



2019 Community Health Needs Assessment Report

Franklin & Ripley Counties, Indiana

Prepared for:
Margaret Mary Health

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Introduction



Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2013 and 2016, 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 that historically have 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 PRC, Inc. PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments 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.

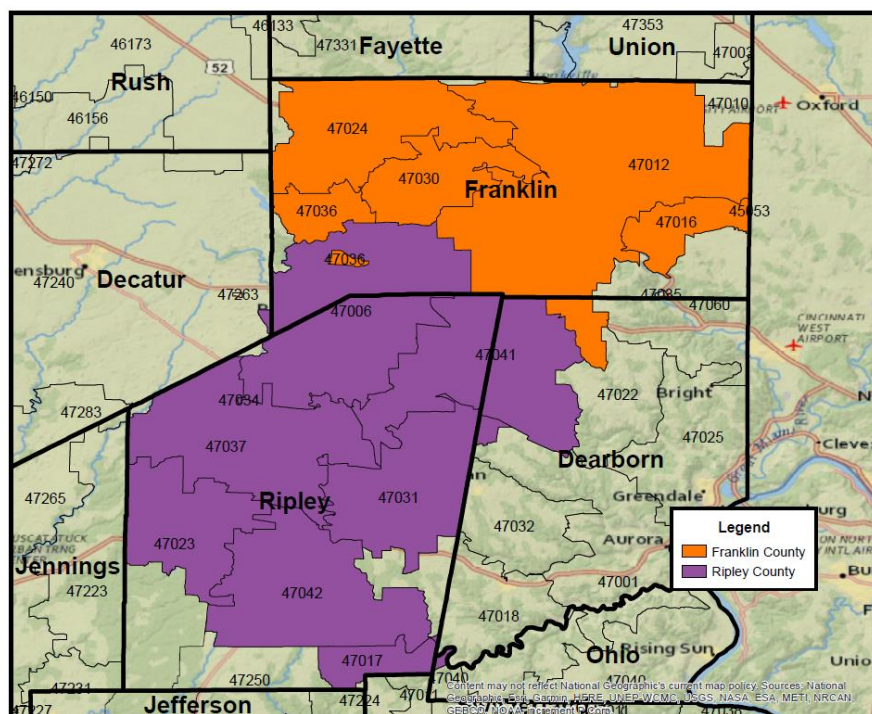
PRC Community Health Survey

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 surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “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, representing ZIP Codes from Margaret Mary Health’s primary service area (from which more than 75% of patients originate), is illustrated in the following map.



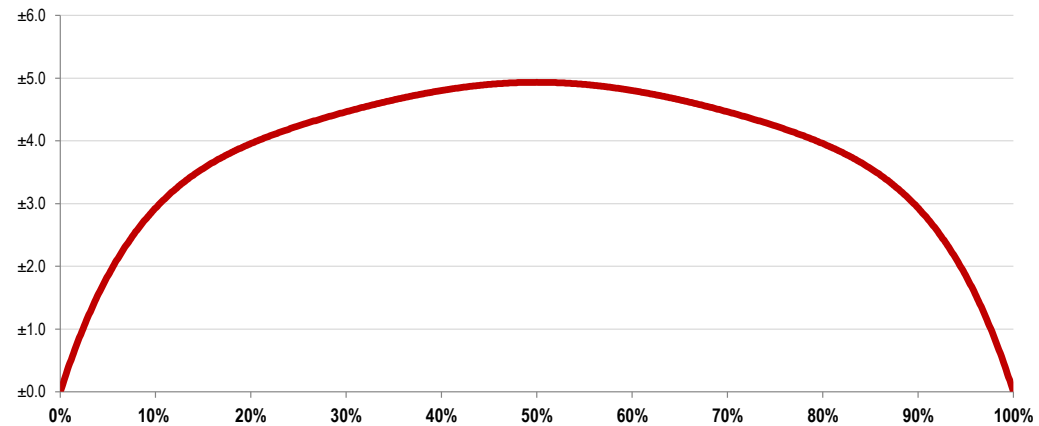
Sample Approach & Design

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 400 individuals age 18 and older in the MMH Service Area, including 200 in Franklin County and 200 in Ripley County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the MMH Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is $\pm 4.9\%$ at the 95 percent confidence level.

Expected Error Ranges for a Sample of 400 Respondents at the 95 Percent Level of Confidence



- Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.
- Examples:
- If 10% of the sample of 400 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% ($10\% \pm 2.9\%$) of the total population would offer this response.
 - If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% ($50\% \pm 4.9\%$) of the total population would respond "yes" if asked this question.

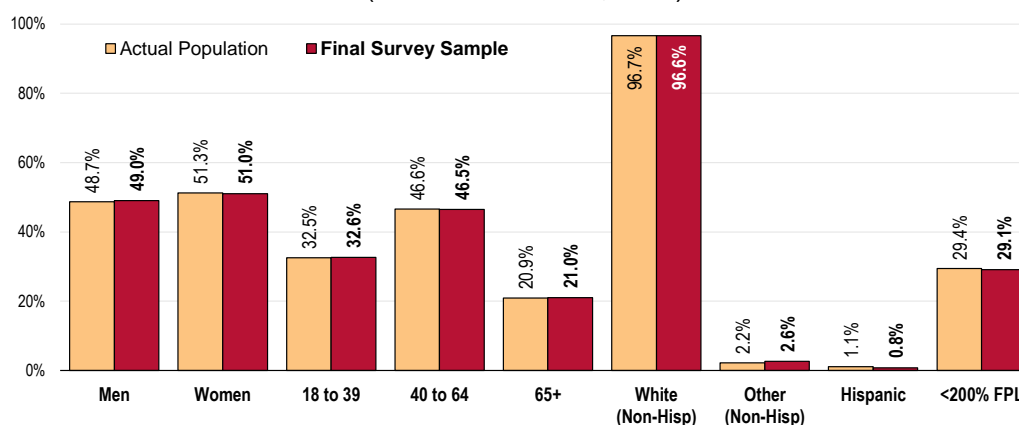
Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. 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 sex, 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 MMH 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, 2019)



Sources: • U.S. Census Bureau, 2011-2015 American Community Survey.
• 2019 PRC Community Health Survey, PRC, Inc.

Notes: • FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

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 2019 guidelines place the poverty threshold for a family of four at \$25,750 annual household income or lower*). In sample segmentation: **“low income”** refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; **“mid/high income”** refers to those households living on incomes which are twice or more (≥200% of) 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 also was 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, 146 community stakeholders took part in the Online Key Informant Survey, as outlined below:

| Online Key Informant Survey Participation | |
|---|----------------------|
| Key Informant Type | Number Participating |
| Physicians | 5 |
| Public Health Representatives | 8 |
| Other Health Providers | 29 |
| Social Services Providers | 13 |
| Other Community Leaders | 91 |

Final participation included representatives of the organizations outlined below.

- A. Hertel Company, Better Options Counseling Services
- Batesville Area Resource Center/First Financial Bank
- Batesville Community School Corporation
- Batesville High School
- Batesville Memorial Public Library
- Brookville Fire Department
- Brookville's Pink Pajama Party
- Chamber of Commerce
- Choices Coordinated Care Solutions
- Choices Emergency Response Team
- Christian Counseling
- Cincinnati Children's Hospital
- City of Batesville
- Coalition for a Drug Free Batesville
- Community Mental Health Center, Inc.
- East Indiana Area Health Education Center
- First Baptist Church of Osgood
- Franklin County Community Foundation

- Franklin County Health Department
- Franklin County High School
- Franklin County Middle School
- Franklin County Public Library District
- Franklin County Sheriff's Department
- Franklin Law Enforcement
- George's Family Pharmacy, Inc.
- Giving Hearts a Hand
- Hill-Rom Holdings, Inc.
- Hispanic Community Advisory Committee
- Huntersville Road Investors
- Indiana
- Jac-Cen-Del School
- Margaret Mary Community Hospital
- Margaret Mary Health
- Milan Community Dollars for Scholars
- Milan Elementary School
- New Hope Services, Healthy Families Program
- One Community One Family, Inc.
- One Step Two Step
- Purdue Extension Franklin County
- Purdue Extension Ripley County
- Realty Exchange
- Ripley County Coroner
- Ripley County Court Services
- Ripley County Health Department
- Ripley County Prosecuting Attorney's Office
- Ripley County Public Official
- Ripley Publishing Company
- Safe Passage, Inc.
- Sisters of St. Francis
- South Ripley Community School Corporation
- Southeastern Indiana Economic Opportunity Corporation (SIEOC)
- Southeastern Indiana Health Services Center
- Southeastern Indiana YMCA
- St. Michael Catholic School
- St. Nicholas School
- St. Paul's Lutheran Church
- The Herald-Tribune
- Wood-Mizer, LLC
- WRBI Radio

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

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 better be 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 regarding participants' opinions and perceptions of the health needs of the residents in the area. Thus, these findings are not necessarily based on fact.

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES) Engagement Network, University of Missouri Extension
- 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
- 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 for Franklin and Ripley counties.

Benchmark Data

Trending

Similar surveys were administered in the MMH Service Area in 2013 and 2016 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 *2017 PRC National Health Survey*; the methodological approach for the national study is similar 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 survey-derived 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 the purpose of this report, “significance” of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% 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 medical conditions that are not specifically addressed.

Public Comment

Margaret Mary Health made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Margaret Mary Health had not received any written comments.

However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Margaret Mary Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

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 Schedule H (Form 990), the following table cross-references related sections.

| IRS Form 990, Schedule H (2018) | | See Report Page |
|---|--|----------------------|
| Part V Section B Line 3a <i>A definition of the community served by the hospital facility</i> | | 8 |
| Part V Section B Line 3b <i>Demographics of the community</i> | | 41 |
| Part V Section B Line 3c <i>Existing health care facilities and resources within the community that are available to respond to the health needs of the community</i> | | 206 |
| Part V Section B Line 3d <i>How data was obtained</i> | | 8 |
| Part V Section B Line 3e <i>The significant health needs of the community</i> | | 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 <i>The process for identifying and prioritizing community health needs and services to meet the community health needs</i> | | 18 |
| Part V Section B Line 3h <i>The process for consulting with persons representing the community's interests</i> | | 11 |
| Part V Section B Line 3i <i>The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)</i> | | 212 |

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. 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. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

| Areas of Opportunity Identified Through This Assessment | |
|---|---|
| Access to Healthcare Services | <ul style="list-style-type: none"> • Primary Care Physician Ratio • Emergency Room Utilization |
| Cancer | <ul style="list-style-type: none"> • Leading Cause of Death • Colorectal Cancer Screenings in Franklin County • Cancer Deaths <ul style="list-style-type: none"> ◦ Including Lung Cancer, Prostate Cancer, Colorectal Cancer Deaths |
| Heart Disease & Stroke | <ul style="list-style-type: none"> • Leading Cause of Death • Overall Cardiovascular Risk |
| Infant Health | <ul style="list-style-type: none"> • Infant Deaths in Ripley County |
| Injury & Violence | <ul style="list-style-type: none"> • Unintentional Injury Deaths <ul style="list-style-type: none"> ◦ Including Motor Vehicle Crash • Firearm-Related Deaths • Domestic Violence Experience • [Age 0-17] Use of Bike Helmets |
| Mental Health | <ul style="list-style-type: none"> • “Fair/Poor” Mental Health • Diagnosed Depression • Symptoms of Chronic Depression • Receiving Treatment for Mental Health • Mental Health Provider Ratio • <i>Key Informants: Mental health ranked as a top concern.</i> |
| Nutrition, Physical Activity & Weight | <ul style="list-style-type: none"> • Fruit/Vegetable Consumption • Sugar-Sweetened Beverages • Overweight & Obesity [Adults] • Trying to Lose Weight [Overweight Adults] |

—continued on the next page—

| Areas of Opportunity (continued) | |
|----------------------------------|--|
| Potentially Disabling Conditions | <ul style="list-style-type: none"> • “Fair/Poor” Overall Health • Activity Limitations • Sciatica/Chronic Back Pain Prevalence • Caregiving |
| Respiratory Diseases | <ul style="list-style-type: none"> • Chronic Lower Respiratory Disease (CLRD) Deaths • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Flu Vaccination [Age 65+] • Pneumonia Vaccination [Age 65+] |
| Substance Abuse | <ul style="list-style-type: none"> • Unintentional Drug-Related Deaths • Illicit Drug Use • Personally Impacted by Substance Abuse (Self or Other’s) • <i>Key Informants: Substance abuse ranked as a top concern.</i> |
| Tobacco Use | <ul style="list-style-type: none"> • Cigarette Smoking Prevalence • Environmental Tobacco Smoke Exposure at Home <ul style="list-style-type: none"> ◦ Including Among Households With Children • Smokeless Tobacco Prevalence • Vaping Prevalence in Franklin County |

Prioritization of Health Needs

Margaret Mary Health convened three groups consisting of the MMH Leadership Team (approximately 35 in attendance), the community outreach group (approximately 12 people) and the MMH Medical Staff (approximately 35 in attendance) to review CHNA highlights, identified needs, community perspective and to prioritize health issues for the community. The prioritization exercise was completed individually and in a group, using a **Scope and Severity** Scale, followed by **Ability to Impact** Scale.

- The scope and severity scale included ratings 1 to 5, with 1 being “not very prevalent, with only minimal health consequences” and with 5 being “extremely prevalent, with serious health consequences.”
- The ability to impact scale included ratings 1 to 5, with 1 being “no ability to impact” and with 5 being a “great ability to impact.”

Using this data, the groups reviewed and made recommendations on the prioritization. The groups were compared, and the final top three priorities were finalized. The top three health priorities for our community are:

1. **Substance Abuse**
2. **Nutrition, Physical Activity and Weight**
3. **Mental Health**

The next three years (2020-2022) will focus on improving these three health needs. The prioritization exercise was helpful to narrow the focus for the Implementation Strategy.

The Implementation Strategy may also have overlap and impact to the other health issues that were ranked 4-11 (as listed below) but will not be the primary focus:

4. Cancer
5. Access to Health Care Services
6. Heart Disease and Stroke
7. Tobacco Use
8. Infant and Child Health
9. Respiratory Disease
10. Injury and Violence
11. Potentially Disabling Conditions

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the MMH Service Area, including comparisons between the two counties, as well as trend data. These data are grouped by health topic.

Reading the Summary Tables

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

Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

■ 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 opposing county.

■ The columns to the right of the service area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 objectives. 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 MMH 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 county-level data for Franklin and Riley counties.





















| Social Determinants | Disparity Between Counties | | MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|--|--|--|------------------|---|--|--|-------|
| | Franklin County | Ripley County | | vs. IN | vs. US | vs. HP2020 | |
| Linguistically Isolated Population (Percent) |  0.1 |  0.5 | 0.3 |  1.8 |  4.4 | | |
| Population in Poverty (Percent) |  9.9 |  10.5 | 10.2 |  14.6 |  14.6 | | |
| Children in Poverty (Percent) |  10.6 |  15.7 | 13.4 |  20.4 |  20.3 | | |
| No High School Diploma (Age 25+, Percent) |  12.4 |  12.0 | 12.2 |  11.7 |  12.7 | | |
| Unemployment Rate (Age 16+, Percent) |  3.9 |  3.8 | 3.8 |  3.6 |  4.0 |  5.2 | |
| % Worry/Stress Over Rent/Mortgage in Past Year |  17.9 |  26.9 | 23.9 | |  30.8 |  20.6 | |
| % Low Health Literacy |  21.5 |  17.6 | 18.9 | |  23.3 |  15.4 | |
| <small>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.</small> | | | |  better |  similar |  worse | |


























| Overall Health | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % "Fair/Poor" Overall Health |  23.4 |  20.5 |
| <small>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.</small> | | |













| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|-------|
| | vs. IN | vs. US | vs. HP2020 | |
| 21.4 |  19.3 |  18.1 |  14.3 | |
| |  better |  similar |  worse | |




























| Access to Health Services | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % [Age 18-64] Lack Health Insurance |  1.6 |  10.4 |
| % Difficulty Accessing Healthcare in Past Year (Composite) |  34.4 |  30.8 |
| % Difficulty Finding Physician in Past Year |  8.2 |  5.5 |
| % Difficulty Getting Appointment in Past Year |  13.6 |  9.2 |
| % Cost Prevented Physician Visit in Past Year |  8.0 |  7.9 |
| % Transportation Hindered Dr Visit in Past Year |  7.1 |  2.3 |
| % Inconvenient Hrs Prevented Dr Visit in Past Year |  14.3 |  11.5 |









| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|---|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 7.4 |  13.7 |  13.7 |  0.0 |  9.6 |
| 32.0 | |  43.2 | |  36.5 |
| 6.4 | |  13.4 | |  8.7 |
| 10.7 | |  17.5 | |  14.6 |
| 8.0 |  12.2 |  15.4 | |  9.6 |
| 3.9 | |  8.3 | |  4.0 |
| 12.4 | |  12.5 | |  18.0 |





















| Access to Health Services (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Language/Culture Prevented Care in Past Year |  0.3 |  0.9 |
| % Cost Prevented Getting Prescription in Past Year |  7.3 |  8.4 |
| % Skipped Prescription Doses to Save Costs |  9.2 |  7.8 |
| % Difficulty Getting Child's Healthcare in Past Year |  2.8 |  0.0 |
| Primary Care Doctors per 100,000 |  87.2 |  7.0 |
| % Have a Specific Source of Ongoing Care |  74.4 |  71.6 |
| % Have Had Routine Checkup in Past Year |  71.6 |  76.5 |
| % Child Has Had Checkup in Past Year |  79.5 |  91.5 |
| % Two or More ER Visits in Past Year |  6.3 |  12.7 |
| % Rate Local Healthcare "Fair/Poor" |  10.1 |  5.8 |
| <small>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.</small> | | |







| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|--|---|---|---|--|
| | vs. IN | vs. US | vs. HP2020 | |
| 0.7 | |  1.2 | |  0.3 |
| 8.1 | |  14.9 | |  9.4 |
| 8.3 | |  15.3 | |  12.8 |
| 1.0 | |  5.6 | |  1.5 |
| 42.8 |  75.9 |  87.8 | | |
| 72.6 | |  74.1 |  95.0 |  76.3 |
| 74.8 |  77.0 |  68.3 | |  68.9 |
| 87.0 | |  87.1 | |  86.9 |
| 10.5 | |  9.3 | |  5.8 |
| 7.2 | |  16.2 | |  8.6 |
|  better  similar  worse | | | | |















| Cancer | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| Cancer (Age-Adjusted Death Rate) |  184.8 |  150.6 |
| Lung Cancer (Age-Adjusted Death Rate) | | |
| Prostate Cancer (Age-Adjusted Death Rate) | | |
| Female Breast Cancer (Age-Adjusted Death Rate) | | |
| Colorectal Cancer (Age-Adjusted Death Rate) | | |
| Female Breast Cancer Incidence Rate |  114.5 |  88.6 |
| Prostate Cancer Incidence Rate |  85.9 |  91.4 |
| Lung Cancer Incidence Rate |  76.5 |  65.3 |
| Colorectal Cancer Incidence Rate |  40.7 |  39.6 |
| % Cancer (Other Than Skin) |  8.7 |  6.6 |









| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|---|--|--|
| | vs. IN | vs. US | vs. HP2020 | |
| 165.4 |  172.9 |  155.6 |  161.4 |  198.2 |
| 54.4 |  48.8 |  38.5 |  45.5 | |
| 26.1 |  18.9 |  18.9 |  21.8 | |
| 19.8 |  20.7 |  20.1 |  20.7 | |
| 17.1 |  15.4 |  13.9 |  14.5 | |
| 99.9 |  121.7 |  124.7 | | |
| 89.0 |  92.7 |  109.0 | | |
| 70.3 |  72.8 |  60.2 | | |
| 40.1 |  42.9 |  39.2 | | |
| 7.3 |  7.3 |  7.1 | |  7.9 |














| Cancer (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Skin Cancer |  10.4 |  7.9 |
| % [Women 50-74] Mammogram in Past 2 Years |  69.1 |  77.1 |
| % [Women 21-65] Pap Smear in Past 3 Years |  77.2 |  72.3 |
| % [Men 50+] Prostate Screening in the Past 2 Years (PSA/DRE) | | |
| % [Age 50-75] Colorectal Cancer Screening |  62.3 |  79.1 |
| <small>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.</small> | | |















| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 8.8 |  6.1 |  8.5 | |  7.2 |
| 74.3 |  76.6 |  77.0 |  81.1 |  75.5 |
| 73.9 |  80.6 |  73.5 |  93.0 |  78.9 |
| 68.0 |  31.2 | | |  62.0 |
| 73.2 |  68.2 |  76.4 |  70.5 |  68.3 |
| |  better |  similar |  worse | |
























| Diabetes | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| Diabetes (Age-Adjusted Death Rate) | | |
| % Diabetes/High Blood Sugar |  16.1 |  12.0 |
| % Borderline/Pre-Diabetes |  9.1 |  7.2 |
| % [Non-Diabetes] Blood Sugar Tested in Past 3 Years |  62.4 |  50.7 |
| <small>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.</small> | | |







| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 23.4 |  26.5 |  21.3 |  20.5 |  28.4 |
| 13.3 |  12.5 |  13.3 | |  10.0 |
| 7.8 | |  9.5 | |  5.1 |
| 54.5 | |  50.0 | |  50.4 |
| |  better |  similar |  worse | |




| Heart Disease & Stroke | Disparity Between Counties | |
|--|--|--|
| | Franklin County | Ripley County |
| Diseases of the Heart (Age-Adjusted Death Rate) |  166.5 |  202.6 |
| Stroke (Age-Adjusted Death Rate) |  27.5 |  33.2 |
| % Heart Disease (Heart Attack, Angina, Coronary Disease) |  9.7 |  7.7 |
| % Stroke |  4.5 |  3.6 |







| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|--|--|--|--|
| | vs. IN | vs. US | vs. HP2020 | |
| 186.1 |  182.0 |  166.3 |  156.9 |  167.7 |
| 30.8 |  39.6 |  37.5 |  34.8 |  44.6 |
| 8.4 | |  8.0 | |  6.6 |
| 3.9 |  4.3 |  4.7 | |  2.6 |














| Heart Disease & Stroke (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Blood Pressure Checked in Past 2 Years |  97.7 |  92.7 |
| % Told Have High Blood Pressure (Ever) |  47.5 |  39.7 |
| % [HBP] Taking Action to Control High Blood Pressure |  96.3 |  96.4 |
| % Cholesterol Checked in Past 5 Years |  93.9 |  89.4 |
| % Told Have High Cholesterol (Ever) |  34.0 |  28.6 |
| % [HBC] Taking Action to Control High Blood Cholesterol |  89.5 |  90.1 |
| % 1+ Cardiovascular Risk Factor |  87.2 |  91.0 |
| <small>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.</small> | | |















| MMH Service Area | MMH Service Area vs. Benchmarks | | | |
|---|---|---|---|---|
| | vs. IN | vs. US | vs. HP2020 | TREND |
| 94.3 | |  90.4 |  92.6 |  95.0 |
| 42.3 |  35.2 |  37.0 |  26.9 |  39.9 |
| 96.4 | |  93.8 | |  91.5 |
| 90.9 |  83.4 |  85.1 |  82.1 |  90.5 |
| 30.4 | |  36.2 |  13.5 |  32.2 |
| 89.9 | |  87.3 | |  90.5 |
| 89.8 | |  87.2 | |  83.8 |
| <div>  better  similar  worse </div> | | | | |

























| Hepatitis | Disparity Between Counties | |
|---|---|---|
| | Franklin County | Ripley County |
| % Have Received the Hepatitis A Vaccination Series |  25.5 |  26.0 |
| % Have Received the Hepatitis B Vaccination Series |  22.3 |  24.2 |
| % [Age 54-74] Have Had Blood Tested for Hepatitis C |  20.6 |  12.8 |
| 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. | | |





| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|--|---------------------------------|--------|------------|-------|
| | vs. IN | vs. US | vs. HP2020 | |
| 25.9 | | | | |
| 23.6 | | | | |
| 15.4 | | | | |
|  better  similar  worse | | | | |









| Infant Health & Family Planning | Disparity Between Counties | |
|---|---|---|
| | Franklin County | Ripley County |
| Low Birthweight Births (Percent) |  7.3 |  6.9 |
| Infant Death Rate |  3.3 |  8.7 |
| Births to Adolescents Age 15 to 19 (Rate per 1,000) |  30.5 |  36.4 |
| 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. | | |













| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|--|---|---|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 7.1 |  8.2 |  8.2 |  7.8 |  7.5 |
| 6.5 |  7.3 |  6.1 |  6.0 | |
| 34.0 |  38.9 |  36.6 | |  38.2 |
|  better  similar  worse | | | | |















| Injury & Violence | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| Unintentional Injury (Age-Adjusted Death Rate) |  51.0 |  67.5 |
| Motor Vehicle Crashes (Age-Adjusted Death Rate) |  13.1 |  17.1 |
| % [Age 45+] Fell in the Past Year |  40.5 |  31.7 |
| Firearm-Related Deaths (Age-Adjusted Death Rate) | | |
| Violent Crime Rate |  40.1 |  75.4 |
| % Victim of Violent Crime in Past 5 Years |  2.0 |  2.4 |
| % Victim of Domestic Violence (Ever) |  13.2 |  16.2 |
| % Child [Age 5-17] "Always" Wears Bicycle Helmet | | |
| % Child [Age 0-17] "Always" Uses Seat Belt/Car Seat |  91.8 |  96.5 |
| <small>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.</small> | | |









| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|--|--|---|---|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 60.3 |  52.7 |  46.7 |  36.4 |  45.1 |
| 15.3 |  11.7 |  11.0 |  12.4 | |
| 34.7 | |  31.6 | |  28.9 |
| 14.6 |  14.3 |  11.6 |  9.3 | |
| 59.3 |  384.0 |  379.7 | | |
| 2.3 | |  3.7 | | |
| 15.2 | |  14.2 | |  5.9 |
| 22.4 | |  48.8 | |  23.3 |
| 94.8 | |  85.6 | |  97.1 |
|  better  similar  worse | | | | |












| Kidney Disease | Disparity Between Counties | |
|---|---|---|
| | Franklin County | Ripley County |
| Kidney Disease (Age-Adjusted Death Rate) |  12.1 |  10.9 |
| % Kidney Disease |  4.1 |  4.4 |
| 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. | | |























| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|--|
| | vs. IN | vs. US | vs. HP2020 | |
| 11.4 |  19.2 |  13.8 | | |
| 4.3 |  3.4 |  3.8 | |  2.9 |
| |  better |  similar |  worse | |






























| Mental Health | Disparity Between Counties | |
|---|---|---|
| | Franklin County | Ripley County |
| % "Fair/Poor" Mental Health |  18.0 |  15.1 |
| % Diagnosed Depression |  22.3 |  25.8 |
| % Symptoms of Chronic Depression (2+ Years) |  32.8 |  34.1 |
| % Typical Day Is "Extremely/Very" Stressful |  17.5 |  9.7 |
| Suicide (Age-Adjusted Death Rate) |  15.8 |  12.0 |
| Mental Health Providers per 100,000 |  30.9 |  45.7 |







| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|--|--|---|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 16.1 | |  13.0 | |  9.6 |
| 24.7 |  19.7 |  21.6 | |  16.6 |
| 33.6 | |  31.4 | |  25.5 |
| 12.2 | |  13.4 | |  8.5 |
| 13.7 |  14.1 |  12.7 |  10.2 | |
| 39.2 |  149.9 |  202.8 | | |





















| Mental Health (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Taking Rx/Receiving Mental Health Trtmt |  21.5 |  15.4 |
| % Have Ever Sought Help for Mental Health |  34.7 |  35.7 |
| % [Those With Diagnosed Depression] Seeking Help |  97.2 |  81.8 |
| % Unable to Get Mental Health Svcs in Past Yr |  3.5 |  0.8 |
| <small>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.</small> | | |





| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|---|---------------------------------|---|------------|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 17.4 | |  13.9 | |  10.5 |
| 35.4 | |  30.8 | |  17.4 |
| 86.5 | |  87.1 | |  78.1 |
| 1.7 | |  6.8 | |  2.2 |
| <div>  better  similar  worse </div> | | | | |













| Nutrition, Physical Activity & Weight | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Food Insecure |  16.0 |  15.4 |
| % 5+ Servings of Fruits/Vegetables per Day |  24.7 |  28.9 |
| % "Very/Somewhat" Difficult to Buy Fresh Produce |  19.4 |  14.5 |
| % 7+ Sugar-Sweetened Drinks in Past Week |  38.1 |  41.0 |
| Population With Low Food Access (Percent) |  7.4 |  4.3 |
| % No Leisure-Time Physical Activity |  25.5 |  19.9 |
| % Meeting Physical Activity Guidelines |  17.7 |  29.7 |
| Recreation/Fitness Facilities per 100,000 |  13.0 |  13.9 |
| % Healthy Weight (BMI 18.5-24.9) |  20.8 |  29.7 |
| % Overweight (BMI 25+) |  78.8 |  70.3 |
| % [Overweights] Trying to Lose Weight |  52.3 |  52.4 |











| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|---|---|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 15.6 | |  27.9 | |  15.2 |
| 27.5 | |  33.5 | |  35.4 |
| 16.1 | |  22.1 | |  22.6 |
| 40.1 | |  29.0 | |  38.2 |
| 5.7 |  25.3 |  22.4 | | |
| 21.7 |  27.4 |  26.2 |  32.6 |  23.3 |
| 25.7 |  17.2 |  22.8 |  20.1 |  19.7 |
| 13.5 |  9.3 |  11.0 | | |
| 26.7 |  31.5 |  30.3 |  33.9 |  33.7 |
| 73.1 |  66.4 |  67.8 | |  65.2 |
| 52.3 | |  61.3 | |  38.0 |












