2016 Community Health Needs Assessment Report

Franklin & Ripley Counties, Indiana

Prepared for: Margaret Mary Health

By:

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

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Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2013, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Margaret Mary Health. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

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

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

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

Methodology

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

PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

The study area for the survey effort (referred to as the "MMH Service Area" in this report) is defined as each of the residential ZIP Codes comprising Franklin and Ripley counties in Indiana. This community definition, determined based on the residences of the majority of patients using Margaret Mary Health for services, is illustrated in the following map.



Sample Approach & Design

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

The sample design used for this effort consisted of a stratified random sample of 800 individuals age 18 and older in the Margaret Mary Health Service Area, including 400 in Franklin County and 400 in Ripley County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Margaret Mary Health Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

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



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

Sample Characteristics

of the total population would respond "yes" if asked this question

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

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



Population & Survey Sample Characteristics (MMH Service Area, 2016)

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

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g., the 2015 guidelines place the poverty threshold for a family of four at \$24,250 annual household income or lower*). In sample segmentation: "**Iow income**" refers to community members living in a household with defined poverty status <u>or</u> living just above the poverty level, earning up to twice the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice or more the federal poverty level.

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

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Margaret Mary Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 144 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation							
Key Informant Type	Number Participating						
Physicians	38	12					
Public Health Experts	6	6					
Other Health Providers	61	46					
Social Service Representatives	16	12					
Other Community Leaders	128	68					

Final participation included representatives of the organizations outlined below.

- Batesville Area Chamber of Commerce
- Batesville Area Resource Center
- Batesville Christian Church
- Batesville Community School
 Corporation
- Batesville Fire and EMS
- Batesville High School
- Batesville Tool and Die, Inc.
- Better Options
- Caring First Home Health LLC
- Children's Health Care

- City of Batesville
- Coalition for a Drug Free Batesville
- Community Mental Health Center, Inc.
- Family Connections
- Franklin County Community Foundation
- Franklin County Community Schools Corporation
- Franklin County Health Department
- Franklin County Public Library District

- Franklin County Sheriff's Department
- George's Family Pharmacy
- Giving Hearts a Hand
- Jennifer Profitt Counseling
- John Dickey Consulting, LLC
- Margaret Mary Health
- Milan Community School Corporation
- Milan Elementary School
- Milan United Methodist Church
- One Community One Family
- Osgood Primary Care Physician
 Partners
- Project T3
- Ripley County
- Ripley County Community
- Foundation
- Ripley County Coroner's Office
- Ripley County Drug Awareness
 Coalition

- Ripley County Health Department
- Ripley County Prosecuting Attorney's
 Office
- Ripley County Tourism Bureau
- Safe Passage, Inc.
- Secure Land, LLC
- South Ripley Community School
 Corporation
- Southeastern Indiana YMCA
- St. Louis Parish
- St. Nicholas and St. Anthony Catholic Churches
- Stayin' Alive
- Sunman Elementary School
- The Herald-Tribune
- Thrive Market
- United Way of Franklin County
- Works of Mercy Center

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

Minority/medically underserved populations represented:

African-American, American Indian, children, disabled, elderly, families struggling with education system, high-deductible insurance, high-risk families, Hispanic, homebound, homeless, low-income, marriages in crisis, Medicare/Medicaid, mentally ill, non-English speaking, Pacific Islanders, pregnant mothers, rural area, self-employed, single families, single parents, substance abusers, teens, traumatic brain injury, undocumented, unemployed, uninsured/underinsured

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

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

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data.

Benchmark Data

Trending

A similar survey was administered in the Margaret Mary Health Service Area in 2013 by PRC on behalf of Margaret Mary Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Indiana Risk Factor Data

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

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the 2015 PRC National Health Survey (or the 2013 PRC National Health Survey if 2015 data is unavailable); the methodological approach for the national studies are identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:



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

Healthy People strives to:

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

Determining Significance

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

Information Gaps

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

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

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

IRS Form 990, Schedule H Compliance

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

IRS Form 990, Schedule H (2015)	See Report Page(s)
Part V Section B Line 3a A definition of the community served by the hospital facility	8
Part V Section B Line 3b Demographics of the community	43
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	239
Part V Section B Line 3d How data was obtained	8
Part V Section B Line 3e The significant health needs of the community	17
Part V Section B Line 3f <i>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</i>	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	18
Part V Section B Line 3h The process for consulting with persons representing the community's interests	11
Part V Section B Line 3i Information gaps that limit the hospital facility's ability to assess the community's health needs	14

Summary of Findings

Significant Health Needs of the Community

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

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Areas of Opportunity Identified Through This Assessment					
Access to Healthcare Services	 Primary Care Physician Ratio Difficulty Finding a Physician in Franklin County Difficult Getting an Appointment in Franklin County 				
Cancer	 Cancer is a leading cause of death. Cancer Deaths Including Lung Cancer, Prostate Cancer, Colorectal Cancer Deaths Lung Cancer Incidence Cervical Cancer Screening (Women 21-65) Mammograms (Women 50-74) in Franklin County 				
Dementia, Including Alzheimer's Disease	Alzheimer's Disease Deaths				
Diabetes	 Diabetes Deaths Diabetes ranked as a top concern in the Online Key Informant Survey. 				
Heart Disease & Stroke	 Cardiovascular disease is a leading cause of death. Heart Disease Deaths Stroke Deaths Stroke Prevalence 				
Injury & Violence	 Unintentional Injury Deaths Including Motor Vehicle Crash Deaths Use of Bicycle Helmets (Children) Firearm-Related Deaths Firearm Prevalence Including in Homes With Children Domestic Violence Experience 				
Mental Health	 Mental Health ranked as a top concern in the Online Key Informant Survey. 				

-continued on next page-

	Areas of Opportunity (continued)
Nutrition, Physical Activity & Weight	 Sweetened Beverage Consumption Overweight [Adults] Obesity [Children] Meeting Physical Activity Guidelines Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey.
Oral Health	Children's Dental CareDental Insurance Coverage in Franklin County
Potentially Disabling Conditions	Activity LimitationsArthritis Prevalence (50+)
Respiratory Diseases	 Chronic Lower Respiratory Disease (CLRD) Deaths Pneumonia Vaccination [65+]
Substance Abuse	 Drug-Induced Deaths Illicit Drug Use Substance Abuse ranked as a top concern in the Online Key Informant Survey.
Tobacco Use	Smokeless Tobacco PrevalenceCigarette Smoking in Ripley County

Prioritization of Health Needs

On September 21 and 22, 2016, Margaret Mary Health convened three groups consisting of approximately 50 community stakeholders (representing a cross-section of community-based agencies and organizations) and hospital representatives to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. A hospital representative also provided guidance to the group, describing existing activities, initiatives, resources, etc., relating to the Areas of Opportunity. Finally, participants were provided an overview of the prioritization exercise that followed.

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

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

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

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

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

- 1. Substance Abuse
- 2. Nutrition, Physical Activity & Weight
- 3. Heart Disease & Stroke
- 4. Diabetes
- 5. Cancer
- 6. Mental Health
- 7. Tobacco Use
- 8. Respiratory Diseases
- 9. Access to Healthcare Services
- 10. Injury & Violence
- 11. Oral Health
- 12. Dementias, Including Alzheimer's Disease
- 13. Potentially Disabling Conditions

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

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the MMH Service Area, including comparisons between the individual counties, as well as trend data. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables

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

■ The green columns [to the left of the MMH Service Area column] provide comparisons between the two counties, identifying differences for each as "better than" (\$), "worse than" (\$), or "similar to" (△) the other county.

■ The columns to the right of the MMH Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the MMH Service Area compares favorably (♠), unfavorably (♠), or comparably (♠) to these external data.

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

TREND SUMMARY (Current vs. Baseline Data)

Survey Data Indicators:

Trends for survey-derived indicators represent significant changes since 2013. Note that survey data reflect the ZIP Code-defined Margaret Mary Health Service Area.

Other (Secondary) Data Indicators: Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

Note that secondary data reflect combined county-level data for Franklin and Ripley counties.

	Each Coun	ty vs. Other		MMH Service Area vs. Benchmarks			
Social Determinants	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
Linguistically Isolated Population (Percent)	0.2	0 .3	0.2	** 1.9	* 4.7		
Population in Poverty (Percent)	13.5	% 8.4	10.7	** 15.5	※ 15.6		
Population Below 200% FPL (Percent)	33.6	** 31.4	32.4	** 35.2	※ 34.5		
Children Below 200% FPL (Percent)	41.6	※ 36.6	38.8	** 45.5	** 44.2		
No High School Diploma (Age 25+, Percent)	14.2) 12.9	13.5	12.4	<u>ب</u> 13.7		
Unemployment Rate (Age 16+, Percent)	<u>ح</u> ے 5.8	6.0	5.9	5.1	5 .3		<u>ح</u> 5.7
% Worry/Stress Over Rent/Mortgage in Past Year	<u>ح</u> ے 22.4	<i>ב</i> ∠ 19.5	20.6		※ 31.6		
% Worried About Food in the Past Year	<u>ح</u> 13.4	<u>کے</u> 10.5	11.6		21.0		
% Ran Out of Food in the Past Year	16.1	※ 9.1	11.5) 19.9		
% Food Insecure	19.5	** 13.1	15.2) 25.9		
	Note: In the green s compared against the o these tables, a blank or data are not available sample sizes are too sn res	ection, each county is other county. Throughout rempty cell indicates that for this indicator or that nall to provide meaningful sults.		better	similar	worse	

	Each County vs. Other					enchmarks	
Overall Health	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
% "Fair/Poor" Physical Health			17.4	Ŕ	È		D3
	15.7	18.2		18.9	18.3		14.3
% Activity Limitations	Ŕ	Ŕ	20.6	Ŕ	Ŕ		
	20.6	20.6		22.2	20.0		16.2
	Note: In the green se compared against the ot these tables, a blank or data are not available f sample sizes are too sm resu	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.		🗱 better	순 similar	worse	

	Each Count	y vs. Other		MMH Serv	MMH Service Area vs. Benchmarks			
Access to Health Services	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% [Age 18-64] Lack Health Insurance		Ŕ	8.2	Ö		87755		
	5.7	9.6		18.0	10.1	0.0	9.6	
% [Insured 18-64] Have Coverage Through ACA		Ö	7.9		Ö			
	11.0	6.2			10.8			
% Difficulty Accessing Healthcare in Past Year (Composite)	Ê	Ŕ	33.8		Ŕ		É	
	36.4	32.4			35.0		36.5	
% Inconvenient Hrs Prevented Dr Visit in Past Year	É	Ŕ	14.4		Ŕ		숨	
	14.8	14.1			14.4		18.0	
% Cost Prevented Getting Prescription in Past Year	Ŕ	É	8.7		谷		谷	
	7.7	9.2			9.5		9.4	
% Cost Prevented Physician Visit in Past Year			8.9		Ŕ		经	
	6.5	10.2			11.5		9.6	

	Each Coun	ty vs. Other		MMH Service Area vs. Benchmarks			
Access to Health Services (continued)	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
% Difficulty Getting Appointment in Past Year			13.3				
	18.2	10.8			15.4		14.6
% Difficulty Finding Physician in Past Year			8.9		Ŕ		Ŕ
	13.3	6.7			8.7		8.7
% Transportation Hindered Dr Visit in Past Year	Ŕ	Ŕ	2.3				É
	3.8	1.6			5.0		4.0
% Language/Culture Prevented Care in Past Year	Ŕ		0.3				
	0.8	0.1			1.7		
% Skipped Prescription Doses to Save Costs	Ŕ		9.2		Ŕ		
	11.0	8.2			10.2		12.8
% Difficulty Getting Child's Healthcare in Past Year	Ŕ		0.9				Ŕ
	0.6	1.1			3.9		1.5
% Have Completed Advance Directive Documents	Ŕ		30.2		Ŕ		
	31.8	29.4			33.7		
% Low Health Literacy	Ŕ		15.4				
	16.3	14.9			23.3		
Primary Care Doctors per 100,000			40.7	8005	8885		
	13.1	63.0		65.9	74.5		33.9
% [Age 18+] Have a Specific Source of Ongoing Care	É		73.9		£		Ŕ
	72.4	74.7			74.0	95.0	76.3
% [Age 18-64] Have a Specific Source of Ongoing Care	Ŕ	Ŕ	71.2		Ŕ		Ŕ
	69.5	72.1			73.1	89.4	75.4

	Each Count	ty vs. Other		MMH Serv	vice Area vs. B	enchmarks	
Access to Health Services (continued)	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
% [Age 65+] Have a Specific Source of Ongoing Care		D3	83.4				D_3
	82.8	83.7			76.8	100.0	80.1
% Have Had Routine Checkup in Past Year		Ŕ	67.9	Ŕ	Ŕ		
	70.7	66.4		65.1	70.5		68.9
% Child Has Had Checkup in Past Year	*		87.2		Ŕ		
	95.3	84.2			89.3		86.9
% Two or More ER Visits in Past Year		\$	5.4				
	8.3	3.9			8.5		5.8
% Rate Local Healthcare "Fair/Poor"			7.3				
	9.3	6.2			14.2		8.6
	Note: In the green se compared against the ot these tables, a blank or data are not available f sample sizes are too sm resu	ction, each county is her county. Throughout empty cell indicates that for this indicator or that all to provide meaningful ults.		پې better	similar	worse	

COMMUNITY HEALTH NEEDS ASSESSMENT

	Each Count	ty vs. Other		MMH Service Area vs. Ben			
Arthritis, Osteoporosis & Chronic Back Conditions	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
% [50+] Arthritis/Rheumatism		D3	45.0				
	44.2	45.5			32.0		38.2
% [50+] Osteoporosis	Â	Ŕ	9.2		Ŕ	-	Ŕ
	9.5	9.1			8.7	5.3	10.8
% Sciatica/Chronic Back Pain	Ê	Ŕ	19.4		Ŕ		Ŕ
	20.2	19.0			19.4		18.6
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			🂢 better	ے۔ similar	worse	

Each County vs. Other MMH Service Area vs. Benchmarks **MMH Service** Franklin Ripley Area TREND Cancer vs. IN vs. US vs. HP2020 County County **Ö** Cancer (Age-Adjusted Death Rate) * 190.2 Ê 176.6 201.1 181.2 163.6 161.4 205.5 Lung Cancer (Age-Adjusted Death Rate) 53.9 R **1** 54.1 43.4 45.5 Prostate Cancer (Age-Adjusted Death Rate) 27.8 8335 8355 19.2 21.8 20.4 R R Female Breast Cancer (Age-Adjusted Death Rate) 20.8 R 21.5 20.7 20.9 É Colorectal Cancer (Age-Adjusted Death Rate) 16.1 8355: 16.0 14.6 14.5

	ty vs. Other		MMH Service Area vs. Benchmarks				
Cancer (continued)	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
Prostate Cancer Incidence per 100,000	123.8	ॐ 97.9	108.9	순 <u>수</u> 108.9	() 131.7		
Female Breast Cancer Incidence per 100,000	93.8	114.3	105.2) 119.0	※ 123.0		
Lung Cancer Incidence per 100,000	6 3.4	80.1	72.6	순 75.2	63.7		
Colorectal Cancer Incidence per 100,000	** 32.6	43 .1	38.5	** 45.1	** 41.9		
% Skin Cancer	<i>∽</i> 7.4	会 7.6	7.6	5.6	2 7.7		۲.2
% Cancer (Other Than Skin)	8.3	会 5.3	6.3	会 6.3	会 7.7		行.9
% [Men 50+] Prostate Exam in Past 2 Years	56.8	% 81.2	73.5		<i>会</i> 75.0		() 62.0
% [Women 50-74] Mammogram in Past 2 Years	73.1	% 84.7	79.9	※ 72.4	2 80.3	2 81.1	会 75.5
% [Women 21-65] Pap Smear in Past 3 Years	✓72.4	公 77.5	75.9	순 78.0	84.8	93.0	۲8.9
% [Age 50+] Sigmoid/Colonoscopy Ever	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	<i>会</i> 72.8	71.8	** 65.0	行75.6		(66.2
% [Age 50+] Blood Stool Test in Past 2 Years	21.3	<i>会</i> 22.9	22.3	12.4	31.8		25.9

	Each Coun	ty vs. Other		MMH Service Area vs. Benchmarks					
Cancer (continued)	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND		
% [Age 50-75] Colorectal Cancer Screening			70.6			D3			
	68.9	71.6		61.6	74.5	70.5	68.3		
	Note: In the green so compared against the o these tables, a blank or data are not available sample sizes are too sm res	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.		🔅 better	similar	worse			

	Each Count	ty vs. Other
Chronic Kidney Disease	Franklin County	Ripley County
Kidney Disease (Age-Adjusted Death Rate)		
% Kidney Disease	4.3	1.6
	Note: In the green se compared against the of these tables, a blank or data are not available sample sizes are too sm resu	ction, each county is her county. Throughout empty cell indicates that for this indicator or that all to provide meaningful ilts.

	MMH Serv	vice Area vs. B	enchmarks	
MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
12.7	Ö	Ŕ		
	18.0	13.2		
2.5				
	2.7	3.6		2.9
	*	É		
	better	similar	worse	

vs. HP2020

	Each County vs. Other						
Dementias, Including Alzheimer's Disease	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2(
Alzheimer's Disease (Age-Adjusted Death Rate)	20.7	AF 1		38.7	29.6	24.2	
	Note: In the green se compared against the ot these tables, a blank or data are not available i sample sizes are too sm resi	40. I ection, each county is ther county. Throughout empty cell indicates that for this indicator or that all to provide meaningful ults.			20.0	24.2 $\stackrel{\frown}{\sim}$ similar	worse

TREND

29.6

	Each Count	ty vs. Other		MMH Service Area vs. Benchmarks					
Diabetes	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND		
Diabetes Mellitus (Age-Adjusted Death Rate)	33.0	** 25.0	28.4	25.5	21.1	20.5	※ 30.7		
% Diabetes/High Blood Sugar	Ŕ		11.9	Ŕ	Ŕ				
	13.4	11.2		10.7	14.5		10.0		
% Borderline/Pre-Diabetes		*	4.7		Ŕ				
	7.3	3.4			5.7		5.1		
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	Ŕ	Ŕ	50.6		Ŕ				
	52.5	49.6			55.1		50.4		
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			ö better	ے۔ similar	worse			

	Each County vs. Other				MMH Service Area vs. Benchmarks			
Family Planning	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
Teen Births per 1,000 (Age 15-19)				34.0	*	*		
	30.5	36.4			38.9	36.6		
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that					Ŕ	***	
	sample sizes are too sm resi	all to provide meaningful ults.			better	similar	worse	

COMMUNITY HEALTH NEEDS ASSESSMENT

	Each Coun	ty vs. Other			MMH Service Area vs. Benchmarks				
Hearing & Other Sensory or Communication Disorders	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% Deafness/Trouble Hearing				10.9					
	12.7	10.0				8.6		10.1	
	Note: In the green s compared against the o these tables, a blank or data are not available sample sizes are too sm res	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			🔅 better	similar	worse		

	Each Count	ty vs. Other		enchmarks			
Heart Disease & Stroke	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	** 174.2	199.6	188.6	<i>6</i> 2 185.8	169.1	156.9	2 11.2
Stroke (Age-Adjusted Death Rate)	52.7	** 45.5	48.4	41.7	36.5	34.8	33.0
% Heart Disease (Heart Attack, Angina, Coronary Disease)	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	8.4		£		£
% Stroke	7.3 2.5	8.9	4.5	公 3.2	2.6		2.6
% Blood Pressure Checked in Past 2 Years	순금 97.9	会 97.6	97.7		\$ 93.6	※ 92.6	\$ 95.0
% Told Have High Blood Pressure (Ever)	谷 41.1	< 36.9	38.3	33.5	ے∠ 36.5	26.9	ے′ے 39.9

	Each County vs. Other		MMH Serv	MMH Service Area vs. Benchmarks				
Heart Disease & Stroke (continued)	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% [HBP] Taking Action to Control High Blood Pressure		D3	93.3					
	93.5	93.1			92.5		91.5	
% Cholesterol Checked in Past 5 Years	Ŕ	经	90.6	*	X			
	91.5	90.2		74.5	87.4	82.1	90.5	
% Told Have High Cholesterol (Ever)	Ŕ		29.6		É			
	31.7	28.5			33.5	13.5	32.2	
% [HBC] Taking Action to Control High Blood Cholesterol	Ŕ		91.7					
	89.6	92.8			84.2		90.5	
% 1+ Cardiovascular Risk Factor			86.1		É			
	86.7	85.8			83.0		83.8	
	Note: In the green se compared against the ot these tables, a blank or data are not available f sample sizes are too sm resu	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.		پې better	<u>ج</u> similar	worse		

