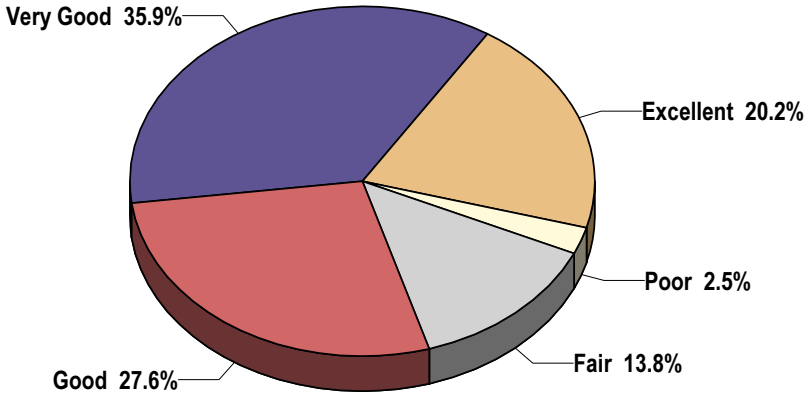
Condition Of Local Housing

When asked to evaluate the condition of local housing, more than one-half (56.1%) of RFSA residents gave "excellent" or "very good" responses; in contrast, 16.3% said "fair" or "poor."

- Statistically unchanged from the 17.4% "fair/ poor" response found in the RFSA in 2002.

Rating Of Condition Of Neighborhood Homes

(Rapides Foundation Service Area, 2005)

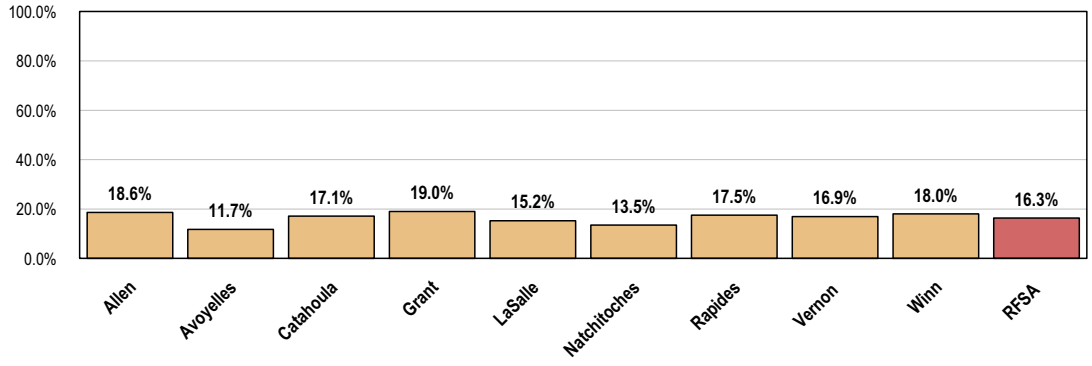


Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 117]
Note: • Asked of all respondents.

- Low ratings of the condition of neighborhood homes ranges from 11.7% in Avoyelles Parish to 19.0% in Grant Parish.

Perceive Condition Of Neighborhood Homes To Be "Fair" Or "Poor"

(By Parish; 2002-2005 Trend Data)



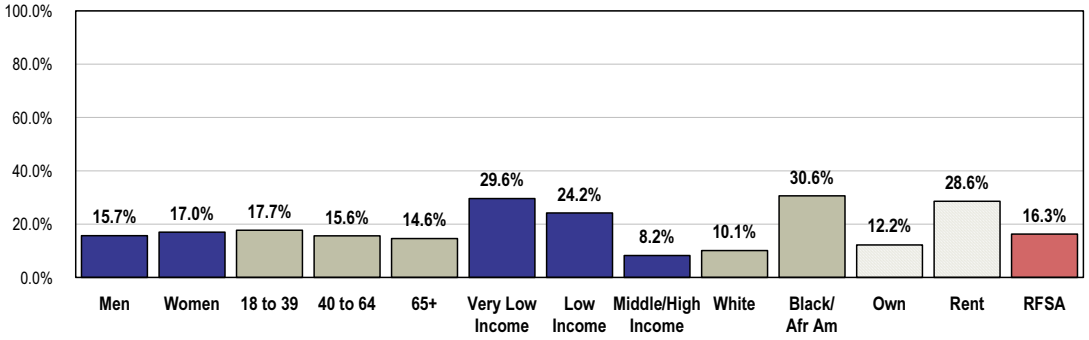
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 117]
Note: • Asked of all respondents.