| Nutrition, Physical Activity & Weight (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Obese (BMI 30+) |  47.8 |  33.7 |
| % Medical Advice on Weight in Past Year |  31.5 |  22.6 |
| % [Overweights] Counseled About Weight in Past Year |  36.8 |  25.9 |
| % Children [Age 5-17] Healthy Weight | | |
| % Children [Age 5-17] Overweight (85th Percentile) | | |
| % Children [Age 5-17] Obese (95th Percentile) | | |
| % Child [Age 2-17] Physically Active 1+ Hours per Day | | |
| <small>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.</small> | | |







| MMH Service Area | MMH Service Area vs. Benchmarks | | | |
|--|---|---|---|---|
| | vs. IN | vs. US | vs. HP2020 | TREND |
| 38.4 |  34.1 |  32.8 |  30.5 |  29.1 |
| 25.6 | |  24.2 | |  21.7 |
| 29.8 | |  29.0 | |  27.9 |
| 62.1 | |  58.4 | |  59.6 |
| 25.9 | |  33.0 | |  31.9 |
| 19.0 | |  20.4 |  14.5 |  14.4 |
| 71.5 | |  50.5 | |  56.5 |
|  better  similar  worse | | | | |









| Oral Health | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Have Dental Insurance |  70.0 |  65.6 |
| % [Age 18+] Dental Visit in Past Year |  60.1 |  58.7 |
| % Child [Age 2-17] Dental Visit in Past Year | | |
| <small>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.</small> | | |







| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 67.1 | |  59.9 | |  60.4 |
| 59.2 |  64.4 |  59.7 |  49.0 |  63.5 |
| 85.4 | |  87.0 |  49.0 |  89.7 |
| |  better |  similar |  worse | |












| Potentially Disabling Conditions | Disparity Between Counties | |
|----------------------------------|---|---|
| | Franklin County | Ripley County |
| % Activity Limitations |  36.2 |  25.8 |
| % [50+] Arthritis/Rheumatism |  45.1 |  41.5 |
| % [50+] Osteoporosis |  8.0 |  12.5 |
| % Sciatica/Chronic Back Pain |  28.5 |  28.3 |
| % Eye Exam in Past 2 Years |  53.5 |  68.5 |







| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---------------------------------|---|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 29.3 | |  25.0 | |  16.2 |
| 42.7 | |  38.3 | |  38.2 |
| 11.0 | |  9.4 |  5.3 |  10.8 |
| 28.4 | |  22.9 | |  18.6 |
| 63.6 | |  55.3 | |  57.8 |















| Potentially Disabling Conditions (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % 3+ Chronic Conditions |  47.7 |  43.4 |
| Alzheimer's Disease (Age-Adjusted Death Rate) |  25.8 |  32.3 |
| % Caregiver to a Friend/Family Member |  29.9 |  25.7 |
| <small>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.</small> | | |





| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 44.8 | |  41.4 | | |
| 29.7 |  34.4 |  30.2 | |  37.2 |
| 27.1 | |  20.8 | | |
| |  better |  similar |  worse | |







| Respiratory Diseases | Disparity Between Counties | |
|---|---|--|
| | Franklin County | Ripley County |
| CLRD (Age-Adjusted Death Rate) |  53.4 |  47.8 |
| Pneumonia/Influenza (Age-Adjusted Death Rate) | | |
| % [Adult] Currently Has Asthma |  12.4 |  6.1 |
| % [Child 0-17] Currently Has Asthma |  4.2 |  6.4 |



| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|---|------------|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 49.8 |  55.1 |  41.0 | |  54.0 |
| 16.2 |  13.4 |  14.3 | |  17.4 |
| 8.2 |  10.0 |  11.8 | |  6.4 |
| 5.6 | |  9.3 | |  6.8 |








| Respiratory Diseases (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % COPD (Lung Disease) |  11.3 |  15.8 |
| % [Age 65+] Flu Vaccine in Past Year |  52.3 |  60.2 |
| % [Age 65+] Pneumonia Vaccine Ever |  74.2 |  72.5 |
| <small>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.</small> | | |











| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 14.3 |  9.0 |  8.6 | |  7.2 |
| 57.7 |  46.9 |  76.8 |  70.0 |  67.0 |
| 73.1 |  72.5 |  82.7 |  90.0 |  62.7 |
| |  better |  similar |  worse | |



















| Sexual Health | Disparity Between Counties | |
|---|--|---|
| | Franklin County | Ripley County |
| Chlamydia Incidence Rate |  100.6 |  219.5 |
| Gonorrhea Incidence Rate |  4.4 |  20.9 |
| % [Unmarried 18-64] 3+ Sexual Partners in Past Year | | |
| % [Unmarried 18-64] Using Condoms | | |









| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|--|--|------------|-------|
| | vs. IN | vs. US | vs. HP2020 | |
| 166.8 |  466.0 |  497.3 | | |
| 13.6 |  142.8 |  145.8 | | |
| 8.4 | |  13.8 | | |
| 29.7 | |  39.4 | | |








| Sexual Health (continued) | Disparity Between Counties | |
|---|---|---|
| | Franklin County | Ripley County |
| HIV Prevalence Rate |  26.2 |  46.0 |
| % [Age 18-44] HIV Test in the Past Year | | |
| 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. | | |













| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 37.2 |  195.7 |  362.3 | | |
| 18.3 | |  24.7 | |  10.4 |
| |  better |  similar |  worse | |























| Substance Abuse | Disparity Between Counties | |
|---|---|---|
| | Franklin County | Ripley County |
| Unintentional Drug-Related Deaths (Age-Adjusted Death Rate) |  19.9 |  13.3 |
| Cirrhosis/Liver Disease (Age-Adjusted Death Rate) | | |
| % Current Drinker |  54.9 |  59.3 |
| % Excessive Drinker |  20.2 |  27.7 |
| % Drinking & Driving in Past Month |  2.0 |  5.3 |
| % Illicit Drug Use in Past Month |  3.6 |  2.5 |

| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|---|---|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 16.3 |  14.5 |  12.3 |  11.3 | |
| 7.6 |  9.9 |  10.1 |  8.2 | |
| 57.9 |  51.1 |  55.0 | |  54.9 |
| 25.2 | |  22.5 |  25.4 |  24.6 |
| 4.2 |  2.8 |  5.2 | |  4.2 |
| 2.9 | |  2.5 |  7.1 |  1.0 |

| Substance Abuse (continued) | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Ever Sought Help for Alcohol or Drug Problem |  2.6 |  7.5 |
| % Personally Impacted by Substance Abuse |  36.9 |  41.8 |
| % Medications Are Kept in a Locked Place |  24.2 |  23.4 |
| % Have Expired or Unused Prescriptions in the Home |  23.4 |  25.2 |
| <small>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.</small> | | |

| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|---|---------------------------------|---|------------|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 5.9 | |  3.4 | |  2.1 |
| 40.2 | |  37.3 | |  33.8 |
| 23.6 | | | | |
| 24.6 | | | | |
| <div>  better  similar  worse </div> | | | | |

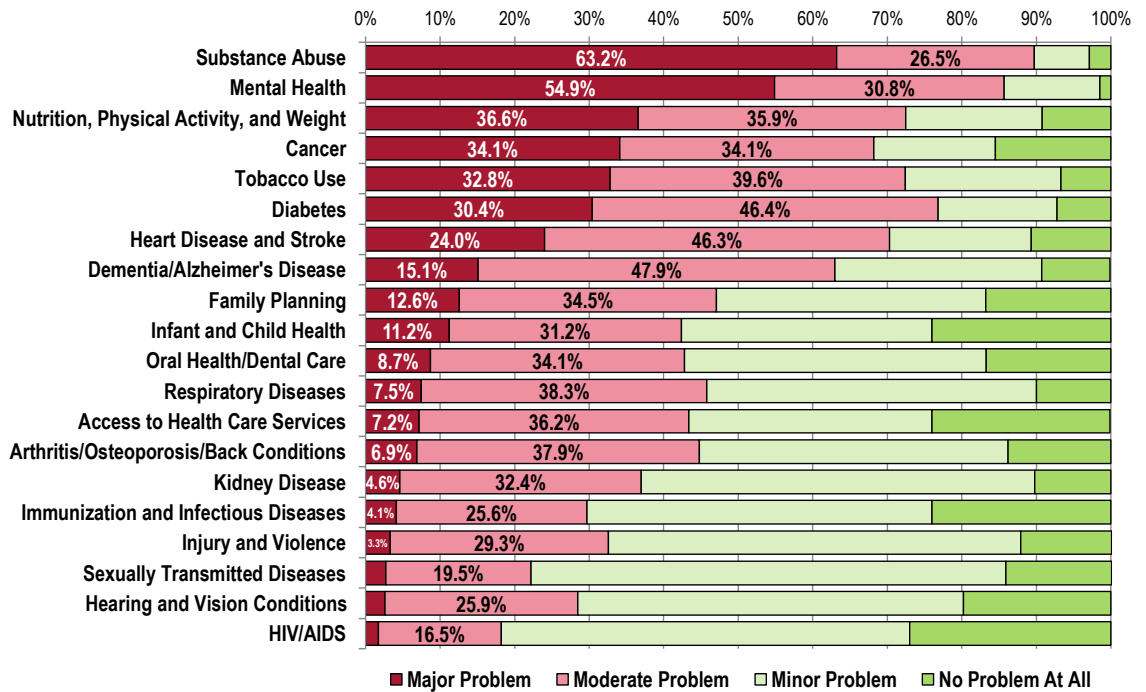
| Tobacco Use | Disparity Between Counties | |
|--|---|---|
| | Franklin County | Ripley County |
| % Current Smoker |  13.3 |  25.3 |
| % Someone Smokes at Home |  16.0 |  15.9 |
| % [Nonsmokers] Someone Smokes in the Home |  7.5 |  4.9 |
| % [Household With Children] Someone Smokes in the Home |  20.6 |  26.3 |
| % [Smokers] Received Advice to Quit Smoking | | |
| % Currently Use Vaping Products |  8.4 |  3.6 |
| % Use Smokeless Tobacco |  12.7 |  6.0 |
| <small>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.</small> | | |

| MMH Service Area | MMH Service Area vs. Benchmarks | | | TREND |
|------------------|---|--|--|---|
| | vs. IN | vs. US | vs. HP2020 | |
| 21.3 |  21.1 |  16.3 |  12.0 |  15.5 |
| 15.9 | |  10.7 | |  10.9 |
| 5.8 | |  4.0 | |  3.5 |
| 24.1 | |  7.2 | |  7.8 |
| 65.6 | |  58.0 | |  72.6 |
| 5.2 |  6.0 |  3.8 | |  3.4 |
| 8.2 |  4.2 |  4.4 |  0.2 |  7.5 |
| |  better |  similar |  worse | |

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)

Key Informants: Relative Position of Health Topics as Problems in the Community



Community Description



Population Characteristics

Total Population

The MMH Service Area, the focus of this Community Health Needs Assessment, encompasses 830.86 square miles and houses a total population of 51,207 residents, according to latest census estimates.

Total Population
(Estimated Population, 2000-2010)

| | Total Population | Total Land Area (Square Miles) | Population Density (Per Square Mile) |
|------------------|------------------|-----------------------------------|---|
| Franklin County | 22,835 | 384.43 | 59.4 |
| Ripley County | 28,372 | 446.43 | 63.55 |
| MMH Service Area | 51,207 | 830.86 | 61.63 |
| Indiana | 6,614,418 | 35,825.56 | 184.63 |
| United States | 321,004,407 | 3,532,315.66 | 90.88 |

Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

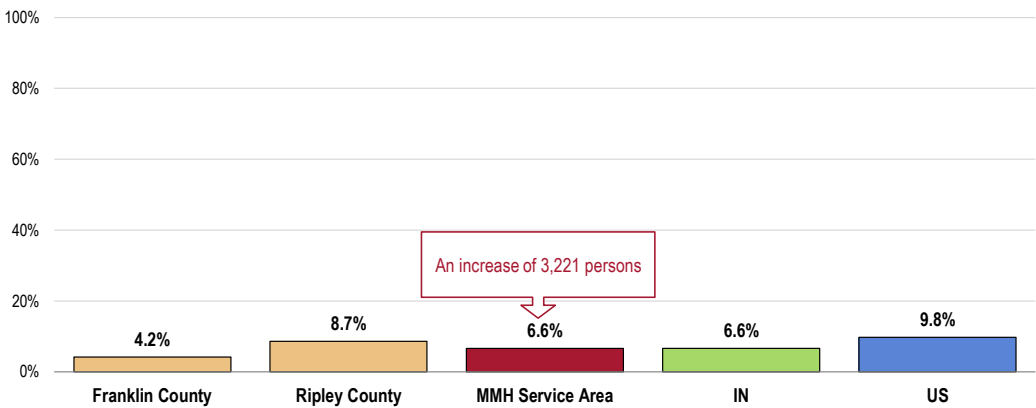
Population Change 2000-2010

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 increased by 3,221 persons, or 6.6%.

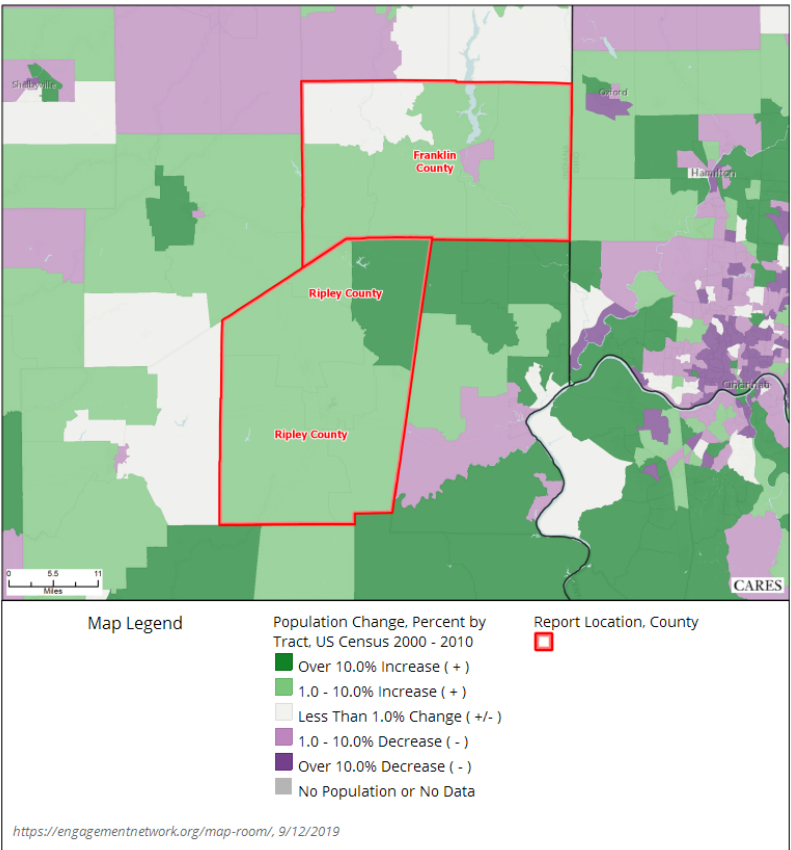
- **BENCHMARK:** Lower than the percentage growth reported nationally.
- **DISPARITY:** The percentage is higher in Ripley County.

Change in Total Population (Percentage Change Between 2000 and 2010)



Sources: • US Census Bureau Decennial Census (2000-2010).
• Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
Notes: • A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

This map shows the areas of greatest increase or decrease in population between 2000 and 2010.

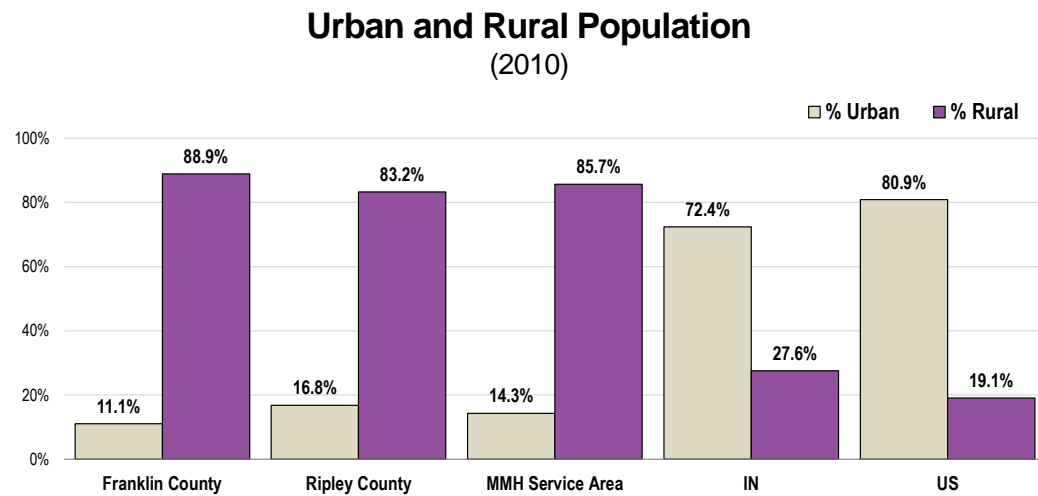


Urban/Rural Population

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 service area is predominantly rural, with 85.7% of the population living in areas designated as urban.

- **BENCHMARK:** A much larger rural population proportionally than reported across Indiana and the US.
- **DISPARITY:** Franklin County reports a slightly higher urban population percentage than does Ripley County.

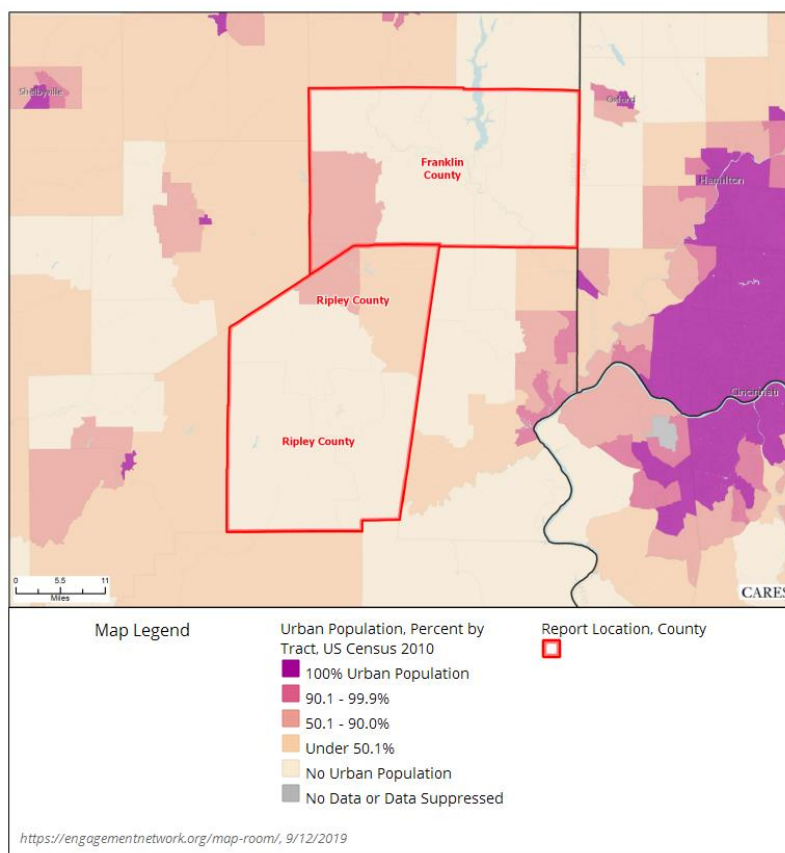


Sources: • US Census Bureau Decennial Census.

• Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes: • This indicator reports the percentage of population living in urban and rural 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.

Note the following map, outlining the urban population in MMH Service Area census tracts as of 2010.



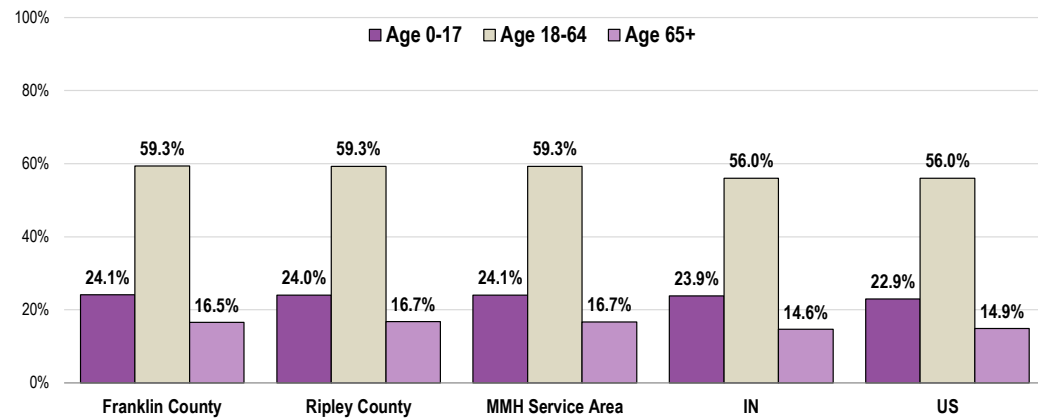
Age

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

In the MMH Service Area, 24.1% of the population are children age 0-17; another 59.3% are age 18 to 64, while 16.7% are age 65 and older.

- **BENCHMARK:** The population of seniors is higher proportionally than found statewide and nationally.

Total Population by Age Groups, Percent (2000-2010)

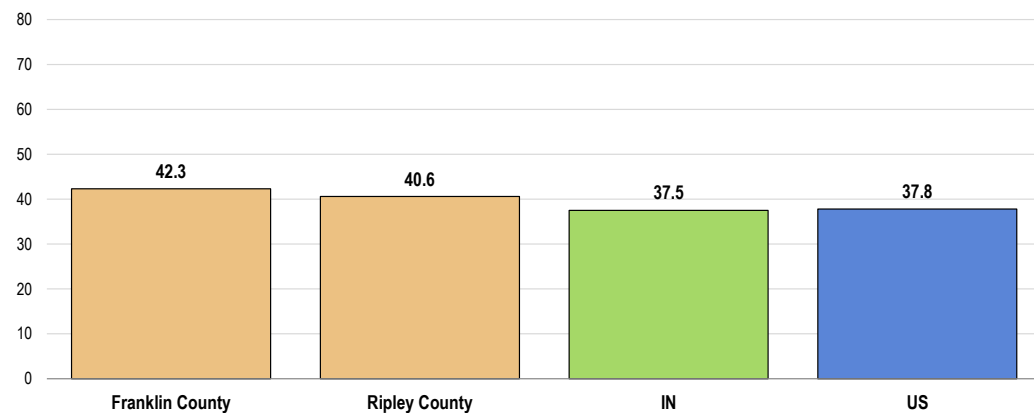


Sources:
 • US Census Bureau American Community Survey 5-year estimates.
 • Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Median Age

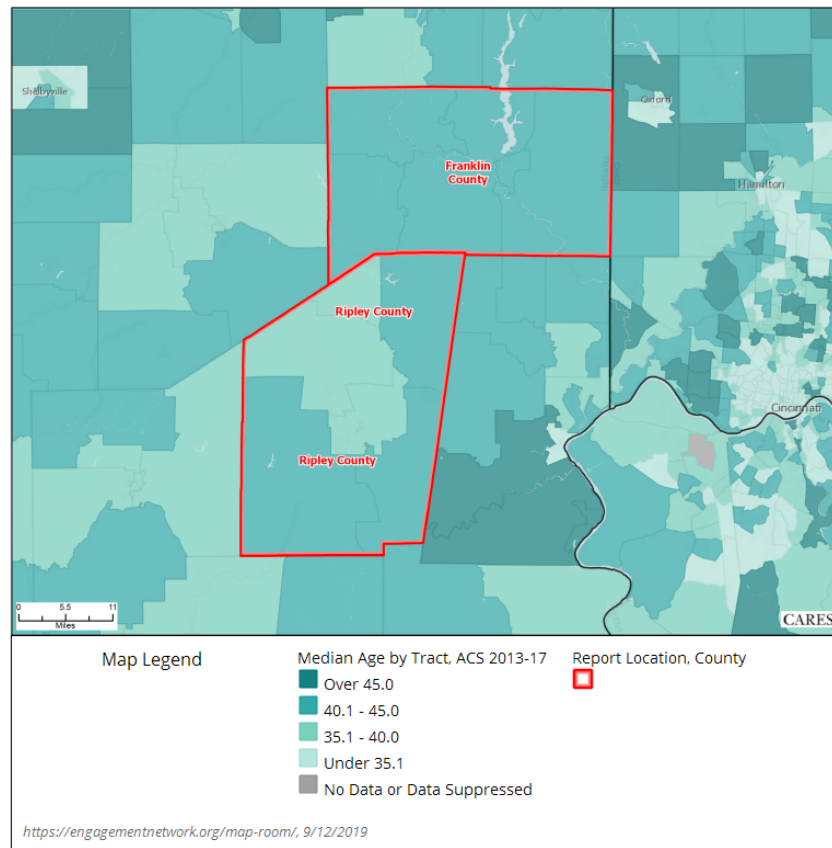
The median age is higher in Franklin and Ripley counties than reported in Indiana and the US overall.

Median Age (2000-2010)



Sources:
 • US Census Bureau American Community Survey 5-year estimates.
 • Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

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



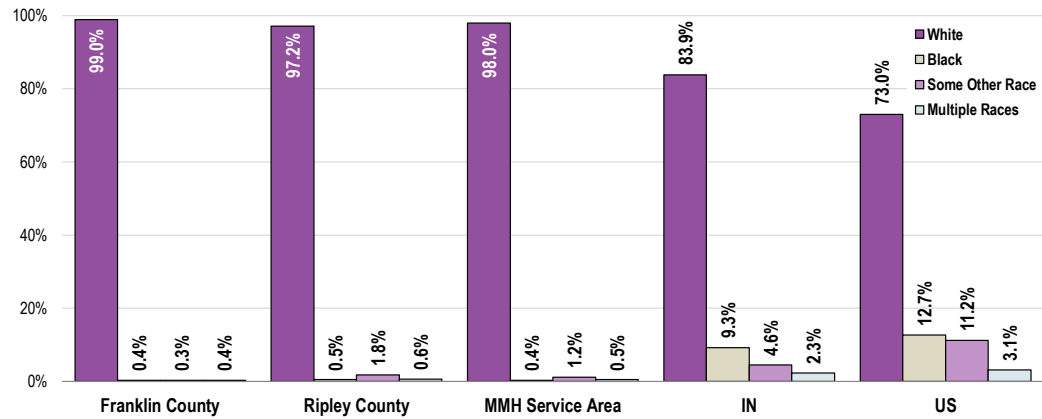
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), nearly all residents (98.0%) of the MMH Service Area are White.

- **BENCHMARK:** Much less diverse than the race breakout statewide and especially nationally.

Total Population by Race Alone, Percent (2000-2010)



Sources:

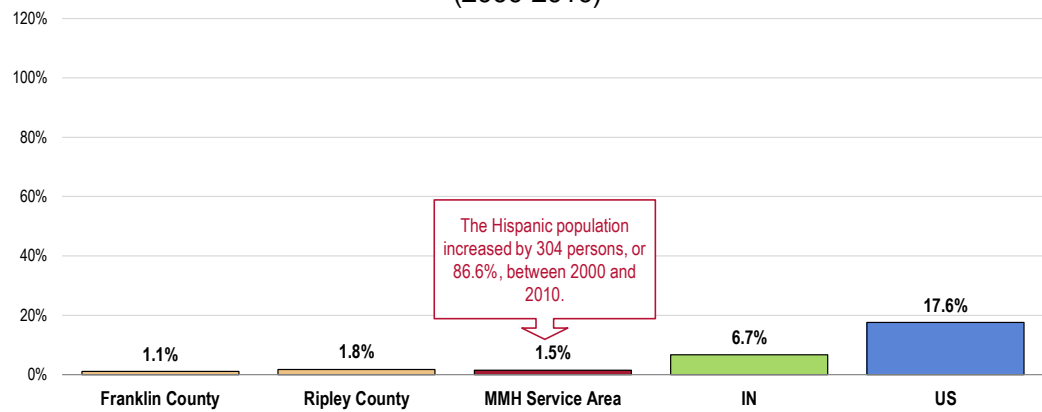
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Ethnicity

A total of 1.5% of MMH Service Area residents are Hispanic or Latino.

- BENCHMARK:** Well below the state and especially the US proportion.
- DISPARITY:** The percentage is marginally higher in Ripley County.