	Each County vs. Other				MMH Service Area vs. Benchmarks					
HIV	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND		
% [Age 18-44] HIV Test in the Past Year				10.4						
	14.7	8.6				21.3				
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			پ better	similar	worse				

	Each County vs. Other		Each County vs. Other			MMH Serv	vice Area vs. B	enchmarks	
Immunization & Infectious Diseases	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND		
% [Age 65+] Flu Vaccine in Past Year		D_{2}	58.9	Ŕ			D3		
	58.2	59.3		56.3	58.9	70.0	67.0		
% [High-Risk 18-64] Flu Vaccine in Past Year			47.5		Ŕ				
	44.0	49.5			48.0	70.0	50.7		
% [Age 65+] Pneumonia Vaccine Ever			63.6						
	74.3	57.8		69.8	76.3	90.0	62.7		
% [High-Risk 18-64] Pneumonia Vaccine Ever	Ś		29.6		Ŕ				
	25.3	31.8			38.7	60.0	38.4		
	Note: In the green se compared against the ot these tables, a blank or data are not available f sample sizes are too sm resu	action, each county is ther county. Throughout empty cell indicates that for this indicator or that all to provide meaningful ults.		پن better	<u>ج</u> ے similar	worse			

	Each Coun	ty vs. Other		MMH Service Area vs. Benchmarks				
Injury & Violence Prevention	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
Unintentional Injury (Age-Adjusted Death Rate)	** 43.6	47.4	45.6	42.8	39.7	36.4	** 49.9	
Motor Vehicle Crashes (Age-Adjusted Death Rate)			18.9	*** 11.4	10.6	12.4		
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	会 98.4	会 96.5	97.0		会 94.8		公 97.1	
% Child [Age 5-17] "Always" Wears Bicycle Helmet			34.2		54.2		23.3	
[65+] Falls (Age-Adjusted Death Rate)			4.8	X 5.5	8.1	※ 7.2		
% [Age 45+] Fell in the Past Year	29.7	28.5	28.9		28.2			
Firearm-Related Deaths (Age-Adjusted Death Rate)	10.3	※ 8.0	9.0	** 11.4) 10.3	순 9.3		
% Firearm in Home	63.9	<u>ح</u> 58.4	60.2		33.8			
% [Homes With Children] Firearm in Home	72.1	\$ 55.7	60.2		31.0			
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	21.0	13.8	16.4		20.4			

COMMUNITY HEALTH NEEDS ASSESSMENT

vs. HP2020

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	Each County vs. Other			Each County vs. Other				MMH Service Area vs. Benchmarks				
Injury & Violence Prevention (continued)	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND				
Violent Crime per 100,000	** 54.8	*** 112.0		86.5	※ 359.1) 395.5						
% Perceive Neighborhood as "Slightly/Not At All Safe"	6.2	云 8.7		7.9) 15.3						
% Victim of Domestic Violence (Ever)	9.4	云 8.2		8.6) 15.1		5.9				
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not valiable for this indicator or that sample sizes are too small to provide meaningful results.			پن better	순 similar	worse						

Each County vs. Other MMH Service Area vs. Benchmarks **MMH Service** Ripley County Franklin Maternal, Infant & Child Health Area vs. US vs. IN County Low Birthweight Births (Percent) 7.1 9.00 7.3 6.9 8.2 8.2 5.3 * Infant Death Rate Ø 7.5 6.5 Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that Ê Ö data are not available for this indicator or that sample sizes are too small to provide meaningful better similar results.

Each County vs. Other				MMH Service Area vs. Benchmarks				
Mental Health & Mental Disorders	Franklin County	Ripley County	MMH S Ar	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
% "Fair/Poor" Mental Health	岔	Ŕ	8	.8		Ŭ		Ŕ
	8.0	9.2				15.5		9.6
% Diagnosed Depression	会	Ŕ	15	5.9	Ŭ	仑		Ŕ
	15.6	16.0			20.7	17.9		16.6
% Symptoms of Chronic Depression (2+ Years)	Ŕ	Ŕ	28	3.0		Ŕ		Ŕ
	27.8	28.1				29.9		25.5
Suicide (Age-Adjusted Death Rate)		*	10).7	Ŭ	Ŭ	Ŕ	
	12.1	9.6			13.2	11.9	10.2	
% Taking Rx/Receiving Mental Health Trtmt	Ŕ	Ŕ	10).5		Ö		
	12.3	9.6				13.6		
% Unable to Get Mental Health Svcs in Past Yr	Ŕ	Ŕ	2	.2		Ŭ		
	1.2	2.7				4.4		
% Ever Sought Help for Mental Health	Ŕ	Ŕ	24	1.6		Ŕ		Ö F
	21.2	26.4				27.4		17.4
% [Those With Diagnosed Depression] Seeking Help	Ŕ	Ŕ	87	7.3		Ŕ		**
	79.9	91.0				91.7		78.1
% Typical Day Is "Extremely/Very" Stressful	Ŕ	Ŕ	8	.5		Ŭ		Ŕ
	9.8	7.9				11.7		8.5
% Average <7 Hours of Sleep per Night	Ŕ	É	38	3.8		Ŕ		
	40.4	38.0				39.5		
	Note: In the green se compared against the of these tables, a blank or data are not available	ection, each county is ther county. Throughout empty cell indicates that for this indicator or that				É	-	
	sample sizes are too sm resi	all to provide meaningful ults.			better	similar	worse	

	Each County vs. Other				MMH Service Area vs. Benchmarks				
Nutrition, Physical Activity & Weight	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% Eat 5+ Servings of Fruit or Vegetables per Day	27.8	ॐ 35.4		32.9		※ 27.4		<u>ح</u> ے 35.4	
% "Very/Somewhat" Difficult to Buy Fresh Produce	<u>ح</u> ے 19.8	<i>会</i> 17.4		18.2		※ 21.9		※ 22.6	
Population With Low Food Access (Percent)	7.4	** 4.3		5.7	※ 26.1	※ 23.6			
% 7+ Sugar-Sweetened Drinks in Past Week	<u>ح</u> 34.6	会 40.0		38.2		30.2			
% Medical Advice on Nutrition in Past Year	38.8	순 33.3		35.2		<u>ح</u> 39.2		公 31.5	
% Healthy Weight (BMI 18.5-24.9)	25.6	27.8		27.0		32.9	33.9	33 .7	
% Overweight (BMI 25+)	✓74.3	<i>会</i> 71.8		72.6	66.4	65.2		6 5.2	
% Obese (BMI 30+)	ے 36.0	ے′ے 30.8		32.6	2 32.7	<u>ح</u> 33.4	<u>ک</u> 30.5	<u>ح</u> ے 29.1	
% Medical Advice on Weight in Past Year	23.2	公 24.1		23.8		<u>6</u> 20.4		公 21.7	
% [Overweights] Counseled About Weight in Past Year	28.5	<i>순</i> 금 30.2		29.6		<i>合</i> 27.1		<i>4</i> ℃ 27.9	
% [Obese Adults] Counseled About Weight in Past Year	<i>€</i> ∂ 47.3	< 37.9		41.5		63 40.8		<i>合</i> 41.6	

	Each County vs. Other			MMH Service Area vs. Benchmarks				
Nutrition, Physical Activity & Weight (continued)	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	Ŕ	谷	51.5		Ŕ		Ŭ	
	49.8	52.4			57.0		38.0	
% Child [Age 5-17] Healthy Weight			42.8		67.2		5 9.6	
% Children [Age 5-17] Overweight (85th Percentile)			31.3		Ŕ		Ŕ	
					24.2		31.9	
% Children [Age 5-17] Obese (95th Percentile)			22.0				Ŕ	
					9.5	14.5	14.4	
% No Leisure-Time Physical Activity	Ê	Ŕ	16.4	*		*	*	
	15.9	16.6		26.1	27.9	32.6	23.3	
% Meeting Physical Activity Guidelines	Ŕ	Ŕ	19.7					
	19.8	19.7		16.2	23.6	20.1		
Recreation/Fitness Facilities per 100,000		-	11.6		Ö			
	13.0	10.4		9.1	9.7			
% Medical Advice on Physical Activity in Past Year	Ŕ	Ŕ	40.2		É		É	
	43.6	38.5			44.0		36.5	
% Child [Age 2-17] Physically Active 1+ Hours per Day	É	É	71.0					
	67.7	72.0			47.9		56.5	
	Note: In the green s compared against the o these tables, a blank or data are not available sample sizes are too sn	section, each county is other county. Throughout rempty cell indicates that for this indicator or that mall to provide meaningful		X	Ś			
	res	sults.		Dellei	Similar	WUISE		
	Each Coun	ty vs. Other		MMH Service Area vs. Benchmarks				
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Oral Health	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% [Age 18+] Dental Visit in Past Year	È		66.0	Ŭ	Ŕ	Ö		
	66.0	66.0		61.5	67.2	49.0	63.5	
% Child [Age 2-17] Dental Visit in Past Year	숨		82.3					
	86.5	81.2			90.7	49.0	89.7	
% Have Dental Insurance			64.1		É			
	58.2	67.2			66.5		60.4	
	Note: In the green s compared against the o these tables, a blank or data are not available sample sizes are too sm	ection, each county is ther county. Throughout empty cell indicates that for this indicator or that nall to provide meaningful wite		پ better	similar	worse		

	Each County vs. Other			MMH Service Area vs. Benchmarks			
Respiratory Diseases	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
CLRD (Age-Adjusted Death Rate)	** 49.1	5 3.8	51.6	5 6.0	41.4		47.3
Pneumonia/Influenza (Age-Adjusted Death Rate)			14.4	<u>ح</u> ے 14.4	<u>ح</u> 15.1		<u>کے</u> 13.9
% COPD (Lung Disease)	순 <u>수</u> 10.9	<u>ح</u> ے 9.1	9.7	8.7	<u>ب</u> 9.5		7.2
% [Adult] Currently Has Asthma	6.1	6.4	6.3	** 10.7	9 .5		6.4

	Each Coun	ty vs. Other	. [MMH Service Area vs. Benchmarks				
Respiratory Diseases (continued)	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% [Child 0-17] Currently Has Asthma				7.3		Ŕ			
	9.5	6.5				6.5		6.8	
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.				پن better	similar	worse		

	Each County vs. Other		MMH Service Area vs. Benchmarks				
Sexually Transmitted Diseases	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
Gonorrhea Incidence per 100,000	* 4.4	*** 35.2	21.4) 110.9) 110.7		
Chlamydia Incidence per 100,000	** 156.9	267.4	218.0	** 433.8	** 456.1		
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	<u>ح</u> ے 4.6	<u>ح</u> 4.4	4.5) 10.3		
% [Unmarried 18-64] Using Condoms	<u>ح</u> ے 33.4	<u>ح</u> 23.5	26.8		44.5		
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			پن better	similar	worse	

	Each County vs. Other			MMH Service Area vs. Benchmarks				
Substance Abuse	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)			7.4	※ 8.7	% 9.5	8.2		
% Current Drinker	Ŕ	Ŕ	55.5		Ŕ			
	54.6	56.0		47.9	59.7		54.9	
% Excessive Drinker	Ŕ		20.0		Ŕ	*		
	22.1	18.9			22.2	25.4	24.6	
% Drinking & Driving in Past Month	Ŕ		2.0					
	3.3	1.3			4.1		4.2	
Drug-Induced Deaths (Age-Adjusted Death Rate)	19.3	** 15.4	17.2	14.9	13.3	11.3		
% Illicit Drug Use in Past Month	Ŕ	Ŕ	2.7		Ŕ	Ŭ	8775	
	1.4	3.4			3.0	7.1	1.0	
% Ever Sought Help for Alcohol or Drug Problem	Ê	Ê	4.0		É			
	2.4	4.9			4.1		2.1	
% Life Negatively Affected by Substance Abuse			33.8		Ŕ			
	33.6	33.8			32.2			
	Note: In the green so compared against the o these tables, a blank or data are not available	ection, each county is ther county. Throughout empty cell indicates that for this indicator or that		۲	<u> </u>			
	sample sizes are too sm res	sults.		better	similar	worse		

	Each County vs. Other			MMH Service Area vs. Benchmarks			
Tobacco Use	Franklin County	Ripley County	MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND
% Current Smoker) 12.2	18.9	16.6	2 2.9	<i>6</i> 14.0	12.0	<u>ک</u> 15.5
% Someone Smokes at Home	2 10.1	<u>ک</u> 11.4	11.0		<u>6</u> 10.2		<i>ב</i> ∠ 10.9
% [Nonsmokers] Someone Smokes in the Home	5.0	** 1.9	3.0		<u>ح</u> ے 3.9		<i>ב</i> ∠ 3.5
% [Household With Children] Someone Smokes in the Home	<u>ج</u> 9.1	6.5	7.2		<i>会</i> 10.2		<i>6</i> 7.8
% [Smokers] Received Advice to Quit Smoking			68.9		<i>会</i> 76.0		<i>ב</i> ∠ 72.6
% [Smokers] Have Quit Smoking 1+ Days in Past Year			47.9		<u>ح</u> 43.7	80.0	<u>ح</u> ے 45.2
% Smoke Cigars	1.0	3.3	2.6		< 3.6	0.2	<u>ب</u> ۲.9
% Use Smokeless Tobacco	<u>ح</u> ے 9.1	6.6	7.5	4.3	3.0	0.3	2 7.5
% Currently Use Electronic Cigarettes	<u>ح</u> 4.5	2.8	3.4		<u>ح</u> ے 3.8		
	Note: In the green so compared against the o these tables, a blank or data are not available sample sizes are too sm res	ection, each county is ther county. Throughout empty cell indicates that for this indicator or that nall to provide meaningful ults.		پ better	similar	worse	

	Each Coun	ty vs. Other			MMH Service Area vs. Benchmarks				
Vision	Franklin County	Ripley County		MMH Service Area	vs. IN	vs. US	vs. HP2020	TREND	
% Blindness/Trouble Seeing		D3		5.2					
	5.3	5.2			4.5	7.3		8.3	
% Eye Exam in Past 2 Years	É			58.5		Ŕ		Ê	
	61.7	56.9				59.3		57.8	
	Note: In the green section, each county is compared against the other county. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			🂢 better	<u>ج</u> similar	worse			

Community Description



Professional Research Consultants, Inc.

Population Characteristics: Franklin & Ripley Counties

Total Population

Franklin and Ripley counties encompass 830.86 square miles and house a total population of 51,581 residents, according to latest census estimates.

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Franklin County	22,980	384.43	59.78
Ripley County	28,601	446.43	64.07
MMH Service Area	51,581	830.86	62.08
Indiana	6,542,411	35,826.58	182.61
United States	314,107,083	3,531,932.26	88.93

Total Population

(Estimated Population, 2010-2014)

Sources: • US Census Bureau American Community Survey 5-year estimates.

Retrieved July 2016 from Community Commons at http://www.chna.org

Population Change 2000-2010

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

Between the 2000 and 2010 US Censuses, the population of the MMH Service Area (represented here as Franklin and Ripley counties) increased by 3,221 persons, or 6.6%.

- An identical proportional increase to that seen across the state.
- A lesser proportional increase than seen across the nation overall.



Change in Total Population

(Percentage Change Between 2000 and 2010)

Sources:

Retrieved July 2016 from Community Commons at http://www.chna.org.
US Census Bureau Decennial Census (2000-2010).
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources. Notes:



Population Change, Percent by Tract, US Census 2000-2010

Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

The MMH Service Area is predominantly rural, with just 14.3% of the population living in areas designated as urban.

• Note that at least 70% of Indiana and US populations live in urban areas.



Urban and Rural Population

Sources: • US Census Bureau Decennial Census (2010).

Retrieved July 2016 from Community Commons at http://www.chna.org.

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



Urban Population, Percent by Tract, US Census 2010

Age

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

In the MMH Service Area, 25.1% of the population are infants, children or adolescents (age 0-17); another 59.4% are age 18 to 64, while 15.5% are age 65 and older.

• The percentage of older adults (65+) is higher than that found statewide and nationwide.



Total Population by Age Groups, Percent

Median Age

The MMH Service Area is "older" than the state and the nation in that the median age of each county is higher.



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

• The following map provides an illustration of the median age in the MMH Service Area, segmented by census tract.



Median age, by Tract, ACS 2010-2014

Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 97.6% of residents of the MMH Service Area are White and 0.4% are Black.

• The area is much less racially diverse than the Indiana and US populations.



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

Ethnicity

A total of 1.4% of MMH Service Area residents are Hispanic or Latino.

• Well below the state and nationwide percentages.



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

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



Population Hispanic or Latino, Percent by Tract, ACS 2010-2014

Between 2000 and 2010, the Hispanic population in the MMH Service Area increased by 304 or 86.6%.

- Higher (in terms of percentage growth) than found statewide and twice the percentage reported found nationally.
- Franklin County experienced a higher percentage growth than Ripley County.



Hispanic Population Change

Sources: • US Census Bureau Decennial Census (2000-2010).

Retrieved July 2016 from Community Commons at http://www.chna.org.

Linguistic Isolation

Just 0.2% of the MMH Service Area population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

• Much lower than found statewide and nationally.





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

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



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

Social Determinants of Health

About Social Determinants

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

• Healthy People 2020 (www.healthypeople.gov)

Poverty

The latest census estimate shows 10.7% of the MMH Service Area population living below the federal poverty level.

In all, 32.4% of MMH Service Area residents (an estimated 16,519 individuals) live below 200% of the federal poverty level.

- Lower than the proportions reported statewide and nationally.
- The proportion of poverty is higher in Franklin County.



Population in Poverty

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

Notes:

Retrieved July 2016 from Community Commons at http://www.chna.org.
Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

• A higher concentration of persons living below the 200% poverty threshold is found in northwest Franklin County.



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

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



Children in Low-Income Households

Additionally, 38.8% of MMH Service Area children age 0-17 (representing an estimated 4,980 children) live below the 200% poverty threshold.

- Below the proportions found statewide and nationally.
- Lower in Ripley County.

Percent of Children in Low-Income Households

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



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

Notes:

This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is

relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.



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

Education

Among the MMH Service Area population age 25 and older, an estimated 13.5% (over 4,600 people) do not have a high school education.

- · Less favorable than found statewide.
- Similar to national findings.
- Less favorable in Franklin County.

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014) 100%



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

Notes: • This indicator is relevant because educational attainment is linked to positive health outcomes.



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

Employment

According to data derived from the US Department of Labor, the unemployment rate in the MMH Service Area as of January 2016 was 5.9%.

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



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

 US Department of Labor, Bureau of Labor Statistics. Sources:

- Retrieved July 2016 from Community Commons at http://www.chna.org. Notes:
 - This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Housing Insecurity

While most surveyed adults rarely, if ever, worry about the cost of housing, a considerable share (20.6%) do, reporting that they were "sometimes," "usually" or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81] Notes: • Asked of all respondents.

es: • Asked

NOTE:

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

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

- Compared to the US prevalence, the percentage of service area adults who worried about paying for rent or mortgage in the past year is lower.
- Housing insecurity is similar by county.



"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year

2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes:
 Asked of all respondents.

- Residents in households with lower incomes are more likely to report housing insecurity.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

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

100%





• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81] Sources: Notes:

Asked of all respondents

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

Food Insecurity

In the past year, 11.6% of MMH Service Area adults "often" or "sometimes" worried about whether their food would run out before they had money to buy more.

Another 11.5% report a time in the past year ("often" or "sometimes") when the food they bought just did not last, and they did not have money to get more.

Both percentages are more favorable than the US benchmarks.



Food Insecurity (MMH Service Area, 2016)

· Reflects the total sample of respondents.

Overall, 15.2% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

- Well below the US figure.
- **Food Insecurity** 100% 80% 60% 40% 25.9% 19.5% 20% 15.2% 13.1% 0% MMH Service Area US Franklin County **Ripley County**
- Higher in Franklin County.

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169] Sources:

• 2015 PRC National Health Survey, Professional Research Consultants, Inc. Notes:

Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Adults more likely affected by food insecurity include:

- Residents age 40 to 64.
- Those living at lower incomes (especially).



Food Insecurity

(MMH Service Area, 2016)

Sources: Notes:

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169] Asked of all respondents.

 Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

General Health Status



Professional Research Consultants, Inc.

Overall Health Status

Evaluation of Health Status

A total of 52.0% of MMH Service Area adults rate their overall health as "excellent" or "very good."

• Another 30.7% gave "good" ratings of their overall health.



Self-Reported Health Status

(MMH Service Area, 2016)

Notes: • Asked of all respondents.