Local adults are clearly divided in terms of perceptions of neighborhood housing. Residents more likely to perceive neighborhood homes to be "fair" or "poor" include:

- Those at low or very low income levels.
- Blacks/African Americans.
- People who rent as opposed to own.

Perceive Condition Of Neighborhood Homes To Be "Fair" Or "Poor"

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 117]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

HOUSING AFFORDABILITY

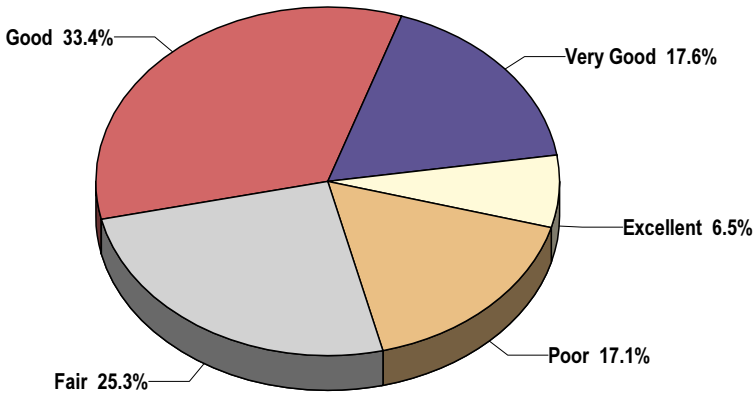
Availability Of Affordable Housing

While most RFSA adults give positive evaluations of the availability of affordable housing in the area, a full 42.4% consider it to be "fair" or "poor."

TREND: Similar to the distribution of responses in 2002.

Rating Of The Availability Of Affordable Local Housing

(Rapides Foundation Service Area, 2005)

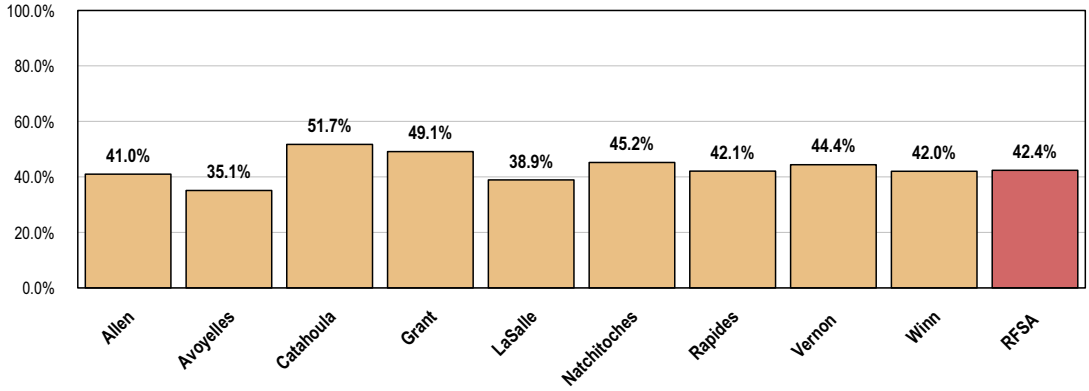


Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 114]
Note: • Asked of all respondents.

- Particularly high "fair/ poor" response in Catahoula and Grant parishes.

Perceive The Availability Of Affordable Neighborhood Homes To Be "Fair" Or "Poor"

(By Parish, 2005)



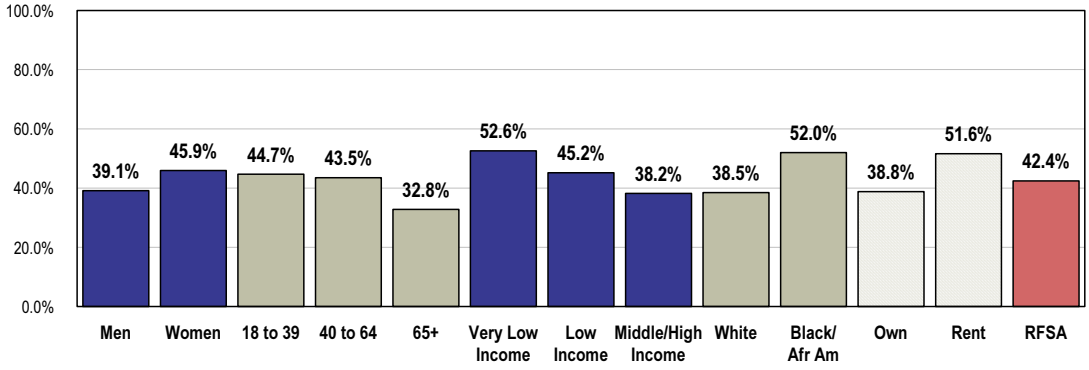
Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 114]
Note: • Asked of all respondents.