Hispanic Population (2000-2010)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes:

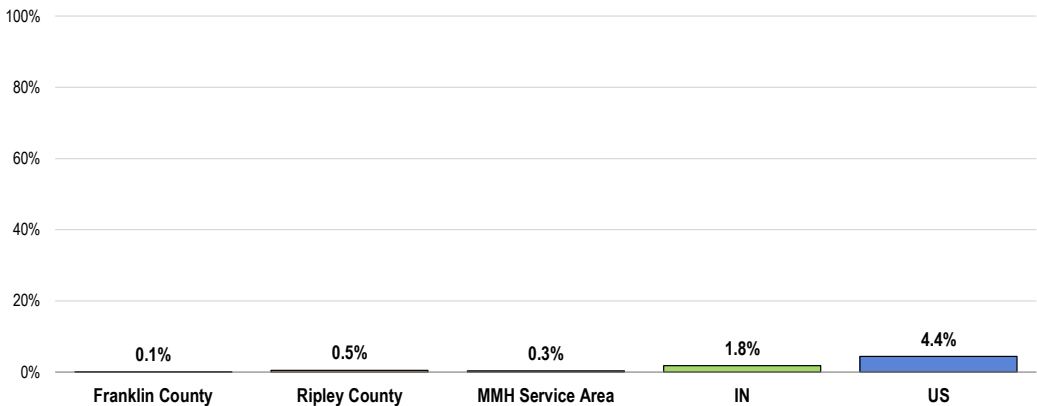
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

Less than one percent (0.3%) of the MMH Service Area population age 5 and older lives in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English “very well”).

- **BENCHMARK:** Well below the state and especially the US percentage.
- **DISPARITY:** Higher in Ripley County.

Linguistically Isolated Population
(2000-2010)



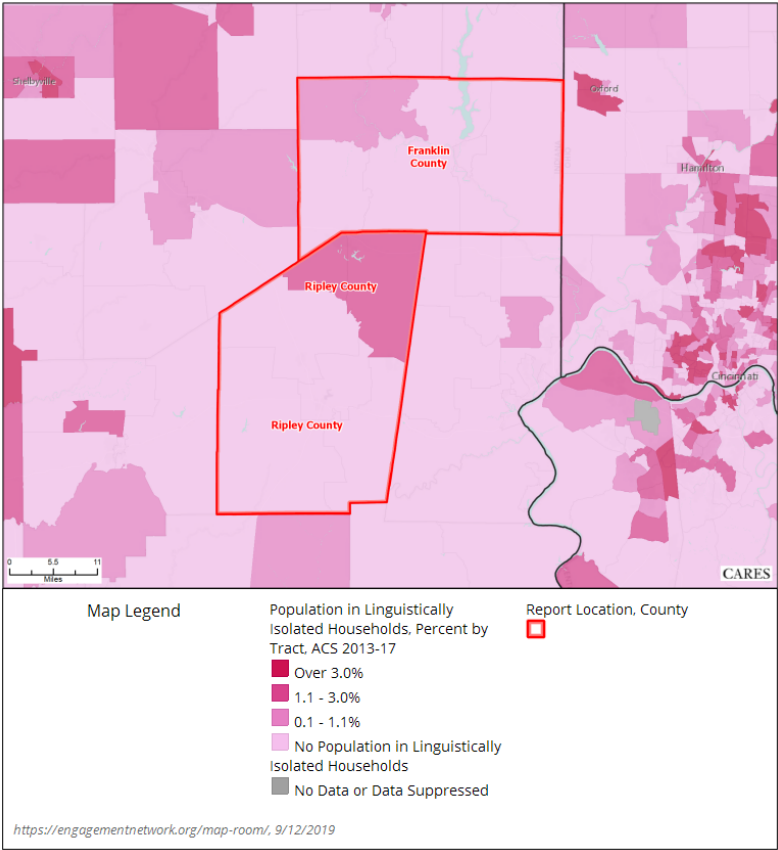
Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.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.”

Note the following map illustrating linguistic isolation throughout the MMH Service Area.



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)

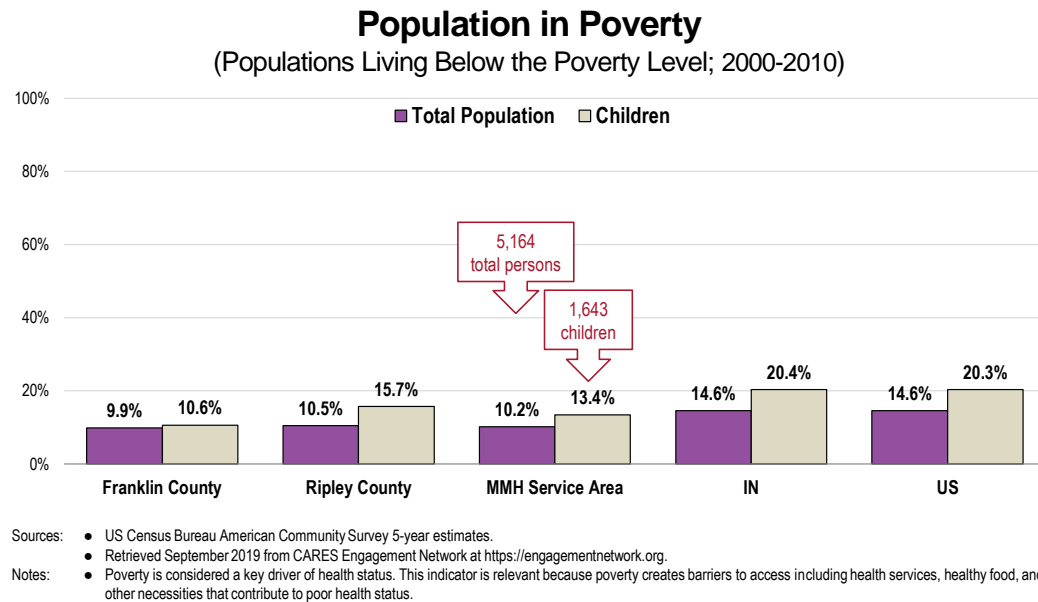
Poverty

The latest census estimate shows **10.2%** of the MMH Service Area total population living below the federal poverty level.

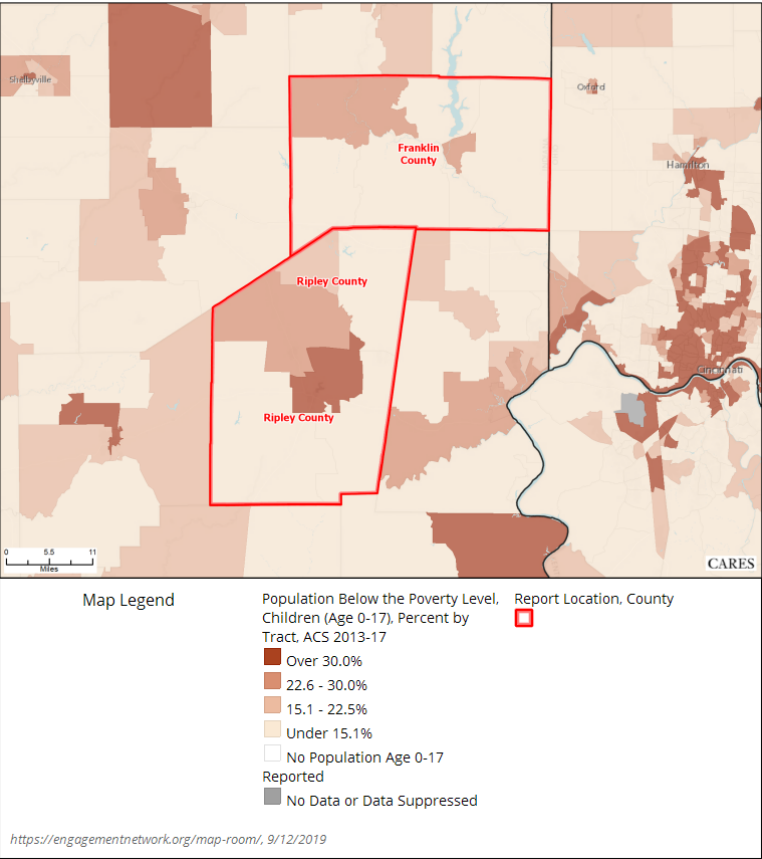
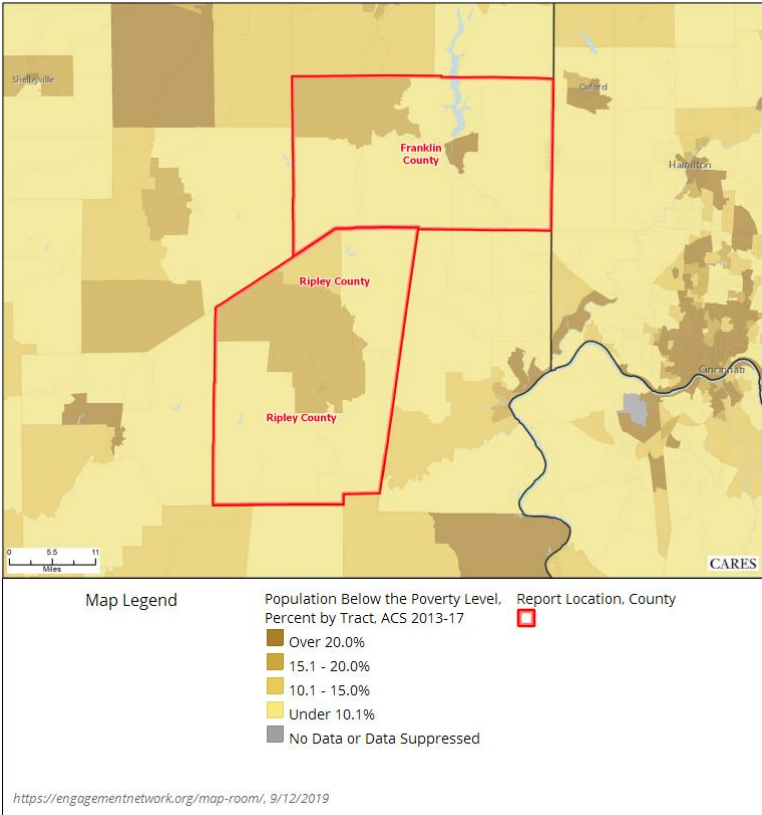
- **BENCHMARK:** Below the Indiana and US percentages.

Among just children (ages 0 to 17), this percentage in the MMH Service Area is **13.4%** (representing an estimated 1,643 children).

- **BENCHMARK:** Below the Indiana and US percentages.
- **DISPARITY:** Higher in Ripley County.



The following maps highlight concentrations of persons living below the federal poverty level.

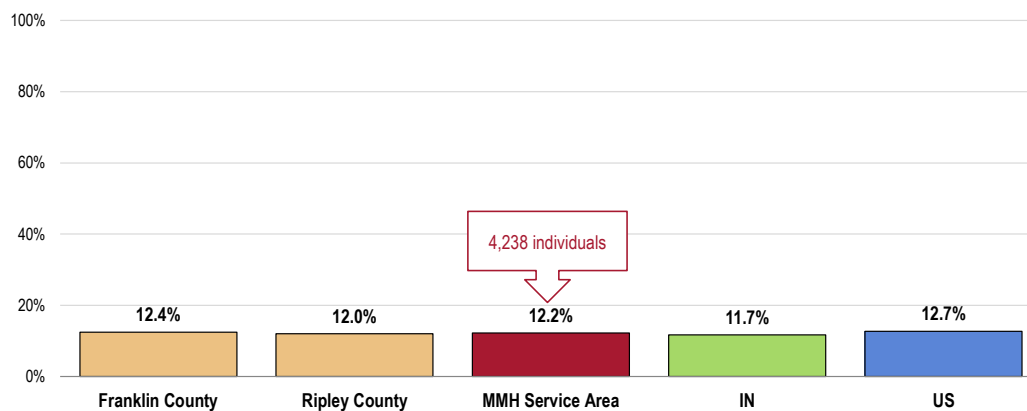


Education

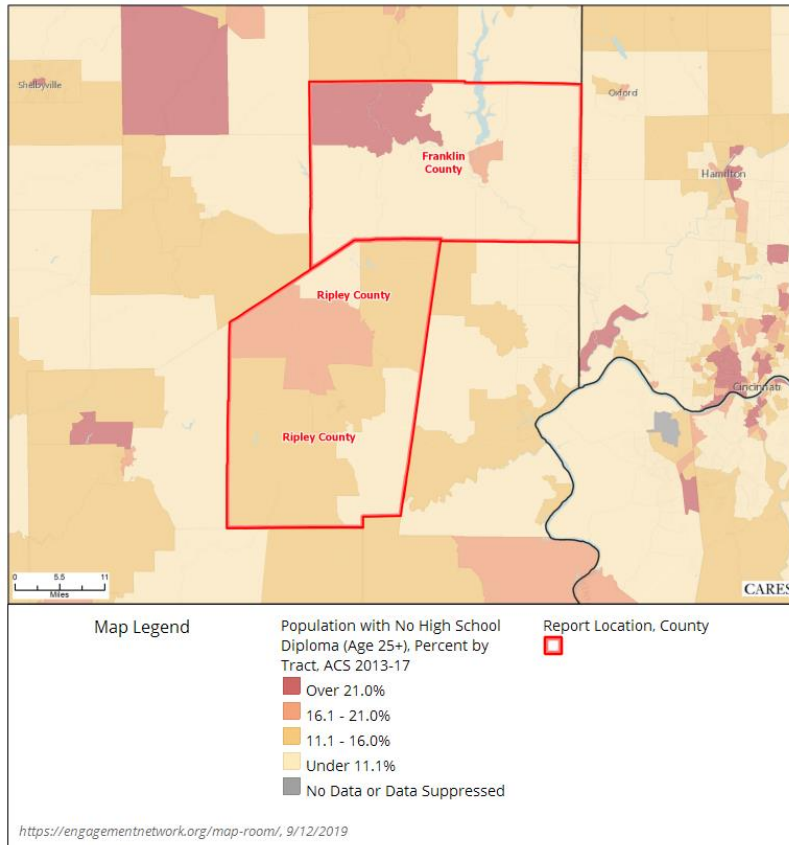
Among the MMH Service Area population age 25 and older, an estimated 12.2% (over 4,000 people) do not have a high school education.

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2000-2010)



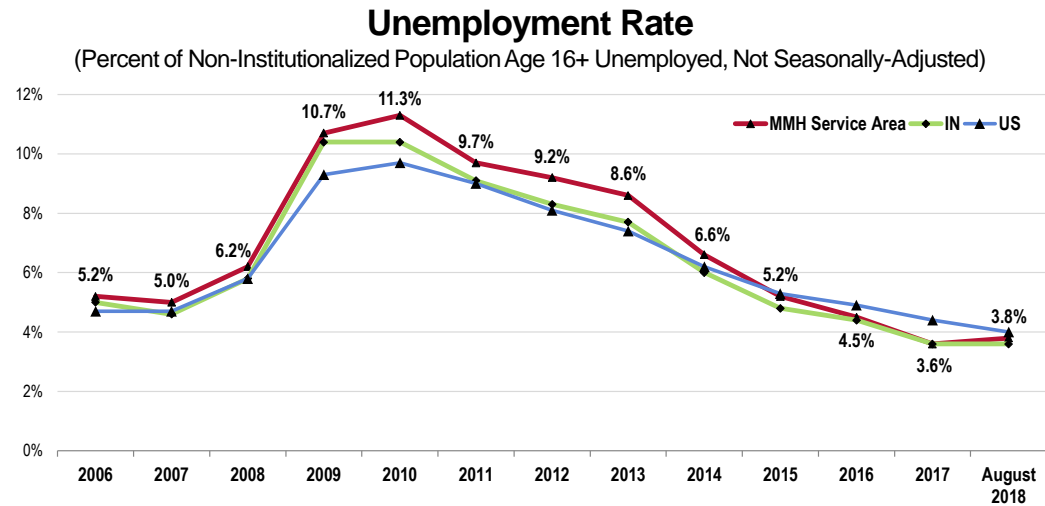
- Sources:
- US Census Bureau American Community Survey 5-year estimates.
 - Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
- Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.



Employment

According to data derived from the US Department of Labor, the unemployment rate in the MMH Service Area as of August 2018 was 3.8%.

- TREND:** The rate has decreased since 2010, echoing state and national trends.



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

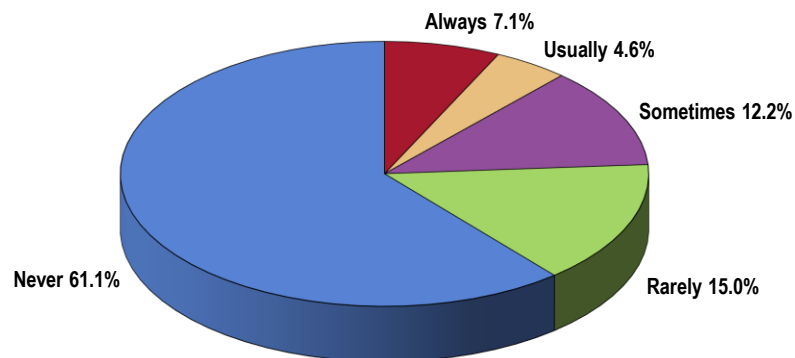
• Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

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

Most surveyed adults rarely, if ever, worry about the cost of housing.

**Frequency of Worry or Stress
Over Paying Rent/Mortgage in the Past Year**
(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 71]

Notes: • Asked of all respondents.

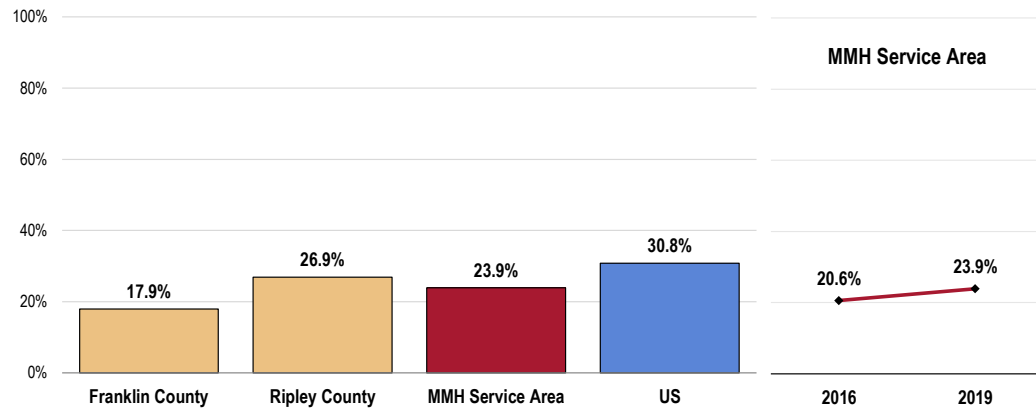
However, a considerable share (23.9%) report that they were “sometimes,” “usually,” or “always” worried or stressed about having enough money to pay their rent or mortgage in the past year.

NOTE:

For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

- **BENCHMARK:** Well below the US prevalence.
- **DISPARITY:** Concern is higher among survey respondents in Ripley County. Higher among adults under 65 and those living on lower household incomes.

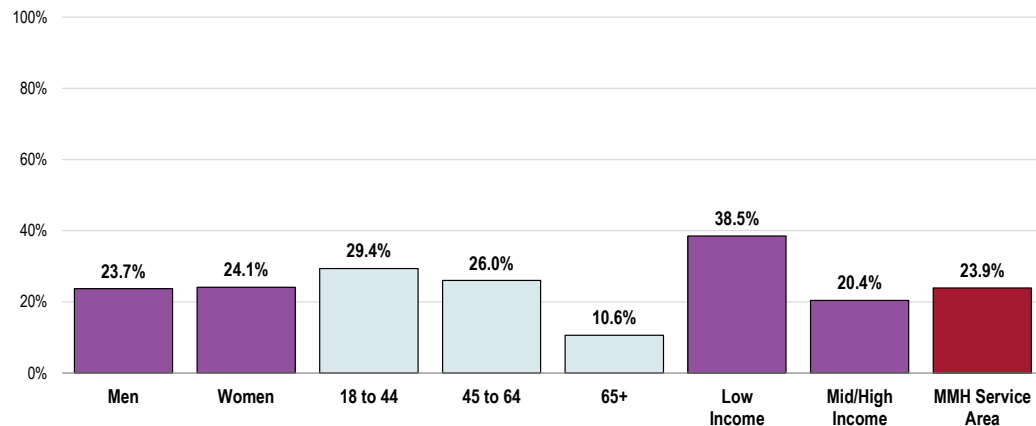
“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 196]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

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

“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 196]
 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 Access

Low Food Access

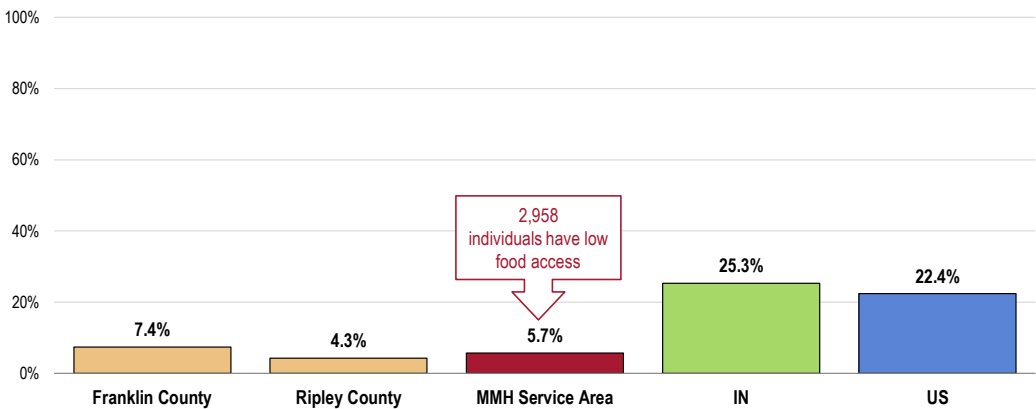
Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

US Department of Agriculture data show that **5.7% of the MMH Service Area population (representing nearly 3,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.**

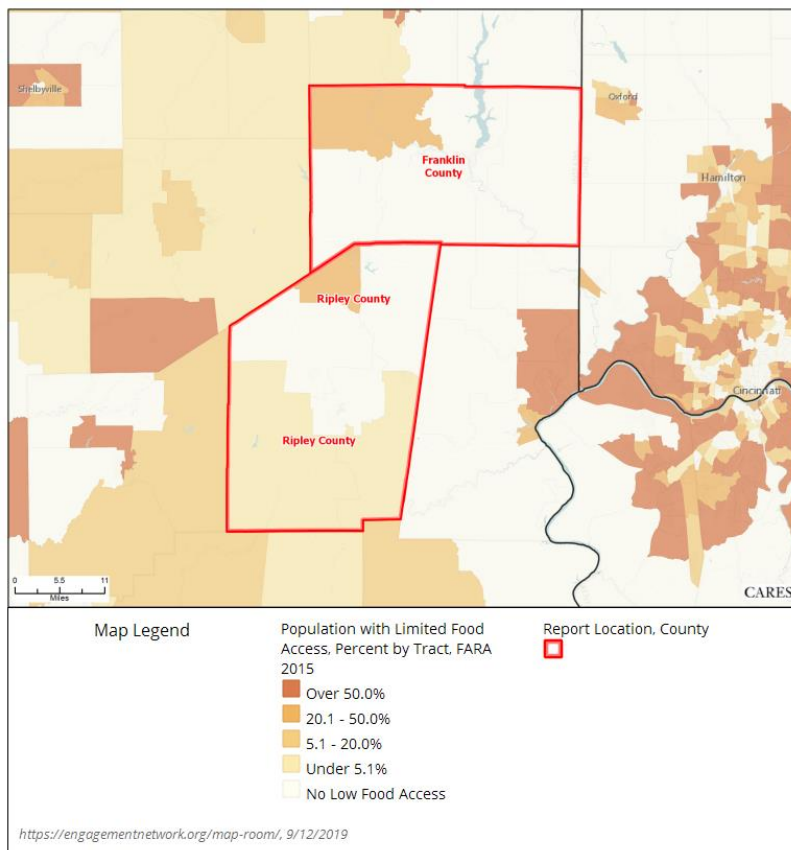
- **BENCHMARK:** Well below state and national percentages.
- **DISPARITY:** Higher among residents of Franklin County.

Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)



- Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
 - Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
- Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



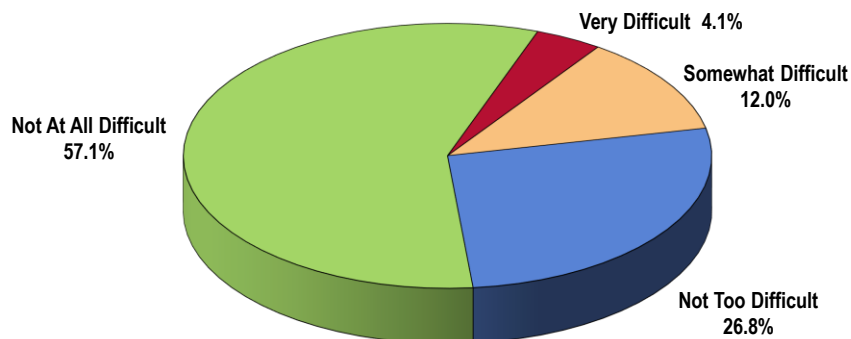
Difficulty Accessing Fresh Produce

Most MMH Service Area adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked:

"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?"

Level of Difficulty Finding Fresh Produce at an Affordable Price (MMH Service Area, 2019)

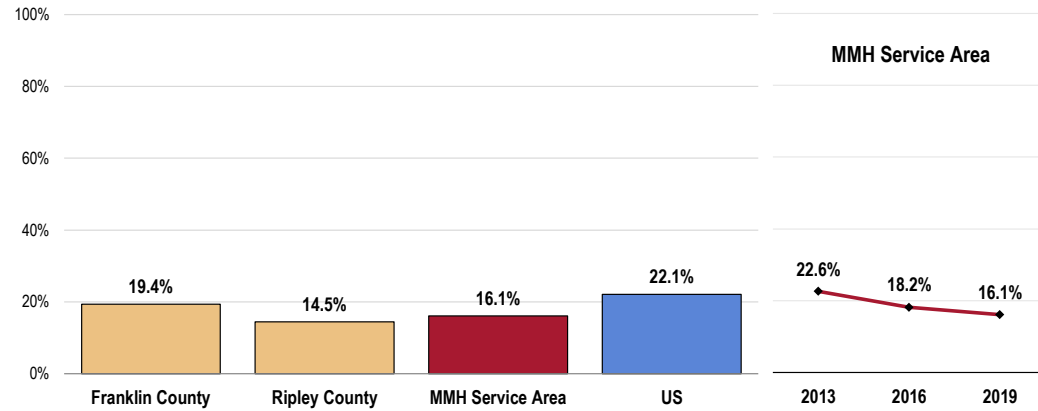


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 86]
Notes: • Asked of all respondents.

However, 16.1% of MMH Service Area adults find it “very” or “somewhat” difficult to access affordable fresh fruits and vegetables.

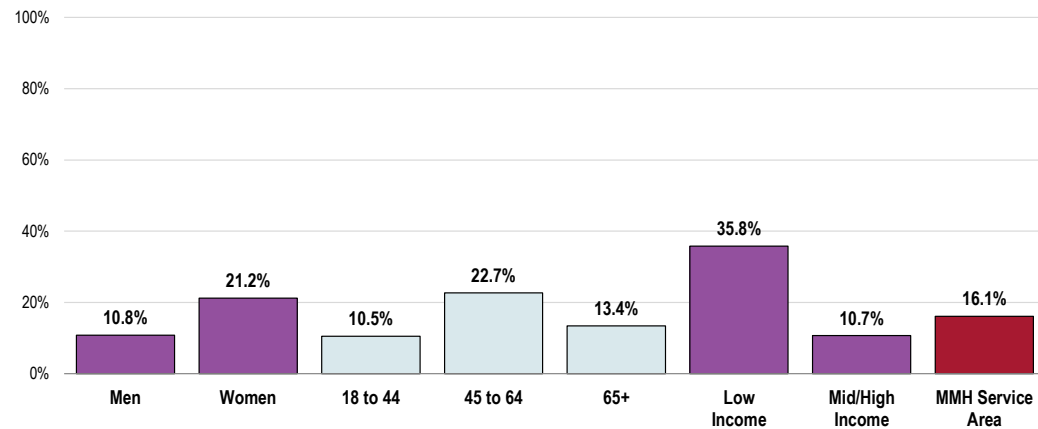
- **BENCHMARK:** Below the US figure.
- **TREND:** Denotes a statistically significant decrease since 2013.
- **DISPARITY:** Higher among service area women, adults age 45 to 64, and those in low-income households.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 189]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 189]
 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

Overall, 15.6% 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.

- **BENCHMARK:** Well below the US prevalence.
- **DISPARITY:** Higher among women, adults under 65, and especially low-income residents.

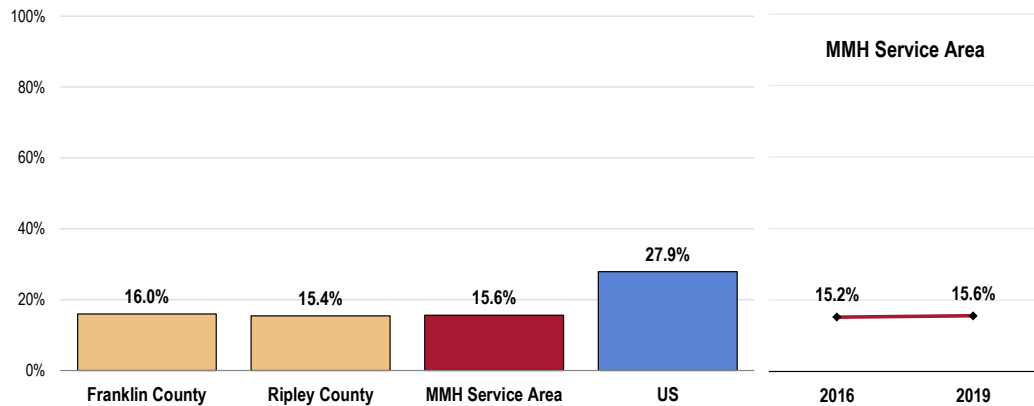
Surveyed adults were asked:

“Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was “Often True,” “Sometimes True,” or “Never True” for you in the past 12 months:

- *I worried about whether our food would run out before we got money to buy more.*
- *The food that we bought just did not last, and we did not have money to get more.”*

Those answering “Often” or “Sometimes True” for either statement are considered to be food insecure.