However, 17.4% of MMH Service Area adults believe that their overall health is "fair" or "poor."

- Similar to statewide and national findings.
- Similar findings by county.
- TREND: No statistically significant change has occurred when comparing "fair/poor" overall health reports to 2013 survey results.

NOTE:

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

The initial inquiry of the PRC Community Health Survey

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

asked respondents the

following:

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]



Experience "Fair" or "Poor" Overall Health

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

- Seniors (note the positive correlation with age).
- Residents living at lower incomes.

Notes:

Asked of all respondents.

Experience "Fair" or "Poor" Overall Health



(MMH Service Area, 2016)

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Asked of all respondents

Notes:

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

Activity Limitations

About Disability & Health

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

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

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

- Improve the conditions of daily life by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- Address the inequitable distribution of resources among people with disabilities and those without disabilities by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- Expand the knowledge base and raise awareness about determinants of health for people with disabilities by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.
- Healthy People 2020 (www.healthypeople.gov)

A total of 20.6% of MMH Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

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

- Comparable to the statewide and national prevalence.
- No difference by county.
- TREND: Marks a statistically significant increase in activity limitations since 2013.



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

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

- Adults age 40 and older (note the positive correlation with age).
- Residents living on lower incomes.



Limited in Activities in Some Way

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128] Notes:

Asked of all respondents

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

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

Other limitations noted with some frequency include those related to mental health (depression, anxiety), heart conditions, and stroke.



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 129]

Notes: • Asked of those respondents reporting activity limitations.

Mental Health

About Mental Health & Mental Disorders

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

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

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

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady
 progress in treating mental disorders as new drugs and stronger evidence-based outcomes
 become available.
- Healthy People 2020 (www.healthypeople.gov)

Evaluation of Mental Health Status

Two in three MMH Service Area adults (67.8%) rate their overall mental health as "excellent" or "very good."

• Another 23.5% gave "good" ratings of their own mental health status.

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

Self-Reported Mental Health Status



 Sources:
 • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]

 Notes:
 • Asked of all respondents.

A total of 8.8% of MMH Service Area adults, however, believe that their overall mental health is "fair" or "poor."

- Lower than the "fair/poor" response reported nationally.
- Similar findings by county.
- TREND: Statistically unchanged since 2013.



Experience "Fair" or "Poor" Mental Health

 No statistically significant difference in percentages when viewed by basic demographic characteristics.



Experience "Fair" or "Poor" Mental Health

Notes: • Asked of all respondents.

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

Depression

Diagnosed Depression

A total of 15.9% of MMH Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Below the Indiana prevalence.
- Similar to the national finding.
- Statistically similar by county.
- TREND: Statistically unchanged over time.



Have Been Diagnosed With a Depressive Disorder

PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 119]
 Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.

Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

A total of 28.0% of MMH Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

- · Comparable to national findings.
- Comparable findings by county.
- TREND: Similar to the prevalence in 2013.



Have Experienced Symptoms of Chronic Depression

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 117]

2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

• Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

 ²⁰¹⁵ PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

 The prevalence of chronic depression is notably higher among adults with lower incomes.



Have Experienced Symptoms of Chronic Depression

Asked of all respondents.

Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
 Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households

with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

Half of MMH Service Area adults consider their typical day to be "not very stressful" (36.6%) or "not at all stressful" (13.8%).

RELATED ISSUE:

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

 Another 41.1% of survey respondents characterize their typical day as "moderately stressful."



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

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

- More favorable than national findings.
- Similar by county.
- TREND: Statistically similar to the 2013 findings.



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

• Note that high stress levels are more prevalent among adults age 40 to 64 and those living in low-income households.



Perceive Most Days as "Extremely" or "Very" Stressful (MMH Service Area, 2016)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]

Notes:

 Asked of all respondents

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

Suicide

Between 2005 and 2014, there was an annual average age-adjusted suicide rate of 10.7 deaths per 100,000 population in the MMH Service Area.

- Lower than the statewide and national rates.
- Similar to the Healthy People 2020 target of 10.2 or lower.
- Higher in Franklin County.



Suicide: Age-Adjusted Mortality

(2005-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 10.2 or Lower

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

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

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

Mental Health Treatment

Notes:

A total of 24.6% of MMH Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

- Similar to the US prevalence.
- Similar findings by county.

A total of 10.5% are currently taking medication or receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

- · Below the national findings.
- Similar findings by county.


Mental Health Treatment

Difficulty Accessing Mental Health Services

A total of 2.2% of MMH Service Area adults report a time in the past year when they needed mental health services, but were not able to get them.

- Below the national finding.
- Statistically similar by county.





Notes: • Asked of all respondents.

• Access difficulty does not vary significantly by demographic characteristics.



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

Among persons citing difficulties accessing mental health services in the past year, these are predominantly attributed to **cost or insurance issues**.

Key Informant Input: Mental Health

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

Perceptions of Mental Health as a Problem in the Community (Key Informants, 2016)

 Major Problem
 Moderate Problem
 Minor Problem
 No Problem At All

 43.5%
 39.1%
 15.2%

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

Challenges

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

Access to Care/Services

I do not think there is adequate mental health care in the community. The wait time for access to a psychiatrist and/or mental health services is too long. There is a shortage of mental health professionals here. Primary care doctors are forced to handle more and more mental health issues that may be beyond their training. – Community Leader

Lack of options and affordable care, especially for those who do not have insurance. Substance abuse treatment is a very high need. – Social Services Provider

Access to mental health care is an issue. CMHC is the player in the area, and they have few psychiatrists and a waning staff due to overwork, underappreciation and low wages, compared to competitors. – Other Health Provider

Access to services and being referred to these services. We have a behavioral health specialist now at MMH; however, it can be challenging to get a referral. – Other Health Provider

Can't get into facility to get help. Many won't take patients without insurance. Local facility difficult to deal with obtaining help for patients. Patients are sent to Emergency Room by PCP or even local mental health facility. The E.R. is not the right place; we, in turn, have to find a place for them, which is a lengthy process. It ties up the E.R., and there's generally nothing we can do to help them. – Other Health Provider

I feel one of the biggest challenges for people with mental health issues is the access to care. There are not enough mental health facilities or programs to accommodate the mentally ill community. There is not enough funding opportunities for these facilities to assist with people's needs, nor is there enough staff to accommodate the clients' needs. The staff are overworked, and it is difficult for potential patients to be seen. The staff is limited for follow-up care with the patients. It is very difficult for a client to access in-house treatment if needed. There is not enough space or staff to accommodate. – Public Health Representative

Services don't exist! You cannot take your child to any hospital in a mental health crisis. You have to take him to another county than ours and pray nothing happens on the way. Also, to make sure you have transportation and money for gas. – Other Health Provider

Access to care in each community. The choices are few and not always well-received by the patient. Also, funding for adequate mental health is poor. Patients really need to see a psychologist, and mostly what is available is a counselor. – Other Health Provider

Access to care, meaning that care provision is available, but individual does not seek care. Compliance with medication and treatment, opportunity for community integration, stigma. – Social Services Provider

Besides the Community Health Center, there are very little resources in our immediate area to recommend to people dealing with mental health issues. We have a number of people at all socioeconomic levels and age levels who are dealing with various forms of mental health problems. I have to recommend resources that are outside of our area. It would be great to have more local options. – Community Leader

We have poor access to inpatient treatment. Poor access to drug and alcohol addiction treatment. Poor access for teen mental health issues or support. – Other Health Provider

There is not enough resources in our community for patients with mental health issues. Many do not have insurance coverage for needed medications or treatments. Medical MD's do not have the skill set for diagnosing. – Community Leader

Access to care and tolerance. - Other Health Provider

Lack of access to care. - Community Leader

Limited access to mental health facilities. Long delays in getting appointments. Issues with travel arrangements to/from the mental health facility in Lawrenceburg. No real gatekeeper used for followup care on patients to ensure they have medications and are taking meds. – Other Health Provider Adequate services. – Community Leader

The lack of mental health resources in Ripley County can create hurdles for schools and families. – Community Leader

The single largest requirement in our community. Behavioral health resources are stretched very thin and are sometimes transient. Mental health access would improve maternal mental health, substance abuse and pediatric behavioral health. I would suggest a non-profit should directly fund mental health as a community contribution - Physician

CMHC is insufficient to respond to community needs. Further, there are no accessible higher-level options in our community. – Community Leader

Access to Providers

Lack of health care providers specializing in mental health issues. Nonexistent live-in facilities with capability to treat long-term issues. – Other Health Provider

Little or no trained psychiatric care available. - Community Leader

No access to mental health care, no providers. - Other Health Provider

Consistent help, high turnover of consultants. - Social Services Provider

Affordable Care/Services

Access to affordable long-term reliable counseling. Confidence the local doctors have in mental health treatment locally and likelihood that they will recommend/prescribe it. – Community Leader

Diagnosis/Treatment

Diagnoses, affordable medications and lack of support. - Social Services Provider

Denial/Stigma

Nobody wants to see a therapist. - Physician

Death, Disease & Chronic Conditions



Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

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



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

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

CLRD is chronic lower respiratory disease

Age-Adjusted Death Rates for Selected Causes

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

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

The following chart outlines 2012-2014 annual average age-adjusted death rates per 100,000 population for selected causes of death in the MMH Service Area.

Each of these is discussed in greater detail in subsequent sections of this report.

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

Age-Adjusted Death Rates for Selected Causes

	MMH Service Area	Indiana	US	HP2020
Malignant Neoplasms (Cancers)	190.2	181.2	163.6	161.4
Diseases of the Heart	188.6	185.8	169.1	156.9*
Chronic Lower Respiratory Disease (CLRD)	51.6	56.0	41.4	n/a
Cerebrovascular Disease (Stroke)	48.4	41.7	36.5	34.8
Unintentional Injuries	45.6	42.8	39.7	36.4
Alzheimer's Disease	38.7	28.6	24.2	n/a
Diabetes Mellitus	28.4	25.5	21.1	20.5*
Motor Vehicle Deaths	18.9	11.4	10.6	12.4
Drug-Induced **	17.2	14.9	13.3	11.3
Pneumonia/Influenza	14.4	14.4	15.1	n/a
Kidney Disease	12.7	18.0	13.2	n/a
Intentional Self-Harm (Suicide) **	10.7	13.2	11.9	10.2
Firearm-Related **	9.0	11.4	10.3	9.3
Cirrhosis/Liver Disease **	7.4	8.7	9.5	8.2
Fall-Related Deaths (65+) **	4.8	5.5	8.1	47.0

(2012-2014 Deaths per 100,000 Population)

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

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

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

orded deaths.
**These death rates represent years 2005-2014.

Note:

Cardiovascular Disease

About Heart Disease & Stroke

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

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

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

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

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

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

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

• Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

Between 2012 and 2014 there was an annual average age-adjusted heart disease mortality rate of 188.6 deaths per 100,000 population in the MMH Service Area.

- Similar to the Indiana rate.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).
- Worse in Ripley County.

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



Heart Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 156.9 or Lower (Adjusted)

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

• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

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

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

The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

TREND: The heart disease mortality rate in the MMH Service Area stopped decreasing during the 2009-2011 reporting period and has since increased, while the Indiana and US rates have continued to decrease over time.

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



Informatics. Data extracted July 2016. US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:

Notes:

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

• The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

Notes:

Between 2012 and 2014, there was an annual average age-adjusted stroke mortality rate of 48.4 deaths per 100,000 population in the MMH Service Area.

- Higher than the Indiana and national rates.
- Fails to satisfy the Healthy People 2020 target of 34.8 or lower.
- Higher in Franklin County.



Stroke: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower

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

• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

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

• TREND: The area stroke rate has increased since the 2005-2007 reporting period, in contrast to the decreasing trends reported across Indiana and the US overall.



Stroke: Age-Adjusted Mortality Trends

Informatics. Data extracted July 2016.

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]
 Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10)

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

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

Notes:

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

- Similar to the national prevalence.
- Similar findings by county.
- TREND: Statistically unchanged since 2013.



Prevalence of Heart Disease

 2015 PRC National Health Survey, Professional Research Consultants, Inc. Notes: ٠ Asked of all respondents.

Includes diagnoses of heart attack, angina or coronary heart disease.

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

- Seniors (positive correlation with age).
- Residents in low-income households.

(MMH Service Area, 2016) 100% 80% 60% 40% 22.9% 15.6% 20% 9.4% 8.0% 8.4% 7.4% 5.7% 0.0% 0% Men Women 18 to 39 40 to 64 65+ Low Mid/High MMH Service Income Income Area • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146] Sources:

Prevalence of Heart Disease

Asked of all respondents

Includes diagnoses of heart attack, angina or coronary heart disease

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

Prevalence of Stroke

Notes:

A total of 4.5% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to statewide findings.
- Worse than national findings.
- Similar findings by county.
- TREND: Denotes a statistically significant increase in stroke prevalence over time.



Prevalence of Stroke

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 35]

2015 PRC National Health Survey, Professional Research Consultants, Inc.

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control
and Prevention (CDC): 2014 Indiana data.

Notes:
 Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

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

Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure

High Blood Pressure Testing

Nearly all MMH Service Area adults (97.7%) have had their blood pressure tested within the past two years.

- Higher than national findings.
- Satisfies the Healthy People 2020 target (92.6% or higher).
- Similar findings by county.
- TREND: Denotes a statistically significant increase over time.



Have Had Blood Pressure Checked in the Past Two Years

Healthy People 2020 Target = 92.6% or Higher

2015 PRC National Health Survey, Professional Research Consultants, Inc.
 US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]

Prevalence of High Blood Pressure

A total of 38.3% of MMH Service Area adults have been told at some point that their blood pressure was high.

- Less favorable than the Indiana prevalence.
- Similar to the national prevalence.
- Fails to satisfy the Healthy People 2020 target (26.9% or lower).
- Similar by county.
- TREND: Statistically unchanged since 2013.
- Among adults with multiple high blood pressure readings, 93.3% are taking action to lower their blood pressure (such as medication, change in diet, and/or exercise).

Notes: Asked of all respondents.



Prevalence of High Blood Pressure

Healthy People 2020 Target = 26.9% or Lower

PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 43, 147] Sources: •

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Indiana data.

- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes: Asked of all respondents.

High blood pressure is more prevalent among:

- Adults age 40 and older, and especially those age 65+ (positive correlation with age).
- Low-income residents.

Prevalence of High Blood Pressure

(MMH Service Area, 2016)

Healthy People 2020 Target = 26.9% or Lower



• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147] Sources:

 US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1] Notes:

Asked of all respondents.

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

High Blood Cholesterol

Blood Cholesterol Testing

A total of 90.6% of MMH Service Area adults have had their blood cholesterol checked within the past five years.

- More favorable than Indiana and US findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- Similar findings by county.
- TREND: Statistically unchanged over time.



Have Had Blood Cholesterol Levels Checked in the Past Five Years Healthy People 2020 Target = 82.1% or Higher

2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control

and Prevention (CDC): 2013 Indiana data. • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

Prevalence of High Blood Cholesterol

A total of 29.6% of adults have been told by a health professional that their cholesterol level was high.

- Similar to the national prevalence.
- Over twice the Healthy People 2020 target (13.5% or lower).
- Similar by county.
- TREND: Statistically unchanged since 2013.
- Among adults with high blood cholesterol readings, 91.7% are taking action to lower their numbers (such as medication, change in diet, and/or exercise).

Notes: • Asked of all respondents.



Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower

2015 PRC National Health Survey, Professional Research Consultants, Inc.

• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

Notes: Asked of all respondents.

100%

Further note the following:

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

Prevalence of High Blood Cholesterol

(MMH Service Area, 2016)

Healthy People 2020 Target = 13.5% or Lower



• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148] Sources:

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7] Notes:

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

[•] Asked of all respondents.

About Cardiovascular Risk

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

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

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

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

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

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

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

Total Cardiovascular Risk

A total of 86.1% of MMH Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Comparable to national findings.
- Comparable findings by county.
- TREND: Statistically similar to the 2013 findings.

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



Present One or More Cardiovascular Risks or Behaviors

Sources:
PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 149]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

Adults more likely to exhibit cardiovascular risk factors include:

- Men.
- Adults age 40 and older (positive correlation with age).
- Residents in low-income households.



Present One or More Cardiovascular Risks or Behaviors

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]

Notes:

Asked of all respondents.

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

Notes: • Asked of all respondents.

Key Informant Input: Heart Disease & Stroke

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

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

(Key Informants, 2016)

Major Problem	Mod	erate Problem	Minor Problem	■ No Problem A	At All
33.6%			41.2%	16.8%	8.4%

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:

Asked of all respondents

Top Concerns

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

Lifestyle

Lifestyle, physical conditioning, diet and lack of prevention. – Physician

The population of Batesville has a high incidence of risk factors for heart disease and stroke, including tobacco use, high alcohol use, poor diet, low physical activity, altered sleep schedules, obesity and diabetes. – Other Health Provider

Tobacco, obesity, diabetes, poor diet and sedentary lifestyle. - Physician

Diet, alcohol and drug use. - Other Health Provider

Leading Cause of Death

One of the top causes of death and disability. - Social Services Provider

At one time, heart disease was the leading cause of death in Indiana. I think it correlates to the substance abuse and decreased amount of physical activity. – Other Health Provider

Access to Primary Care Providers

Difficulty getting in or establishing with a primary care physician, difficulty paying for medications, transportation to/from physician appointments, smoking, diabetes issues. – Other Health Provider

Vulnerable Populations

Large farming population, large elderly population that are not accustomed to health promotion. – Other Health Provider

Insufficient Physical Activity

Lack of exercise. – Community Leader

Obesity

Overweight population. - Community Leader

Prevalence/Incidence

It's a major problem everywhere. - Social Services Provider

Cancer

About Cancer

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

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

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

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

• Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2012 and 2014, there was an annual average age-adjusted cancer mortality rate of 190.2 deaths per 100,000 population in the MMH Service Area.

- Statistically comparable to the statewide finding.
- Well above the national rate.
- Fails to satisfy the Healthy People 2020 target of 161.4 or lower.
- Higher in Ripley County.



Cancer: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 161.4 or Lower

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

• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

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

Notes:

Notes:

• TREND: Cancer mortality in the MMH Service Area decreased over time, echoing the state and national trends.

Cancer: Age-Adjusted Mortality Trends



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

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

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

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

Cancer Deaths by Site

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

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

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

- The MMH Service Area **lung cancer** and **colorectal cancer** death rates are nearly <u>identical</u> to the state rates and less favorable than the national rates.
- The MMH Service Area **prostate cancer** death rate is <u>higher</u> than both the state and national rates.
- The MMH Service Area **female breast cancer** death rate is <u>similar</u> to both the Indiana and US rates.

Note that each of the MMH Service Area cancer death rates detailed below fails to satisfy the related Healthy People 2020 target, with the exception of female breast cancer (which is comparable to the related target).

	MMH Service Area	Indiana	US	HP2020
ALL CANCERS	190.2	181.2	163.6	161.4
Lung Cancer	53.9	54.1	43.4	45.5
Prostate Cancer	27.8	20.4	19.2	21.8
Female Breast Cancer	20.8	21.5	20.9	20.7
Colorectal Cancer	16.1	16.0	14.6	14.5

Age-Adjusted Cancer Death Rates by Site (2012-2014 Annual Average Deaths per 100,000 Population)

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

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

Cancer Incidence

Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. Here, these rates are also age-adjusted.

The 2008-2012 MMH Service Area annual average age-adjusted <u>lung cancer</u> incidence rate is worse than the correlating US rate.

None of the service area cancer incidence rates are worse than state rates for the same years.



Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-2012)

Sources: • State Cancer Profiles.

Retrieved July 2016 from Community Commons at http://www.chna.org.
 This indicator reports the age adjusted incidence rate (cases per 100.00

 This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

• Cancer incidence is worse in Ripley County for each type of cancer, with the exception of prostate cancer (which is worse in Franklin County).

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

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

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-2012)



State Cancer Profiles.

Retrieved July 2016 from Community Commons at http://www.chna.org. This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

Skin Cancer

Notes:

A total of 7.6% of surveyed MMH Service Area adults report having been diagnosed with skin cancer.

- Higher than what is found statewide.
- Similar to the national average.
- Similar findings by county.
- TREND: The prevalence of skin cancer has remained statistically unchanged over time.



Prevalence of Skin Cancer

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30] • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.

- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes: Asked of all respondents.

Other Cancer

A total of 6.3% of survey respondents have been diagnosed with some type of (nonskin) cancer.

- Similar to the statewide and national percentages.
- Similar findings by county.
- TREND: Statistically unchanged over time.

100% MMH Service Area 80% 60% 40% 20% 7.9% 8.3% 7.7% 6.3% 6.3% 6.3% 5.3% 0% Franklin MMH Service US 2016 Ripley IN 2013 County County Area

Prevalence of Cancer (Other Than Skin Cancer)

Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.