Those more likely to rate the availability of affordable housing in the area as "fair" or "poor" include:

- Women.
- Adults under 65.
- Those living on very low incomes.
- Blacks/African Americans.
- Residents who rent their dwellings.

Perceive The Availability Of Affordable Neighborhood Homes To Be "Fair" Or "Poor"

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 114]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Housing Displacement

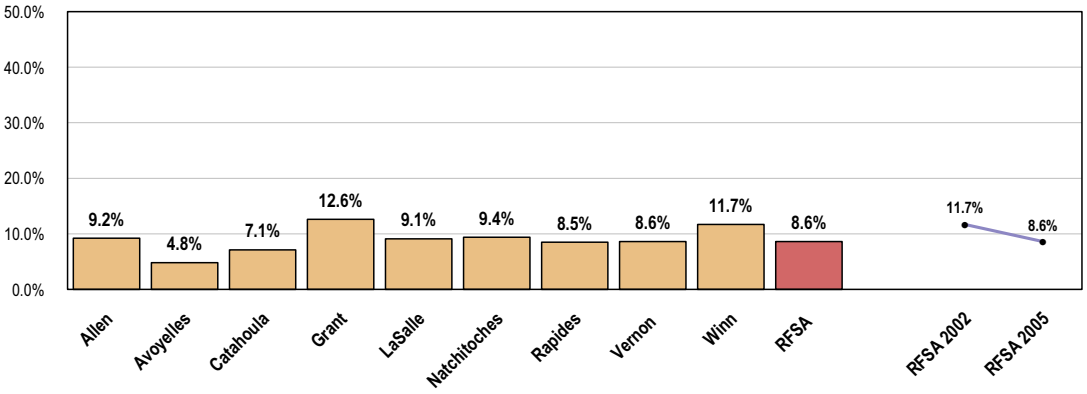
A total of 8.6% of RFSA respondents have had to go live with a friend or relative some time in the past two years due to a housing emergency (even though this has may have been only temporary).

- Highest (12.6%) in Grant Parish.

TREND: Marks a *statistically significant decrease* since 2002.

Had To Live With A Friend/Relative In The Past Two Years Due To An Emergency (Even Temporarily)

(By Parish; 2002-2005 Trend Data)



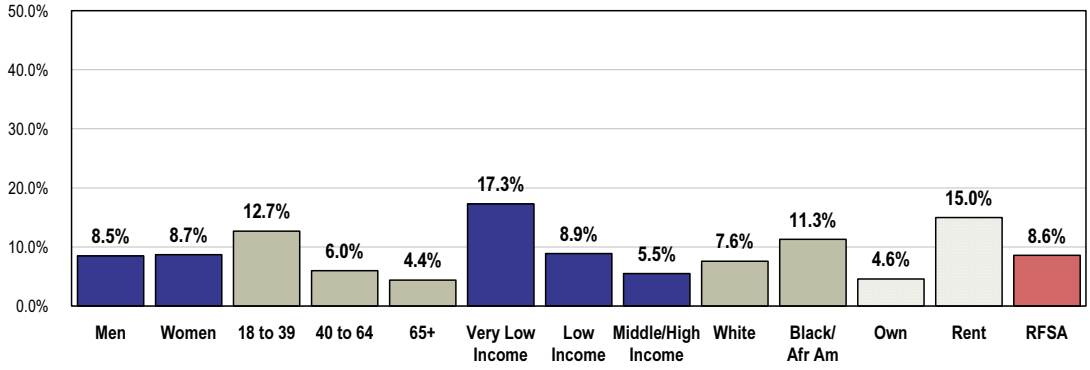
Source: • PRC Community Health Surveys, Professional Research Consultants. [Item 115]
Note: • Asked of all respondents.
• State and national data not available.

Adults more likely to report living with a friend or relative due to a housing emergency include:

- Those under age 40.
- Adults living at very low income levels.
- Blacks/African Americans.
- Renters.

Had To Live With A Friend/Relative In The Past Two Years Due To An Emergency (Even Temporarily)

(Rapides Foundation Service Area, 2005)



Source: • 2005 PRC Community Health Survey, Professional Research Consultants. [Item 115]
Note: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level for their household size: "very low income" = below poverty; "low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

PERCEPTIONS OF TEEN ISSUES

Survey respondents were asked to evaluate the degree to which each of five youth issues is a problem in the RFSA. These issues include: teen alcohol use; teen drinking and driving; teen drug use; teen pregnancy; and teen tobacco use. For each issue, respondents were asked if they see this as a "major problem," "moderate problem," "minor problem" or "no problem at all" for adolescents in their own community.