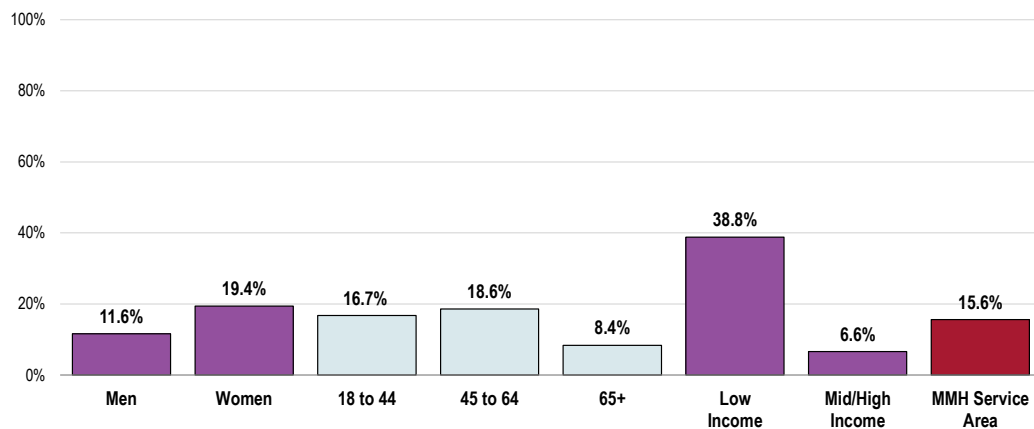
Food Insecurity



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 149]
• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• 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.

Food Insecurity (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 149]

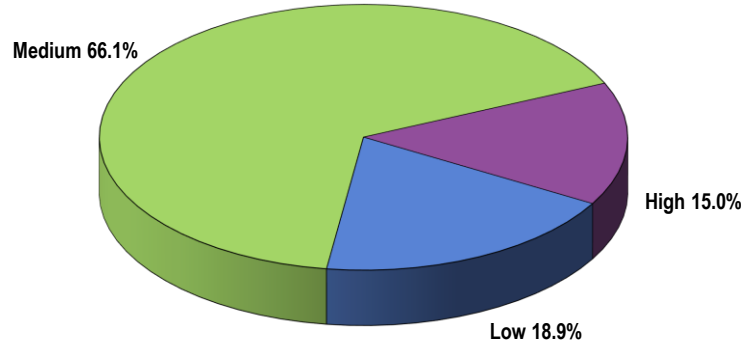
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes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

Health Literacy

Most surveyed adults in the MMH Service Area are found to have a moderate level of health literacy.

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.

Level of Health Literacy
(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 172]

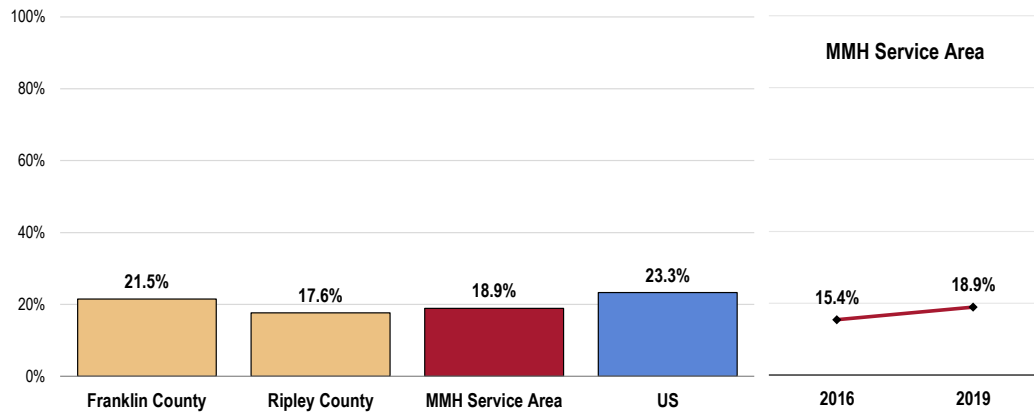
Notes: • Asked of all respondents.

• 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.

A total of 18.9% are determined to have low health literacy.

- **DISPARITY:** The prevalence is higher among seniors and low-income adults.

Low Health Literacy



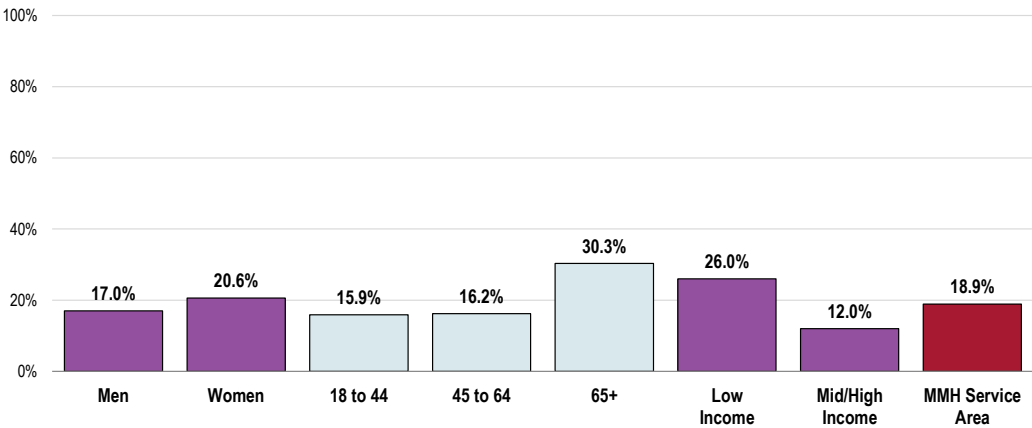
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 172]

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • 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.

Low Health Literacy
(MMH Service Area, 2019)



Sources:

- 2019 PRC Community Health Survey, PRC, Inc. [Item 172]

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.
- 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.

General Health Status

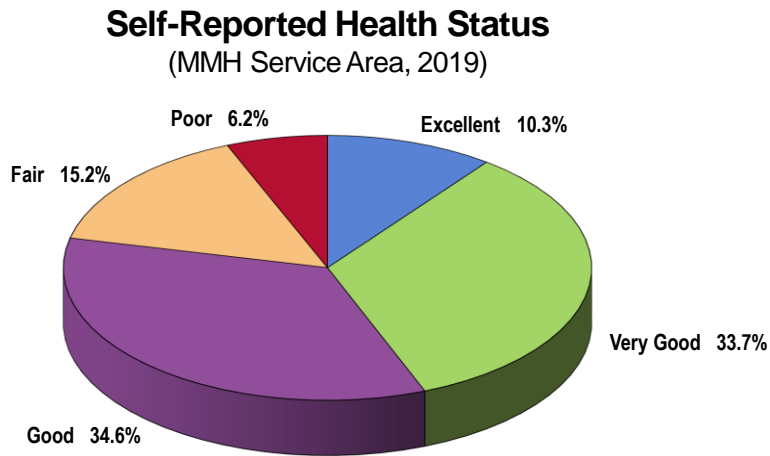


Overall Health Status

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

"Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"

Most MMH Service Area residents rate their overall health favorably (responding "excellent," "very good," or "good").

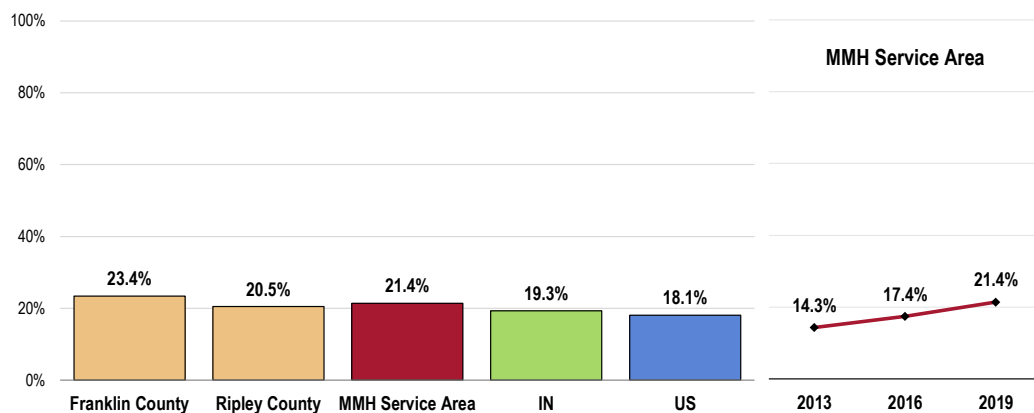


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

However, 21.4% of MMH Service Area adults believe that their overall health is "fair" or "poor."

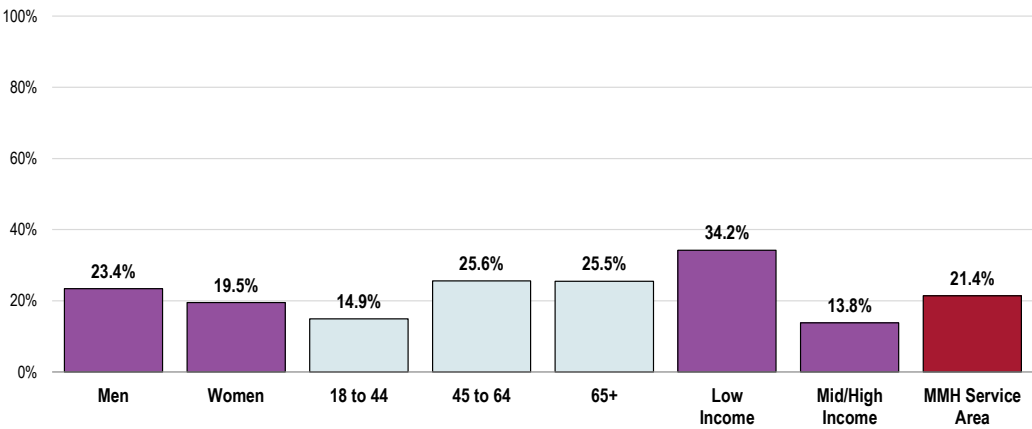
- **TREND:** Marks a statistically significant increase since 2013
- **DISPARITY:** The prevalence is higher among low-income residents.

Experience "Fair" or "Poor" Overall Health



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

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, and it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

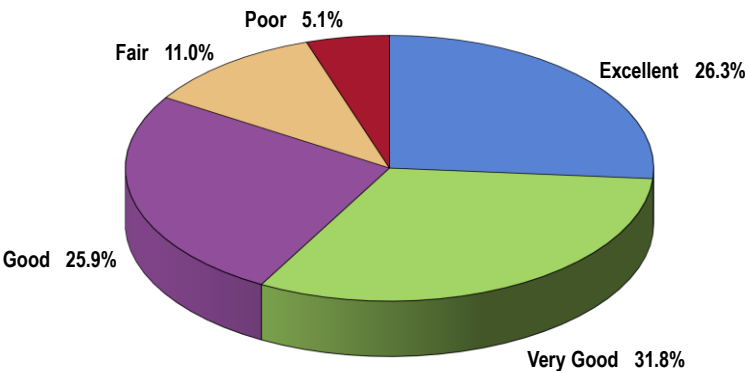
— Healthy People 2020 (www.healthypeople.gov)

Mental Health Status

Most MMH Service Area adults rate their overall mental health favorably (“excellent,” “very good,” or “good”).

“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
(MMH Service Area, 2019)

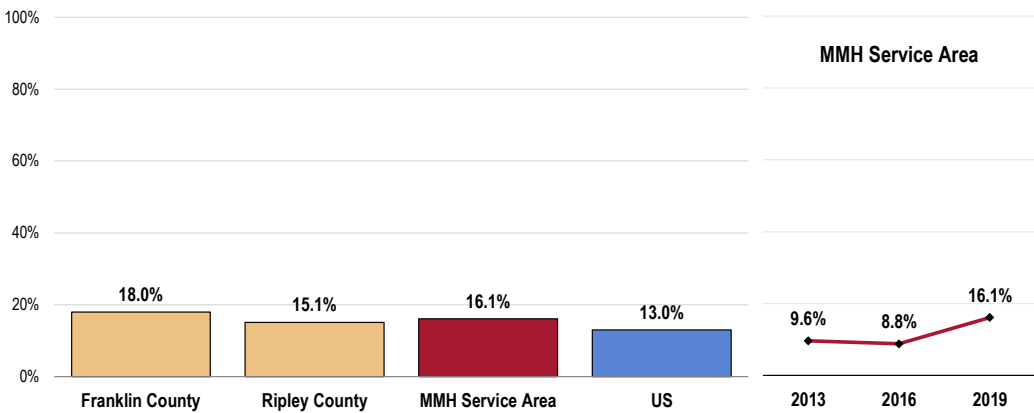


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 99]
Notes: • Asked of all respondents.

However, 16.1% believe that their overall mental health is “fair” or “poor.”

- **TREND:** Denotes a statistically significant increase from previous survey findings.

Experience “Fair” or “Poor” Mental Health



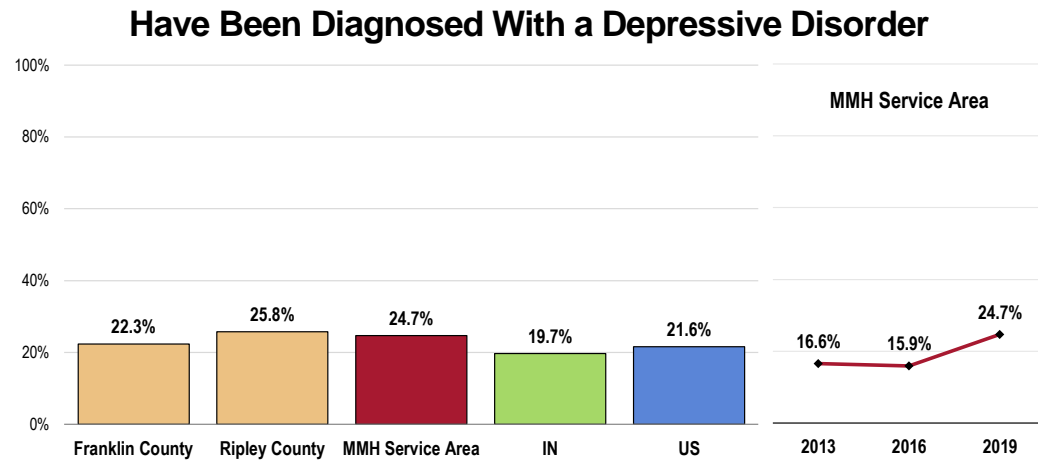
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 99]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Depression

Diagnosed Depression

A total of 24.7% 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).

- **BENCHMARK:** Above the Indiana prevalence.
- **TREND:** Marks a statistically significant increase from 2013 and 2016 findings.



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 102]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

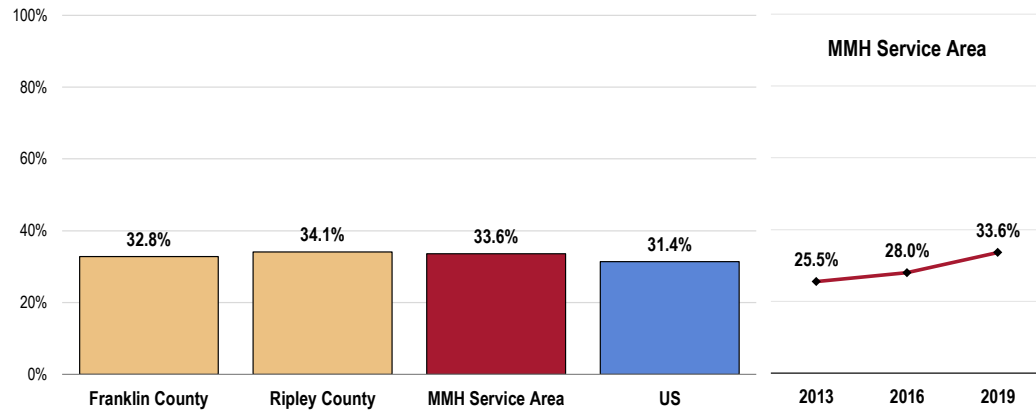
Notes: • Asked of all respondents.
 • Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

One-third (33.6%) 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).

- **TREND:** Denotes a statistically significant increase since 2013.
- **DISPARITY:** More often reported among adults under 65 and those in low-income households.

Have Experienced Symptoms of Chronic Depression



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 100]

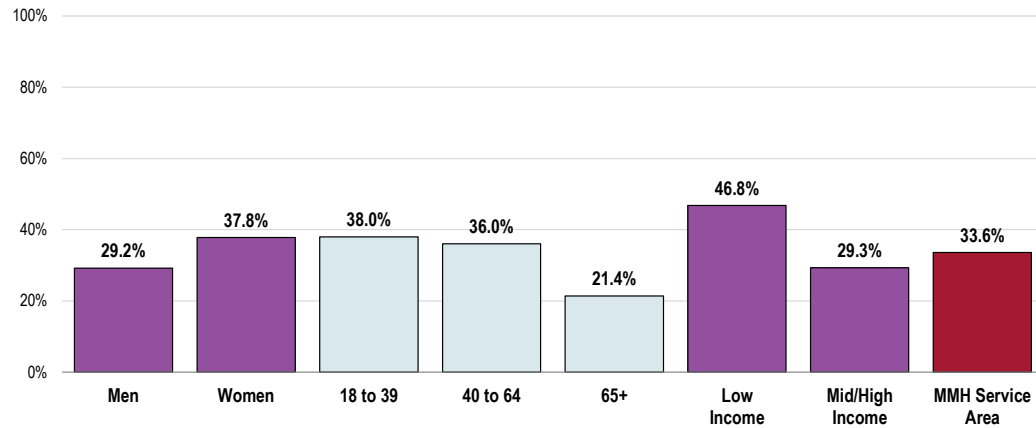
• 2017 PRC National Health Survey, PRC, Inc.

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.

Have Experienced Symptoms of Chronic Depression

(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 100]

Notes: • Asked of all respondents.

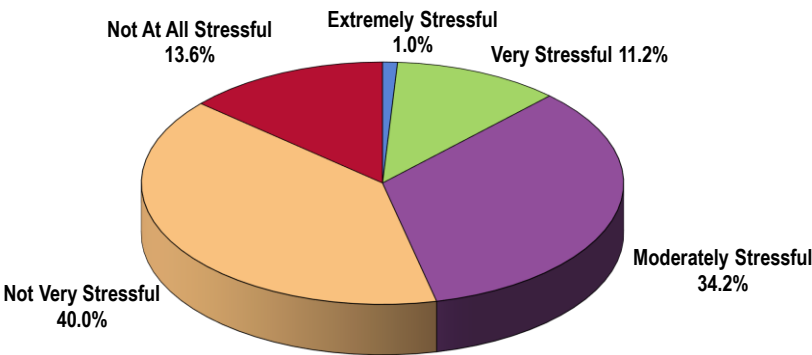
• Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

• 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

A majority of surveyed adults characterize most days as no more than “moderately” stressful.

Perceived Level of Stress On a Typical Day
(MMH Service Area, 2019)

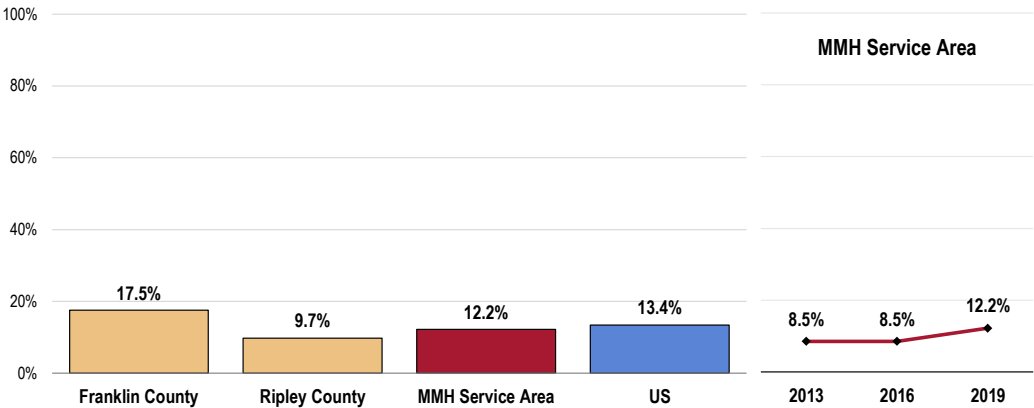


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 101]
Notes: • Asked of all respondents.

In contrast, 12.2% of MMH Service Area adults feel that most days for them are “very” or “extremely” stressful.

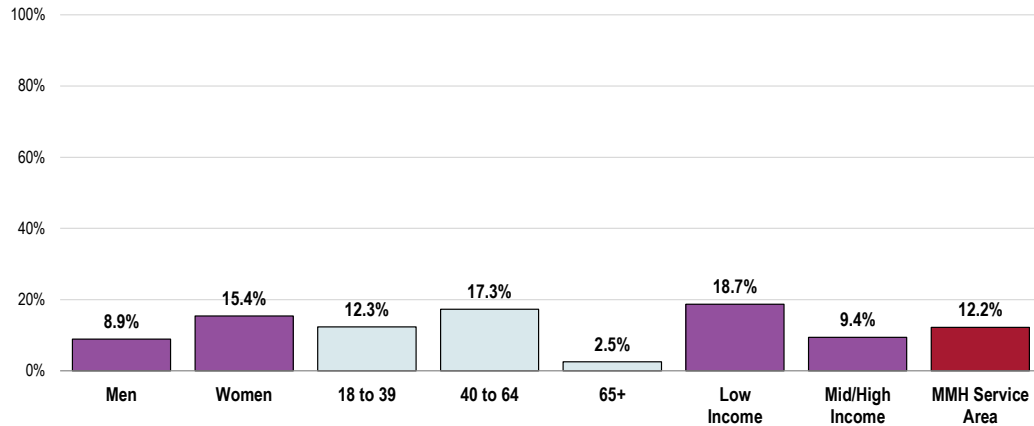
- DISPARITY: The prevalence is much higher in Franklin County. Higher among adults under 65 and those in low-income households.

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



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 101]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 101]

Notes: • Asked of all respondents.

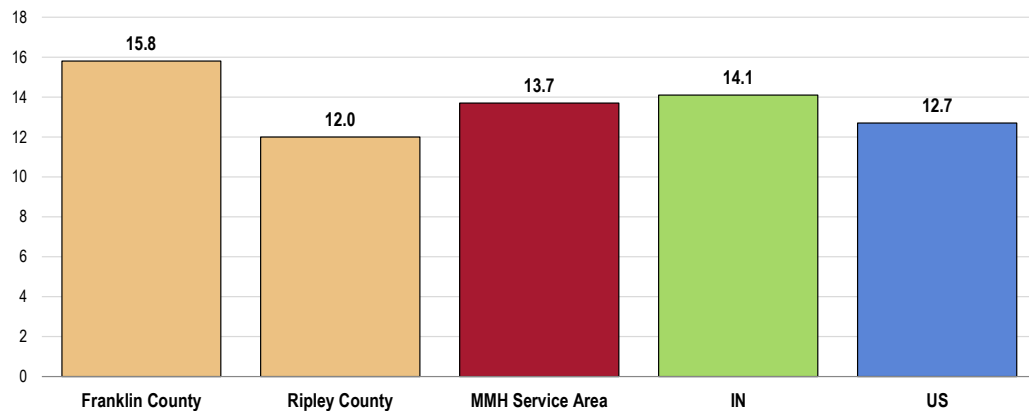
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty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

Suicide

Between 2008 and 2017, there was an annual average age-adjusted suicide rate of 13.7 deaths per 100,000 population in the MMH Service Area.

- **BENCHMARK:** Fails to satisfy the Healthy People 2020 objective.
- **DISPARITY:** The rate is higher in Franklin County.

Suicide: Age-Adjusted Mortality (2008-2017 Annual Average Deaths per 100,000 Population) Healthy People 2020 = 10.2 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 September 2019.

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

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

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

Mental Health Treatment

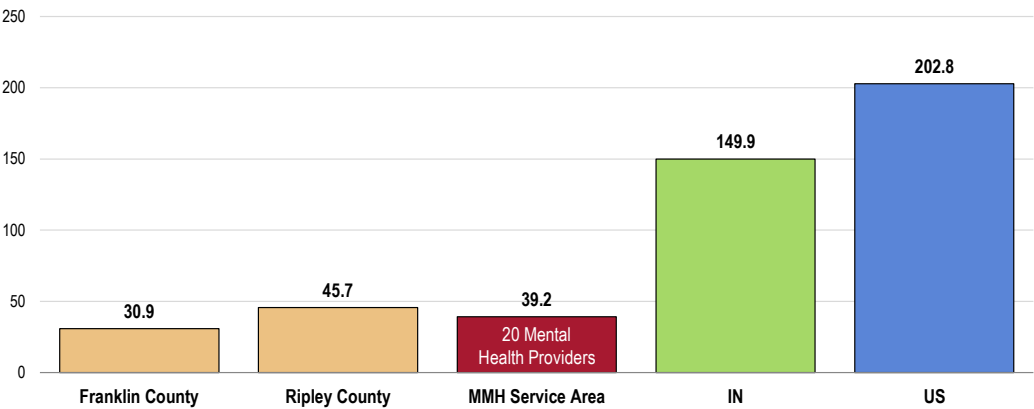
Mental Health Providers

In the MMH Service Area in 2017, there were 39.2 mental health providers for every 100,000 population.

- **BENCHMARK:** Much lower than state and national ratios.
- **DISPARITY:** Somewhat higher in Ripley County.

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care.

Access to Mental Health Providers
(Number of Mental Health Providers per 100,000 Population, 2017)



Sources:

- University of Wisconsin Population Health Institute, County Health Rankings.
- Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes:

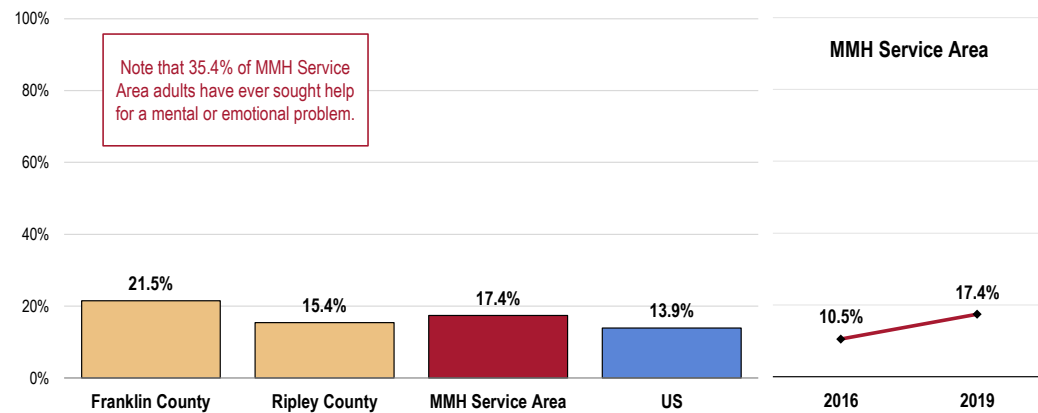
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Currently Receiving Treatment

A total of 17.4% are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

- **TREND:** Marks a statistically significant increase since 2016.

Currently Receiving Mental Health Treatment



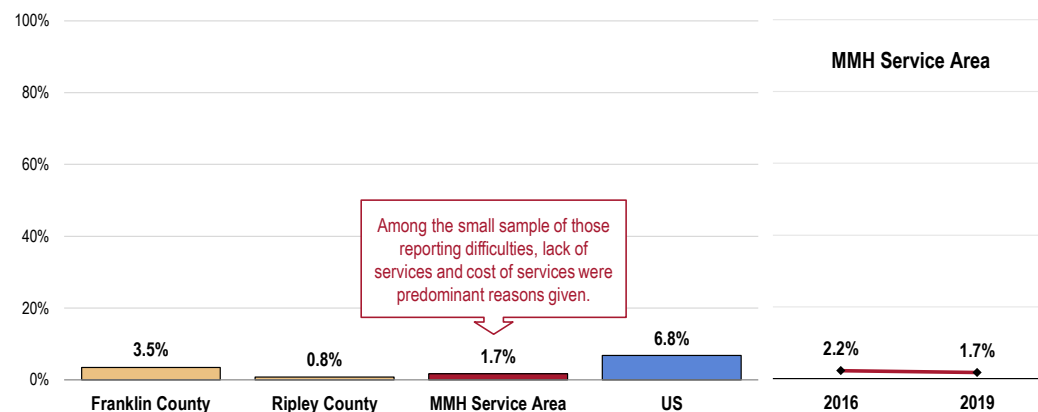
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 103-104]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • "Treatment" can include taking medications for mental health.

Difficulty Accessing Mental Health Services

A total of 1.7% 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.