2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
 Asked of all respondents.

Cancer Risk

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

About Cancer Risk

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

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

Cancer Screenings

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

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

Prostate Cancer Screenings

About Screening for Prostate Cancer

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

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

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

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

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

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

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

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

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

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

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

PSA Testing and/or Digital Rectal Examination

Among men age 50 and older, nearly 3 in 4 (73.5%) have had a PSA (prostate-specific

antigen) test and/or a digital rectal examination for prostate problems within the past two years.

- Similar to 2013 national findings.
- Much lower in Franklin County.
- TREND: Denotes a statistically significant increase since 2013.



Have Had a Prostate Screening in the Past Two Years (Among Men Age 50 and Older)

- Notes: Asked of all male respondents age 50 and older.

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 218] • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Female Breast Cancer Screening

About Screening for Breast Cancer

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

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

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

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

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

Mammography

Among women age 50-74, 79.9% have had a mammogram within the past 2 years.

- Higher than statewide findings.
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- Lower among women in Franklin County.
- TREND: Statistically unchanged since 2013.



Have Had a Mammogram in the Past Two Years (Among Women Age 50-74)

Sources:
• PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]

- Rehavioral Disk Factor Survey Data. Atlanta Consultants, Inc.

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.

- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]
- Notes: Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

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

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

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

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

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

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

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

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

Pap Smear Testing

Among MMH Service Area women age 21 to 65, 75.9% have had a Pap smear within the past 3 years.

- Comparable to Indiana findings.
- Lower than national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- Comparable findings by county.
- TREND: Statistically unchanged since 2013.



Have Had a Pap Smear in the Past Three Years

(Among Women Age 21-65) Healthy People 2020 Target = 93.0% or Higher

PRC community Health Surveys, Protessional Research Consultants, Inc. [Item 152]
 Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.

• 2015 PRC National Health Survey, Professional Research Consultants, Inc.

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes: • Reflects female respondents age 21 to 65.

100%

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

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

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

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

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

Colorectal Cancer Screening

Among adults age 50-75, 70.6% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years).

- Higher than statewide findings, similar to national findings.
- Similar to the Healthy People 2020 target (70.5% or higher).
- Similar findings by county.
- TREND: Statistically unchanged over time.

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



Have Had a Colorectal Cancer Screening (Among Adults Age 50-75)

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community, followed closely by "major problem" responses.



Notes: • Asked of all respondents.

Top Concerns

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

Prevalence/Incidence

It appears that just about everyone I know has been touched by cancer in their family. It could be my age, but it appears to be worse than ever. – Community Leader

I see cancer disaster stories every day. Our community has epidemic proportions of tobacco and obesity-related cancers. Until our community realizes that the best chance of avoiding being a cancer patient is- 1) avoiding all tobacco, 2) avoid the obesity epidemic that plagues an unbelievably high proportion of my patients, and 3) avoid unhealthy diet- again, until these three things happen for many decades, this community will continue to suffer disproportionate cancer deaths. – Physician

There seems to be a high incidence of cancer among residents of the tri-state area, including our local community. I believe that while environmental factors contribute to this high statistic, personal lifestyles must also be considered. Poor diet, lack of exercise, and a higher-than-normal consumption of alcohol and forms of tobacco also contribute to many of our residents' health issues, some of which ultimately progress to a cancer diagnosis. While whole food choices are being promoted via our school gardening efforts, and local food sources are made available via a weekly farmers' market 7-8 months each year, many residents still do not fully understand the concept 'whole foods' and the importance of locally-grown food sources. In addition, for a community of our size, we have too many fast-food restaurants offering residents convenience without regard to the food items' long-term impact on one's health. – Community Leader

I know that MMH Oncology Center is very busy. I worked there for a couple months earlier this year, and they are very busy and growing. I also have heard that our area of Indiana has a higher degree of cancer incidence that other parts of the state. – Other Health Provider

There is a high incidence, and we see many cancer patients. - Other Health Provider

We have a high population that has cancer in our area. - Community Leader

I consider it a major problem, because it seems to affect so many people and families. It is complicated to treat and very financially taxing on the patients. – Community Leader

Hearing about those who have it and deaths. - Social Services Provider

I believe that cancer is a major problem in every community. There is a lack of knowledge in prevention and education. The community does not take advantage of the free or low-cost screenings. – Public Health Representative

It seems that every family has someone who has been diagnosed with cancer of some kind. – Other Health Provider

Lifestyle

I feel like we have a large population that smokes, drinks alcohol and partakes in other substance abuse. Large majority of young people with cancer. – Other Health Provider

Smoking rates and people not utilizing cancer screening. - Community Leader

Our community has a high rate of tobacco use, poor diet and low physical activity, which all contribute to cancer risk. Also, many people live in rural areas and don't access primary care often enough to catch cancer in its early stages. – Other Health Provider

Access to Care/Services

No cancer treatment centers in Franklin County. Number of persons with cancer diagnoses seems high. – Social Services Provider

Access to Primary Care Providers

A lot of people don't have a primary care physician, therefore routine tests are not performed. – Public Health Representative

Leading Cause of Death

So many people seem to die from it. - Community Leader

Respiratory Disease

About Asthma & COPD

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

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

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

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

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

Risk factors for asthma currently being investigated include:

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

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

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

Healthy People 2020 (www.healthypeople.gov)

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

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

Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2012 and 2014, there was an annual average age-adjusted CLRD mortality rate of 51.6 deaths per 100,000 population in the MMH Service Area.

- Lower than found statewide.
- Notably higher than the national rate.
- Higher in Ripley County.



CLRD: Age-Adjusted Mortality

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

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

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

· CLRD is chronic lower respiratory disease

• TREND: CLRD mortality in the area has fluctuated widely over time, showing no clear trend. The statewide rate has increased slightly, while the nationwide rate has remained relatively stable over the past decade.


CLRD: Age-Adjusted Mortality Trends

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

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

CLRD is chronic lower respiratory disease

Notes:

Pneumonia/Influenza Deaths

Between 2012 and 2014, the MMH Service Area reported an annual average ageadjusted pneumonia influenza mortality rate of 14.4 deaths per 100,000 population.

• Identical to Indiana findings and similar to the US figure.

Pneumonia/Influenza: Age-Adjusted Mortality

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



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

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

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



• TREND: No clear trend is evident in MMH Service Area pneumonia/ influenza mortality over the past decade. Statewide and nationally, pneumonia/influenza death rates have decreased.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



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

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

Asthma

Adults

A total of 6.3% of MMH Service Area adults currently suffer from asthma.

• Lower than state and US figures.

- Statistically similar by county.
- TREND: The prevalence of adults with current asthma has not changed significantly since 2013.

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



Adult Asthma: Current Prevalence

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control
and Prevention (CDC): 2014 Indiana data.

Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

The following adults are more likely to suffer from asthma:

- Women.
- Low-income residents.

Currently Have Asthma

(MMH Service Area, 2016)



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

Notes: • Asked of all respondents.

Children

Among MMH Service Area children under age 18, 7.3% currently have asthma.

- Comparable to national findings.
- Comparable findings by county.
- TREND: Statistically unchanged over time.
- Similar by child's gender; much higher among teens than among children age 12 and under.



Childhood Asthma: Current Prevalence

Chronic Obstructive Pulmonary Disease (COPD)

A total of 9.7% of MMH Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Similar to the state and national prevalence.
- Similar by county.
- TREND: In comparing to 2013 data, the change in prevalence is <u>not</u> statistically significant.



Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

and Prevention (CDC): 2014 Indiana data. 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2016)

Major Problem		Moderate Problem Minor F		Problem In No Problem At All		
16.5%		40.2%			37.8%	5.5%

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

Top Concerns

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

Tobacco Use

Smoking and allergies. - Community Leader

Large smoking community. – Other Health Provider

Tobacco and obesity. – Physician

They are a major problem due to the high incidence of tobacco use in our community. – Other Health Provider

Access to Providers

No specialists in Franklin County. - Social Services Provider

Asthma

Asthma seems to be the major respiratory disease. - Other Health Provider

Environmental Contributors

We live in a state where there is overcast weather 54% of the time. There is also a lot of poverty. Depression and smoking have been associated through research for years. A lot of people smoke in this area, even if cigarettes are taxed to the hilt. – Other Health Provider

Prevalence/Incidence

Allergies. - Social Services Provider

Injury & Violence

About Injury & Violence

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

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

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

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

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

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

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

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

Efforts to prevent violence may focus on:

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

• Healthy People 2020 (www.healthypeople.gov)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2012 and 2014, there was an annual average age-adjusted unintentional injury mortality rate of 45.6 deaths per 100,000 population in the MMH Service Area.

- Less favorable than the Indiana and national rates.
- Fails to satisfy the Healthy People 2020 target (36.4 or lower).
- Higher in Ripley County.



Unintentional Injuries: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower

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

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 Data are any 400,000 activities are adjusted to the 2000 US Chardred Deadlating.

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

 TREND: The service area's unintentional injury mortality rate has not shown a clear trend in recent years.

Unintentional Injuries: Age-Adjusted Mortality Trends



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

38.2

38.2

38.7

39.2

39.7

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

39.0

Notes: •

-US

Notes:

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

39.9

40.0

Leading Causes of Accidental Death

Motor vehicle accidents, poisoning (including accidental drug overdose), and falls accounted for most accidental deaths in the MMH Service Area between 2010 and 2014.



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

Selected Injury Deaths

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

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

- Motor vehicle accidents.
- Drug-related deaths.

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

- Motor vehicle accidents.
- Drug-related deaths.



Select Injury Death Rates

(By Cause of Death; 2005-14 Annual Average Deaths per 100,000 Population)

Motor Vehicle Safety

Seat Belt Usage - Children

A full 97.0% of MMH Service Area parents report that their child (age 0 to 17) "always" wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

• Statistically similar to what is found nationally.

*Drug-induced deaths include both intentional and unintentional drug overdoses.

**Motor vehicle accident deaths represent the years 2012-2014.

- Similar findings by county.
- TREND: Statistically unchanged since 2013.



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

(Among Parents of Children Age 0-17)

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 306]

2015 PRC National Health Survey, Professional Research Consultants, Inc. Notes:

Bicycle Safety

Just over one-third (34.2%) of service area children age 5 to 17 are reported to "always" wear a helmet when riding a bicycle.

- Well below the national prevalence.
- TREND: Denotes a statistically significant increase over time.



Child "Always" Wears a Helmet When Riding a Bicycle (Among Parents of Children Age 5-17)

Falls

Falls

Each year, an estimated one-third of older adults fall, and the likelihood of falling increases substantially with advancing age. In 2005, a total of 15,802 persons age \geq 65 years died as a result of injuries from falls.

Falls are the leading cause of fatal and nonfatal injuries for persons aged \geq 65 years ... in 2006, approximately 1.8 million persons aged \geq 65 years (nearly 5% of all persons in that age group) sustained some type of recent fall-related injury. Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

In addition, fall-related medical treatment places a burden on US healthcare services. In 2000, direct medical costs for fall-related injuries totaled approximately \$19 billion. A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of daily living as a result, and among them, 58.5% were expected to require help for at least 6 months.

Modifiable fall risk factors include muscle weakness, gait and balance problems, poor vision, use of psychoactive medications, and home hazards. Falls among older adults can be reduced through evidence-based fall-prevention programs that address these modifiable risk factors. Most effective interventions focus on exercise, alone or as part of a multifaceted approach that includes medication management, vision correction, and home modifications.

Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC

Among surveyed MMH Service Area adults age 45 and older, 28.9% fell at least once in the past year, including 7.8% who fell three or more times.



- the national proportion.
- No difference by county.

Among those who fell in the past year, 36.8% were injured as a result of the fall.



• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 125-126] Sources: 2015 PRC National Health Survey, Professional Research Consultants, Inc. Notes:

These population groups (age 45+) were more likely to have fallen in the past year:

- Seniors (age 65+).
- Residents in low-income households.

Fell One or More Times in the Past Year

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



Asked of those respondents age 45 and older.

Income categories released to spontant ego to the down of the spontant ego to the spontant ego to the down of the spontant ego to the

Firearm Safety

Notes:

Age-Adjusted Firearm-Related Deaths

Between 2005 and 2014, there was an annual average age-adjusted rate of 9.0 deaths per 100,000 population due to firearms in the MMH Service Area.

- Lower than found statewide and nationally.
- Similar to the Healthy People 2020 objective (9.3 or lower).
- Higher in Franklin County.



Firearms-Related Deaths: Age-Adjusted Mortality

(2005-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 9.3 or Lower

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

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]
Notes:
 Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

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

Presence of Firearms in Homes

A full 6 in 10 MMH Service Area adults (60.2%) have a firearm kept in or around their home.

- Much higher than the national prevalence.
- Among MMH Service Area households with children, 60.2% have a firearm kept in or around the house (well above that reported nationally).

Among MMH Service Area households with firearms, 16.4% report that there is at least one weapon that is kept unlocked and loaded.

• Statistically similar to that found nationally.

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

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

Have a Firearm Kept in or Around the Home

Firearms Kept Unlocked, Loaded





Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 51, 159-160]

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

Intentional Injury (Violence)

Violent Crime

Violent Crime Rates

Between 2010 and 2012, there were a reported 86.5 violent crimes per 100,000 population in the MMH Service Area.

- Well below the Indiana and US rates for the same period.
- Twice as high in Ripley County as in Franklin County.



Violent Crime

Sources:

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

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

• Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

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

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

Notes:

 ²⁰¹⁵ PRC National Health Survey, Professional Research Consultants, Inc.

Notes Asked of all respondents.

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

Family Violence

A total of 8.6% of MMH Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- More favorable than national findings.
- Statistically similar by county.
- TREND: Marks a statistically significant increase over time.



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

Notes:
 Asked of all respondents.

• Statistically comparable findings by demographic characteristics.



Kicked, or Hurt in Any Way by an Intimate Partner (MMH Service Area 2016)

Have Ever Been Hit, Slapped, Pushed,

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]

Notes: • Asked of all respondents.

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

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

 ²⁰¹⁵ PRC National Health Survey, Professional Research Consultants, Inc.

Perceived Neighborhood Safety

While most MMH Service Area adults consider their own neighborhoods to be "extremely safe" or "quite safe," 7.9% considering it "slightly safe" (none gave "not at all safe" responses).



- Compared with the US prevalence, local adults are less likely to consider their neighborhood to be "slightly" or "not at all" safe.
- Similar findings by county.



Perceive Own Neighborhood as "Slightly" or "Not At All" Safe

Reports of unsafe neighborhoods are notably higher among these residents:

- Men.
- Older adults (positive correlation with age).
- Those in lower-income households.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe (MMH Service Area, 2016)



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

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized Injury

& Violence as a "minor problem" in the community.

Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2016)

l	Major Problem	Moderate Problem		Minor Problem	No Problem A	o Problem At All		
5.5%	32.8%			53.9%		7.8%		
ources:	ress							

Notes: • Asked of all respondents

Top Concerns

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

Access to Care
Long response times for help. – Social Services Provider
School Injuries
Injury, two high schools locally. – Other Health Provider

Diabetes

About Diabetes

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

Diabetes mellitus:

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

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

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

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

• Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Between 2012 and 2014, there was an annual average age-adjusted diabetes mortality rate of 28.4 deaths per 100,000 population in the MMH Service Area.

- Worse than that found statewide or nationally.
- Fails to satisfy the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).
- Worse in Franklin County.



Diabetes: Age-Adjusted Mortality

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

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

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

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

 Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population. • The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Diabetes: Age-Adjusted Mortality Trends

TREND: No clear diabetes mortality trend is apparent in the MMH Service Area.

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



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

• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

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

• The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Notes:

Notes:

Prevalence of Diabetes

A total of 11.9% of MMH Service Area adults report having been diagnosed with diabetes.

- Similar to the statewide and US proportions.
- Statistically similar by county.
- TREND: Statistically unchanged since 2013.

In addition to the prevalence of diagnosed diabetes referenced above, another 4.7% of MMH Service Area adults report that they have "pre-diabetes" or "borderline diabetes."

- Comparable to the US prevalence.
- Higher in Franklin County (not shown).



Prevalence of Diabetes

- Ources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 158]
 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.

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

- Older adults (note the strong positive correlation between diabetes and age, with 21.1% of seniors with diabetes).
- · Residents in low-income households.

Notes: • Asked of all respondents.



Prevalence of Diabetes (MMH Service Area, 2016)

Notes:

Asked of all respondents.

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

• Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

Of area adults who have not been diagnosed with diabetes, half (50.6%) report having had their blood sugar level tested within the past three years.

- Similar to the national proportion.
- Statistically similar by county.
- TREND: Statistically unchanged since 2013.



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

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 39]

Notes: Asked of respondents who have not been diagnosed with diabetes.

²⁰¹⁵ PRC National Health Survey, Professional Research Consultants, Inc.

Key Informant Input: Diabetes

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

Perceptions of Diabetes as a Problem in the Community

(Key Informants, 2016)

Major Problem Moderate		blem Minor Proble	No Problem At All	
39.6%		29.9%	18.7%	11.9%

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Asked of all respondents.

Challenges

Among those rating diabetes as a "major problem," the biggest challenges for people with diabetes are seen as:

Health Education

No access to diabetes health coaching. Any diabetic education is at least 30 minutes away. Patients have no transportation and limited funds, so they cannot travel to appointments out of their home area. – Other Health Provider

Understanding their disease, how to properly manage it. There is a great knowledge deficit surrounding proper nutrition, physical activity, medication compliance and stress management. There is also challenges in affording medication and testing supplies. – Other Health Provider

Lack of education and support. - Social Services Provider

Certified diabetes educators to educate patients and their families. - Community Leader

Diagnosis/Treatment

Unwillingness to accept the seriousness of the disease and continue to make poor lifestyle decisions. Many will not accept education and resources that are offered. – Community Leader

Follow-up care with diabetics is a large issue. They leave the hospital controlled but then fall right back into uncontrolled sugars. Feel we need a nurse gatekeeper who would follow up on how often they test, last few sugars, carb issues, fluid issues. Many diabetics do not understand how to use sliding scales. Also, wound issues with diabetics. Slow to heal and very costly in wound clinic or surgery. – Other Health Provider

Type II diabetes prevention and treatment through engagement in healthy lifestyle choices. Obesity is becoming an epidemic. – Physician

Nutrition

Following a healthy diet in an area of the state that has a history of eating fried foods, starchy foods and sweets. Fried chicken, fried tenderloin sandwiches. – Other Health Provider

Poor eating habits, leading to an increase in diabetes. - Community Leader

Diet, lack of endocrinology. - Community Leader

Disease Management

Compliance with diet restrictions and weight loss. – Other Health Provider Lifestyle changes. – Physician

Prevalence/Incidence

Diabetes is a very prevalent disease found in many residents of our community. Some lack the resources for treatment or supplies. – Community Leader Increasing numbers of DM1 and DM2. – Physician

J J

Access to Providers

No specialists and no support systems. - Social Services Provider

Affordable Care/Services

Paying for medications. Affording high quality food. Education and knowledge. – Other Health Provider

Obesity

The obesity epidemic and ignorance regarding what qualifies as obese. Fast food and poor food choices. Poor lifestyle. – Physician

Alzheimer's Disease

About Dementia

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

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

Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2012 and 2014, there was an annual average age-adjusted Alzheimer's disease mortality rate of 38.7 deaths per 100,000 population in the MMH Service Area.

- Considerably higher than the statewide and national rates.
- Much higher in Ripley County.



Alzheimer's Disease: Age-Adjusted Mortality

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

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

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

• TREND: Despite the significant drop within the past few years, Alzheimer's disease mortality in the area has increased since 2005, and at a much faster rate than seen across Indiana and the US.

Alzheimer's Disease: Age-Adjusted Mortality Trends



Informatics. Data extracted July 2016. • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

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

Key Informant Input: Dementias, Including Alzheimer's Disease

Nearly half of key informants taking part in an online survey consider *Dementias, Including Alzheimer's Disease* to be a "moderate problem" in the community.