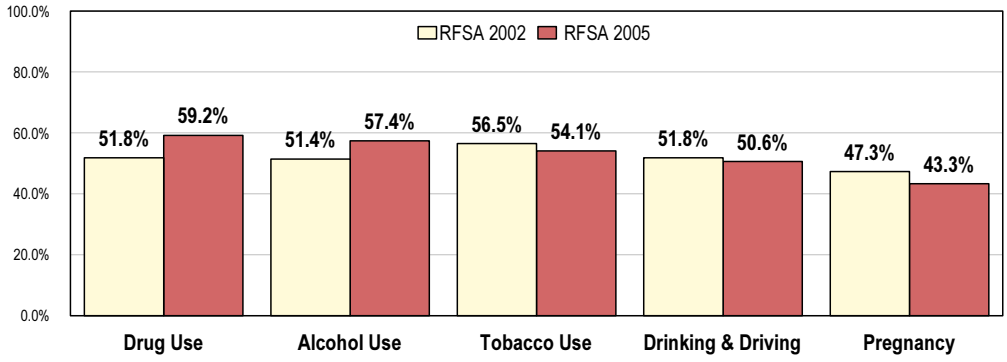
Of the tested youth issues, teen drug use was the biggest concern in the RFSA (59.2% said this is a "major problem").

- More than one-half of respondents also view teen alcohol use, teen tobacco use, and drinking/driving as "major problems" for local adolescents.
- Fewer adults (43.3%) consider teen pregnancy to be a "major" issue in the RFSA.

TREND: *Statistically significant increases* occurred this year for perceptions of drug use and alcohol use, whereas *decreases* were noted for tobacco use and teen pregnancy among adolescents in the RFSA.

Teen Issues Perceived As "Major" Problems In Rapides Foundation Service Area

(Rapides Foundation Service Area; 2002-2005 Trend Data)



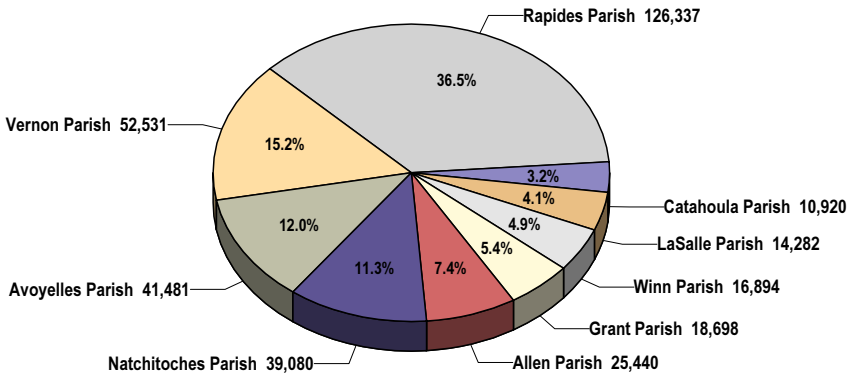
Source: • PRC Community Health Surveys, Professional Research Consultants. [Items 109-113]
Note: • Asked of all respondents.
• State and national data not available.

DEMOGRAPHIC PROFILE

Population

The 2000 Census population for The Rapides Foundation Service Area was 345,663 persons. The following chart illustrated the population distribution among parishes in the RFSA.

Population Distribution Of
The Rapides Foundation Service Area
(US Census 2000)
RFSA Total Population = 345,663