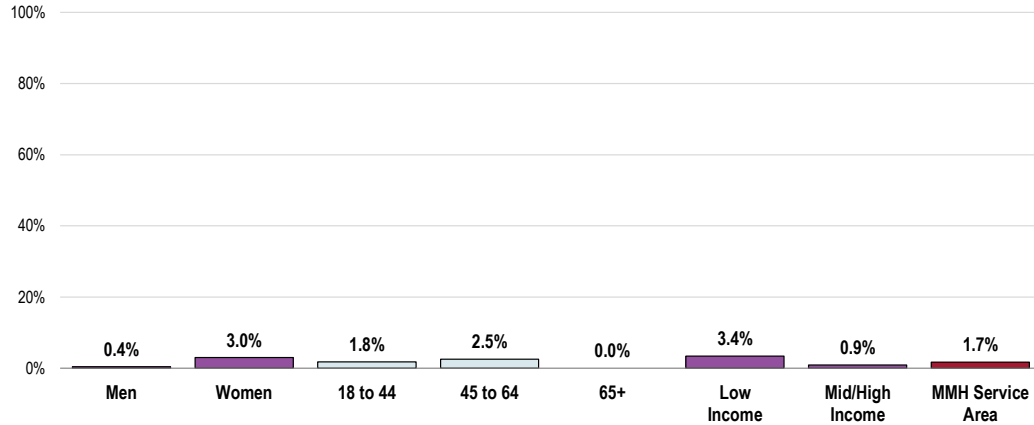
- **BENCHMARK:** Well below the US figure.
- **DISPARITY:** Higher among women and adults age 45 to 64.

Unable to Get Mental Health Services When Needed in the Past Year



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 105, 106]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 105]

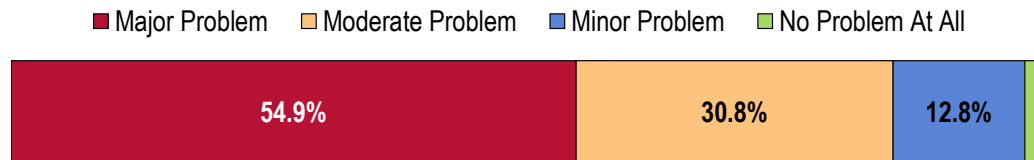
Notes: • Asked of all respondents.

• 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.

Key Informant Input: Mental Health

Over half 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, 2019)



Sources: • PRC Online Key Informant Survey, PRC, 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

I think that Centerstone and Community Mental Health have a near monopoly on the market when it comes to providing Mental Health and Substance Abuse related treatment. I think that gaining access to initial or ongoing treatment is a huge problem. Both Centerstone and Community Mental Health require patients to come to open-hours events that have limited hours in order to attempt to obtain an appointment. I think that it is unrealistic to expect people with depression to get up early to attend open-hour walk-in times in the hopes of possibly being able to get an appointment. – Community Leader

Access to consistent, appropriate treatment and medication management. – Other Health Provider

Access to care and ongoing treatment. – Community Leader

People unable to cope with stress and not having qualified people to speak to in a timely manner. – Community Leader

The lack of counseling services in proximity to our community (and the cost not covered by insurance) is a barrier for far too many community members (kids). Exponentially, the lack of counseling impacts schools and addiction counselors. Depression and anxiety are issues becoming issues that impact our community daily. – Community Leader

Very few or no resources exist locally for those with mental health issues or problems. No place for them to get help. – Community Leader

Very low coverage. – Community Leader

Lack of mental health services. – Community Leader

There are not enough medical resources in our community to provide the needed care. Many B/H needs are undiagnosed due to the limited access to B/H care. – Community Leader

Poor resource in Community Mental Health. – Community Leader

Access to mental health care plus after-hours help is hard to get. – Other Health Provider

On regular occasions individuals are located and suffer from mental illness. We as law enforcement have no resources available, or convenient to our location. – Community Leader

I believe our mental health facilities do not have the capacity to handle the problem in this area. I also believe the stigma around mental health issues keeps people from seeking help. – Community Leader

Lack of options, especially those with limited transportation and income. Franklin County gets no attention, all focus is on Ripley County. – Community Leader

They have to travel too far to receive help. – Community Leader

Services, education, and counselor turnover. – Community Leader

There are not local short-term inpatient facilities for patients needing stabilization. – Community Leader

There just are not enough resources for those who need it. Whether it is mental health as it relates to substance abuse or those who have natural mental health issues. As a police officer I hear from many people they have no options for their loved one or themselves to seek treatment. – Community Leader

Access to reliable treatment, and a sustained support system. – Community Leader

Lack of treatment for people struggling. – Community Leader

There is such an overturn with CMH in Batesville. Shortages of beds for inpatient care. Also, the opioid crisis and marijuana use tends to lead to psychosis. – Community Leader

Access to timely and quality assistance in a close vicinity. – Community Leader

Access to treatment, support and education on mental health. – Community Leader

The biggest issues are there is no resource in our community to have an evaluation and or treatment for mental health issues. I would have to transport a subject to Lawrenceburg or Richmond for a 48 hour hold over for evaluation. Then the subject is released. Many subjects in the local jail have mental issues and addition issues that have no means to be addressed in our small community. – Community Leader

Access to care. – Other Health Provider

Access to psychiatrist. – Physician

There are few options for persons with mental health problems. We need more therapists (psychologists/social workers) and psychiatrists (MD/DO) in the community. The biggest unmet need is that those with substance abuse problems need more assistance; incarceration does not help. The prosecutor's office knows this and does what it can, but people need help, not incarceration. – Physician

Access to care is the biggest challenge. Current providers are unable to meet the number of people and unique needs within this community (agriculture and youth nicotine/substance addiction). Stigma is still a barrier to treatment, though it seems to be decreasing. – Public Health Representative

Access to psychiatric services, primary care physicians, hospitalists, and surgeons have expressed difficulty in managing the multiple medications that people with mental health issues are typically on.

Access to alternative therapies for managing mental health issues. – Other Health Provider

I am very concerned about the mental health of many in our community but especially in our youth; we need to develop programs to educate these kids. One lost to suicide is one too many. Depression, anger management, bullying are all issues that need to be addressed on a deeper level. – Public Health Representative

Access to counseling, insurance coverage, access to psychiatric prescribing providers, monitoring and ongoing management for chronic conditions, access to inpatient psych. – Physician

Inability to have sufficient resources available to people. – Other Health Provider

Lack of patient care facilities and providers. – Other Health Provider

Access, payer source, stigma, and social determinants of health. – Social Services Provider

Access to resources and facilities or even affordable help, especially those with Medicaid or no health insurance. Individuals are reluctant to go to the city, Cincy or Indy, for help. Wished we had more facilities to refer to for help. – Social Services Provider

Facilities are full and won't accept patients. – Other Health Provider

Access to services. It seems like it is very challenging to receive quality mental health services in a timely manner, especially if they are needed urgently. More specifically, there is a lack of resources in our community for eating disorder patients needing intensive management. – Other Health Provider

Access to Providers

Not enough case workers for individuals with mental health issues. – Social Services Provider

Lack of access to mental health providers, lack of safe/sober living. – Other Health Provider

Shortage of mental health care providers. – Community Leader

There are not enough specifically trained mental health workers for the county. Example, eating disorders has the highest death rate for a mental health disorder, yet there are no services offered in the county for eating disorders. – Community Leader

Getting into a mental health facility or provider who can truly help them. Even when they are already established at a facility, they often won't get them in directly. – Other Health Provider

Lack of psychiatrists in the area; lack of social workers and therapists to work with those who have serious mental health disorders; housing that is not secure enough or needs more activities for clients; we have many adolescents who are unable to find therapists in the area due to lack of resources; we desperately need more therapists for young people and more psychiatrists and psychologists. – Community Leader

Lack of quality care and options. – Social Services Provider

Lack of providers and lack of insurance for such conditions. – Other Health Provider

No regular mental health support like local psychiatrist. Few therapists. – Physician

Limited access to providers; would be difficult to access services like counseling or psychiatry unless almost at crisis level. Community and culture not necessarily conducive to good mental health—economy/work demands, midwestern grit-it-out culture, etc. Stigma around mental illness/criminal justice system sometimes becomes default provider of services. – Community Leader

Lack of mental health providers. – Other Health Provider

There is no therapist available in the area aside from CMHC and a few local therapists that do not take Medicaid. There is no HSPP, outside the hospital/CMHC, that provide psychological assessments, at least that I'm aware of. – Social Services Provider

Awareness/Education

Lack of understanding among residents. – Community Leader

The lack of acknowledgement or secrecy, due to embarrassment, behind families who have a family member with mental health issues. Not all families know where to seek help in these circumstances. – Social Services Provider

Parents are unsure about what it means to have mental health issues. As a result, some parents are in denial. This causes a delay in students getting help. I believe educating the public is the answer to this issue. – Community Leader

Making people realize that mental health issues are diseases just like heart disease, diabetes and cancer. – Community Leader

Mental Health is an issue in our community because it is not an easy topic. Mental health needs to be addressed starting at a young age and resources need to be more accessible to all ages. – Community Leader

Denial/Stigma

Them getting the care they need as there is a stigma that goes with having a mental health issue. I feel that mental health and substance abuse go "hand in hand." – Other Health Provider

Stigma in the community which prevents people from seeking treatment and feeling supported. Access to services due to a limited number of providers and workforce recruitment issues. – Social Services Provider

I feel there is a stigma that follows mental health and is often "pushed under the rug". If we had open dialogue in our community about varying mental health challenges – suicide, depression, anxiety, etc. then the community can address it together. There is also a significant lack of resources available for treatment. – Community Leader

Contributing Factors

Children living with grandparents or relatives and lack of counseling for both. – Community Leader

More and more children are having issues since there are so many divided families. – Other Health Provider

Mental illness; 185th

see much more anxiety, depression. I feel more folks take medication. – Other Health Provider

Prevalence/Incidence

Again, working in the library, we see several people come to the library daily with mental issues. We get to know some of them well. They need to feel like they belong and are part of the community. They need someone to talk to and feel like others care. – Community Leader

It's a problem everywhere. – Community Leader

Affordable Care/Services

Cost incurred if no insurance. Waiting time to see a doctor. System is not user friendly to navigate. – Other Health Provider

Disease Management

Not getting the help they need, are they taking their medication. A lot of the time they end up in the jail. – Community Leader

Suicide

Increased suicide planning and attempts, especially with our youth. – Community Leader

Death, Disease & Chronic Conditions

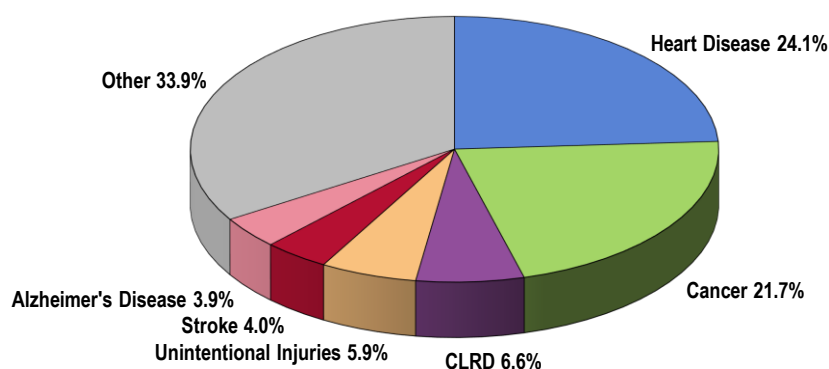


Leading Causes of Death

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for over 4 in 10 deaths in the MMH Service Area between 2015 and 2017.

Leading Causes of Death
(MMH Service Area, 2015-2017)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

About Age-Adjusted Death Rates

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 objectives.

The following chart outlines 2015-2017 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 (2015-2017 Deaths per 100,000 Population)

| | MMH Service Area | Indiana | US | HP2020 |
|--|------------------|---------|-------|--------|
| Diseases of the Heart | 186.1 | 182.0 | 166.3 | 156.9* |
| Malignant Neoplasms (Cancers) | 165.4 | 172.9 | 155.6 | 161.4 |
| Unintentional Injuries | 60.3 | 52.7 | 46.7 | 36.4 |
| Chronic Lower Respiratory Disease (CLRD) | 49.8 | 55.1 | 41.0 | n/a |
| Cerebrovascular Disease (Stroke) | 30.8 | 39.6 | 37.5 | 34.8 |
| Alzheimer's Disease | 29.7 | 34.4 | 30.2 | n/a |
| Diabetes | 23.4 | 26.5 | 21.3 | 20.5* |
| Unintentional Drug-Related Deaths** | 16.3 | 14.5 | 12.3 | 11.3 |
| Pneumonia/Influenza | 16.2 | 13.4 | 14.3 | n/a |
| Motor Vehicle Deaths** | 15.3 | 11.7 | 11.0 | 12.4 |
| Firearm-Related | 14.6 | 14.3 | 11.6 | 9.3 |
| Intentional Self-Harm (Suicide)** | 13.7 | 14.1 | 12.7 | 10.2 |
| Kidney Disease** | 11.4 | 19.2 | 13.8 | n/a |
| Cirrhosis/Liver Disease** | 7.6 | 9.9 | 10.1 | 8.2 |

- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.
- Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
 - *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
 - **Rates reflect 2008-2017 annual age-adjusted rates.

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 2015 and 2017, there was an annual average age-adjusted heart disease mortality rate of 186.1 deaths per 100,000 population in the MMH Service Area.

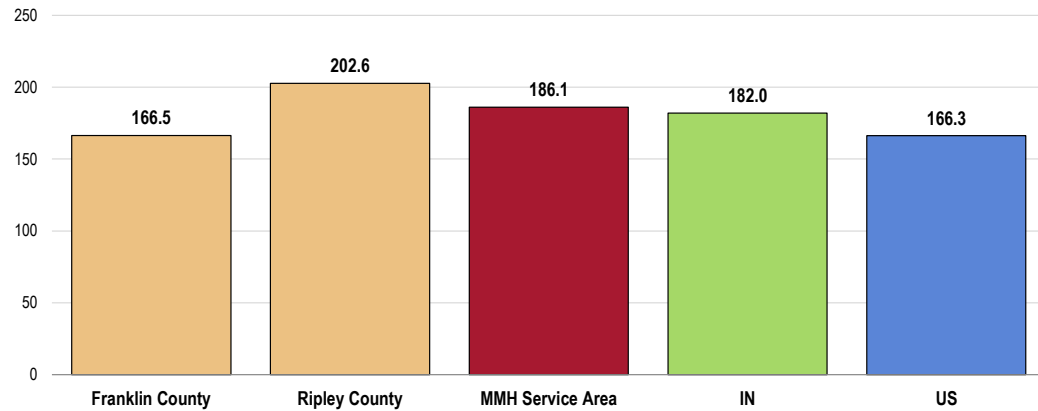
- **BENCHMARK:** Fails to satisfy the Healthy People 2020 objective.
- **TREND:**
- **DISPARITY:**

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

Heart Disease: Age-Adjusted Mortality

(2015-2017 Annual Average Deaths per 100,000 Population)

Healthy People 2020 = 156.9 or Lower (Adjusted)

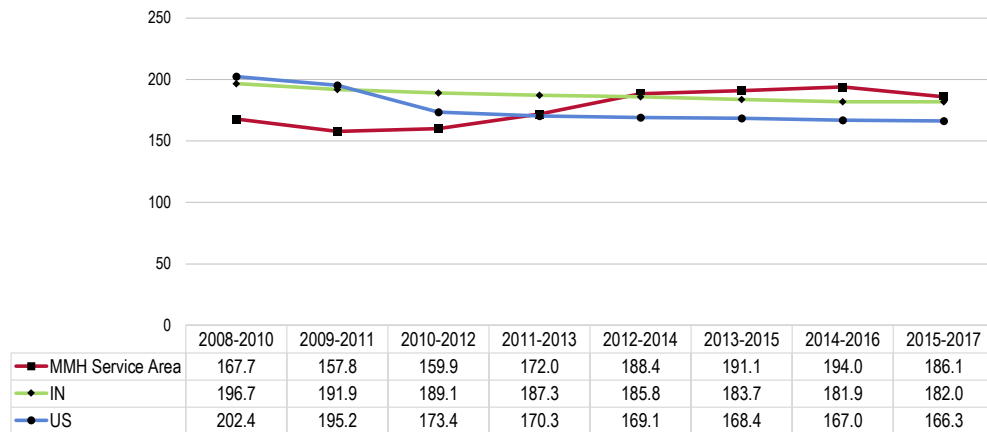


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 = 156.9 or Lower (Adjusted)



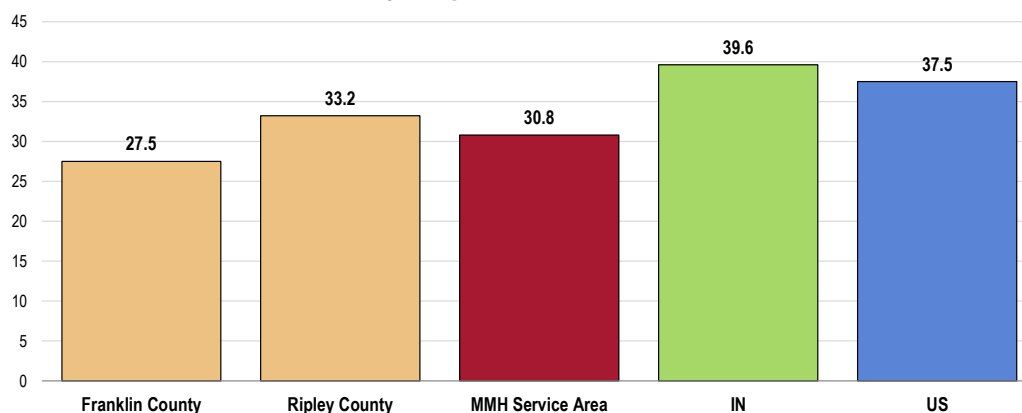
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

Between 2015 and 2017, there was an annual average age-adjusted stroke mortality rate of 30.8 deaths per 100,000 population in the MMH Service Area.

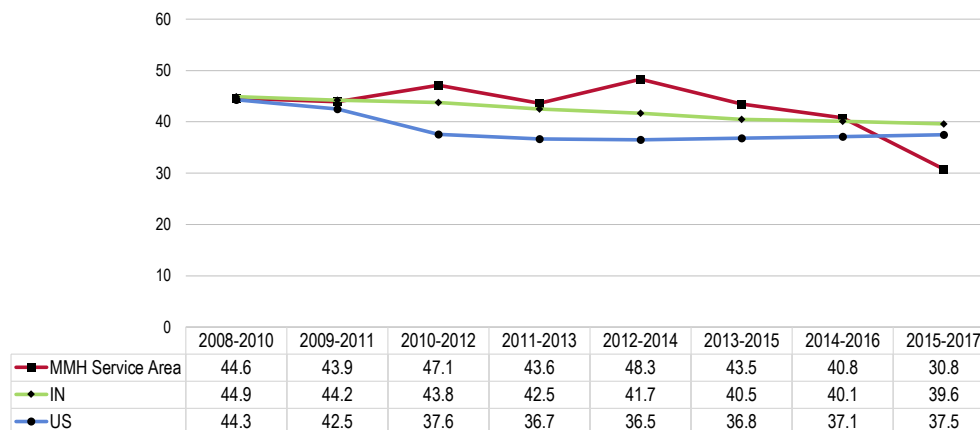
- **BENCHMARK:** Well below the state and US mortality rates.
- **TREND:** Declining in recent years.

Stroke: Age-Adjusted Mortality (2015-2017 Annual Average Deaths per 100,000 Population) Healthy People 2020 = 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 September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Stroke: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 = 34.8 or Lower



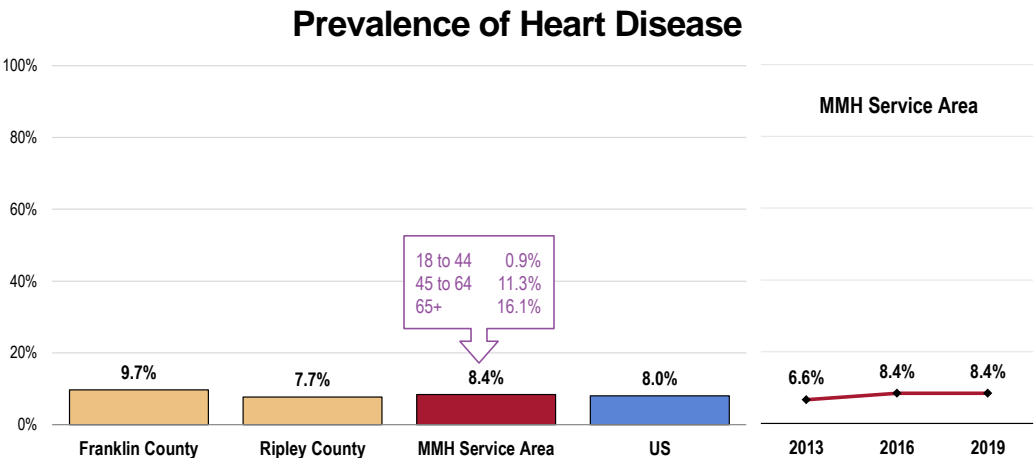
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

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.

- DISPARITY: The prevalence correlates with age.



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 128]
• 2017 PRC National Health Survey, PRC, Inc.

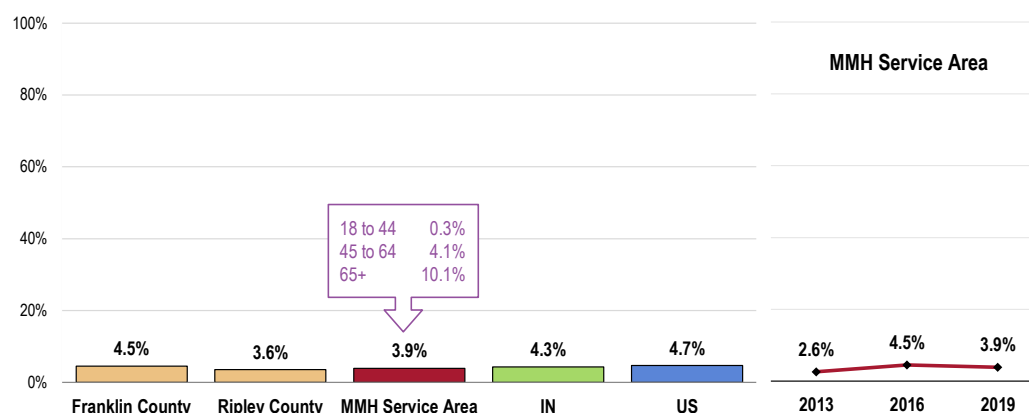
Notes: • Asked of all respondents.
• Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke

A total of 3.9% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- DISPARITY: The prevalence correlates with age.

Prevalence of Stroke



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 33]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

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)

Blood Pressure & Cholesterol

A total of 42.3% of MMH Service Area adults have been told at some point that their blood pressure was high.

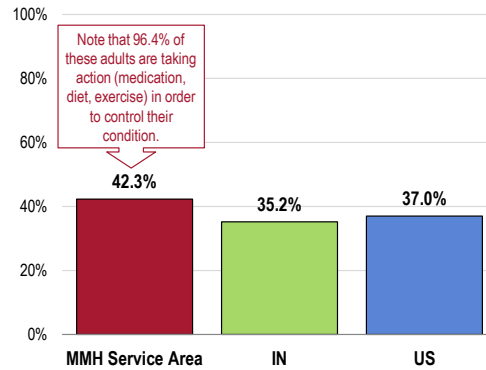
- **BENCHMARK:** Higher than the state prevalence and failing to meet the Healthy People 2020 goal.

A total of 30.4% of adults have been told by a health professional that their cholesterol level was high.

- **BENCHMARK:** Below the US prevalence but failing to satisfy the Healthy People 2020 objective.

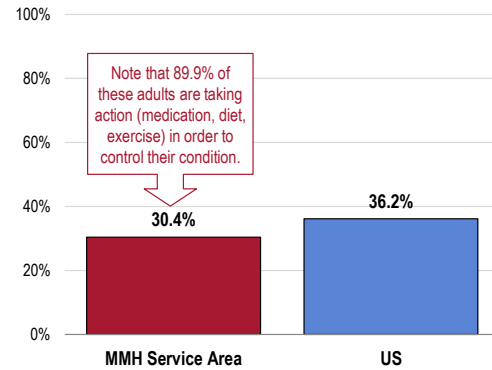
Prevalence of High Blood Pressure

Healthy People 2020 = 26.9% or Lower



Prevalence of High Blood Cholesterol

Healthy People 2020 = 13.5% or Lower

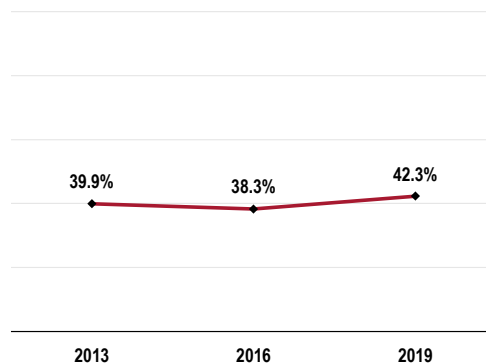


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 41, 44, 129, 130]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives HDS-5.1, HDS-7]

Notes: • Asked of all respondents.

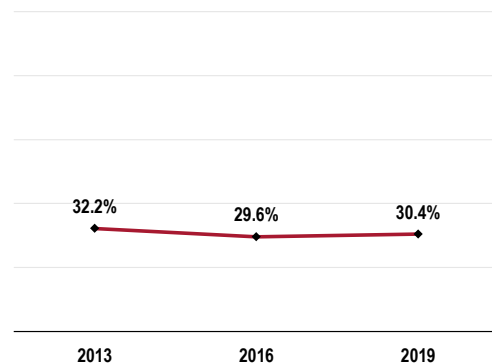
Prevalence of High Blood Pressure (MMH Service Area)

Healthy People 2020 = 26.9% or Lower



Prevalence of High Blood Cholesterol (MMH Service Area)

Healthy People 2020 = 13.5% or Lower



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 129, 130]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives HDS-5.1, HDS-7]

Notes: • Asked of all respondents.

Total Cardiovascular Risk

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.

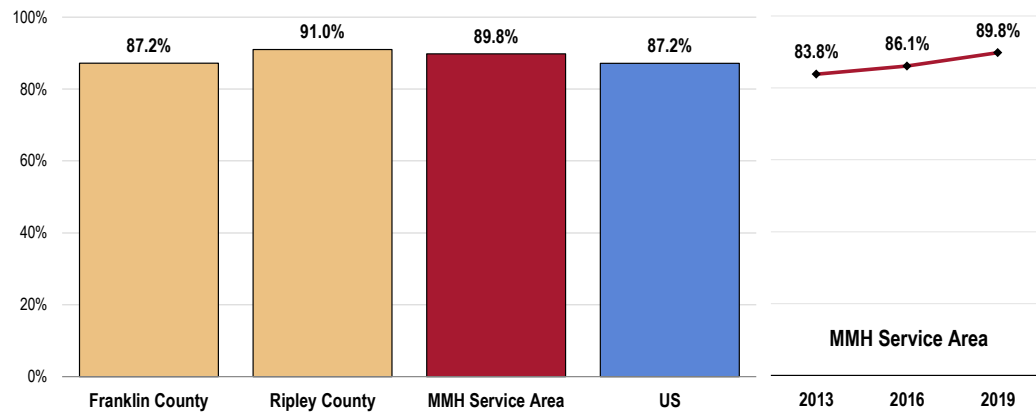
— National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Most (89.8%) 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.

- **TREND:** A statistically significant increase since 2013.
- **DISPARITY:** Service area men are statistically more likely than women to report at least one cardiovascular risk factor.

RELATED ISSUE:
See also *Nutrition, Physical Activity, Weight Status, and Tobacco Use* in the **Modifiable Health Risks** section of this report.