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

(Key Informants, 2016)



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

Top Concerns

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

Aging Population

Longevity of life seems to have added to this problem. As people live longer because of increased health care options, the minds don't seem to be aging, as well. Too few people are equipped to deal with these issues within their families. – Community Leader

Aging population. - Community Leader

We have a large population of elderly people living in the counties of Ripley and Franklin. Symptoms are usually displayed at later stages of life. Several NHF in our community have special units for the care of these individuals. Personally affected in my family. – Other Health Provider

Impact on Families/Caregivers

I know of many, who are responsible for parents or spouses who are afflicted with it. Resources for them seem to be minimal in our area. I know there are some support groups, and we have some excellent assisted-living facilities, but beyond that there doesn't seem to be much. Providing care for loved ones with dementia/Alzheimer's can be very taxing and isolating. – Community Leader

I feel that as a family member, we were never explained about the disease. Put them in a nursing home, and forget. What to look for, how they can help the family member or themselves through this. – Other Health Provider

Prevalence/Incidence

High rate, services are hard to locate. - Social Services Provider

Kidney Disease

About Chronic Kidney Disease

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

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

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

Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2012 and 2014 there was an annual average age-adjusted kidney disease mortality rate of 12.7 deaths per 100,000 population in the MMH Service Area.

- Lower than the rate found statewide.
- Comparable to the national rate.

Kidney Disease: Age-Adjusted Mortality



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

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

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

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

Notes

Prevalence of Kidney Disease

A total of 2.5% of MMH Service Area adults report having been diagnosed with kidney disease.

- Similar to the state and national proportions.
- Unfavorably high in Franklin County.
- TREND: Statistically unchanged since 2013.



Prevalence of Kidney Disease

- Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 32] Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Asked of all respondents. Notes:
 - Note the positive correlation between age and kidney disease in the area.



Prevalence of Kidney Disease

2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32] .

Asked of all respondents

Notes:

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

Key Informant Input: Chronic Kidney Disease

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

Perceptions of Chronic Kidney Disease as a Problem in the Community

(Key Informants, 2016)

	Major Problem	Moderate Problem		Minor Problem	No Problem A	No Problem At All	
5.7%	36.6	%		49.6%		8.1%	

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Top Concerns

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

Prevalence/Incidence

Compared to the population, there are a lot of individuals diagnosed with chronic kidney disease. Have a free-standing dialysis center in our town of Batesville and another just 16 miles north of town. – Other Health Provider

Access to Care/Services

Must leave Franklin County for diagnosis and treatment. - Social Services Provider

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

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

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

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

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

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

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

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

• Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

More than 4 in 10 MMH Service Area adults age 50 and older (45.0%) report suffering from arthritis or rheumatism.

Well above that found nationwide.

A total of 9.2% MMH Service Area adults age 50 and older have osteoporosis.

- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.

A total of 19.4% of MMH Service Area adults (18 and older) suffer from chronic back pain or sciatica.

Identical to that found nationwide.

RELATED ISSUE:

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



Prevalence of Potentially Disabling Conditions

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161-162]

2015 PRC National Health Survey, Professional Research Consultants, Inc.
 US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]

• The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

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

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

(Key Informants, 2016)

Major Problem		Moderate Problem	Minor Problem	No Problem At All	
10.6%		39.0%	43.9	%	6.5%

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

Top Concerns

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

Prevalence/Incidence

Working in the healthcare community, there are very few health assessments completed that do not include one of the aforementioned. There are many total joint replacement procedures completed on people of all ages with the younger population, increasing in volume. – Other Health Provider Talking to people, many express problems with these issues. – Social Services Provider

Obesity

I see people for weight loss, and one of the limiting factors to participating in exercise for many of the people who participate in our programs is arthritis or back problems. – Other Health Provider Morbid obesity, lack of exercise and poor diet. – Physician

Work Issues

Heavy labor activities in the community lead to degenerative conditions. - Physician

Access to Providers

No specialists in Franklin County. - Social Services Provider

Vision & Hearing Impairment

About Vision

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

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

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

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

Healthy People 2020 (www.healthypeople.gov)

Vision and Hearing Trouble

A total of 5.2% of MMH Service Area adults are blind or have trouble seeing even when wearing corrective lenses, and 10.9% are deaf or have trouble hearing.

- The local prevalence of blindness is similar to the statewide figure.
- Both local percentages are comparable to the related US benchmarks.
- No difference by county for either indicator.

RELATED ISSUE:

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



Prevalence of Blindness/Deafness

 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25-26]
 2015 PRC National Health Survey, Professional Research Consultants, Inc. Sources:

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

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

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

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

Healthy People 2020 (www.healthypeople.gov)

Notes Reflects the total sample of respondents.

Key Informant Input: Vision & Hearing

Key informants taking part in an online survey most often characterized *Vision & Hearing* as a "minor problem" in the community.

Perceptions of Hearing and Vision as a Problem in the Community

(Key Informants, 2016)

	Major Problem		loderate Problem	Minor Problem	No Problem At All		
	27.9%		48.8%			20.2%	
Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.							

Notes: • Asked of all respondents.

Infectious Disease



Professional Research Consultants, Inc.
Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

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

• Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

Among MMH Service Area seniors, 58.9% received a flu shot (or FluMist[®]) within the past year.

- Statistically comparable to the Indiana and US findings.
- Fails to satisfy the Healthy People 2020 target (70% or higher).
- Statistically comparable by county.
- TREND: Statistically unchanged since 2013.

A total of 47.5% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist[®]) within the past year.

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

(Among Adults Age 65+) Healthy People 2020 Target = 70.0% or Higher



2015 PRC bitmining Health Survey, Professional Research Consultants, Inc. 2015 PRC bitmining Health Survey, Professional Research Consultants, Inc. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control Denavorar his r actor surveinance system survey bata. Autama, debuga. Online States bepartment of realmain formal envices, center and Prevention (CDC): 2014 Indiana data. US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12] Reflects respondents 65 and older.

Notes:

"High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease Includes FluMist as a form of vaccination.

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

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

Pneumonia Vaccination

Among MMH Service Area adults age 65 and older, 63.6% have received a pneumonia vaccination at some point in their lives.

- Lower than the Indiana and US benchmarks.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- Unfavorably low in Ripley County.
- TREND: Statistically unchanged since 2013.
- A total of 29.6% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.



Older Adults: Have Ever Had a Pneumonia Vaccine (Among Adults Age 65+)

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 165-166]

2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CPC): 2014 Indiana data

and Prevention (CDC): 2014 Indiana data. US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IID-13.1, IID-13.2] Reflects respondents 65 and older.

"High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

Notes:

HIV

About HIV

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

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

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

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

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

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

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

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

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

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

Healthy People 2020 (www.healthypeople.gov)

HIV Testing

Among MMH Service Area adults age 18-44, 10.4% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Lower than the proportion found nationwide.
- Statistically comparable findings by county.



 Persons age 18 to 44 living in households with higher incomes more often report having been tested for HIV.



Tested for HIV in the Past Year

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]

Reflects respondents age 18 to 44.

Sources:

Notes:

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

Key Informant Input: HIV/AIDS

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

Perceptions of HIV/AIDS as a Problem in the Community

(Key Informants, 2016)

Major Problem	Moderate Problem	No Prob	No Problem At All	
18.9%		63.1%		13.9%

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc. Notes:

· Asked of all respondents

Top Concerns

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

Drug Use

This seems to be a growing issue in other parts of Indiana because of dangerous drug use practices, in particular. I wouldn't be surprised if it was an issue in our part of the state. While it doesn't seem to be a pressing issue, it does seem like one our community should prepare for. - Community Leader Hepatitis C and AIDS are on the rise due to heroin epidemic. - Other Health Provider

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

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

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

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

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

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons "linked" by sequential or concurrent sexual partners).

Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

In 2014, the chlamydia incidence rate in the MMH Service Area was 218.0 cases per 100,000 population.

- Notably lower than the Indiana and national incidence rates.
- Higher in Ripley County.

The service area gonorrhea incidence rate in 2014 was 21.4 cases per 100,000 population.

- Notably lower than the Indiana and national incidence rates.
- Higher in Ripley County.



Chlamydia & Gonorrhea Incidence

Retrieved July 2016 from Community Commons at http://www.chna.org.
 This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Safe Sexual Practices

Among unmarried MMH Service Area adults under the age of 65, the majority cites having one (49.8%) or no (41.1%) sexual partners in the past 12 months. However, 4.5% report three or more sexual partners in the past year.

• Well below that reported nationally.

A total of 26.8% of unmarried MMH Service Area adults age 18 to 64 report that a condom was used during their last sexual intercourse.



• Well below the national findings.



Key Informant Input: Sexually Transmitted Diseases

A plurality of key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a "minor problem" in the community.

Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2016)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:

Asked of all respondents.

Top Concerns

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

Prevalence/Incidence

Large teenage population with STDs, lack of education. – Other Health Provider Ripley County has a high incidence of STDs in the community. There is a lack of prevention education. – Public Health Representative

Hepatitis C and AIDS are on the rise due to heroin epidemic. - Other Health Provider

Marriage Health

Marriage health. We have a lot of marriages in crisis. The stronger our marriages and homes, the better off our children. The weaker the foundation is at home beginning with marriage, the more we'll see issues addressed in other parts of this survey (i.e. drug abuse, STDs, mental health challenges, etc.). – Community Leader

Health Education

Another issue that doesn't get a lot of public notice. With increasing cultural acceptance of all forms of sexual promiscuity, it would seem that more STDs would follow in its wake. Our community should be prepared—not just to address preventing, but treatment, as well. – Community Leader

Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

Key informants taking part in an online survey most often characterized *Immunization* & *Infectious Diseases* as a "minor problem" in the community.

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2016)

Major Problem		Ioderate Problem Minor Problem No		No Pro	Problem At All	
28.7%			52.7%		15.5%	

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Prevalence/Incidence

Significant number of population not actively getting immunized. – Community Leader Hepatitis C and AIDS are on the rise due to heroin epidemic. – Other Health Provider

Insurance Issues

Lack of medical care coverage is often preventing parents from seeking treatment for infectious diseases or immunizations for cost; fear of unknown behind immunizations. – Other Health Provider

Cultural/Personal Beliefs

Many parents claim religious exemptions and choose to not vaccinate their children. – Other Health Provider



Birth Outcomes & Risks

Low-Weight Births

A total of 7.1% of 2006-2012 MMH Service Area births were low-weight.

- Better than the Indiana and US proportions.
- Satisfies the Healthy People 2020 target (7.8% or lower).
- Higher in Franklin County.



Low-Weight Births

Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.

Retrieved July 2016 from Community Commons at http://www.chna.org.
 US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high
risk for health problems. This indicator can also highlight the existence of health disparities.

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.

Note:

Infant Mortality

Between 2005 and 2014, there was an annual average of 5.3 infant deaths per 1,000 live births.

- Better than the Indiana and national rates.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.

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



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.

Retrieved July 2016 from Community Commons at http://www.chna.org.

Notes:

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]
 Infant deaths include deaths of children under 1 year old.

This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Key Informant Input: Infant & Child Health

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

Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

Local and state resources that are available that are not being used or mentioned to parents. – Social Services Provider

Encourage all children to be seen at their medical home annually, rather than utilizing urgent care or school sports physicals, as these access points to do not practice population health management, in addition to assessment for the acute visit or physical. – Physician

SEEK screening is performed twice (soon to be 3 times) in the first 2 years of life to assess for food insecurities, interpersonal violence, maternal depression, harsh discipline, substance addiction and to align community resources with identified gaps in improving health outcomes for the patient and family. – Physician

Infant Mortality

The leading cause of infant mortality is prematurity. A social determinants of health screening tool should be utilized to screen mothers for risk factors such as substance abuse, depression, anxiety, and smoking at each delivery to decrease the likelihood of poor maternal health, precipitating a premature delivery. Breastfeeding has also been shown to decrease post-delivery complications such as bronchiolitis, gastroenteritis, etc. A program such as the CDC '10 Steps to Successful Breastfeeding,' implemented in the nursery, would be helpful to increase breastfeeding rates. – Physician

Poverty

Parents in poverty may not provide adequate prenatal and infant care due to a lack of resources and understanding. That lack of resources can have a detrimental residual effect on young students. – Community Leader

Obesity

The high incidence of childhood obesity, as 14.3% of low income children between the ages of two and four are obese. This sets them up for a lifetime of chronic illness. – Other Health Provider

Access to Providers

Lack of providers. - Other Health Provider

Family Planning

Births to Teen Mothers

About Teen Births

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

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

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

Healthy People 2020 (www.healthypeople.gov)

Between 2006 and 2012, there was an annual average of 34.0 births to women age 15-19 per 1,000 population in that age group.

- Below the state and US figures.
- Higher in Ripley County.



Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)

Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.

Notes:

Retrieved July 2016 from Community Commons at http://www.chna.org.
This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices

Key Informant Input: Family Planning

Key informants taking part in an online survey largely characterized *Family Planning* as a "minor problem" in the community.

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2016)

 Major Problem
 Moderate Problem
 Minor Problem
 No Problem At All

 11.1%
 31.0%
 39.7%
 18.3%

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Top Concerns

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

Access to Care/Services

Teen pregnancy continues to be an issue, and open discussion regarding family planning and birth spacing with contraception easily available could improve patient and family health. Preconception and prenatal risk screening should be performed prior to conception in primary care offices. – Physician

For people dealing with a crisis pregnancy, we do have a hotline that will connect an individual with some resources. However, beyond that, the nearest pregnancy care center is in Greensburg. The church I serve began looking into this last year because it seems like our community offers very little life-affirming options for those dealing with a crisis pregnancy. I'd like to see a bricks and mortar presence for some kind of pregnancy care center. – Community Leader

We have little to no resources to offer parents. Many without transportation and without insurance. – Other Health Provider

Teen Pregnancies

Large population of teenage pregnancy and STDs. – Other Health Provider

There are a large percentage of young pregnant mothers and high school students. – Other Health Provider

Single Parent Families

High number of single-parent homes or cohabitation families. - Community Leader

Modifiable Health Risks



Professional Research Consultants, Inc.

Actual Causes of Death

About Contributors to Mortality

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

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

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

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

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



Factors Contributing to Premature Deaths in the United States

Sources: • "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/July 2002. "Actual Causes of Death in the United States": (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Nutrition

About Healthful Diet & Healthy Weight

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

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

Americans with a healthful diet:

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

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

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

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

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

Social factors thought to influence diet include:

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

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

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

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

• Healthy People 2020 (www.healthypeople.gov)

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

Daily Recommendation of Fruits/Vegetables

A total of 32.9% of MMH Service Area adults report eating five or more servings of fruits and/or vegetables per day.

- More favorable than national findings.
- Lower in Franklin County.
- TREND: Fruit/vegetable intake has not changed significantly since 2013.

Consume Five or More Servings of Fruits/Vegetables Per Day



Asked of all respondents.

For this issue, respondents were asked to recall their food intake on the previous day.

 Area men and seniors are less likely to get the recommended servings of daily fruits/vegetables.

Consume Five or More Servings of Fruits/Vegetables Per Day (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]

Notes: Asked of all respondents.

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

· For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

Difficulty Accessing Fresh Produce

While most report little or no difficulty, 81.8% of MMH Service Area adults find it "very" or "somewhat" difficult to access affordable, fresh fruits and vegetables.

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

Respondents were asked:





Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]

Notes: • Asked of all respondents

- More favorable than national findings.
- Similar findings by county.
- TREND: Has not changed significantly since 2013.



Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce

 ²⁰¹⁵ PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
 Asked of all respondents.

Those more likely to report difficulty getting fresh fruits and vegetables include:

- Residents age 40 to 64.
- Lower-income residents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce

(MMH Service Area, 2016)



Asked of all respondents.

Notes:

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

Low Food Access (Food Deserts)

US Department of Agriculture data show that 5.7% of the MMH Service Area population (representing over 2,900 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Much more favorable than statewide and national findings.
- Particularly low in Ripley County.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.



Population With Low Food Access (Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)

 US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
 Retrieved July 2016 from Community Commons at http://www.chna.org. Sources:

Notes:

This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where 'far' is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.



Population With Limited Food Access, Percent by Tract, FARA 2010

Sugar-Sweetened Beverages

A total of 38.2% of MMH Service Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

- Higher than national findings.
- Similar by county.

Notes:

Notes:

· Asked of all respondents.



Had Seven or More Sugar-Sweetened Beverages in the Past Week

. Men, young adults, and those in lower-income households are more likely to consume 7+ sugar-sweetened beverages per week.



Had Seven or More Sugar-Sweetened Beverages in the Past Week (Metro Area, 2015)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 212] Asked of all respondents

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

Health Advice About Diet & Nutrition

A total of 35.2% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Comparable to national findings.
- Comparable by county (not shown).
- TREND: Statistically unchanged since 2013.
- Note: Among overweight/obese respondents, 39.0% report receiving diet/nutrition advice (meaning that 6 in 10 did not).

Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional



(By Weight Classification)

Notes:
 Asked of all respondents.

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- · Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

• Healthy People 2020 (www.healthypeople.gov)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work. A total of 16.4% of MMH Service Area adults report no leisure-time physical activity in the past month.

- More favorable than statewide and national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).

- Similar findings by county.
- TREND: Marks a statistically significant improvement since 2013.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower



- Benavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human and Prevention (CDC): 2014 Indiana data.
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes: • Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

- Seniors (positive correlation with age).
- Lower-income residents.





US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes: Asked of all respondents.

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

Activity Levels

Adults

Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity
 Learn more about CDC's efforts to promote walking by visiting http://www.cdc.gov/vitalsigns/walking.

Aerobic & Strengthening Physical Activity

Based on reported physical activity intensity, frequency and duration over the past month, 33.0% of MMH Service Area adults are found to be "insufficiently active" or "inactive."

A total of 62.4% of MMH Service Area adults do not participate in any types of physical activities or exercises to strengthen their muscles.



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 113, 173]

Notes: • Reflects the total sample of respondents.

 In this case, "inactive" aerobic activity represents those adults participating in no aerobic activity in the past week; "insufficiently active" reflects those respondents with 1–149 minutes of aerobic activity in the past week; "active" adults are those with 150–300 minutes of aerobic activity per week; and "highly active" adults participate in 301+ minutes of aerobic activity weekly.

Survey respondents were asked about the types of physical activities they engaged in during the past month, as well as the frequency and duration of these activities.

- "Inactive" includes those reporting no aerobic physical activity in the past month.
- "Insufficiently active" includes those with the equivalent of 1-150 minutes of aerobic physical activity per week.
- "Active" includes those with 150-300 minutes of weekly aerobic physical activity.
- "Highly active" includes those with >300 minutes of weekly aerobic physical activity.

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

Aerobic activity is at least 150 minutes per week of light to moderate activity or 75 minutes per week of vigorous physical activity or an equivalent combination of both; and

Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Recommended Levels of Physical Activity

A total of 19.7% of MMH Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

- More favorable than Indiana findings.
- Less favorable than the US benchmark.
- Similar to the Healthy People 2020 target (20.1% or higher)



Meets Physical Activity Recommendations

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]

2016 PRC National Health Survey, Professional Research Consultants, Inc. Item 199
 2016 PRC National Health Survey, Professional Research Consultants, Inc.
 Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia.
 United States Department of Health and Human Services, Centers for Disease Control
 and Prevention (CDC): 2013 Indiana data.
 US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-4]

Notes: Asked of all respondents. Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities sp designed to strengthen muscles at least twice per week. . ecifically

 Note the negative correlation between age and meeting physical activity recommendations among service area residents.



Meets Physical Activity Recommendations

(MMH Service Area, 2016)



Sources:

2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174] ٠ US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-4]

Notes: Asked of all respondents.

Acked on an espondents. Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level, "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level. Meeting both guidelines is defined as the number of persons age 18 + who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity <u>and</u> report doing physical activities specifically •

designed to strengthen muscles at least twice per week.

Health Advice About Physical Activity & Exercise

A total of 40.2% of service area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Similar to the national average.
- TREND: Similar to 2013 survey findings.
- Note: 47.0% of overweight/obese MMH Service Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.



Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional

Notes:

Children

Recommended Levels of Physical Activity

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

• 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among MMH Service Area children age 2 to 17, 71.0% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

- Well above that found nationally.
- Similar by county (not shown).
- Similar by child's gender; much lower among teens than among younger children in the service area.
- TREND: Marks a statistically significant increase from 2013 survey findings.



Child Is Physically Active for One or More Hours per Day (Among Children Age 2-17)

• Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

In 2013, there were 11.6 recreation/fitness facilities for every 100,000 population in the MMH Service Area.

- Above what is found statewide and nationally.
- Higher in Franklin County.

Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 2013)



Sources:

80

• Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which in clude Establishments engaged in Notes: operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities". Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

[•] US Census Bureau, County Business Patterns. Additional data analysis by CARES. Retrieved July 2016 from Community Commons at http://www.chna.org.

Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

• Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m²). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m² and obesity as a BMI \ge 30 kg/m². The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m². The increase in mortality, however, tends to be modest until a BMI of 30 kg/m² is reached. For persons with a BMI \ge 30 kg/m², mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m².