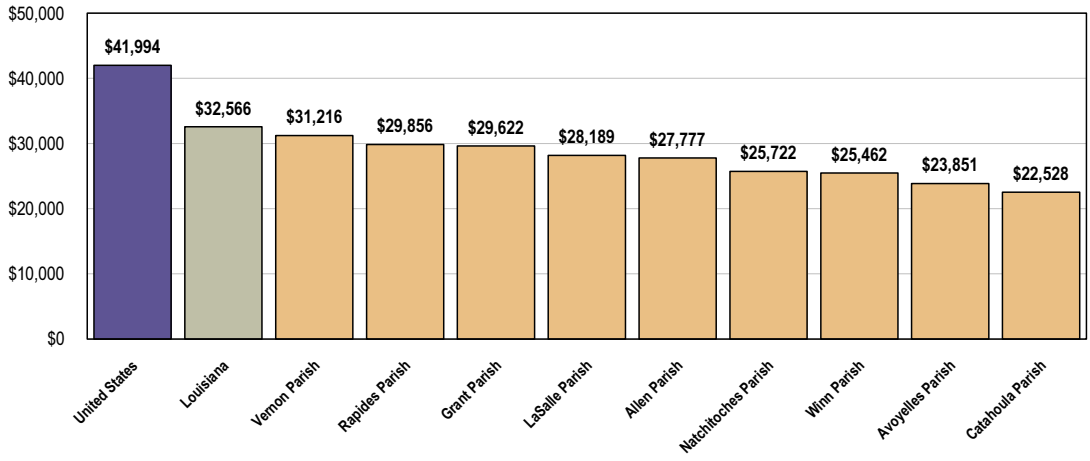


Income

Median Income

Median incomes across the RFSA (in 1999) range from $22,528 in Catahoula Parish to $31,216 in Vernon Parish. Note the higher median incomes statewide and particularly nationwide.

Median Household Income In 1999
(By Parish; In Dollars)



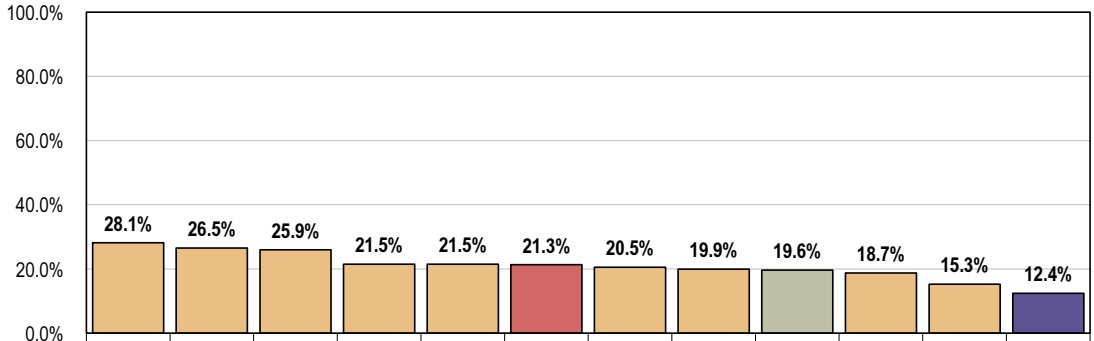
Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.

Population Living Below Poverty

A total of 21.3% of the RFSA population lives below the federal poverty level. This is higher than the proportions statewide and much higher than nationally.

Total Population: Percent/Number Living Below Poverty

(By Parish, 2000)



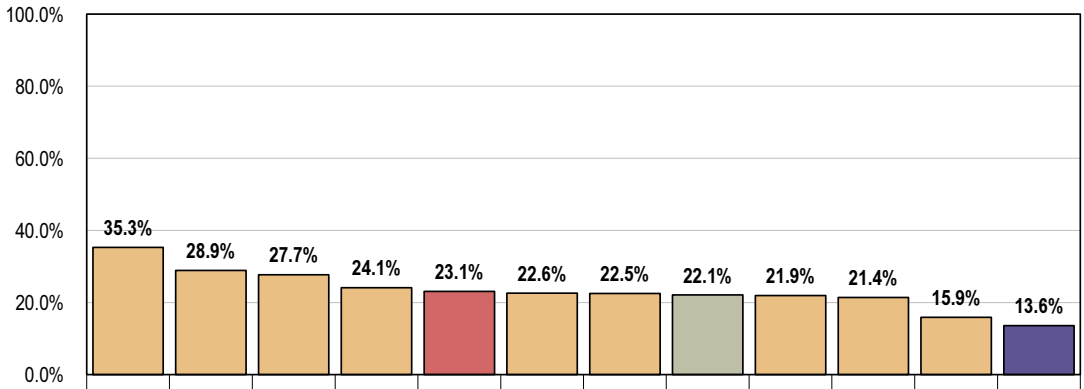
	Catahoula Parish	Natchitoches Parish	Avoyelles Parish	Grant Parish	Winn Parish	RFSA	Rapides Parish	Allen Parish	Louisiana	LaSalle Parish	Vernon Parish	United States
Actual Number Of People Living Below Poverty	2,921	9,653	9,939	3,948	3,253	69,001	25,097	4,225	851,113	2,486	7,479	33,899,812

Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.

A total of 23.1% of RFSA families with children under age 18 live below poverty (similar to the 22.1% statewide but much higher than the 13.6% found across the nation). The proportion is particularly high in Catahoula Parish.