Present One or More Cardiovascular Risks or Behaviors

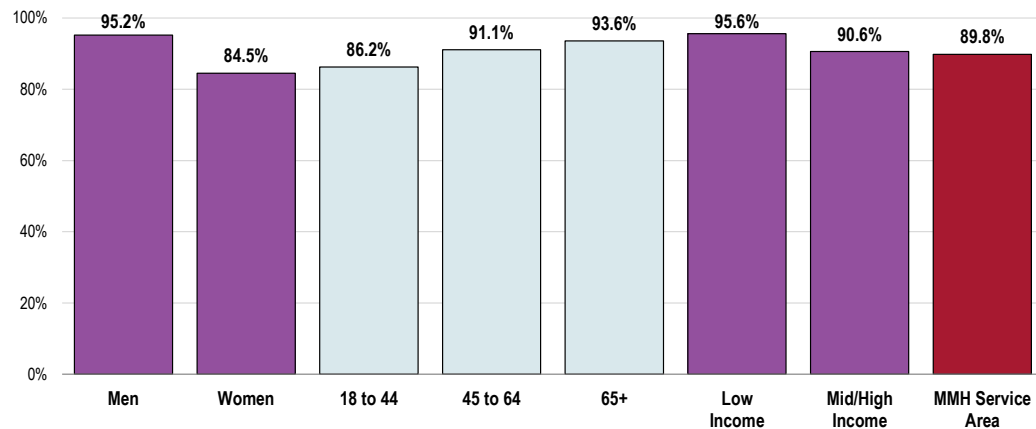


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 131]
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Reflects 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) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Present One or More Cardiovascular Risks or Behaviors

(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 131]

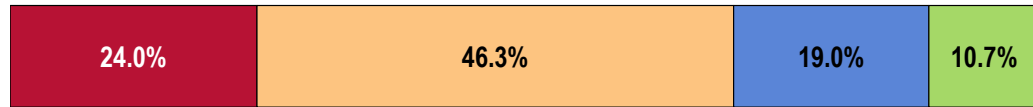
Notes: • Reflects all respondents.
 • Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.
 • Income categories reflect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

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, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Prevalence/Incidence

I feel heart and stroke is affecting the much younger. I again know more friends and family who suffer from heart disease. – Other Health Provider

Heart disease and stroke is a major concern as the majority of citizens in Ripley and Franklin Counties are overweight, have a horrible diet, smoke tobacco, and consume extreme amounts of alcohol. – Community Leader

I think it's a problem nationwide. – Community Leader

So many heart attacks and strokes in young population. – Community Leader

I believe that's based on national statistics and my belief that it is an equal problem locally. No independent knowledge that it's more or less than described nationally. – Community Leader

Numerous incidents occurring. Seems to be more common and frequent. – Community Leader

A large percentage of all the patients that I see for nutrition counseling are on statins. – Other Health Provider

Increased incident; need for immediate treatment. – Other Health Provider

They are major problems as they are prevalent here. – Other Health Provider

It is a common disease that we usually find in our patients here at the hospital. – Social Services Provider

Need coronary CT scoring here due to widespread CAD. – Physician

Prevalence of CAD and stroke, after event care, accessibility to rehab, subacute, SNF, cardiopulmonary. – Physician

This is a nationwide problem; our community is not immune to it. – Public Health Representative

Even young people, younger than 50, are having heart attacks and strokes. – Other Health Provider

These diseases have a long history of being a major health concern. Genetics and lifestyle influence greatly impact individuals. – Social Services Provider

I believe heart disease and stroke are major problems with one common denominator with diabetes. Good fresh food and the lack of exercise. – Community Leader

Lifestyle

Poor health practices. – Community Leader

Lack of a health-conscious culture in the community. Smoking, poor nutrition and lack of exercise is prevalent with lower income households. – Social Services Provider

Poor nutrition, lack of exercise, and lack of education. – Social Services Provider

Traditional dietary habits not challenged. – Community Leader

Lack of healthy eating, lack of healthy eating options, lots of people are under stress or have anxiety due to work or home or lack of financial security, smoking, excessive drinking. – Community Leader

Awareness/Education

Lack of education, obesity, elevated blood pressure. Community members not having a PCP. – Other Health Provider

Comorbidities

Many of the patients that are seen in our ED have co-morbid conditions of heart disease and risk factors for strokes. – Community Leader

Leading Cause of Death

Number of deaths and illnesses among the citizenry due to heart disease and stroke. – Community Leader

Obesity

In our society, many people are overweight/obese, don't eat healthy foods and don't exercise regularly. These are things that can lead to heart disease and stroke. – Community Leader

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)

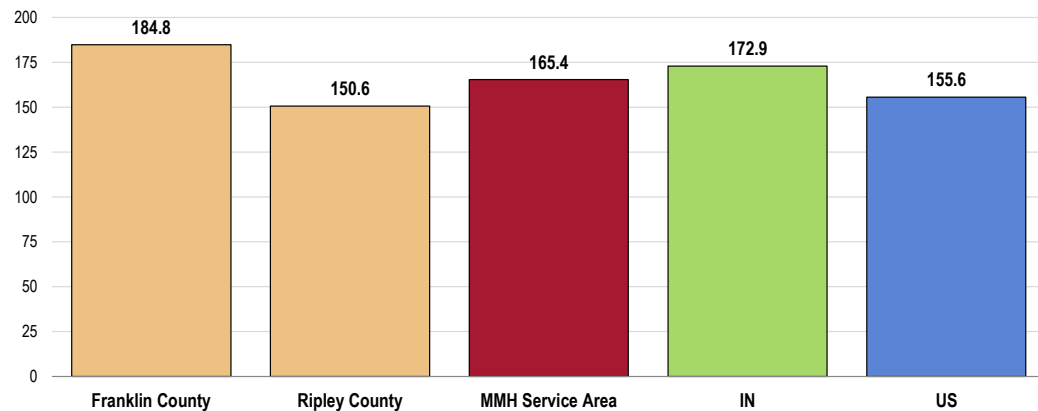
Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2015 and 2017, there was an annual average age-adjusted cancer mortality rate of 165.4 deaths per 100,000 population in the MMH Service Area.

- **TREND:** Decreasing in recent years.

Cancer: Age-Adjusted Mortality
(2015-2017 Annual Average Deaths per 100,000 Population)
Healthy People 2020 = 161.4 or Lower



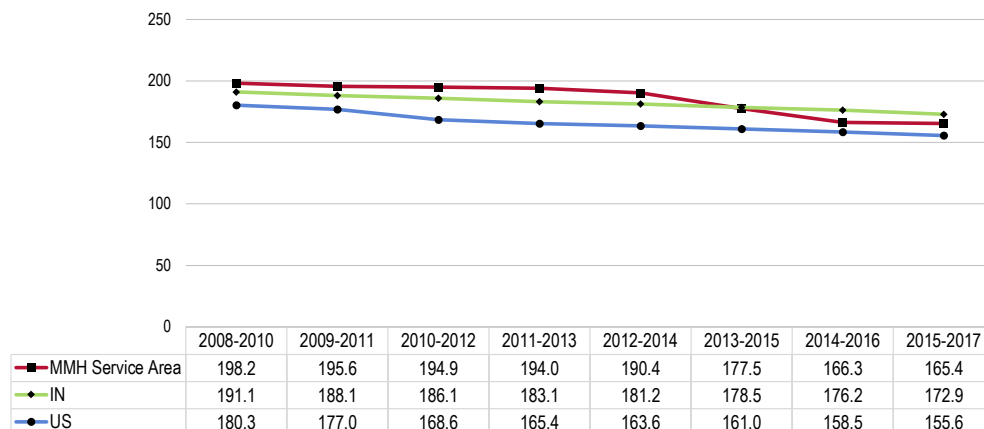
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.

Notes: • 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: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 = 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 September 2019.

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

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

BENCHMARKS: Based on 2008-2017 annual average age-adjusted cancer death rates by site, note the following unfavorable comparisons for the MMH Service Area:

- **Lung Cancer:** Higher than the national rate. Fails to satisfy the Healthy People 2020 objective.
- **Prostate Cancer:** Higher than both state and national rates. Fails to satisfy the Healthy People 2020 objective.
- **Colorectal Cancer:** Higher than the national rate. Fails to satisfy the Healthy People 2020 objective.

Age-Adjusted Cancer Death Rates by Site (2008-2017 Annual Average Deaths per 100,000 Population)

| | MMH Service Area | Indiana | US | HP2020 |
|-----------------------------|------------------|--------------|--------------|--------------|
| ALL CANCERS | 165.4 | 172.9 | 155.6 | 161.4 |
| Lung Cancer | 54.4 | 48.8 | 38.5 | 45.5 |
| Prostate Cancer | 26.1 | 18.9 | 18.9 | 21.8 |
| Female Breast Cancer | 19.8 | 20.7 | 20.1 | 20.7 |
| Colorectal Cancer | 17.1 | 15.4 | 13.9 | 14.5 |

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

Cancer Incidence

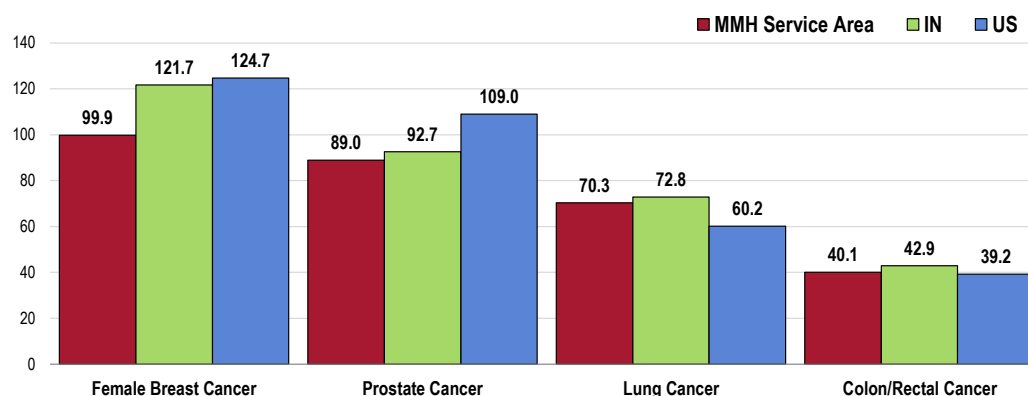
Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted.

The highest cancer incidence rates are for breast cancer in women and prostate cancer in men.

BENCHMARKS: Based on 2011-2015 annual average incidence rates by site, note the following favorable comparisons for the MMH Service Area:

- **Female Breast Cancer:** Lower than both state and national rates.
- **Prostate Cancer:** Lower than the national rate.

Cancer Incidence Rates by Site (Annual Average Age-Adjusted Incidence per 100,000 Population, 2011-2015)



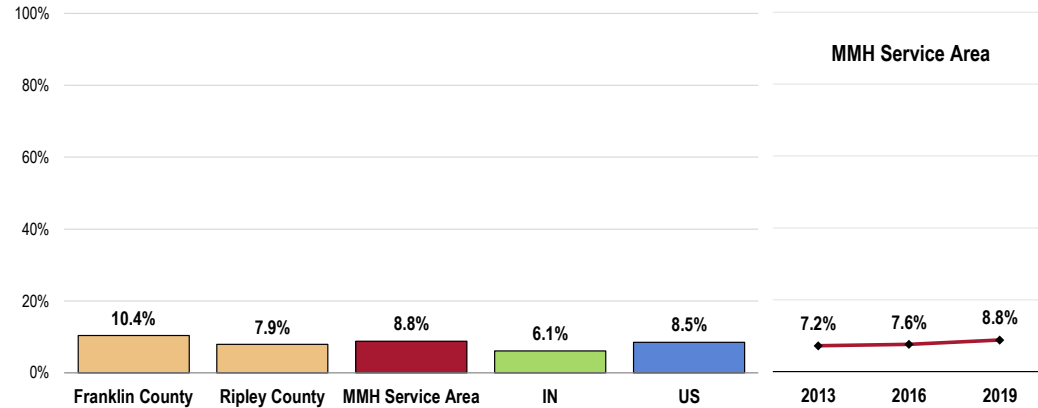
Sources: • State Cancer Profiles.
• Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under 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

A total of 8.8% of surveyed MMH Service Area adults report having been diagnosed with skin cancer.

Prevalence of Skin Cancer



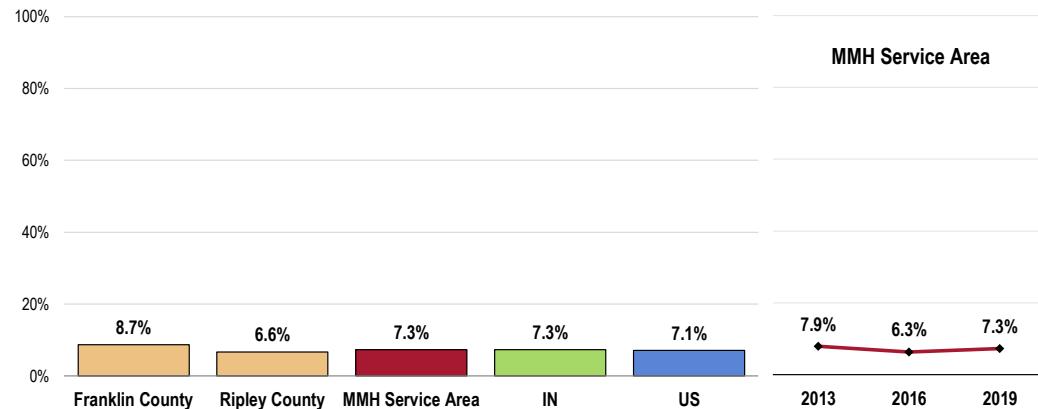
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 28]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Other Cancers

A total of 7.3% of survey respondents have been diagnosed with some type of (non-skin) cancer.

Prevalence of Cancer (Other Than Skin Cancer)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 27]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

RELATED ISSUE:

See also *Nutrition, Physical Activity, Weight Status, and Tobacco Use* in the **Modifiable Health Risks** section of this report.

Cancer Risk

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

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.

Female Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years.

Colorectal Cancer

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

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

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

Among men age 50 and older, 68.0% have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

- **BENCHMARK:** Much higher than the state prevalence.

Among women age 50-74, 74.3% have had a mammogram within the past 2 years.

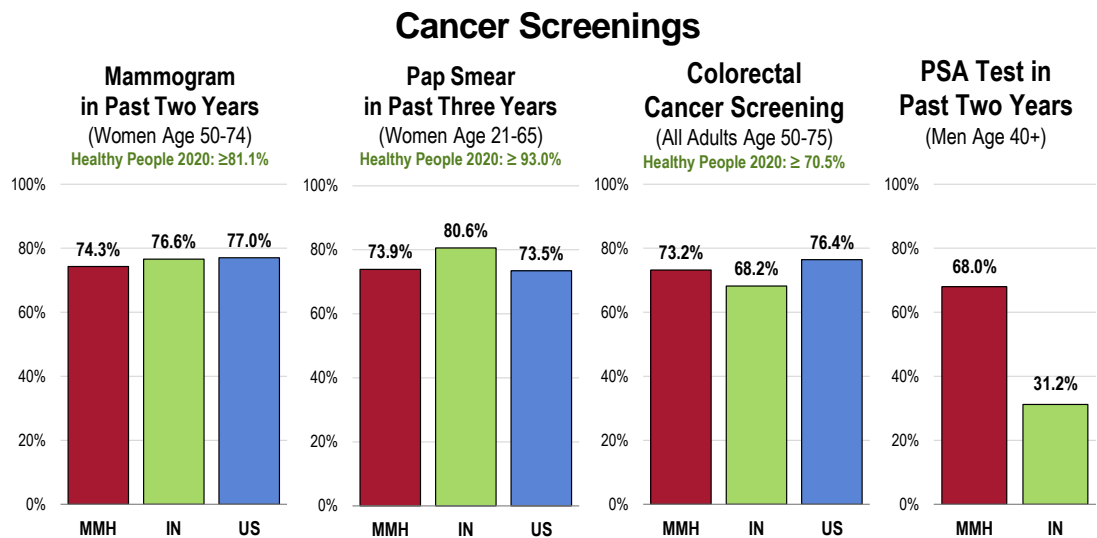
Among MMH Service Area women age 21 to 65, 73.9% have had a Pap smear within the past 3 years.

- **BENCHMARK:** Higher than the Indiana figure and failing to satisfy the Healthy People 2020 objective.

Among all adults age 50-75, 73.2% have had appropriate colorectal cancer screening.

- **DISPARITY:** Lower in Franklin County (not shown).

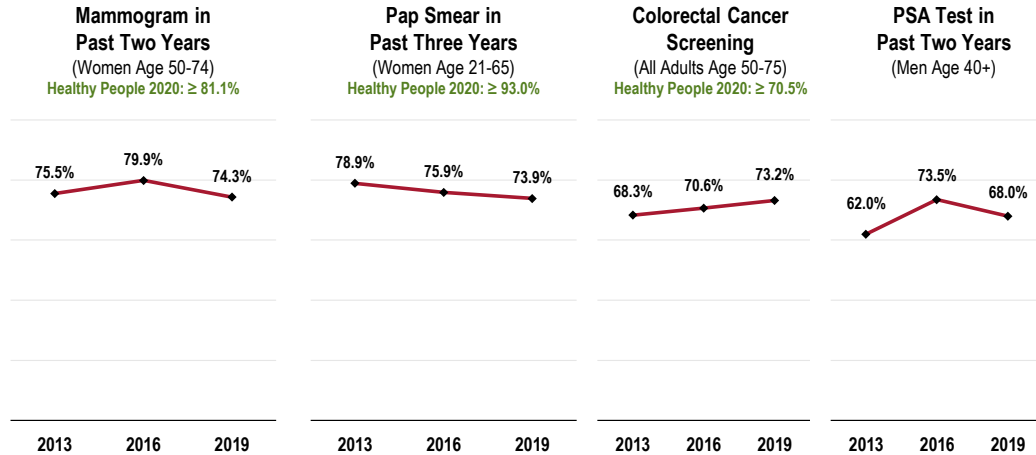
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 133, 134, 137, 319]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives C-15, C-16, C-17]

Notes: • Each indicator is shown among the gender and/or age group specified.

Cancer Screenings: MMH Service Area Trends

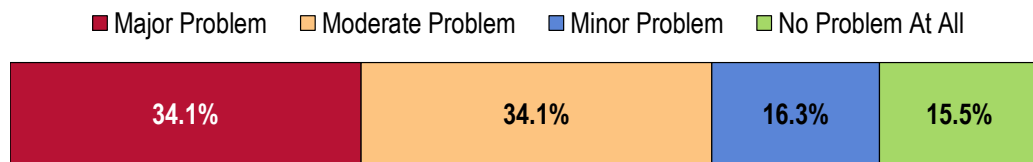


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 133, 134, 137, 319]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives C-15, C-16, C-17]
 Notes: • Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey were equally likely to characterize **Cancer** as a “major problem” or a “moderate problem” in the community.

Perceptions of Cancer as a Problem in the Community (Key Informants, 2019)



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

Top Concerns

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

Prevalence/Incidence

- It's a major killer among the small population of Franklin county. The cost of treatment is out of control. – Community Leader*
- It seems like lots of new cancer diagnosis happen in this area. – Social Services Provider*
- So many people I know, of all ages in our community, suffer from this disease. – Community Leader*

Seems like many that you talk with have experienced cancer themselves or someone close to them. – Community Leader

Seems to be numerous people are being diagnosed with some form of cancer. – Community Leader

So many cancer diagnoses for young to middle-age populations. – Community Leader

I see it in the history of many of our patients. Many members of my own family have been diagnosed with or have had cancer. – Community Leader

It seems to affect many people in all age ranges in our area. Every day you hear about another person who has been diagnosed with some type of cancer. – Community Leader

It seems like we're always hearing about another person who has been diagnosed with cancer in our community. About three years ago I was also diagnosed with cancer and it was a big surprise for me. I don't know exactly why, but it seems that we have a large amount of people in Franklin and Ripley counties who have cancer. – Community Leader

Our local area, and the tri-state, in general, has a higher than average rate of cancer. In my opinion, more research needs to be dedicated to why different forms of cancer are so prevalent in this area, and what can be done about it. We have excellent facilities and professionals to treat cancer, but let's get to the root cause and avoid cancer. – Community Leader

Many in and outside of my family have been diagnosed with the disease. – Community Leader

I have had friends and relatives with it and I also hear of many others who are affected. – Community Leader

Appears, per capita, many citizens in this area have been diagnosed with some form of cancer. – Community Leader

I had recently read the Southeastern Indiana region is seeing an increase in cancer diagnosis. Every day I hear of someone in our being diagnosed. – Community Leader

There seems to be a large amount of people in this area with cancer. – Community Leader

It seems like we have had an exceptional number of people diagnosed with cancer recently. We are lucky to have the Hanson Center, but I wish we had even more treatments available to people locally. I also worry about environmental factors and smoking. – Community Leader

There seems to be a high rate of cancer in our community compared to national averages. – Community Leader

Cancer is prevalent in our community, breast and lung especially. – Other Health Provider

Just seems very prevalent. – Social Services Provider

Cancer is far reaching, impacting many systems of the body. Environmental influences, smoking, genetics, etc. all play a role. – Social Services Provider

It seems like every time you turn around there is someone else you hear about in the community with cancer. It may due to early detection but possibly an issue environmentally that needs to be examined. – Social Services Provider

Too many people are getting it. We're fortunate to have access to a good treatment center though. – Public Health Representative

For such a small community, I know so many people and their families who are dealing with various forms and stages of cancer. – Public Health Representative

I write several stories a year concerning people dealing with various kinds of cancer. I know it is a serious problem in the community. Many people I know personally have cancer. I am a cancer survivor. – Community Leader

I know many people in the community that have been diagnosed with some form of cancer. My family has personally been affected by cancer. We have a cancer treatment facility located within our health care system. – Other Health Provider

It seems more and more people are identified with cancer and so I believe we need more resources dedicated to resolving and or helping with the issues created. – Community Leader

Knowing and hearing of young people, younger than 40, being diagnosed with breast cancer. – Other Health Provider

GI cancer appears to have a higher rate in this area. – Other Health Provider

See many patients with it. Several family members have it or had it. – Other Health Provider

I feel cancer is an issue everywhere. – Other Health Provider

I know many friends and family members who have or have battled cancer. – Other Health Provider

Many people are affected by different types of cancer. – Community Leader

Many people I know are impacted by cancer. – Community Leader

Access to Care/Services

The nearest treatment center is a half hour away. Individuals have to travel and be prepared for fatigue, illness, etc. due to treatment. – Community Leader

We are fortunate to have an Oncology Center in our area that stays busy. We often see them at our hospital as well. We are seeing cancer patient from all ages. – Social Services Provider

Contributing Factor

Very low cure rate. – Community Leader

Seems like so many have it and find it once it is untreatable. – Community Leader

Affordable Care/Services

Access to affordable care, access to dependable care. People are traveling out of state for treatment opposed to staying within our community. – Community Leader

Tobacco Use

Smoking, poor health habits, lack of money for routine cancer screenings. – 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)

Age-Adjusted Respiratory Disease Deaths

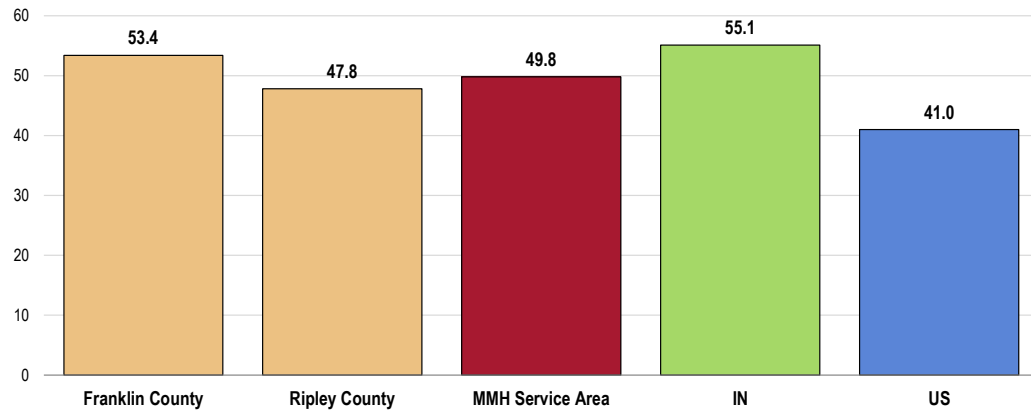
Chronic Lower Respiratory Disease Deaths (CLRD)

Note: Chronic lower respiratory disease (CLRD) includes lung diseases such as emphysema, chronic bronchitis, and asthma.

Between 2015 and 2017, there was an annual average age-adjusted CLRD mortality rate of 49.8 deaths per 100,000 population in the MMH Service Area.

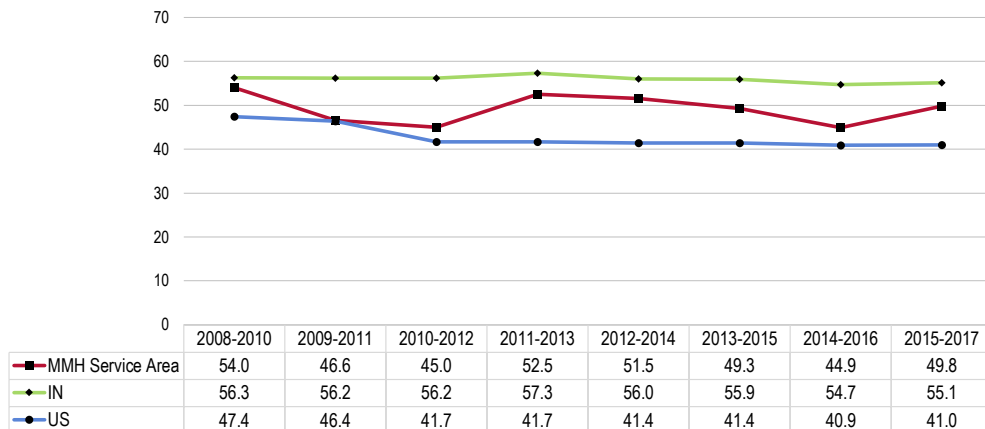
- **BENCHMARK:** Worse than the US mortality rate for CLRD.

CLRD: Age-Adjusted Mortality (2015-2017 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 September 2019.
- 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.

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



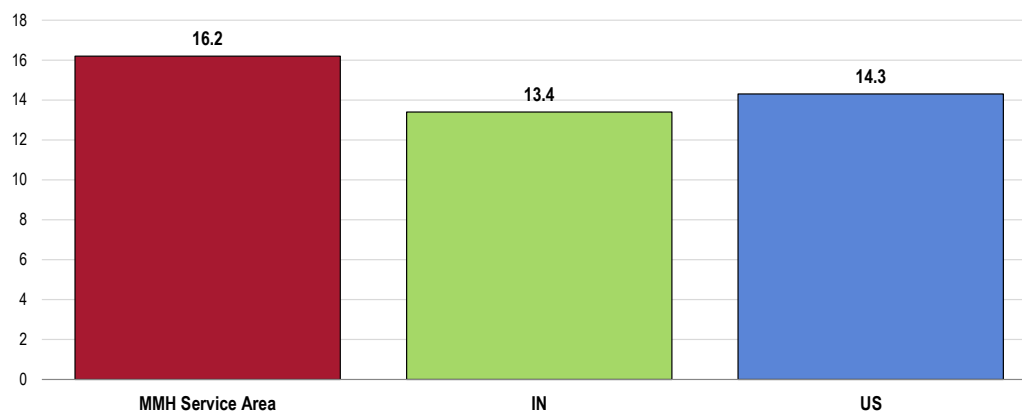
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification 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.

Pneumonia/Influenza Deaths

Between 2015 and 2017, the MMH Service Area reported an annual average age-adjusted pneumonia/influenza mortality rate of 16.2 deaths per 100,000 population.

- **BENCHMARK:** Higher than the state mortality rate.

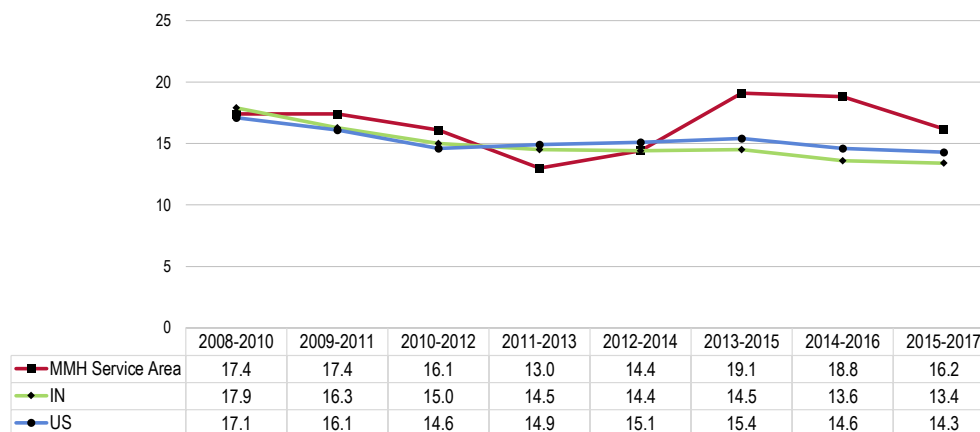
Pneumonia/Influenza: Age-Adjusted Mortality (2015-2017 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.

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.

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 September 2019.

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.

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)

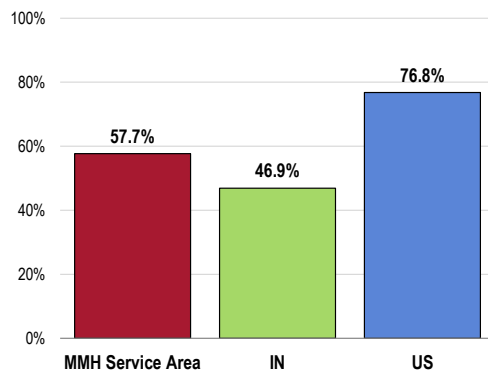
Among MMH Service Area adults age 65 and older, 57.7% received a flu vaccination within the past year.

- **BENCHMARK:** Above the Indiana percentage but below the US. Fails to satisfy the Healthy People 2020 objective.

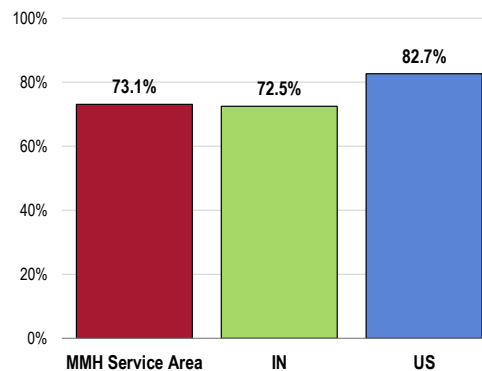
Among MMH Service Area adults age 65 and older, 73.1% have received a pneumonia vaccination at some point in their lives.

- **BENCHMARK:** Below the US prevalence and failing to meet the Healthy People 2020 objective.
- **TREND:** Denotes a statistically significant increase from 2013 (not shown).