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

Classification of Overweight and Obesity by BMI	BMI (kg/m ²)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 - 29.9
Obese	≥30.0

Adult Weight Status

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

Overweight Status

Over 7 in 10 MMH Service Area adults (72.6%) are overweight.

• Worse than the Indiana and US overweight benchmarks.

- Comparable by county.
- TREND: Denotes a statistically significant increase since 2013.

Note that 51.5% of overweight adults are currently trying to lose weight.



Prevalence of Total Overweight

(Percent of Adults With a Body Mass Index of 25.0 or Higher)

- - and Prevention (CDC): 2014 Indiana data.
 - Based on reported heights and weights, asked of all respondents. ٠

The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Further, 32.6% of MMH Service Area adults are obese.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30

Notes:

Here, "overweight" includes

value ≥25.

those respondents with a BMI

- · Comparable to state and US findings.
- Comparable to the Healthy People 2020 target (30.5% or lower).
- Comparable findings by county.
- TREND: Statistically unchanged over time.



Prevalence of Obesity

(Percent of Adults With a Body Mass Index of 30.0 or Higher) Healthy People 2020 Target = 30.5% or Lower

Obesity is notably more prevalent among:

- Those between the ages of 40 and 64.
- Respondents living in lower-income households.

Prevalence of Obesity

(Percent of Adults With a BMI of 30.0 or Higher; MMH Service Area, 2016) Healthy People 2020 Target = 30.5% or Lower



• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176] Sources:

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
 Based on reported heights and weights, asked of all respondents.

Notes:

Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, response of conders.

regardless of gender.

Health Advice

A total of 23.8% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Statistically similar to the national findings.
- TREND: Statistically unchanged from that reported in 2013.
- Note that 29.6% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while 7 in 10 have not).



Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions.

Among these are:

- High blood pressure
- High cholesterol.
- "Fair" or "poor" physical health.
- Sciatica/chronic back pain.
- Diabetes.
- Diagnosed depression.
- COPD.
- Asthma.
- Kidney disease.

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



Relationship of Overweight With Other Health Issues (By Weight Classification; MMH Service Area, 2016)

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 24, 28, 32, 38, 119, 147, 148, 156] Sources: · Based on reported heights and weights, asked of all respondents Notes:

Children's Weight Status

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status - underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight
- <5th percentile Healthy Weight ≥5th and <85th percentile
 - ≥85th and <95th percentile Overweight
- Obese
 - ≥95th percentile

· Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 31.3% of MMH Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Comparable to that found nationally.
- TREND: Statistically unchanged since 2013.


Child Total Overweight Prevalence

Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Further, 22.0% of area children age 5 to 17 are obese (≥95th percentile).

- Well above the national percentage.
- Similar to the Healthy People 2020 target (14.5% or lower for children age 2-19).
- TREND: Statistically unchanged since 2013.
- Statistically similar by child's age and gender.



• Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Child Obesity Prevalence

Professional Research Consultants, Inc.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized Nutrition, Physical Activity & Weight as a "major problem" in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2016)

Major Problem	Moderate Problem		Minor Problem No F		Problem At All	
40.7%		33.6%			15.0%	10.7%

 PRC Online Key Informant Survey, Professional Research Consultants, Inc. Sources: Notes:

Asked of all respondents

Top Concerns

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

Nutrition

People who live in this community are exposed to a diet of rich foods heavy in fats and carbs, such as fried chicken, beer, potatoes, hamburgers, etc. While there are many physical activities to participate in, many find it difficult to participate or lack the motivation needed to become more active. -Community Leader

Overeating and underactivity. Ignorance in understanding the unbelievable impact obesity and sedentary lifestyle has on health and cancer development. - Physician

High use of fast food options and poor eating habits, in general, combined with inactivity. - Community Leader

Plethora of fast food chains offering unhealthy foods at low prices: sedentary lifestyles: fitness memberships to local gyms are costly; very little community planning and/or marketing regarding yearround fitness opportunities for the community (i.e., walk programs at local schools could be marketed as "this is free"). Local events such as a 5K walk are marketed, but this will not engage an individual in lifestyle change fitness. Walking groups that utilize free community venues could be developed using area schools in the winter and local outdoor walking paths that are accessible in the warmer months. Year-round, sustainable fitness groups and/or access to free or low cost fitness locations that are heavily marketed to the community and healthcare providers would be helpful. Free talks from dieticians, grocers, farmer's markets on low-cost, healthy food items, easy quick prep healthy meals, etc. Even if it is on "Making healthier choices at the drive-thru." - Physician

Our community's diet is characterized by choices high in fat and low in nutritional quality, including poor fruit and vegetable consumption, high soda intake and high fast food intake. Physical activity is also not a routine part of most people's day. As a result, a very high percentage of our community is overweight or obese. - Other Health Provider

I feel the biggest challenges related to nutrition and physical activity is the limited opportunities for the youth. Fitness centers, YMCA's and after-school sports are very expensive for many of the students; therefore, they are unable to participate. The students many times have to have transportation to get them to these facilities. Nutritional food/snacks are too expensive. We have an abundance of fast food establishments that offer high fat/high calorie foods at a reasonable price that is easily accessible. Public Health Representative

Access to Healthful Food

Our community lacks the connection between healthy food choices and exercise and the correlation to decreased health issues later in life. – Community Leader

There is an added expense with eating healthy. - Other Health Provider

The biggest challenge is the inability to make time to prepare proper meals, so many use fast food or junk food. The cost and gym intimidation for overweight adults to exercise. – Other Health Provider

Hunger. There are few options for the low-income families to access fresh, healthy food, such as fruits and vegetables. Food pantries are great for canned/boxed, carb-loaded options, but there is very little available for fresh options. This leads to eating foods loaded with carbs and calories and increased weight gain. Also sets bad examples for children. – Other Health Provider

Health Education

Nutrition education. - Social Services Provider

Education and motivation. Consistent message from local institutions and leaders as to wellness and a healthy lifestyle, emphasizing benefits. – Community Leader

Lack of knowledge. We often hear that eating healthy is too expensive, but when I have been in situations/programs/meals where fruits and vegetables are part of a buffet - no matter what the income level - people do not choose to eat the fruits and vegetables and healthier foods. They truly do not realize the how to follow a healthy diet. I teach a weight loss class to a wide variety of educational levels. Many do not have even a basic understanding of how to eat healthy. – Other Health Provider

Lack of education and lack of providers. - Other Health Provider

Insufficient Physical Activity

Getting the children to be active is the biggest challenge, and getting them to enjoy and make healthy choices on their own. Health education seems get less and less each year. I feel there's little focus on health education in the school setting. – Other Health Provider

Access to physical activity for youth not involved in organized athletics. Batesville is very sportsoriented, which works well for the few student athletes who are rewarded, but this results in a large group of youth who do not have access to physical fitness facilities. Community resources for basketball, soccer, tennis, with no relationship to competition would be helpful. Community access to all residents to the YMCA would help providers align recommendations for diet and exercise with availability, regardless of weather, to those who are at risk (BMI less than the 85th percentile but trending up). – Physician

You see many people exercising, but there appear to be more weight problems than ever amongst those who are not exercising. – Community Leader

Changing the culture to be an active and healthy community. - Community Leader

Obesity

There is an increasing number of obese people in both counties. Educational level about nutrition, desire to cook at home, and income level to afford "good real food." Safe roads to ride bikes or walk near homes. Options at fast food places have improved slightly, but still poor. – Other Health Provider

Overweight, poor nutrition and lack of physical activity. - Physician

Overweight population. - Community Leader

Access to Care/Services

Lack of local support systems. - Social Services Provider

Lack of resources. Wherever there is poverty, there are weight issues. No community center where working out is free, and classes to educate people how to eat are not free in most places. – Other Health Provider

Sleep

<u>Sleep</u>

Sleep is an important part of good health, but an estimated 35% of US adults do not get enough sleep. Approximately 83 million US adults report usually sleeping less than 7 hours in a 24-hour period. According to professional sleep societies, adults aged 18 to 60 years should sleep at least 7 hours each night for the best health and wellness.

Sleeping less than 7 hours per night is linked to increased risk of chronic diseases such as diabetes, stroke, high blood pressure, heart disease, obesity, and poor mental health, as well as early death. Not getting the recommended amount of sleep can affect one's ability to make good decisions and increases the chances of motor vehicle crashes.

Habits for improving sleep health can include:

- Be consistent. Go to bed at the same time each night and get up at the same time each morning, including on the weekends.
- Make sure your bedroom is quiet, dark, relaxing, and at a comfortable temperature.
- Remove electronic devices, such as TVs, computers, and smart phones, from the bedroom.
- Avoid large meals, caffeine, and alcohol before bedtime.
- Avoid tobacco/nicotine.
- Get some exercise. Being physically active during the day can help you fall asleep more easily at night.
- Institute of Medicine (US) Committee on Sleep Medicine and Research; 2014 Behavioral Risk Factor Surveillance System (BRFSS), CDC

When asked how many hours of sleep they average per night, 53.9% of survey respondents stated between 7 and 8 hours, and 7.3% get 9+ hours of sleep per night.

• In contrast, 34.8% of local adults sleep **fewer than 7 hours** per night (most of whom report sleeping 5-6 hours or less on an average night).



Average Hours of Sleep Per Night

(MMH Service Area, 2016)

 Sources:
 • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]

 Notes:
 • Asked of all respondents.

- The percentage of survey respondents averaging fewer than 7 hours per night is comparable to the national figure.
- Comparable findings by county.



Generally Sleep Less Than Seven Hours Per Night

Asked of all respondents.

• No difference when viewed by demographic characteristics.



Generally Sleep Less Than Seven Hours Per Night

Notes:

Asked of all respondents.

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

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- CrimeHomicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

• Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2005 and 2014, the MMH Service Area reported an annual average ageadjusted cirrhosis/liver disease mortality rate of 7.4 deaths per 100,000 population.

- Lower than the statewide and national rates.
- Satisfies the Healthy People 2020 target (8.2 or lower).

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2005-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



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

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]
 Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Notes:

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

Alcohol Use

Excessive Drinking

A total of 20.0% of area adults are excessive drinkers (heavy and/or binge drinkers).

- Similar to the national proportion.
- Satisfies the Healthy People 2020 target (25.4% or lower).
- Similar by county.
- TREND: Marks a statistically significant decrease since 2013.



Excessive Drinkers

Healthy People 2020 Target = 25.4% or Lower

Sources:

PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes: Asked of all respondents

Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

"Excessive drinking" includes heavy and/or binge drinkers:

- Heavy drinkers include men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- Binge drinkers include men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

RELATED ISSUE: See also Stress in the Mental Health section of this report.

• Excessive drinking is more prevalent among men, young adults (negative correlation with age), and residents in upper-income households.



Excessive Drinkers (MMH Service Area, 2016)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]
 Asked of all respondents.

Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) <u>OR</u> who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the east 30 days.

Drinking & Driving

Notes:

A total of 2.0% of MMH Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- Below the national findings.
- Similar by county.
- TREND: The drinking and driving prevalence has decreased significantly since 2013.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.



Have Driven in the Past Month After Perhaps Having Too Much to Drink

2015 PRC National Health Survey, Professional Research Consultants, Inc. Notes: Asked of all respondents.

Age-Adjusted Drug-Induced Deaths

Between 2005 and 2014, there was an annual average age-adjusted drug-induced mortality rate of 17.2 deaths per 100,000 population in the MMH Service Area.

- Worse than the statewide and national rates.
- Fails to satisfy the Healthy People 2020 target (11.3 or lower).
- Worse in Franklin County.



Drug-Induced Deaths: Age-Adjusted Mortality

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

• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

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

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

Illicit Drug Use

A total of 2.7% of area adults acknowledge using an illicit drug in the past month.

- Similar to the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.
- Similar by county.
- TREND: Marks a statistically significant increase over time.



Illicit Drug Use in the Past Month

Healthy People 2020 Target = 7.1% or Lower

2015 PRC National Health Survey, Professional Research Consultants, Inc.

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
 Asked of all respondents.

• Illicit drug use is more prevalent among men, young adults, and those in households with higher incomes.



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

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Alcohol & Drug Treatment

A total of 4.0% of MMH Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Similar to national findings.
- Similar by county.
- TREND: Denotes a statistically significant increase over time.



Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Negative Effects of Substance Abuse

Area adults were also asked to what degree their lives have been negatively affected by substance abuse (whether their own abuse or that of another).

In all, 2 in 3 respondents have not been negatively affected (66.2% "not at all" responses).

Notes: · Asked of all respondents.

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)

(MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69] Notes: Asked of all respondents.

In contrast, 33.8% of survey respondents indicate that their lives have been negatively affected by substance abuse, including 7.6% who gave "a great deal" responses.

- Similar to the US figure.
- Similar by county.



Life Has Been Negatively Affected

 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
 2015 PRC National Health Survey, Professional Research Consultants, Inc. Notes: Asked of all respondents.

The prevalence of survey respondents whose lives have been negatively impacted by substance abuse, whether their own abuse or that of another, is higher among the following:

- Adults age 40 to 64.
- Residents in lower-income households.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



(MMH Service Area, 2016)

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

Key Informant Input: Substance Abuse

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

Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2016)



Notes: • Asked of all respondents.

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Access to Care/Services

Pretty much same as mental illness: lack of facilities and trained individuals. I believe they may use ESD to stabilize, but then have only AA outpatient for follow-up. No transportation assistance, no drug assistance program to help with medications. – Other Health Provider

There are not programs in the community. Patients have to travel to get it. - Other Health Provider

Lack of available treatment facilities. - Community Leader

Perhaps just having a safe place for the users to go. It is so hidden that most people are not aware of the addiction until an OD occurs. – Other Health Provider

Lack of available facilities. - Social Services Provider

Treatment options, inpatient and intensive outpatient. - Community Leader

No treatment centers and making sure the person has insurance. - Other Health Provider

There is no intensive, residential, and aftercare treatment for substance abuse in the immediate Batesville area. Furthermore, for individuals with children, there are no options for childcare for the individual in treatment. The cost of private treatment centers is prohibitive for most people, and most do not have insurance coverage for substance abuse. – Social Services Provider

We have no actual hospitals in our county. - Community Leader

The ability for Ripley County residents to access substance abuse treatment is challenging. Substance abuse by young parents presents numerous educational obstacles in our elementary because those young students do not have guidance/resources at home in the evening. – Community Leader

Distance to and lack of facilities. - Community Leader

Distance. Valle Vista and Community Mental Health in Lawrenceburg are about the closest access points. These are some excellent substance abuse resources, but all require travel. Some local counseling services are beneficial but are not typically overseen by an MD. The increase in Hepatitis C, at-risk pregnancies, infants with neonatal abstinence syndrome make this community investment very reasonable. – Physician

Too high of demand and not enough resources. Not able to get patients to needed treatment timely. Cost is another barrier--often not a covered item. Limited treatment facilities in our area--need to go to Indy or Cincinnati areas, and it is also difficult to 'become a patient' in these facilities--need to meet certain criteria to be accepted. Have had some change in legislation in relation to the new prescribing laws and physicians not routinely prescribing narcotics but, unfortunately, there has been a rise in the Heroin problem. – Other Health Provider

Facilities and services. – Social Services Provider

Time and money. - Community Leader

Knowledge on how to find such services. Lack of services, and cost of services. – Other Health Provider

There really isn't anywhere in our community that manages drug addiction or alcohol addiction. – Other Health Provider

Not aware of any programs locally. - Other Health Provider

Unsure where to go and how to send people that way. More prevention education. – Community Leader

Affordable Care/Services

They all cost money, and there are no inpatient or long-term (greater than six months) inpatient programs locally. Screening and prevention initiatives targeted at youths do not seem successful. Evidenced-based prevention. – Physician

Willingness to access help, cost of and payment for care, lack of providers to provide MAT. – Social Services Provider

The greatest barriers are cost of treatments, stigma of others knowing, desire to want treatment, sustaining being drug-free. – Community Leader

Cost of programs, lack of insurance and lack of programs locally. - Community Leader

Heroin

Heroin epidemic. More treatment options like suboxone, Vivitrol. Need programs that are coordinated from inpatient detox to IOP and OP. – Other Health Provider

Large population of teenage and adult heroin use. - Other Health Provider

Heroin and prescription drugs are killing us. – Community Leader

Denial/Stigma

The one who is addicted to opiates, heroin, pot or alcohol must want to change his or her life, or no counseling or rehabilitation program will enable him or her to regain it. Once the decision is made to seek help, cost or lack of insurance coverage is often a barrier. – Community Leader

The stigma associated with drug use and lack of advertised and readily-available resources. – Other Health Provider

Social stigma attached to abusing drugs. There are many people in the community who struggle with substance abuse- but do so secretly because they or their families don't want to be identified as one of "those people." Plus, many don't know where to turn. And, if they do know where to go, many cannot afford it. – Community Leader

Family and patients not admitting there is a problem until it is too late and then the person needs more intensive treatment. Also not willing to participate as readily once the abuse has gone on too long. – Other Health Provider

Health Education

Prevention and education. Funding is also a huge issue. There are not any local substance abuse centers available for treatment. – Public Health Representative

Lack of programs and indicatives to educate youth and the community on the dangers of trying narcotics. A lot of resources misguided to a perceived alcohol problem instead of the real problem of over-prescribed opioids and the dangers of heroin. – Community Leader

Integration of Services

Partnership of courts, medical, mental health services and recovery community to respond in an effective long-term way to individuals in need, on a case-by-case basis. – Community Leader

Access to Providers

Trained personnel, facilities and access. - Other Health Provider

Home Life

Breakdowns in family unit. - Physician

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **heroin/other opioids** and **alcohol** as the most problematic substances abused in the community.

Problematic Substances							
	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions			
Heroin or Other Opioids	46.7%	20.0%	22.7%	40			
Alcohol	42.2%	20.0%	18.2%	36			
Prescription Medications	2.2%	22.2%	15.9%	18			
Methamphetamines or Other Amphetamines	4.4%	17.8%	15.9%	17			
Marijuana	2.2%	15.6%	11.4%	13			
Over-The-Counter Medications	2.2%	2.2%	6.8%	5			
Cocaine or Crack	0.0%	2.2%	2.3%	2			
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	0.0%	2.3%	1			
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	0.0%	0.0%	2.3%	1			
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	0.0%	2.3%	1			

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

• Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 16.6% of MMH Service Area adults currently smoke cigarettes, either regularly (11.0% every day) or occasionally (5.6% on some days).



- Lower than statewide infulfigs.
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (12% or lower).
- Unfavorably high in Ripley County.

• TREND: The percentage is statistically unchanged since 2013.



Current Smokers

Healthy People 2020 Target = 12.0% or Lower

Cigarette smoking is more prevalent among:

- Adults under 65 (negative correlation with age).
- Lower-income residents.

Current Smokers

(MMH Service Area, 2016)

Healthy People 2020 Target = 12.0% or Lower

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes: Asked of all respondents.

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

[·] Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

A total of 11.0% of MMH Service Area adults (including smokers and nonsmokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Comparable to national findings.
- Comparable by county.
- TREND: Statistically unchanged over time.
- Note that 7.2% of MMH Service Area children are exposed to cigarette smoke at home, similar to what is found nationally.

Member of Household Smokes at Home

2015 PRC National Health Survey, Professional Research Consultants, Inc.

 Asked of all respondents. Notes:

"Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Notably higher among the following population samples:

- Adults age 40 to 64.
- Those in lower-income households.

Member of Household Smokes At Home

Sources:

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]

Notes: • Asked of all respondents

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

• "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

• Healthy People 2020 (www.healthypeople.gov)

Smoking Cessation Attempts

Less than half of regular smokers (47.9%) went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).
- TREND: No statistically significant change since 2013.
- Most current smokers (68.9%) have been advised by a healthcare professional in the past year to quit smoking.

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers) Healthy People 2020 Target = 80.0% or Higher

Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 56-57] 2015 PRC National Health Survey, Professional Research Consultants, Inc. US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-4.1]

Notes: • Asked of respondents who smoke cigarettes every day.

Other Tobacco Use

Electronic Cigarettes

A total of 3.4% of MMH Service Area adults currently use electronic cigarettes ("ecigarettes"), either regularly (1.0% every day) or occasionally (2.4% on some days).

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]

Notes: • Asked of all respondents.

- Similar to national findings.
- Similar by county.

Asked of all respondents.

Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

• Note the negative correlation between age and e-cigarette use in the MMH Service Area.

Currently Use Electronic Cigarettes

Asked of all respondents.

· Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households

with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Cigars & Smokeless Tobacco

A total of 2.6% of MMH Service Area adults use cigars every day or on some days.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).
- Higher in Ripley County.
- TREND: No statistically significant change since 2013 (not shown).

A total of 7.5% of area adults use some type of smokeless tobacco every day or on some days.