Families With Children (Age 0 To 17): Percent/Number Living Below Poverty

(By Parish, 2000)



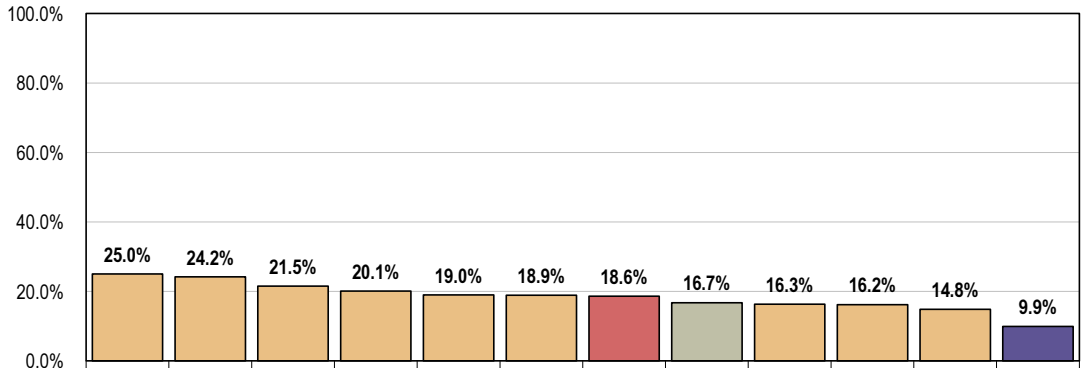
	Catahoula Parish	Natchitoches Parish	Avoyelles Parish	Grant Parish	RFSA	Winn Parish	Rapides Parish	Louisiana	Allen Parish	LaSalle Parish	Vernon Parish	United States
Number Of Families With Children Below Poverty	557	1,539	1,602	685	11,555	523	4,187	143,172	734	421	1,307	5,155,866

Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.

A total of 18.6% of RFSA seniors (65+) live below poverty (higher than state and national proportions).

Population Aged 65 And Older: Percent/Number Living Below Poverty

(By Parish, 2000)



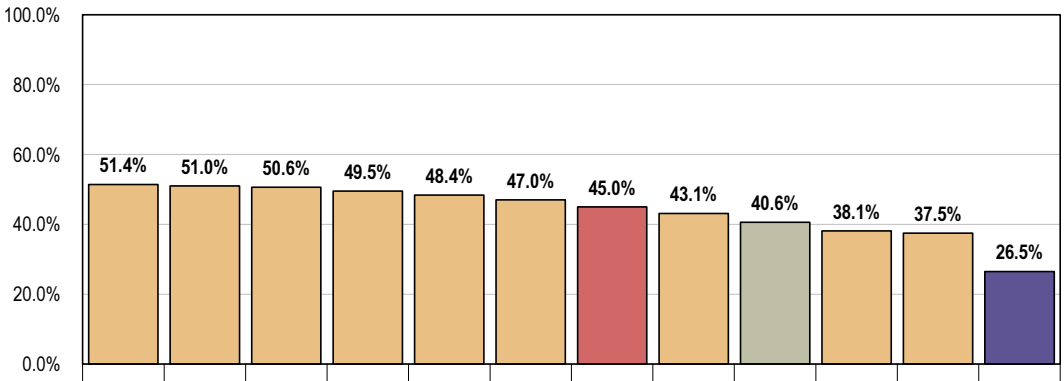
	Avoyelles Parish	Winn Parish	Allen Parish	Catahoula Parish	Natchitoches Parish	LaSalle Parish	RFSA	Louisiana	Rapides Parish	Grant Parish	Vernon Parish	United States
Number Of Adults 65+ Living Below Poverty	1,268	547	589	292	857	362	7,367	81,693	2,498	366	588	3,287,774

Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.

A total of 45.0% of female-headed family households in the RFSA live below poverty (higher than the 40.6% reported statewide and much higher than the 26.5% national average).

Female-Headed Family Households: Percent/Number Living Below Poverty

(By Parish, 2000)



	Avoyelles Parish	Winn Parish	Catahoula Parish	Natchitoches Parish	Grant Parish	LaSalle Parish	RFSA	Rapides Parish	Louisiana	Vernon Parish	Allen Parish	United States
Number Of Female-Headed Family Households Below Poverty	1,146	429	308	1,237	437	254	8,342	3,321	3,315,916	745	465	109,526

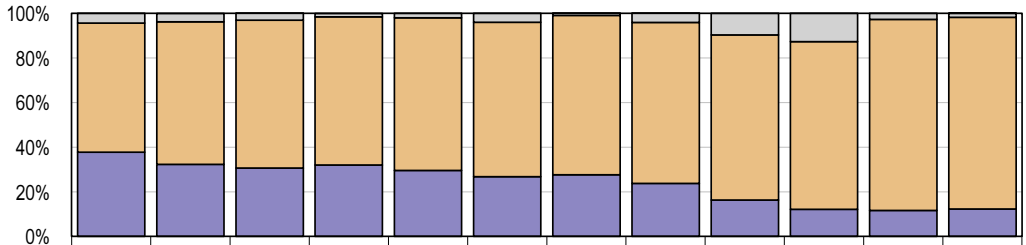
Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.