**Older Adults:
Flu Vaccination in the Past Year
(Adults Age 65+)**
Healthy People 2020 = 70.0% or Higher



**Older Adults:
Ever Had a Pneumonia Vaccine
(Adults Age 65+)**
Healthy People 2020 = 90.0% or Higher



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 144, 146]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.12]
 Notes: • Reflects respondents 65 and older.

Prevalence of Respiratory Disease

Asthma

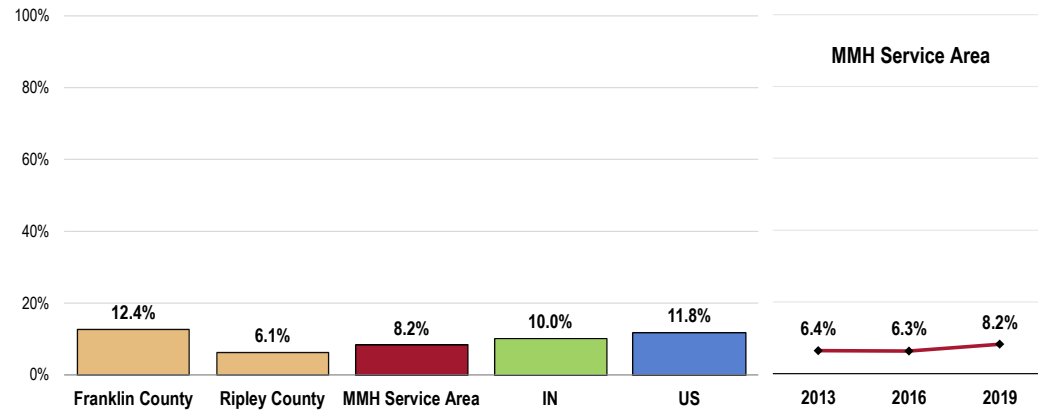
Adults

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

- **BENCHMARK:** Well below the US prevalence.
- **DISPARITY:** Twice as high in Franklin County as in Ripley County. Higher among women and low-income respondents.

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

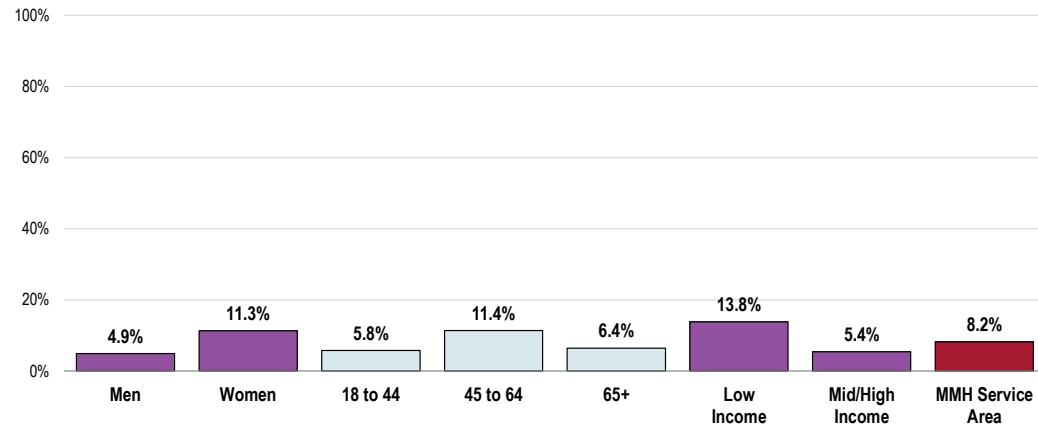
Prevalence of Asthma



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 138]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma (MMH Service Area, 2019)

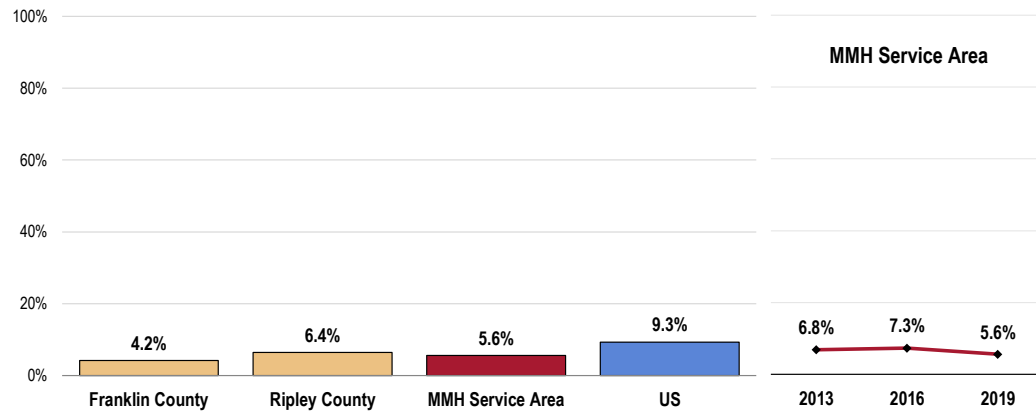


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 138]
 • Asked of all respondents.
 • Includes those who have ever been diagnosed with asthma and report that they still have asthma.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

Among MMH Service Area children under age 18, 5.6% currently have asthma.

Prevalence of Asthma in Children (Parents of Children Age 0-17)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 139]

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children 0 to 17 in the household.

• Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

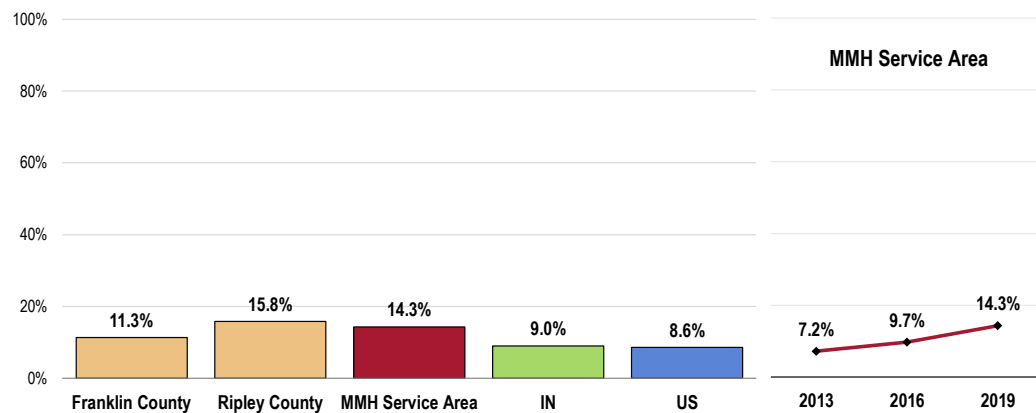
Chronic Obstructive Pulmonary Disease (COPD)

Note: COPD includes lung diseases such as emphysema and chronic bronchitis.

A total of 14.3% of MMH Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- **BENCHMARK:** Much higher than the state and nationwide percentages.
- **TREND:** Denotes a statistically significant increase since 2013.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 24]

• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents; in prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

• 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 “minor problem” in the community.

Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, PRC, Inc.
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 obesity. – Social Services Provider

Smoking cigarettes is still very prevalent in our community. The addition of vaping has increased the number of users as well as the frequency of use. Many who could not smoke inside would wait longer to go outside. Now they can use a vape inside, so they do it more frequently. It is astonishing to see how many people are walking around with oxygen tanks and still vape. – Other Health Provider

Smoking is ingrained in some families as being fine. – Community Leader

Smoking. – Community Leader

Comorbidities

There are co-morbid patients that are admitted seen in the ED or primary care MD office that have COPD. Respiratory conditions are the most frequently seen readmission diagnosis. – Community Leader

Environmental Contributors

There are respiratory diseases, due to environmental reasons, that are prevalent in the Ohio Valley. These diseases cause many issues on their own plus add to the reasons people get pneumonia. – Social Services Provider

Access to Care/Services

I personally have respiratory disease when referred to local pulmonologist was told it would be 5-months before I could get a first appointment. Totally unacceptable. – Public Health Representative

Prevalence/Incidence

COPD in a large section of adult and childhood asthma. Both conditions are cost drivers on EMS and county health nurses, etc. – Public Health Representative

Affordable Care

Affordability of medications and access to durable medical equipment, tobacco use. – Physician

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

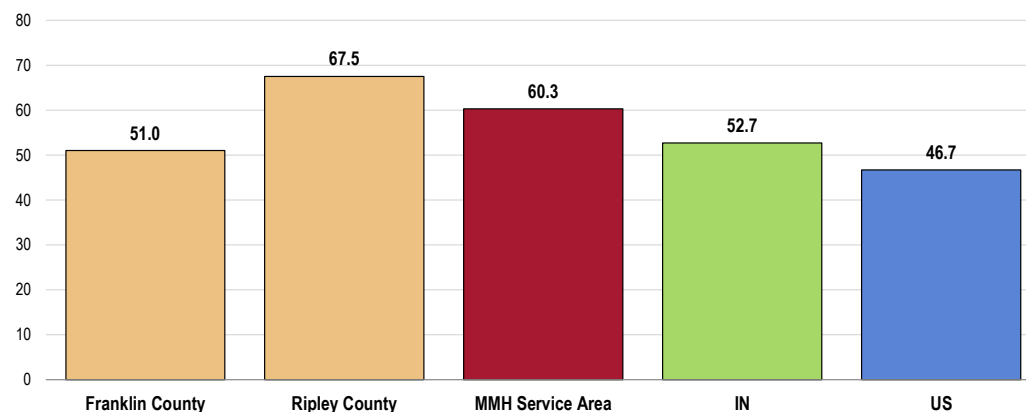
Age-Adjusted Unintentional Injury Deaths

Between 2015 and 2017, there was an annual average age-adjusted unintentional injury mortality rate of 60.3 deaths per 100,000 population in the MMH Service Area.

- **BENCHMARK:** Well above the US mortality rate and failing to satisfy the Healthy People 2020 objective.
- **TREND:** Note the increase over time, echoing the state and national trends.
- **DISPARITY:** Lower in Franklin County.

Unintentional Injuries: Age-Adjusted Mortality (2015-2017 Annual Average Deaths per 100,000 Population)

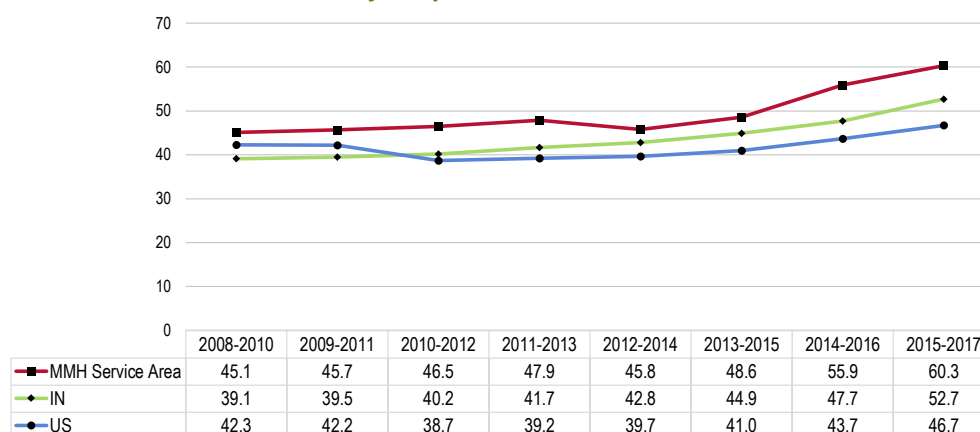
Healthy People 2020 = 36.4 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Healthy People 2020 = 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 September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

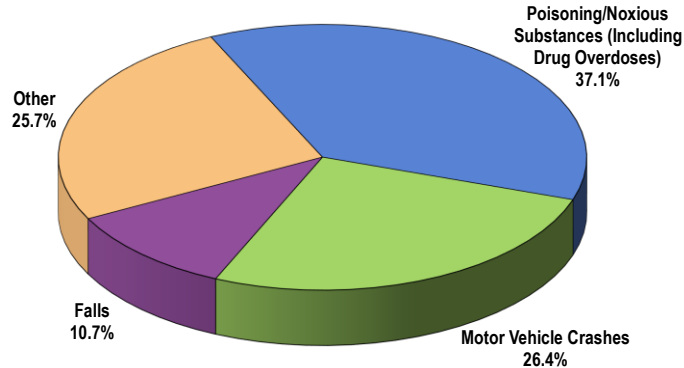
RELATED ISSUE:

For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading Causes of Unintentional Injury Deaths

Poisoning (including unintentional drug overdose), motor vehicle crashes, and falls accounted for most unintentional injury deaths in the MMH Service Area between 2015 and 2017.

Leading Causes of Unintentional Injury Deaths
(MMH Service Area, 2015-2017)



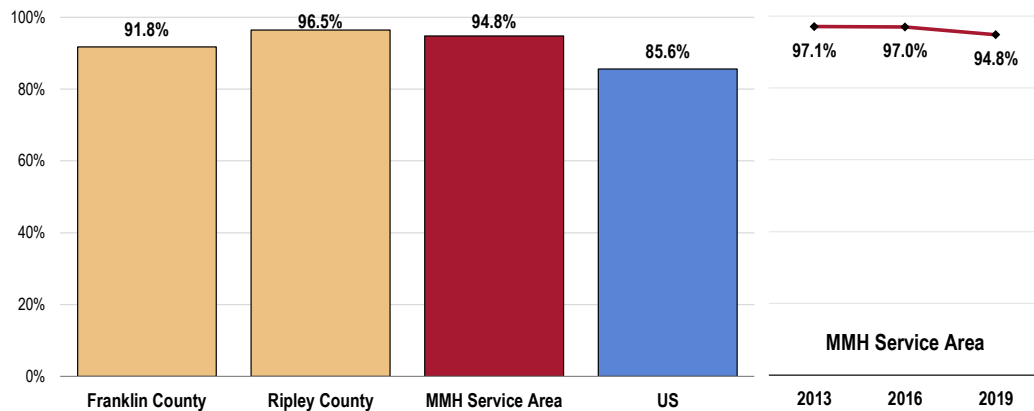
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Motor Vehicle Safety

A total of 94.8% of surveyed 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.

- **BENCHMARK:** Above the US prevalence.

Child “Always” Uses a Seat Belt/Car Seat in a Vehicle
(Among Parents of Children Age 0-17)



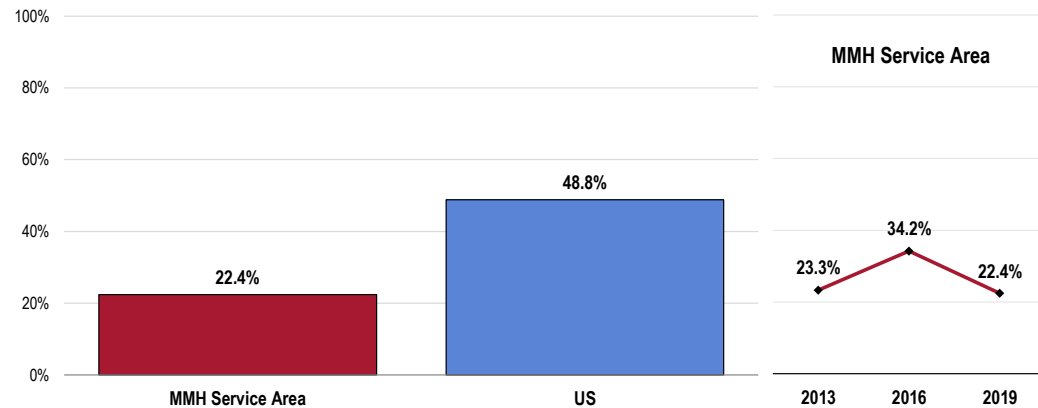
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 315]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with a child under 18 at home.

Bicycle Safety

A total of 22.4% of service area children age 5 to 17 are reported to “always” wear a helmet when riding a bicycle.

- **BENCHMARK:** Less than half the US prevalence.
- **TREND:** Unchanged from 2013 but a statistically significant decrease since 2016.

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



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 314]

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with a child age 5-17 at home.

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 ≥ 65 years died as a result of injuries from falls.

Falls are the leading cause of fatal and nonfatal injuries for persons aged ≥ 65 years ... In 2006, approximately 1.8 million persons aged ≥ 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.

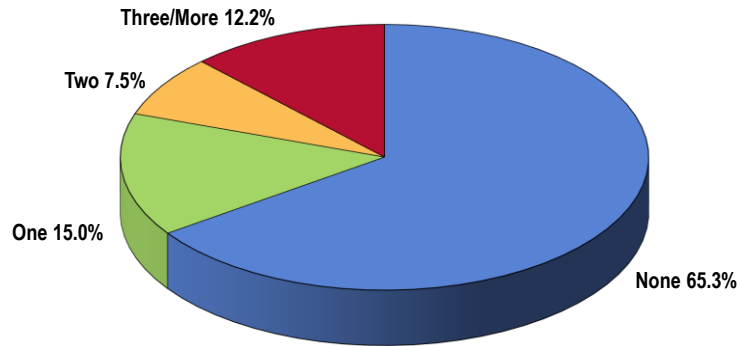
In addition, fall-related medical treatment places a burden on US healthcare services. In 2000, direct medical costs for fall-related injuries totaled approximately \$19 billion. A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of 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, most have not fallen in the past year.

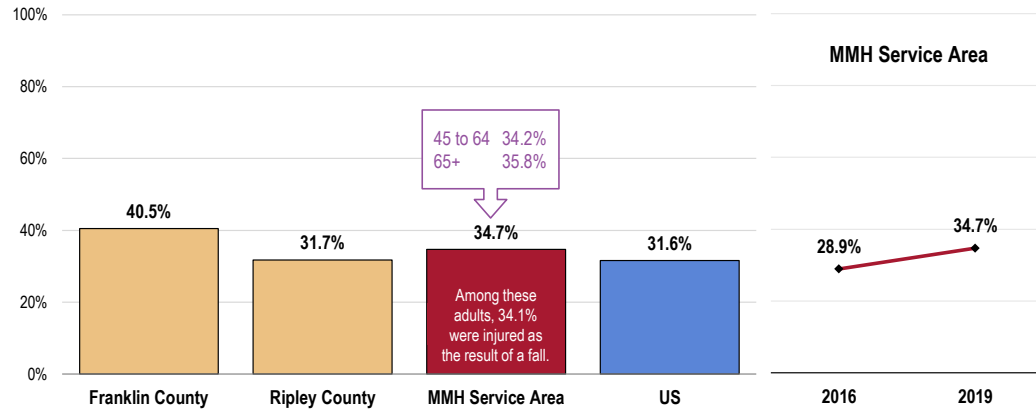
Number of Falls in Past 12 Months
(Adults Age 45 and Older; MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: • Asked of all respondents age 45+.

However, 34.7% have experienced a fall at least once in the past year.

Fell One or More Times in the Past Year
(Adults Age 45 and Older)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 107-108]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of those respondents age 45 and older.

Intentional Injury (Violence)

Violent Crime

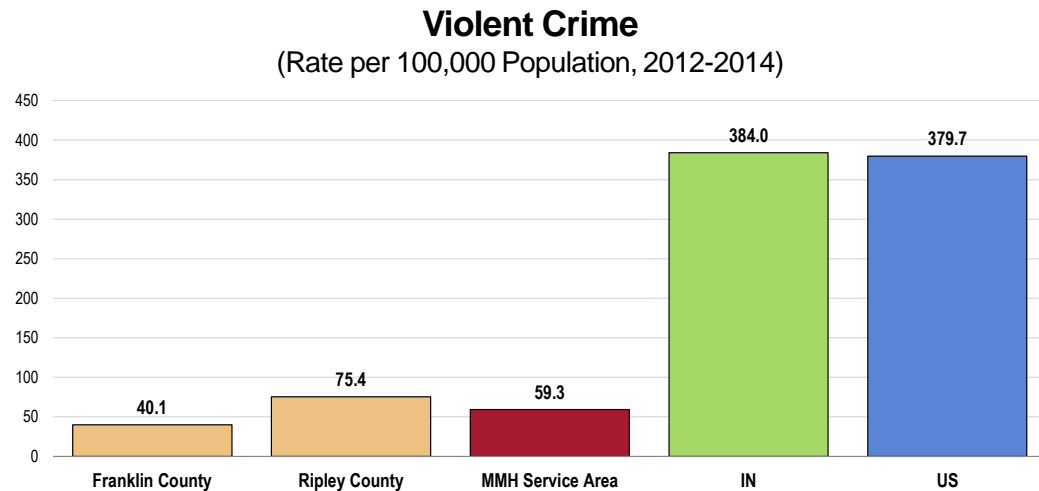
Violent Crime Rates

Between 2012 and 2014, there were a reported 59.3 violent crimes per 100,000 population in the MMH Service Area.

- **BENCHMARK:** Well below the state and national violent crime rates.
- **DISPARITY:** Higher in Ripley County than in Franklin County.

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

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



Sources: • Federal Bureau of Investigation, FBI Uniform Crime Reports.

• Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

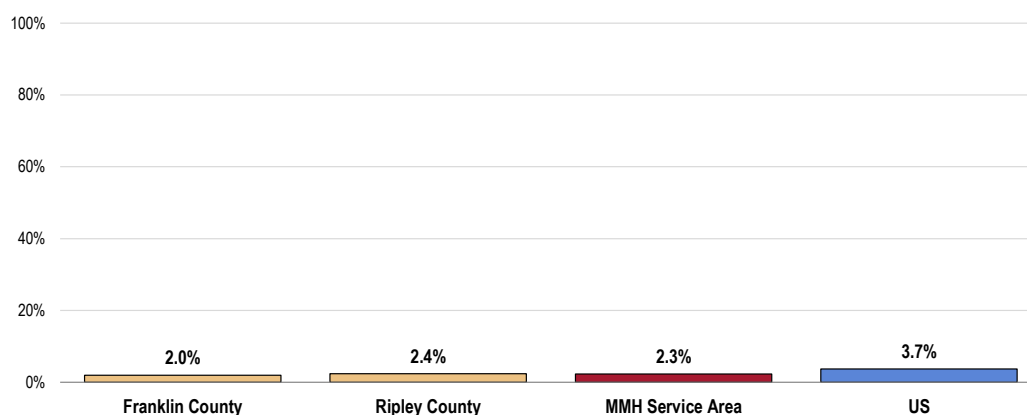
Notes: • This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.

• 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.

Community Violence

A total of 2.3% of surveyed MMH Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

Victim of a Violent Crime in the Past Five Years

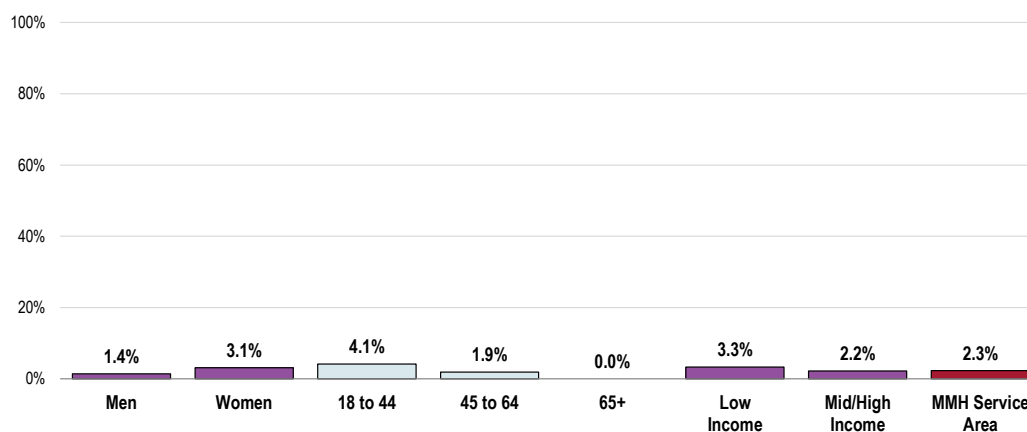


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 46]

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Victim of a Violent Crime in the Past Five Years (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 46]

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.

Family Violence

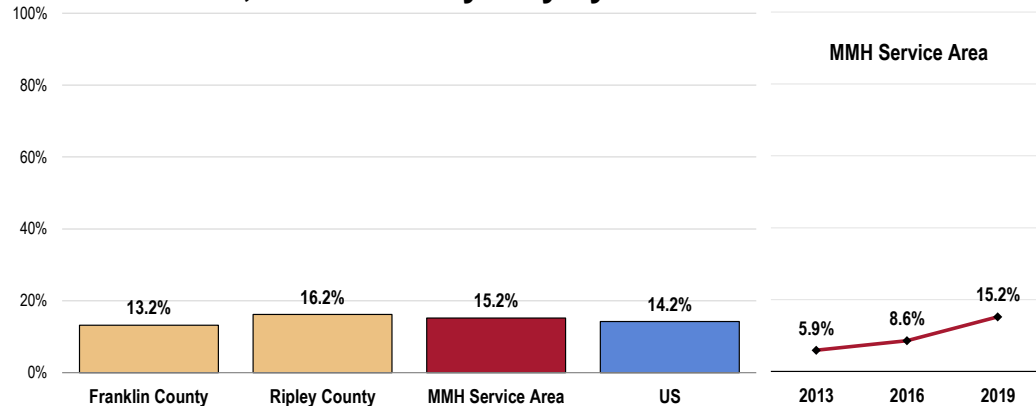
A total of 15.2% of MMH Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- **TREND:** A statistically significant increase since 2013.

Respondents were read:

"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."

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

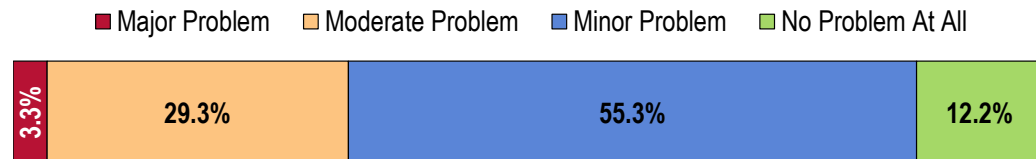


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 47]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

Over half 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, 2019)



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

Top Concerns

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

Domestic/Child Abuse

Domestic violence services have grown on average 15% annually for the past several years. Batesville High School youth report a higher than national average of teen dating violence. Child abuse rates are also high. – Social Services Provider

Domestic violence is quite common in our rural community. Through our work, we see victims and perpetrators frequently. We also live in a culture where people do not report violence and often cover for each other. For some, it is normalized generationally so the victim or perpetrator does not really acknowledge that it is an issue. – Other Health Provider

Contributing Factors

I believe injury is due in part to the rural area and activities that are known to cause injury, i.e. farming etc. Also, there are many people who are underprivileged and turn to alternative resources to have fun, therefore causing unneeded injury. Violence is often caused from substance dependence and poverty. – Community Leader

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 high-risk individuals.

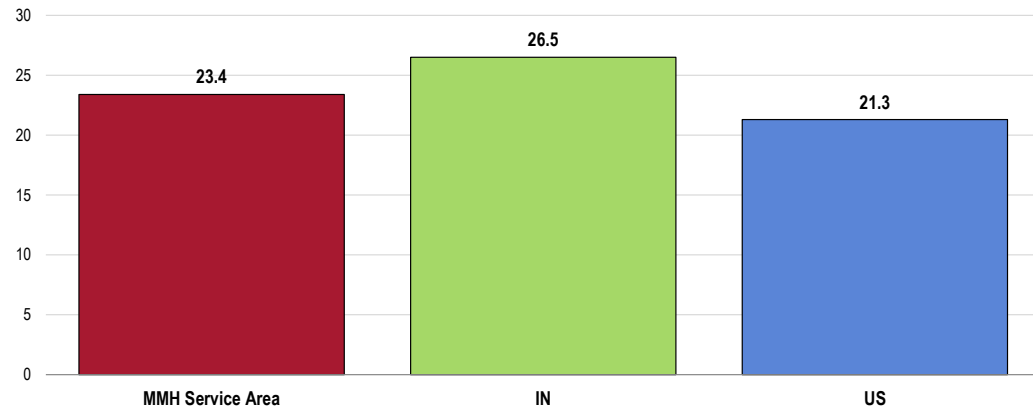
— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Between 2015 and 2017, there was an annual average age-adjusted diabetes mortality rate of 23.4 deaths per 100,000 population in the MMH Service Area.

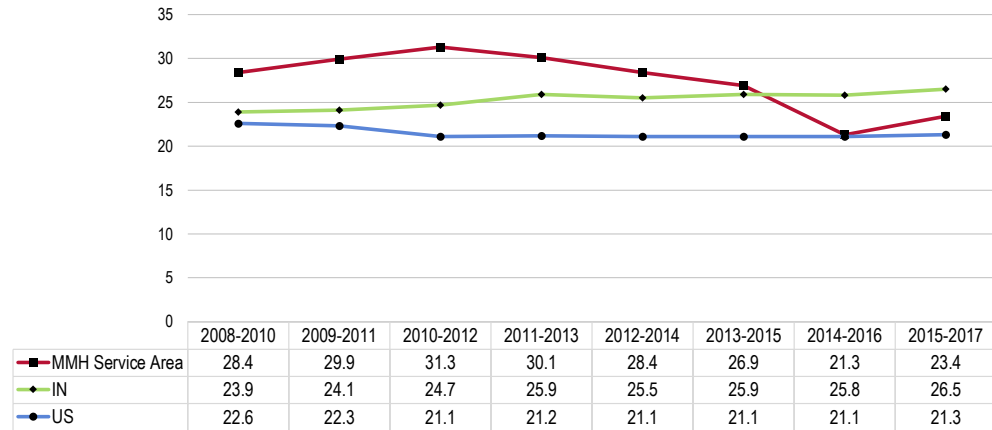
- **TREND:** Decreasing over the past decade, despite a recent increase in mortality rate.