- Higher than state and national percentages.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- Comparable by county.

Examples of smokeless tobacco include chewing

tobacco, snuff, or "snus."

• TREND: Statistically unchanged over time (not shown).

Other Tobacco Use

Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a "moderate problem" in the community.

Perceptions of Tobacco Use as a Problem in the Community

(Key Informants, 2016)

 Major Problem
 Moderate Problem
 Minor Problem
 No Problem At All

 37.4%
 46.0%
 10.1%
 6.5%

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

Top Concerns

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

Prevalence/Incidence

In 2013 our smoking rates were higher than the national average and well above the Healthy People 2020 goal. With our high incidence of esophageal cancer and COPD, my assumption is our rates continue to be higher than average currently. – Other Health Provider

Often see either the patient or someone in the household that is a smoker. Even through several smoking cessation offerings, the attempts often fail; therefore, smoking remains and becomes a part of the children's lifestyle, also. They are exposed with secondhand smoke at an early age and often become smokers themselves. – Other Health Provider

Many people in the community smoke or chew tobacco. When going to any outdoor event, there are continuously people using one of these substances. – Community Leader

Seems many patients and families coming to the hospital who report smoking and have odor of smoke on clothing. – Other Health Provider

Nineteen percent of new moms are still smoking. See more teenagers smoking and parents smoking, so it becomes culturally okay. – Community Leader

Many community residents continue to smoke tobacco, despite the health risks. - Community Leader

Even one person smoking is still too many. - Other Health Provider

Large smoking population and lack of education. - Other Health Provider

I see more young people using tobacco. - Community Leader

Observation of number of smokers and number of young smokers I encounter. – Social Services Provider

Smoking numbers in SE Indiana. - Physician

High volume of people smoke, and men especially chew. - Community Leader

Co-Occurrences

Tobacco seems to be causing respiratory illness and killing people. – Community Leader Depression is high. Weather is poor. Smoking is related to both. – Other Health Provider

Easily Accessible

I feel that cigarettes and tobacco products are easily accessible. Although our percentages for smoking are lower, it is still a major health problem for the community. – Public Health Representative

Affordable Care/Services

Smoking cessation aids are expensive. - Public Health Representative

Vulnerable Populations

Smoking is still a major health issue with low-income individuals. – Social Services Provider Low socioeconomic society that uses it as a crutch and something to do. – Other Health Provider

Health Education

Ignorance. – Physician

Access to Health Services

Professional Research Consultants, Inc.

Health Insurance Coverage

Type of Healthcare Coverage

A total of 76.1% of MMH Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 15.6% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

^{• 2016} PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190] Sources: · Reflects respondents age 18 to 64 Notes:

A total of 7.9% of residents under 65 with private coverage or Medicaid secured their coverage under the Affordable Care Act (ACA), otherwise known as "Obamacare."

- Lower than the national finding.
- Note the 61.2% of affirmative responses among adults with Medicaid compared with privately insured individuals (5.2%).

Insurance Was Secured Under the Affordable Care Act/"Obamacare"

2015 PRC National Health Survey, Professional Research Consultants, Inc. Notes:

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

Asked of all respondents under 65 with private insurance or Medicaid.

Lack of Health Insurance Coverage

Among adults age 18 to 64, 8.2% report having no insurance coverage for healthcare expenses.

- Well below the state finding; note, however, that state data predate the implementation of the health insurance marketplace.
- Similar to the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).

Lack of Healthcare Insurance Coverage

- Similar by county.
- TREND: Statistically similar to 2013 findings.

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 190]

- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

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

> MMH Service Area residents living at lower incomes are more likely to be without healthcare insurance coverage.

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services - neither private insurance nor governmentsponsored plans (e.g., Medicaid).

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64; MMH Service Area, 2016) Healthy People 2020 Target = 0.0% (Universal Coverage)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190] • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

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

Income clear or long o

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

Healthy People 2020 (www.healthypeople.gov)

This indicator reflects the

in the past year, regardless of

whether they needed or sought

percentage of the total population experiencing problems accessing healthcare

care.

Difficulties Accessing Services

A total of 33.8% of MMH Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Comparable to national findings.
- Comparable findings by county.
- TREND: Similar to the percentage reported in 2013.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 194]

2015 PRC National Health Survey, Professional Research Consultants, Inc.

Asked of all respondents

Notes:

• Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups <u>more often</u> report difficulties accessing healthcare services:

- Adults under the age of 65.
- Lower-income residents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(MMH Service Area, 2016)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]

Asked of all respondents.

Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

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

Barriers to Healthcare Access

Of the tested barriers, inconvenient office hours impacted the greatest share of MMH Service Area adults (14.4% say that this prevented them from obtaining a visit to a physician in the past year).

- The proportion of service area adults impacted was statistically comparable to or better than that found nationwide for each of the tested barriers.
- Higher in Franklin County for getting a doctor's appointment and finding a doctor.

Barriers to Access Have Prevented Medical Care in the Past Year

To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Prescriptions

Among all MMH Service Area adults, 9.2% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Comparable to national findings.
- Comparable by county.
- TREND: Denotes a statistically significant decrease over time.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

Adults more likely to have skipped or reduced their prescription doses include:

- Adults age 40 and older.
- · Respondents with lower incomes.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money (MMH Service Area, 2016)

Asked of all respondents.

Notes:

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

Accessing Healthcare for Children

A total of 0.9% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Well below that reported nationwide.
- Comparable by county.
- TREND: Statistically unchanged since 2013.

Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 136-137] 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents with children 0 to 17 in the household

Among the parents experiencing difficulties, the majority cited inconvenient office hours and availability as the primary reasons; others cited cost or lack of insurance.

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

Key Informant Input: Access to Healthcare Services

Key informants taking part in an online survey most often characterized *Access to Healthcare Services* as a "moderate problem" in the community.

Perceptions of Access to Healthcare Services as a Problem in the Community

(Key Informants, 2016)

Major F	Problem	Moderate Problem	Minor Problem	No Pro	blem At All
16.2%		35.9%	28.9%		19.0%

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Access to Providers

Lack of capacity for general practitioners to accept new patients. And even once secured, the ability to timely treat patients. – Community Leader

Need to establish primary care doctors and ability to be seen within quickly. Currently we have too many people in our counties without an established medical doctor. They use the emergency room as a physician office, driving up costs and creating wait times for emergencies. And if the patients do call for appointments, it takes too long to get a new patient appointment with a primary care doctor. Also need to look at the age of our primary care physicians. – Other Health Provider

Patients seen in the emergency room at Margaret Mary Health and need follow-up are seen within 48 hours, regardless of their access to primary care. They are then integrated into the PCMH or engaged with their assigned primary care provider, while attempting to decrease the probability of a follow-up emergency room visit or admission. – Physician

Access to Care/Services

Access to healthcare and not enough providers. Not enough healthcare nurses to help with educating patients and give them resources they need. – Other Health Provider

Having access to health care and compliance from parents. - Other Health Provider

The biggest challenge that I see in Franklin County is that there is not a hospital present in our county. The other issue that I see relates to living in a rural community, with a lot of dependency on volunteer types agencies such as EMS, fire, etc. Transportation has posed some restraints. Lack of jobs and, therefore, underinsured or uninsured. – Other Health Provider

Transportation

Transportation/work schedules prohibiting ability to schedule appointments, lack of insurance coverage and no child care. – Other Health Provider

Transportation issues, no physicians to accept Medicaid patients, lack of dental services and lack of mental health services. – Public Health Representative

Distance to 24 hour emergency care. - Community Leader

Vulnerable Populations

Our underserved student population does not have consistent access to health care outside of the services provided by school nurses. – Community Leader

Substitute school nurses leaves the students vulnerable when the current school nurses get sick or have matters to attend to. There is no coverage, leaving the responsibility to teachers, principals or clerical staff. – Other Health Provider

Affordable Care/Services

Affordable health care for adults. Transportation to health care and specialty health care closer to home. – Public Health Representative Costs. – Physician

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified **substance abuse treatment** as the most difficult to access in the community, followed by **mental health services** and **primary care**.

Medical Care Difficult to Access Locally							
	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions			
Substance Abuse Treatment	39.1%	19.0%	14.3%	16			
Mental Health Services	13.0%	33.3%	4.8% 11				
Primary Care	17.4%	14.3%	9.5%	9			
Chronic Disease Care	8.7%	4.8%	19.0%	7			
Dental Care	4.3%	14.3%	4.8%	5			
Specialty Care	4.3%	4.8%	9.5%	4			
Urgent Care	4.3%	0.0%	9.5%	3			
Prenatal Care	0.0%	4.8%	9.5%	3			
Elder Care	0.0%	4.8%	4.8%	2			
Palliative Care	0.0%	0.0%	9.5%	2			
Hospice Care	4.3%	0.0%	0.0%	1			
Pediatric Care	4.3%	0.0%	0.0%	1			
Pain Management	0.0%	0.0%	4.8%	1			

Health Literacy

Understanding Health Information

Written & Spoken Information

When asked about the frequency with which health information is <u>written</u> in an easily understood way, 56.6% of MMH Service Area adults said "always" or "nearly always."

• On the other hand, 43.4% of MMH Service Area adults consider **written** health information to be difficult to understand, including 4.2% who gave "never" reports.

When asked about <u>spoken</u> health information, 77.0% stated that this is "always" or "nearly always" easy for them to understand.

• On the other hand, 23.0% of MMH Service Area adults consider **spoken** health information to be difficult to understand, including 2.7% who gave "never" reports.

Understanding Health Information

(MMH Service Area, 2016)

 Sources:
 • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87, 89]

 Notes:
 • Asked of all respondents.

Help Reading Health Information

A total of 76.6% of MMH Service Area adults report "seldom" or "never" needing help reading health information.

- Another 20.7% of community adults "sometimes" need someone to help them read health information.
- Note that 2.8% of residents "always" or "nearly always" need help reading health information.

Respondents were read:

"You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor's office, in clinics, and many other places.

How often is health information <u>written</u> in a way that is easy for you to understand?

How often is health information **<u>spoken</u>** in a way that is easy for you to understand?"

Frequency of Needing Someone to Help Read Health Information

 Sources:
 • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]

 Notes:
 • Asked of all respondents.

Completing Health Forms

Asked to describe their confidence in filling out health forms, most survey respondents are "extremely confident" (60.6%).

- Another 37.9% of community adults are "somewhat confident" in their own ability to fill out health forms.
- However, 1.5% of respondents gave "not at all confident" ratings.

Self-Perceived Confidence in Ability to Fill Out Health Forms (MMH Service Area, 2016)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 90]

- Notes: Asked of all respondents
 - In this case, health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

Examples of health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.
Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/ nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms

Population With Low Health Literacy

Among MMH Service Area survey respondents, 11.6% are considered to be of high health literacy, while 73.0% have medium health literacy, and the remaining 15.4% are considered to be of low health literacy.



Notes:

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

Asked of all respondents.

Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

- The prevalence of MMH Service Area adults with low levels of health literacy is lower than the national average.
- The prevalence does not vary significantly by county.



Low Health Literacy

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

2015 PRC National Health Survey, Professional Research Consultants, Inc.

 Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Asked of all respondents. Notes:

These local adults are more likely to have low health literacy levels:

- Men.
- Older residents (positive correlation with age).



Low Health Literacy

Asked of all respondents.

Notes:

- · Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always"
- need help reading health information, and/or who are "not at all confident" in filling out health forms.

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- · Greater patient trust in the provider
- Good patient-provider communication
 Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

In the MMH Service Area in 2012, there were 21 primary care physicians, translating to a rate of 40.7 primary care physicians per 100,000 population.

- Well below the primary care physician-to-population ratios found statewide and nationwide.
- The rate is notably lower in Franklin County.



Access to Primary Care

(Number of Primary Care Physicians per 100,000 Population, 2012)

Sources: • US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.

Notes:

Retrieved July 2016 from Community Commons at http://www.chna.org.
 This indicator is relevant because a shortage of health professionals contributes to access and health status issues

 TREND: Access to primary care (in terms of the ratio of primary care physicians to population) has decreased since 2009 in the MMH Service Area but is still significantly higher than what was reported in 2002. The state and national ratios have increased in recent years.



Trends in Access to Primary Care (Number of Primary Care Physicians per 100,000 Population)

• US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. Sources:

Notes:

• This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

• These figures represent all primary care physicians practicing patient care, including hospital residents. In counties with teaching hospitals, this figure may differ from the rate reported in the previous chart.

Specific Source of Ongoing Care

A total of 73.9% of MMH Service Area adults were determined to have a specific source of ongoing medical care.

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 objective (95% or higher).
- Similar by county.
- TREND: Statistically unchanged since 2013.

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patientcentered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

Retrieved July 2016 from Community Commons at http://www.chna.org.



Have a Specific Source of Ongoing Medical Care

Healthy People 2020 Target = 95.0% or Higher

When viewed by demographic characteristics, the following population segments are <u>less</u> <u>likely</u> to have a specific source of care:

- Women.
- Adults under age 65 (positive correlation with age).



Have a Specific Source of Ongoing Medical Care

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes: • Asked of all respondents.

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

Utilization of Primary Care Services

Adults

Two-thirds of adults (67.9%) visited a physician for a routine checkup in the past year.

- Comparable to state and national findings.
- Comparable by county.
- TREND: Statistically similar to 2013 findings.



Have Visited a Physician for a Checkup in the Past Year

 Adults under age 40 are <u>less likely</u> to have received routine care in the past year (note the positive correlation with age), as are upper-income residents.



Have Visited a Physician for a Checkup in the Past Year (MMH Service Area, 2016)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]

Notes:
 Asked of all respondents.

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

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.
 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
 Asked of all respondents.

Children

Among surveyed parents, 87.2% report that their child has had a routine checkup in the past year.

- Similar to national findings.
- Higher in Franklin County.
- TREND: Statistically similar to 2013 findings.



Child Has Visited a Physician for a Routine Checkup in the Past Year

 Sources:
 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 138]
 2015 PRC National Health Survey, Professional Research Consultants, Inc.

 Notes:
 Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 5.4% of MMH Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Well below national findings.
- Higher in Franklin County.
- TREND: Statistically unchanged over time.



Have Used a Hospital Emergency Room More Than Once in the Past Year

Of those using a hospital ER, 62.9% say this was due to an **emergency or life-threatening situation**, while 25.6% indicated that the visit was during **after-hours or on the weekend**. A total of 8.3% cited **difficulties accessing primary care** for various reasons.

These population segments are more likely to have used an ER for their medical care more than once in the past year:

- Seniors (positive correlation with age).
- Low-income residents.



Have Used a Hospital Emergency Room More Than Once in the Past Year

(MMH Service Area, 2016)

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22] Notes:

Asked of all respondents.

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

Advance Directives

A total of 30.2% of MMH Service Area adults have completed Advance Directive documents.

- The prevalence is similar to the US figure.
- Similar findings by county.



Have Completed Advance Directive Documents

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 85] Sources:

Asked of those respondents age 45 and older.

An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions Formal Advance Directives include Living Wills and Health Care Powers of Attorney

Note the positive correlation with age in the service area.



Have Completed Advance Directive Documents

Notes:

• Asked of those respondents age 45 and older.

 An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Health Care Powers of Attorney.

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

An Advance Directive document is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

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 ²⁰¹⁵ PRC National Health Survey, Professional Research Consultants, Inc. Notes:

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use;** excessive alcohol use; and poor dietary choices.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.
- Healthy People 2020 (www.healthypeople.gov)

Dental Insurance

Over 6 in 10 MMH Service Area adults (64.1%) have dental insurance that covers all or part of their dental care costs.

- Similar to the national finding.
- Lower in Franklin County.
- TREND: Statistically unchanged since 2013.



Have Insurance Coverage That Pays All or Part of Dental Care Costs

These adults are less likely to be covered by dental insurance:

- Seniors.
- Low-income adults.

Have Insurance Coverage That Pays All or Part of Dental Care Costs (MMH Service Area, 2016)



Notes: • 2016 PRC Community He Notes: • Asked of all respondents.

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

Dental Care

Adults

A total of 66.0% of MMH Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- Better than statewide findings.
- Comparable to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Comparable by county.
- TREND: Statistically unchanged since 2013.

Healthy People 2020 Target = 49.0% or Higher 100% MMH Service Area 80% 67.2% 66.0% 66.0% 66.0% 66.0% 63.5% 61.5% 60% 40% 20% 0% Franklin Ripley MMH Service IN US 2013 2016 County County Area

Dental Clinic Within the Past Year

Have Visited a Dentist or

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20] 2015 PRC National Health Survey, Professional Research Consultants, Inc. US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Indiana data.

Notes: Asked of all respondents.

Note the following:

- Service area men are less likely than women to have visited a dentist in the past year.
- There is a negative correlation between age and recent dental visits.
- Persons living in the higher income categories report much higher utilization of oral health services (low-income adults fail to satisfy the Healthy People 2020 target).
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.



Have Visited a Dentist or **Dental Clinic Within the Past Year**

(MMH Service Area, 2016)

Healthy People 2020 Target = 49.0% or Higher

• 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Asked of all respondents.

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

Children

Notes:

A total of 82.3% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Less favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Similar findings by county.
- TREND: Marks a statistically significant decrease in children's dental care since 2013.



Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children Age 2-17) Healthy People 2020 Target = 49.0% or Higher

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 141]

2015 PRC National Health Survey, Professional Research Consultants, Inc.

US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes: • Asked of all respondents with children age 2 through 17

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized Oral Health as a "moderate problem" in the community.

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2016)

Major	Problem	Moderate Problem	Minor Problem	No Proble	m At All
15.4%		35.4%	33.8%		15.4%

• PRC Online Key Informant Survey, Professional Research Consultants, Inc. Sources:

Notes: Asked of all respondents.

Top Concerns

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

Access to Services

Lack of providers willing and able to keep up with latest methods, equipment and training. -Community Leader

Lack of providers, lack of finances and insurance for families. - Other Health Provider

There is no access of dental care for families in our community. We have one dentist office in town, and they do not except Medicaid or Hoosier Healthwise. - Other Health Provider

I haven't been able to find a dentist with modern equipment or nearby. - Social Services Provider

There are only private practices, and resources for vulnerable population seem to be nonexistent. -Community Leader

Medicaid

There is a lack of dental staff who will assist with Medicaid patients or those needing to schedule payments for care. – Public Health Representative

The only local dentist who took pediatric Medicaid patients is no longer accepting, due to poor reimbursement (no increase in 20 years). For the same reimbursement issues, Margaret Mary Health no longer allows them to schedule OR time. Those patients requiring extensive dental hygiene or surgery must now travel to Cincinnati Children's, and travel is a barrier for many of the at-risk population. School-based dental care is not a replacement for a dental home. This lack of dental access is going to adversely impact the adult population health of Batesville in 10-20 years. – Physician

Not enough dentists who take state insurance. - Other Health Provider

Poor Dental Hygiene

The number of students who do not see a dentist annually or biannually is an issue. The issue is magnified by diets high in sugars and low in nutrition. – Community Leader

Poor dental hygiene. High numbers of dentures. Personal lack of interest or self-care. Laziness. Poor parenting. – Physician

Affordable Care/Services

Affordability is a barrier for those who are of moderate income, and low income individuals have a difficult time finding providers. Without reliable transportation or easily-accessible public transportation, most low/moderate families cannot access dental care. – Social Services Provider

Vision Care

RELATED ISSUE:

See also <u>Vision & Hearing</u> in the **Death, Disease & Chronic Conditions** section of this report. A total of 58.5% of MMH Service Area residents had an eye exam in the past two years during which their pupils were dilated.

- Statistically comparable to national findings.
- Comparable findings by county.
- TREND: Statistically unchanged over time.



Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

- Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 19]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
 Asked of all respondents.

Recent vision care in MMH Service Area is more often reported among:

- Women.
- Older residents (positive correlation with age).

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(MMH Service Area, 2016)



^{• 2016} PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]

Asked of all respondents.

Notes:

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

Local Resources



Professional Research Consultants, Inc.

Perceptions of Local Healthcare Services

A total of 2 in 3 MMH Service Area adults (67.6%) rate the overall healthcare services available in their community as "excellent" or "very good."

• Another 5.1% gave "good" ratings.



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6] • Asked of all respondents.

However, 7.3% of residents characterize local healthcare services as "fair" or "poor."

- Well below that reported nationally.
- Similar by county.
- TREND: Statistically unchanged over time.



Perceive Local Healthcare Services as "Fair/Poor"

The following residents are more critical of local healthcare services:

- Men.
- Seniors.

Perceive Local Healthcare Services as "Fair/Poor"



Sources: Notes:

Asked of all respondents.