Race/Ethnicity

A total of 69.2% of the RFSA population is White, 26.8% is Black/African American, 2.5% is other races, and 4.0% is of two or more races. The RFSA has a much larger proportion of the population that is Black/African American than the nation as a whole.

Racial Distribution Of The Population

(By Parish, 2000)



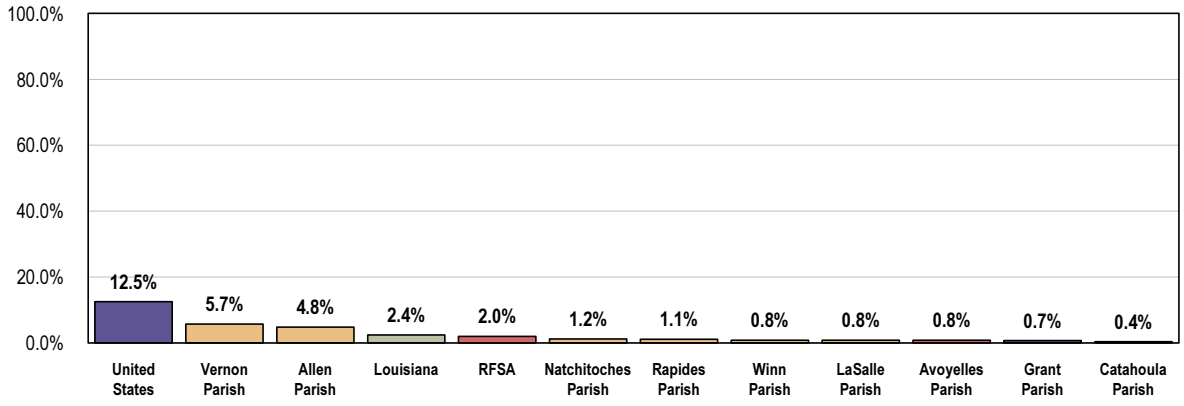
	Natchi-toches Parish	**Louisiana**	Rapides Parish	Winn Parish	Avoyelles Parish	**RFSA**	Catahoula Parish	Allen Parish	Vernon Parish	**United States**	Grant Parish	LaSalle Parish
Other Combined	4.4%	**3.7%**	3.2%	1.5%	2%	**4%**	1%	4.2%	9.7%	**12.7%**	2.7%	1.8%
White	57.8%	**63.9%**	66.2%	66.4%	68.4%	**69.2%**	71.5%	72.1%	74%	**75.1%**	85.6%	85.9%
Black/African American	37.8%	**32.3%**	30.7%	32%	29.6%	**26.8%**	27.6%	23.8%	16.3%	**12.2%**	11.7%	12.3%
American Indian/Alaska Native	1.2%	**0.6%**	0.6%	0.6%	0.7%	**0.9%**	0.2%	1.9%	1.4%	**0.9%**	1.1%	0.6%
Asian	0.6%	**1.2%**	0.9%	0.1%	0.4%	**0.8%**	0%	0.6%	2.1%	**3.6%**	0.2%	0.2%
Nat. Hawaiian/Other Pac. Islander	0%	**0%**	0.1%	0%	0%	**0.1%**	0%	0%	0.2%	**0.1%**	0.1%	0%
Other Race	0.8%	**0.7%**	0.5%	0.3%	0.2%	**0.7%**	0.1%	0.3%	2.1%	**5.5%**	0.4%	0.4%
Two Or More Races	1.8%	**1.2%**	1.1%	0.5%	0.7%	**1.5%**	0.7%	1.4%	3.9%	**2.6%**	0.9%	0.6%

Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.
• Includes persons of Hispanic origin; Hispanic can be of any race.

While 12.5% of the national population is Hispanic, this proportion is much smaller (2.0%) across The Rapides Foundation Service Area (highest in Vernon Parish, with a 5.7% population).

Proportion Of The Population That Is Hispanic

(By Parish, 2000)



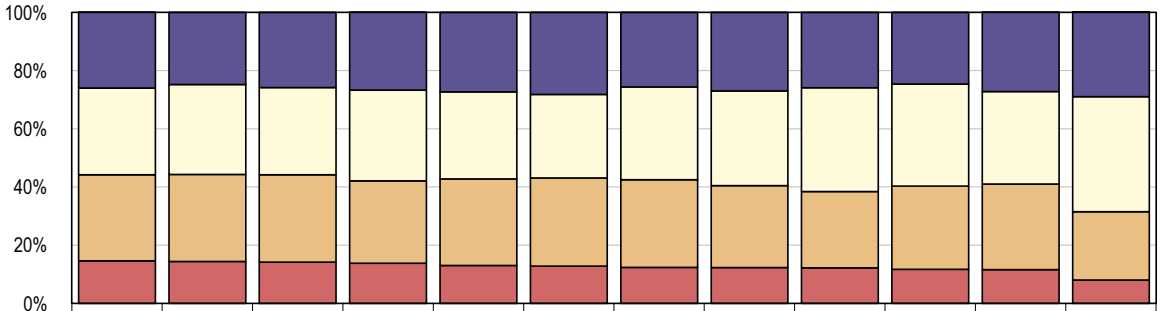
Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.

Age

In the RFSA, 27.0% of the population is under age 18 years. Another 32.5% of residents are 18 to 39 and 28.2% are between 40 and 64 years of age. A total of 12.3% of the RFSA population is age 65 or older.

Age Distribution Of The Population

(By Parish, 2000)



	LaSalle Parish	Winn Parish	Catahoula Parish	Avoyelles Parish	Rapides Parish	Grant Parish	United States	RFSA	Natchitoches Parish	Allen Parish	Louisiana	Vernon Parish
0 To 17	26.1%	24.8%	25.8%	26.8%	27.3%	28.2%	25.6%	27%	25.9%	24.6%	27.3%	29.1%
18 To 39	29.8%	30.9%	30%	31.2%	29.9%	28.7%	31.9%	32.5%	35.7%	35.1%	31.8%	39.5%
40 To 64	29.6%	29.9%	30%	28.3%	29.8%	30.3%	30.1%	28.2%	26.2%	28.6%	29.4%	23.5%
65+	14.6%	14.4%	14.2%	13.8%	13%	12.8%	12.4%	12.3%	12.2%	11.7%	11.6%	8%

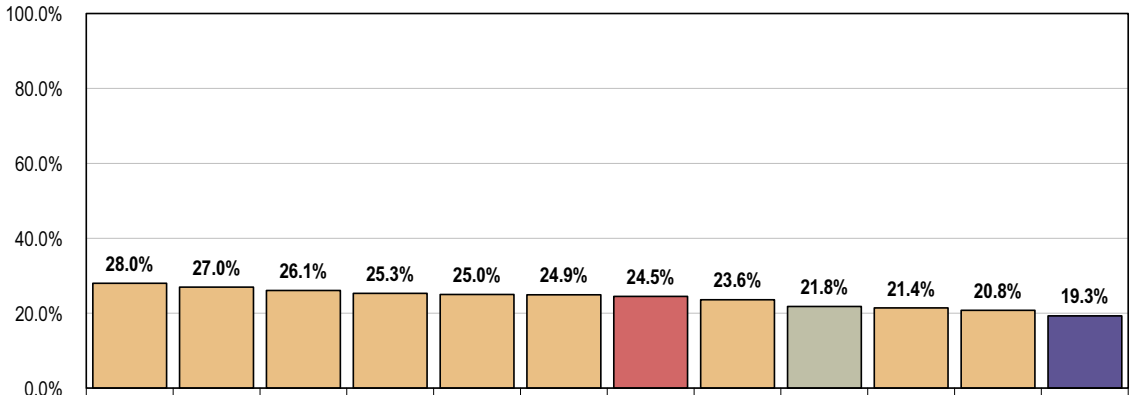
Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.

Disability

Among persons age 5 years and older in the RFSA, one out of four (24.5%) is disabled. The regional percentage is higher than state and national proportions.

Population Aged 5 And Older: Percent/Number Living With A Disability

(By Parish, 2000; Noninstitutionalized Civilian Population)



	Catahoula Parish	Avoyelles Parish	Allen Parish	Rapides Parish	Grant Parish	Winn Parish	RFSA	LaSalle Parish	Louisiana	Natchitoches Parish	Vernon Parish	United States
Population 5+ With A Disability	2,720	9,587	5,123	28,829	4,272	3,512	72,960	2,943	880,047	7,631	8,343	49,700,000

Source: • Census 2000 Summary File 3 (SF 3) - Sample Data.