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

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map details the hospitals and Federally Qualified Health Centers (FQHCs) within the MMH Service Area as of September 2015.



Hospitals and Federally Qualified Health Centers, POS Sept. 2015

Resources Available to Address the Significant Health Needs

Incorporating input from community stakeholders taking part in the Online Key Informant Survey, the following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

Brookville Healthcare Center Catch a Ride Charity Care Child Care and Development Fund Community Mental Health Center Dearborn County Hospital Doctor's Office Fayette Regional Health Plex FC Senior Center Free Clinic Hospitals Kings Daughters Hospital and Clinic Lifetime Resources Lion's Club Margaret Mary Health Margaret Mary Health Diabetes Program Margaret Mary Health Physicians Osgood Primary Care Public Transportation Reid Hospital **Ripley County Health Department** Rural Health Clinic School System Southeastern Indiana Health Clinic The Smile Program Tri County Ambulance Urgent Care

Arthritis, Osteoporosis & Chronic Back Conditions

Batesville Clinic Beacon Orthopedics Chiropractic Care Doctor's Office Health Coaches Margaret Mary Health Margaret Mary Health Rehabilitation Margaret Mary Health Weight Management School System

Cancer

1-800-Quit Line American Cancer Society Cancer Center Doctor's Office Farmer's Market Fayette County Hospital Franklin County Cancer Assistance Now Free Screeninas Hansen Center Health Screenings Margaret Mary Health Margaret Mary Health Cancer Center Margaret Mary Health Mammograms Margaret Mary Health Nutrition Services Margaret Mary Health Weight Management Nutritional Services Relay for Life School System YMCA

Chronic Kidney Disease

Devita Dialysis Doctor's Office Nursing Home

Dementias, Including Alzheimer's

Disease

Brookville Healthcare Center Margaret Mary Health Support Groups Nursing Home St. Andrews Support Groups

The Waters

Diabetes

Decatur County Memorial Hospital Diabetes Forecast Magazine Diabetic Care Doctor's Office Health Coaches Home Health Care Lifetime Resources Margaret Mary Health Margaret Mary Health Diabetes Program Margaret Mary Health Nutrition Services Nutritional Services Online Resources School System Southeastern Indiana Health Clinic Trainers Weight Watchers YMCA

Family Planning

Association of Families First Batta Counseling Brookville Pregnancy Center Centerstone Department of Child Services Franciscan Counseling Services Health Department Hotline Phone Number LifeWorks Ripley County Health Department

Heart Disease & Stroke

Cardiac Care Christ Hospital Community Mental Health Center Doctor's Office Employers Free Clinic Health Fair Kings Daughters Hospital and Clinic Margaret Mary Health Margaret Mary Health Margaret Mary Health Diabetes Program Margaret Mary Health Diabetes Program Margaret Mary Health Physicians Margaret Mary Health Smoking Cessation Osgood Primary Care Urgent Care

HIV/AIDS

Margaret Mary Health

Immunization & Infectious Diseases

Margaret Mary Health Margaret Mary Health Wellness Program Ripley County Health Department Urgent Care

Infant & Child Health

Batta Counseling Children's Health Care Churches Community Mental Health Center Doctor's Office Margaret Mary Health Nutrition Services Osgood Primary Care School System SEEK screening WIC

Mental Health

Batta Counseling Centerstone Choices Churches Cincinnati Children's Hospital Community Mental Health Center Doctor's Office Faith Based Communities Franciscan Counseling Services Hospitals Lawrenceburg Mental Health LifeWorks Margaret Mary Health Margaret Mary Health Behavioral Health Mental Health Providers One Community One Family Riley School System SEIOC Southeastern Indiana Health Clinic

Nutrition, Physical Activity & Weight

Anytime Fitness Batesville Liberty Park Batesville Memorial Pool Brum Woods Celebrate Recovery Doctor's Office Employers Farmer's Market Fitness Centers/Gyms Health Centers Health Coaches HMR Hospitals Margaret Mary Health Margaret Mary Health Nutrition Services Margaret Mary Health Weight Management **Overeaters Anonymous** Parks and Recreation Personal Fitness Devices Right Way Fitness Romm Weber School System Slim Down Now Sports and Activity Centers Third Space Weight Watchers YMCA

Oral Health

Children's Dental Care Cincinnati Children's Hospital County Trustees Dentist's Office Margaret Mary Health Mobile Dentist School System The Smile Program

Respiratory Diseases

1-800-Quit Line Decatur County Memorial Hospital Doctor's Office Margaret Mary Health Margaret Mary Health Pulmonary Services Margaret Mary Health Smoking Cessation Osgood Primary Care Smoking Cessation

Sexually Transmitted Diseases

Churches Community Mental Health Center Margaret Mary Health Southeastern Indiana Health Clinic

Substance Abuse

AA/NA Batesville Christian Church Batesville Drug Free Coalition Behavioral Health Services Bethesda Oak **Better Options** Brookville United Methodist Church Centerstone Coalition for a Drug Free Batesville Community Awareness Organizations Community Mental Health Center County Courts Decatur County Memorial Hospital Doctor's Office Drug Rehabilitation Centers Fear Factory Events Gateways Here's Hope Hospitals Jail Linder Center of Hope Margaret Mary Health Mental Health Providers Police Department Recovery Community Recovery Group Ripley County Drug Awareness Coalition Ripley County Health Department School System Social Workers Stavin' Alive Valle Vista Youthquake

Tobacco Use

1-800-Quit Line American Cancer Society Baby and Me Tobacco Free Batesville Drug Free Coalition Coalition for a Drug Free Batesville Community Mental Health Center Cooper Clayton Decatur County Memorial Hospital Doctor's Office Employers Hospitals Indiana Quitline Indiana Smoking Cessation Margaret Mary Health Margaret Mary Health Pulmonary Services Margaret Mary Health Smoking Cessation Mental Health Providers Ripley County Drug Awareness Coalition Ripley County Health Department SEIOC Statewide Initiatives Stayin' Alive WorkOne Youthquake

Appendix Professional Research Consultants, Inc.

Evaluation of Past Activities & Outcomes

PRIORITY 1: ACCESS TO CARE

Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care and prescription medicines.

Recruitment efforts

2014	2015	2016	
 Dr. Michelle Shorten, MD (Family Practice) Marcy Baumer, PA (Family Practice) Dr. Daniel Shirley, DO (Anesthesia) 	 Dr. Duncan Hamilton, DO (General Surgery) Dr. Olga Petrovic, MD (Rheumatology) Dr. Raheem Nazeer, MD (Rheumatology) Dr. James Connors, DPM (Podiatry) Trisha Candelot, CFNP (OB/Gyn) Dr. Stephen Rush, MD (Behavioral Health) 	 Dr. Richard Turner, MD (Pediatrics) Dr. Kristina Wang, MD (Pediatrics) Dr. Kenneth Pahren, MD (Emergency Medicine/Minor Care) Jeff Coy, ANS (Primary Care) Christine Romani, FNP (Primary Care) Jennifer Couchin, FNP (Primary Care) 	

- Acquired and opened new practice location in Brookville offering Minor Care and Primary Care, Lab and Imaging services.
- Implemented Hospitalist Program in November, 2015.
- Implemented Team Care approach starting in February, 2015 in the physician offices. Allowed MMH to increase visits by 15%.
- Open access appointments and expanded hours in the physician offices.
- Schedule patient appointments within 2 weeks of request.
- Implemented Diabetes and Intensive Behavior Therapy (IBT), 2016 in two of the physician offices.
- Implemented Clinical Health Coaching in October, 2015. We currently have 16 trained coaches.
- Recruited and implemented Behavioral Health Services in October, 2015 and expanded to an additional practice in October, 2016.
- NRACO efforts allowed for the coordination of care with two designated nurses leading the efforts.
- Provided financial and in-kind support to the Southeast Indiana Health Center.
- Answered more than 2,900 Ask a Nurse calls. (2014 & 2015 only)

PRIORITY 2: SUBSTANCE ABUSE

To educate citizens in both Ripley and Franklin Counties about substance abuse issues and encourage citizens to make healthy choices; therefore, decreasing the use of alcohol and other drugs in our youth in Ripley and Franklin County.

- Margaret Mary Health was the first hospital in Indiana to perform maternal drug testing in our maternity department (2014). Of the 475 deliveries (2014, 2015 & 2016 to date) and only 2 have refused testing.
- Prevention efforts included the following drug awareness and educational programs:

- Provided Drug and Alcohol Education to 420 local middle school aged children. (2015)
- Implemented 'Get Real about Tobacco' in the local schools. (2016)
- Provided 'Hidden in Plain Sight'. The purpose is to educate parents and guardians about the common places that drugs can be hidden in plain sight. (2015, 2016)
 - Reached 96 people with 30 wanting home drug testing kits. These events were held at MMH, Oldenburg Academy and South Ripley High School.
- Provided drug education to 1,248 community members at numerous events. (2016)
- Provided grants to Franklin County schools to support their Red Ribbon Week activities. (2015, 2016)
- Partnered with local organizations to provide education and awareness.
 - Critical Issues about Heroin. (2016)
 - Lunch and Learn on Marijuana. (2016)
 - State of the Street Address. (2016)
 - National Night Out. (2014, 2015 & 2016)
 - Annual Chad Varga community engagement. (2014, 2015 & 2016)
 - BOUNCE curriculum to 2 local schools.
 - Home health workers training on drug awareness and safety.
 - CASA flyers (How to talk to your teen about drugs) distribution. (2016)
- Expanded our partnerships with the following organizations to address the identified drug issues in our community: Local police and sheriff departments, private and public schools, all three local drug coalitions, City of Batesville, Rotary Club and Better Options. This list is not all inclusive and represents a sampling of our current partners.
- Presented at a state conference regarding partnering between hospitals and coalitions. (2016)
- Family Fun Night served more than 500 people in the community for drug prevention efforts. (2016)
- Developed and promoted drug disposal in community. Over 784 pounds collected.
 - Installed a Drug Drop-Off Box at the hospital for unused or expired medications disposal. (2014)
 - Drug Drop-Off Drive Thru event for Ripley County (2015) and Franklin County. (2016)
- Provided a meeting space for Alcoholics Anonymous and Al-Anon to meet. (2014, 2015 & 2016)
- Provided 2 Alco Blow devices to Oldenburg Academy. (2015)
- Purchased Narcan and trained four local law enforcement departments (2015). We have agreed to provide this program for the next 3 years.
- Protect your Family was created in 2015. We have over 8 locations that provide the drug testing kits. A total of 295 home drug testing kits have been provided.
- Developed and distributed a drug resource packet for local physicians.
- Provided INSPECT training for local physicians.
- Collaborate with local coalitions and task forces to address drug prevention, education and awareness:
 - Ripley County Drug Awareness Coalition
 - Franklin County Stayin' Alive
 - Coalition for a Drug Free Batesville
 - Hepatitis C and HIV Task Force
- Provided over 1,800 Sharps containers to community members (2014, 2015 & 2016) to ensure proper needle disposal.

PRIORITY 3: NUTRITION AND PHYSICAL ACTIVITY

Reduce the proportion of adults, children and adolescents who are considered obese.

- Walking Club is a program where we partner with local schools to allow community members to continue to get physical activity during the winter months in the school hallways.
 - In 2014 and 2015, we saw an increase of 10% and 31.5% over the previous year.
- Provided HMR classes to 916 individuals. The medically supervised weight loss program continually performs at or above the national average for similar clinics. (2014, 2015 & 2016)
- 426 participated in the 'Slim Down Now' classes. (2014, 2015 & 2016)
- 42 participated in the 'Count Me In' program (2014, 2015 & 2016) which is a four week series for kids ages 5-12. The program includes cooking demonstrations, interactive games and food tastings.
- 89 attended 'Baby under Construction' (2014, 2015 & 2016). This is a free class for pregnant women who want to learn about healthy weight gain and diet during pregnancy.
- 96 people attended our cooking fair.
- Provided two 5k run/walk events in the community where 1,331 participated. (2014, 2015 & 2016)
- 1,263 girls participated in the Girls on the Run program. (2014, 2015 & 2016)
- 1,500 children attended Farm Fit. (2014, 2015 & 2016)
- Partnered with local schools to provide a Farm to School program. This includes planting and caring for gardens, taste testing of their efforts and teaching students to eat healthy.
- 680 students participated in the indoor grow labs. (2014, 2015 & 2016)
- 600 students participated in the food tastings. Each year there is a different vegetable. (2014, 2015 & 2016)
 - Partnered with local organizations to provide Velo in the Ville Get Psyched about Bikes bike ride. (2015, 2016)
 - Partnered with local schools to host Neon Night. More than 420 people participated in a glow-in-the-dark activity that included completing laps around the track. (2015, 2016)
 - Proceeds went toward exercise equipment to be used on walking trails.
 - Host Nutritionally Yours, a weekly radio show.
 - Nearly 3,000 community members received nutrition education through various events. (2014, 2015 & 2016)
 - Opened a paved trail at our campus along Six Pine Ranch Road.
 - Serving local foods in our cafeteria.
 - Hosted a mid-week farmers market which continues to grow. (2015, 2016)
 - Hosted a program for picky and problem eaters. This is designed to get people to try new food, to eat the correct foods and stay within your portion. (2015, 2016)
 - Provided a meeting space for the Overeaters Anonymous. (2014, 2015 & 2016)

PRIORITY 4: CANCER

Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.

- Provided cervical screenings to perform pap smears and breasts exams to help detect earlier onset of cancer. In 2014, we had an increase in 62.5% served. (2014,2015 & 2016)
- Provided free prostate cancer screenings to 212 men. (2014, 2015 & 2016)
- Provided over 60 free screening mammograms. (2014, 2015 & 2016)
- Provided skin cancer screenings with over 60 people screened. (2014)
- Raising awareness for colon cancer at various events by providing information and testing kits. Participation increased by 120% in 2015 over 2014.
- Raising awareness for colon cancer screenings by distributing toilet paper. (2016)
- 693 have attended our Think Pink awareness and survivorship event. (2014, 2015 & 2016)
 - Cancer Boutique opened in 2015 features wig fittings, mastectomy prosthesis fittings by certified fitter.
- 156 people attended the HOPE Support Group. (2014, 2015 & 2016)
- 138 people attended the Breast Cancer Support Groups. (2014, 2015 & 2016)
- 12 people attended the Building Strength Program. (2014, 2015 & 2016)
- 25 people attended the Look Good Feel Better sessions. (2014, 2015 & 2016)
- 152 people attend the Grief support program. (2014, 2015 & 2016)
- Increased referral and support services program for cancer care.
 - Hosted focus groups to enhance oncology support services.
 - 547 people were provided financial advocacy.
 - 896 people were provided psychosocial support.
 - Caregiver workshops.
- Participated in Relay for Life for Ripley and Franklin Counties.
- Participate in the Indiana Cancer Consortium and received the Employee Gold Standard in 2015.
- Send yearly reminders for mammograms.
- Targeted preventive messaging through the Portal.
- 'Get Real about Tobacco' Education focused on cancer prevention in the schools.
- Promote I 800-QUIT-NOW for smoking cessation needs.
- Provided HPV vaccine coverage in both the clinical and school settings. (2014,2015 & 2016)
- Women's Day of Health in Laurel and Brookville.
- Participated in the Pajama Event in Brookville.
- Implemented distress screening and survivorship care planning.
 - 25% of all eligible patients in 2016 received a survivorship care session and plan from an oncology nurse.
- A Kiazen event was conducted to improve the capacity and efficiency endoscopy procedures in the Outpatient Center.
 - Results included additional capacity, improved patient through put and increased physician and patient satisfaction.

PRIORITY 5: HEART DISEASE AND STROKE

Increase overall cardiovascular health in the U.S. population.

- Provided cardiac screenings to local high schools for their athletes.
 - 399 were screened for heart issues. (2014, 2015 & 2016)
 - Referred 24 for abnormal ECHO and 16 for abnormal EKG. (2014, 2015)
- Provided 141 vascular screenings (2014, 2015 & 2016) to help determine an individual's risk of heart disease and stroke.
 - In this population, 71% of our patients were overweight or obese, 34% were referred for an abnormal EKG, 58% were referred for some level of carotid stenosis and 28% referred for abnormal for Hemoglobin A1C.
- Cholesterol only screenings reached 428 people. (2014)
- Cholesterol screenings with individual education sessions reaching over 290 people. (2015,2016)
- Annual heart awareness dinner.
- Partnered with the YMCA for cardiac rehab. (2016)
- Donated AED and cabinet to the youth sports complex.
- Community wide CPR and AED training. (2014, 2015 & 2016)
- Blood pressure screenings reached over 3,000 people. (2014, 2015 & 2016)
- Partnership with Christ Hospital for Chest Pain Accreditation.
- Partnership with Christ Hospital for Heart Failure Accreditation.
- American Association of Cardiovascular and Pulmonary Rehabilitation Certification.
- Brain Injury Support Group. (New 2015)

PRIORITY 6: RESPIRATORY DISEASE

Increase the percentage of adults who are vaccinated against respiratory diseases.

- Provided Influenza vaccines to adults. (2014, 2015 & 2016)
 - Provided PPV23 vaccines to adults. (2014, 2015 & 2016)
- Provided Prevnar-13 vaccines to adults. (2014, 2015 & 2016)
- Inpatient standing orders for pneumonia and influenza for administration.
- Antepartum administration of Tdap.
- Promotion campaigns to family members / caregivers of infant recommending Tdap vaccination.
- Vaccine for Children and an Adult Immunization Provider.

PRIORITY 7: DIABETES

To reduce the annual number of new cases diabetes in the population and to reduce the proportion of the diabetic population with an A1C value greater than 7%.

- Increased total attendance at our diabetes screenings by 180% from 2014 to 2015.
- Increased number of new screened participants by 46% over 2014 to 2015.
- 100% referral rate for patients with an A1C greater than 7%.
- 454 received diabetes screenings and hemoglobin A1C monitoring for those already diagnosed. (2014, 2015 & 2016)
- 83 attend the Hispanic dinner event with educational information and screening.

- Recognized by the ADA diabetes outpatient program.
- Provided diabetes education in individual or group sessions.
 - 881 received diabetes education. (2014 & 2015)
 - Provided diabetes education in the offices. (New in 2016)
 - Diabetes Awareness Event. (2014, 2015 & 2016)
 - Provide meter and insulin pump downloads.

PRIORITY 8: MENTAL HEALTH AND MENTAL DISORDERS

For an individual, decrease the amount of perceived days as being "Extremely" or "Very" Stressful.

- Stop Stress This Minute program. (New 2015)
- 'Road to Wellness Program' which incorporates daily living and how to deal with stress. (New in 2015 and 2016 increased by 33%)
- Recruited and implemented Behavioral Health Services in October, 2015 and expanded to an additional practice in October, 2016.
- Referrals to Better Options for substance abuse and to Community Mental Health Center.
- Provided a meeting space for the class 'Children Cope with Divorce'. (2014, 2015 & 2016)

PRIORITY 9: TOBACCO USE

Reduce tobacco use by adults and adolescents.

- In 2015, enrolled providers in the 1-800-QUIT-NOW program.
 - We processed 25 referrals in 2015.
- New in 2016, 'Get Real About Tobacco' education in the schools for 5th or 6th grade.

PRIORITY 10: DEMENTIAS, INCLUDING ALZHEIMER'S DISEASE

Provided a Diabetes, Alzheimer's & The Brain Connection event. (2016)

PRIORITY 11: INJURY AND VIOLENCE PREVENTION

Increase age-appropriate vehicle restraint system use in children. Provide safety services to community members to reduce injuries and prevent death. Reduce the number of communicable diseases.

Provided 1,829 free Sharps containers and disposal. (2014, 2015 & 2016)

This was a 2% increase in 2015 and year to date a 10% increase.

- 1,677 attended the bike helmet safety presentations in local schools and 420 helmets purchased at a discounted price. (2014, 2015 & 2016)
- Gave away 1,926 free bike flashers. (2014, 2015 & YTD 2016)
- Sold a total of 551 bike helmets. (2014, 2015 & YTD 2016)
- Provided 147 free car seats to those who qualify. (2014, 2015 & YTD 2016)
- Certified Car Seat Station installed and /or checked 217 car seats by certified car seat technicians. (2014, 2015 & YTD 2016)
- Discounted booster seats are offered.
- Provide Halo Sleep Sacs to every infant born at MMH.

- Provide medication wallets to community members to assist with keeping a accurate record.
- Narcan training and kits provided to law enforcement.
- Permanent Drug Drop off site.
- 175 attended the Safe Sitter training. (2014, 2015 & 2016)
- Hidden in Plain Sight.

PRIORITY 12: ORAL HEALTH

• Get Real About Tobacco. (2016)