Diabetes: Age-Adjusted Mortality (2015-2017 Annual Average Deaths per 100,000 Population) Healthy People 2020 = 20.5 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 September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 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 (Annual Average Deaths per 100,000 Population) Healthy People 2020 = 20.5 or Lower (Adjusted)



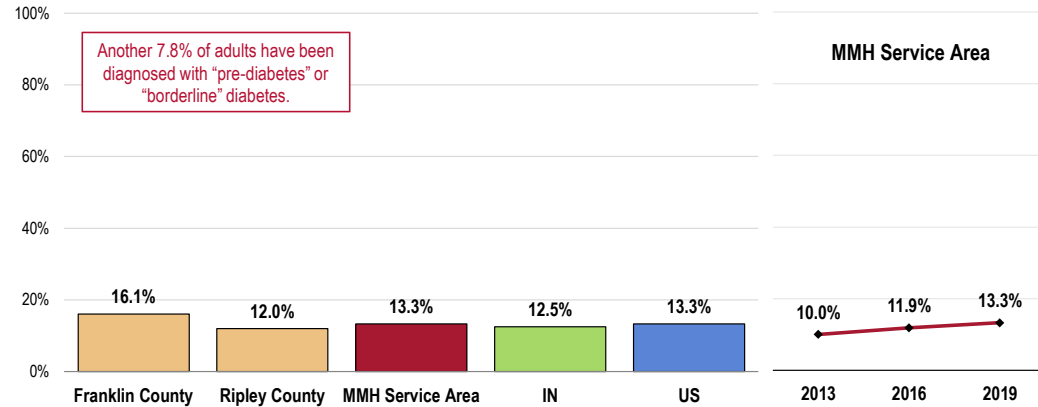
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

A total of 13.3% of MMH Service Area adults report having been diagnosed with diabetes.

- **DISPARITY:** The prevalence increases with age and is especially high among low-income residents.

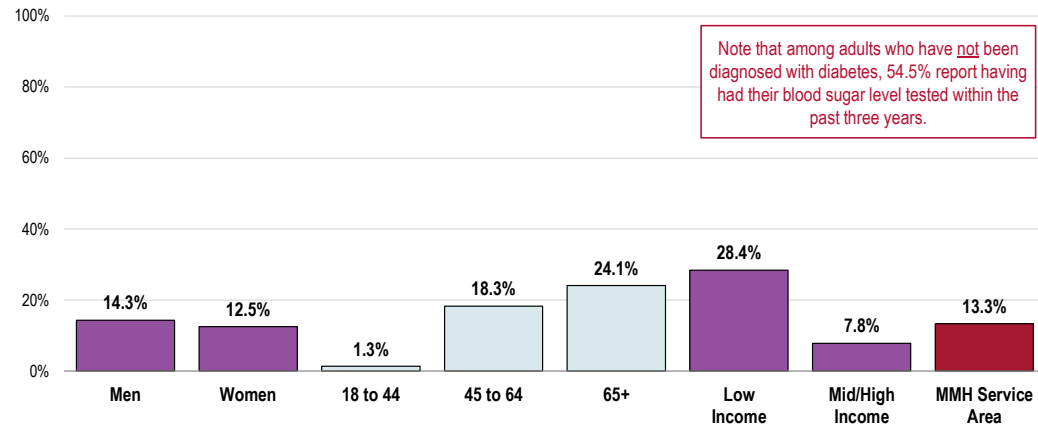
Prevalence of Diabetes



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 140]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Prevalence of Diabetes (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 37, 140]
 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).

Key Informant Input: Diabetes

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

Perceptions of Diabetes as a Problem in the Community (Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Lifestyle

1. Southeast Indiana is a culture of poor food choices and little activity. A person who wants to live a healthier lifestyle has to go down a different path than most other people and that is hard to do, i.e., church picnics, festivals, restaurant food, cooking habits, lack of value on activity, etc. 2. There are some PCPs who do not refer people for diabetes education when they are first diagnosed. This misses an opportunity to educate people properly from the beginning. People are not given the chance to meet with diabetes educators who can tailor a lifestyle program to meet their needs. 3. Lower income/ low health literacy patients do not value education or think that they can't afford it. We need to find ways to reach these people outside of the traditional educational means. – Other Health Provider

I think it's so easy to just go out to eat in this area that many people have unhealthy diets. There are some healthy choices at restaurants, but not a lot. – Community Leader

I think that patients with diabetes are challenged due to unhealthy eating habits supported by our local restaurants/fast food. Testing supplies and insulin are very expensive, and it can be hard for all that need them to get them. – Community Leader

Changing lifestyle. – Community Leader

Their diets and lack of attention to pre-diabetes symptoms. – Community Leader

Getting the disease under control via diet, exercise, and medication; along with the mental health co-morbidity. Unless the disease is under control, many organ systems are impacted, impacting the quality of life and shortening life. – Social Services Provider

Eating healthy, we do not have many local restaurants that focus on healthy eating. They might have one or two items we need more options. – Community Leader

Awareness/Education

Access to education and programming to combat diabetes or to know if one should be tested. – Community Leader

Understanding carbohydrates and how their medications work for them. Most need help with simple problem solving. – Other Health Provider

Education and diet. Maybe restaurants have a diabetic menu. Young families not eating a balance diet, going through fast food places to and from work, school, and sports events. – Community Leader

Proper education and maintaining good dietary habits. Maintaining a healthy weight. – Community Leader

Education and support groups. – Social Services Provider

Lack of understanding about nutrition and education about healthy eating habits. – Social Services Provider

Access to Medications/Supplies

Cost of medication. – Other Health Provider

Cost and access to insulin. – Community Leader

Affording the medication whether it's pills or insulin. Also, the cost of strips for checking blood sugars daily. – Social Services Provider

Cost of medication. – Community Leader

The cost of insulin is a huge factor to people treating their diabetes. It's so expensive. – Social Services Provider

Affordable medication, affordable diabetes education. – Physician

Lack of Providers

Need endocrinologist ASAP. – Physician

No endocrinologist. – Other Health Provider

Lack of endocrinologist. – Community Leader

No endocrine coverage, people must leave town for care. – Community Leader

Access to Healthy Food

Access to healthier food/meals. – Community Leader

The availability of fresh food daily and the resources to purchase them. Also, the knowledge about a daily diet to keep diabetes under check. – Community Leader

Our mentality as a community surrounding food choices is not good. We are more concerned about gluten than sugar. – Community Leader

Affordable Care/Services

There are a few big challenges. First, many patients cannot afford their medications including insulin, so their care significantly suffers as a result. Also, many patients are not treated aggressively enough. We are currently not following ADA guidelines for most patients in regards to A1C testing frequency, medication advancement and offering structured diabetes self-management education. It's challenging for patients to best manage their diabetes when they aren't offered all the available tools. – Other Health Provider

Cost to see a resource for education. – Other Health Provider

Contributing Factors

The biggest challenges that I see include the lack of places to exercise, especially during the winter. Also, the lack of fresh produce/food. Some people do not have access to the foods that they need or they do not understand how to shop for those foods. – Public Health Representative

Prevention and management. – Other Health Provider

Obesity

Weight Loss, lack of motivation to make changes. Lack of education. Too many unhealthy restaurant options. Cost of healthier food choices. – Other Health Provider

Obesity. – Community Leader

Access to Care/Services

Access to long-term lifestyle programs for people of less means. – Physician

Prevalence/Incidence

A lot of people have it. – Other Health Provider

Kidney Disease

About 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.

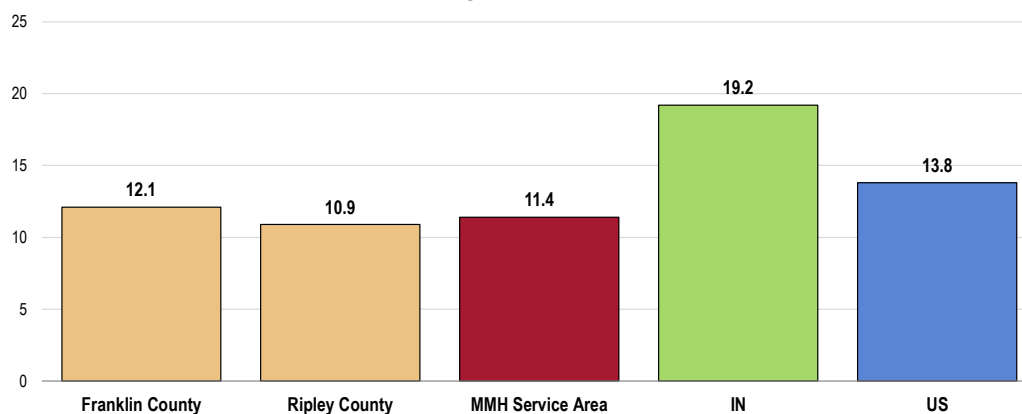
— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2008 and 2017, there was an annual average age-adjusted kidney disease mortality rate of 11.4 deaths per 100,000 population in the MMH Service Area.

- **BENCHMARK:** Below the US rate and especially the Indiana rate.

Kidney Disease: Age-Adjusted Mortality
(2008-2017 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 September 2019.

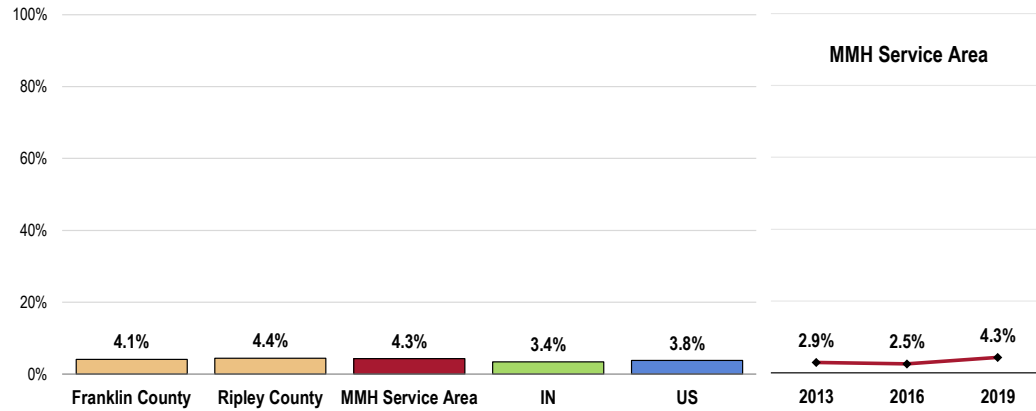
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

A total of 4.3% of MMH Service Area adults report having been diagnosed with kidney disease.

- **DISPARITY:** The prevalence increases with age and is especially high among respondents in low-income households.

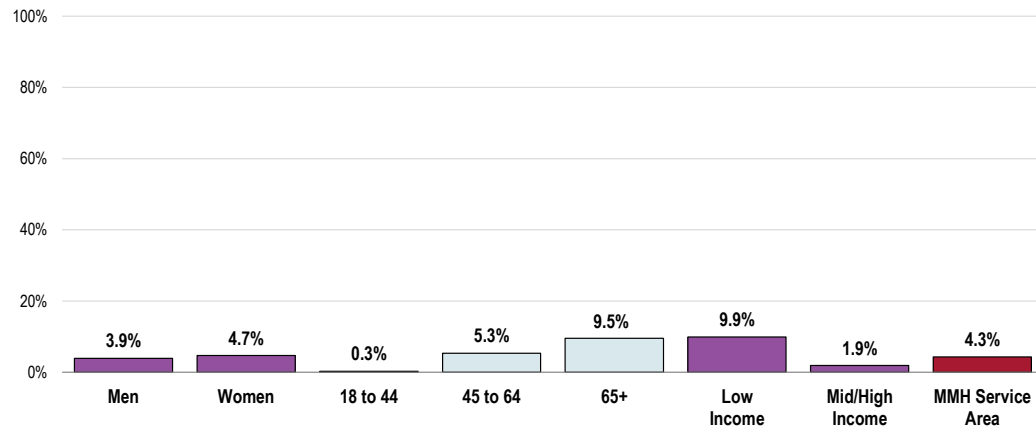
Prevalence of Kidney Disease



Sources: • 2019 PRC Community Health Survey, PRC, 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); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Prevalence of Kidney Disease (MMH Service Area, 2019)



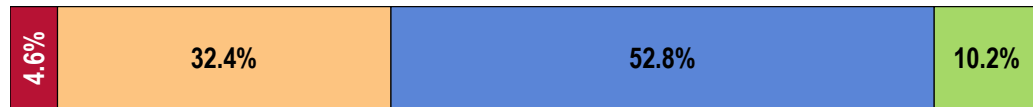
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 30]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Kidney Disease

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

Perceptions of Kidney Disease as a Problem in the Community (Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Prevalence/Incidence

DaVita Dialysis. – Social Services Provider

More prevalent with patients being admitted to the hospital. – Social Services Provider

Access to Care/Services

I did not ever think this was, but my mom started seeing a doctor at the dialysis center, and every time I take her there for an appointment, they are very busy. – Community Leader

Contributing Factor

Once again, the treatment is rigorous, and patients are far from home when receiving them. – Community Leader

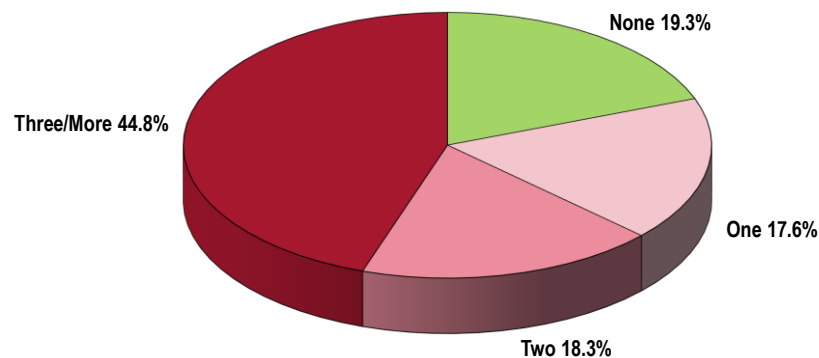
Potentially Disabling Conditions

Multiple Chronic Conditions

Among MMH Service Area survey respondents, most report currently having at least one chronic health condition.

For the purposes of this assessment, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression. Multiple chronic conditions are concurrent conditions.

Number of Current Chronic Conditions
(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 143]

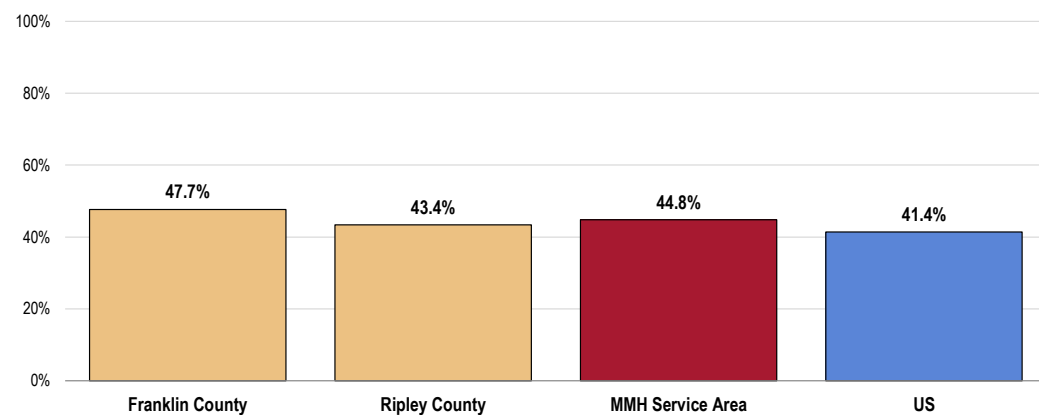
Notes: • Asked of all respondents.

• In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

In fact, 44.8% of service area adults report having three or more chronic conditions.

- **DISPARITY:** Increasing with age and higher among low-income residents.

Currently Have Three or More Chronic Conditions



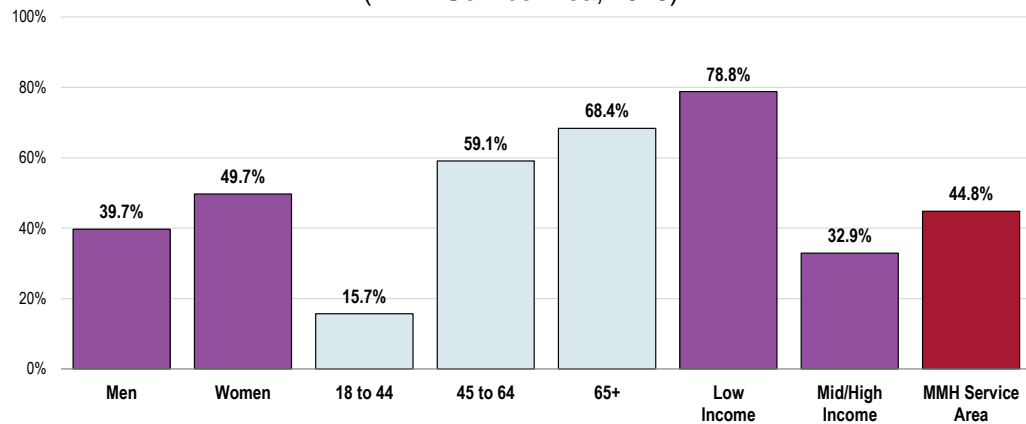
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 143]

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

• In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 143]
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.
• In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

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.

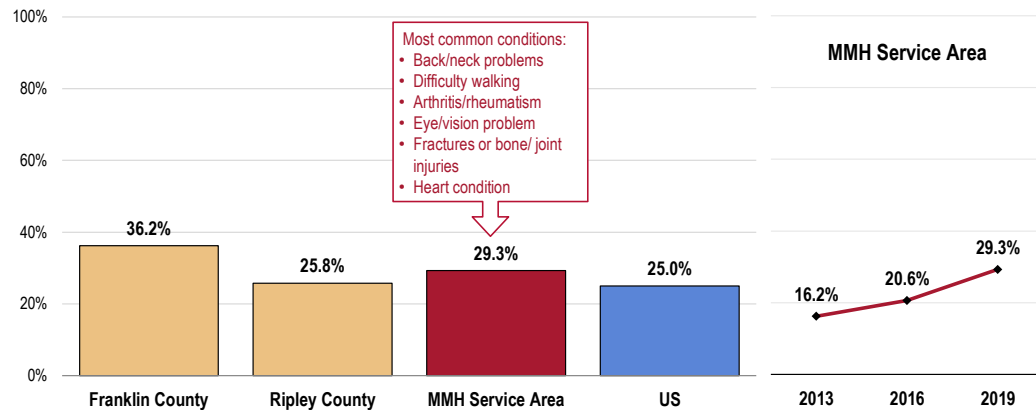
- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **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 29.3% of MMH Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

- **TREND:** Denotes a steady, significant increase since 2013.
- **DISPARITY:** Higher among Franklin County respondents. Higher among adults age 45 to 64 and those in low-income households.

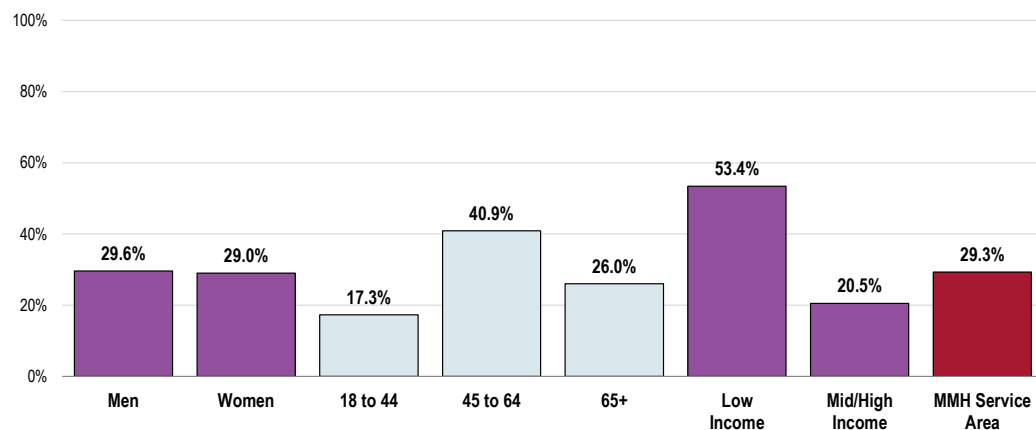
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 109-110]
• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 109]

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.

Arthritis, Osteoporosis & Chronic Back 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)

A total of 42.7% of MMH Service Area adults age 50 and older report suffering from arthritis or rheumatism.

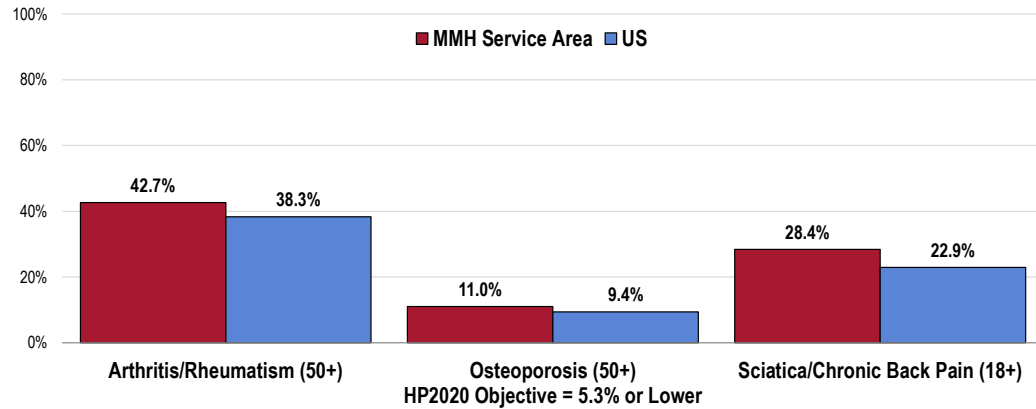
A total of 11.0% of MMH Service Area adults age 50 and older have osteoporosis.

- **BENCHMARK:** Fails to satisfy the Healthy People 2020 objective.

A total of 28.4% of MMH Service Area adults (18 and older) suffer from chronic back pain or sciatica.

- **BENCHMARK:** Higher than the US prevalence.

Prevalence of Potentially Disabling Conditions



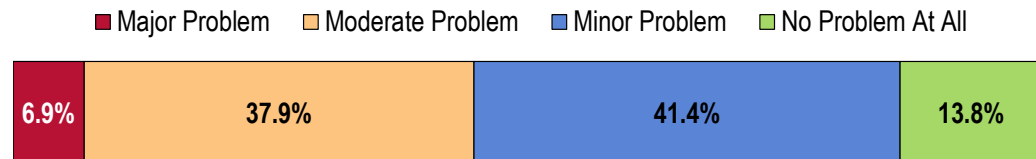
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 26, 141-142]
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]
 Notes: • The sciatica indicator reflects the 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, 2019)



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

Top Concerns

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

Prevalence/Incidence

There are many people going to a Chiropractor. A new business entered a space near the old Pamida store. – Other Health Provider

So many of my friends and exercise group suffer from back or arthritis problems. – Community Leader

Affordable Care/Services

Lower income Senior citizens are lacking affordable and appealing opportunities for physical activity. The community does not promote or invest in an active senior lifestyle. While there are several senior living areas, no walking paths, senior exercise activities or education about active lifestyle are present.
– Social Services Provider

Contributing Factor

We are a community historically of “laborers” who often experience these conditions but have employment that requires they “carry on” and traditionally that has been with the use of analgesic RX and we need more education and offerings for alternatives to that TX type. – Public Health Representative

Lack of Providers

No local service providers. – Community Leader

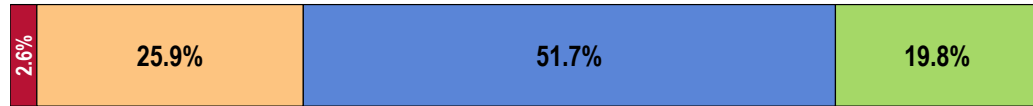
Key Informant Input: Vision & Hearing

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

Perceptions of Vision and Hearing as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Aging Population

As our population ages there are more problems and issues with vision and hearing. To my knowledge we have very limited resources available for these issues. – Community Leader

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.

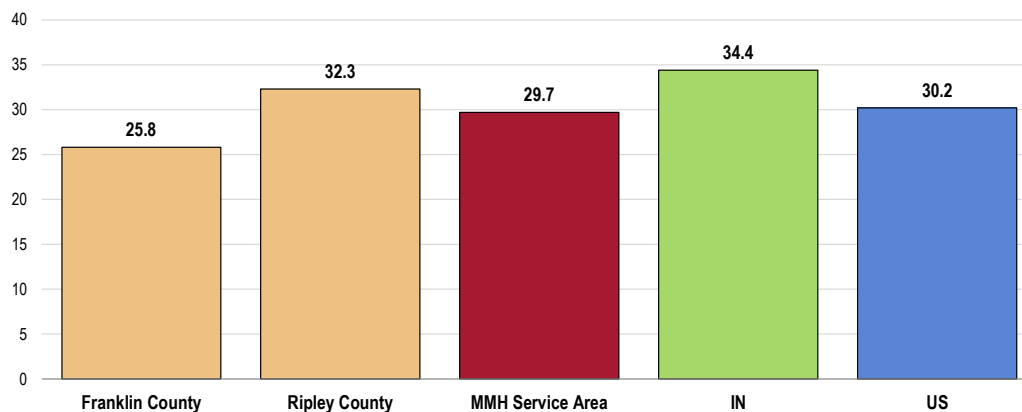
— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2015 and 2017, there was an annual average age-adjusted Alzheimer's disease mortality rate of 29.7 deaths per 100,000 population in the MMH Service Area.

- **BENCHMARK:** Below the state death rate.
- **TREND:** After increasing for years, Alzheimer's mortality has decreased in the service area since the 2011-2013 reporting period and has recently stabilized.

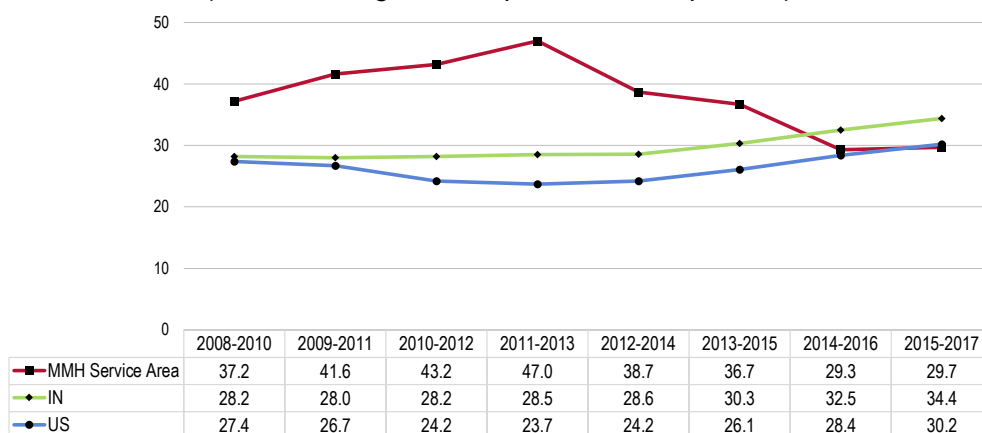
Alzheimer's Disease: Age-Adjusted Mortality
(2015-2017 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.

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.

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



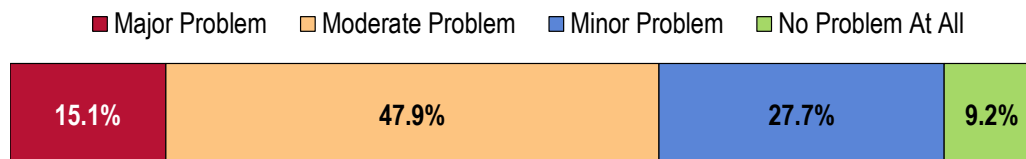
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.

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.

Key Informant Input: Dementias, Including Alzheimer's Disease

Nearly half of key informants taking part in an online survey are most likely to consider *Dementias, Including Alzheimer's Disease* as a “moderate problem” in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Top Concerns

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

Aging Population

Median age of population. – Community Leader

As our community continues to experience, like the rest of the country, an upsurge in our aging population, we too are living longer and resultantly are on the cusp of experiencing explosive dementia numbers. There is no longer a free-standing Memory Care unit in Franklin County, clearly advertised adult care-giver respite, family education groups, etc. – Public Health Representative

People are living longer and longer, and it seems like almost everyone has someone in their family or knows of someone who has dementia or Alzheimer’s disease. – Community Leader

Considering the changing demographics and lack of knowledge associated with dementia/Alzheimer’s, complicated by the limited number of facilities caring for patients, this is a major concern. – Community Leader

Prevalence among the elderly citizens. Lack of education on fitness, dietary and other methods to abate the onset of dementia/Alzheimer’s disease. – Community Leader

Our nursing homes are frequently filled, and the care givers need support and a place to go to get relief especially the folks that don’t have family in the area. Need more support groups and daycare for the person with the disease. – Community Leader

A common diagnosis for our elderly population. – Social Services Provider

Senior Care, assistance with home care, medication, daily tasks of personal hygiene, family guidance, meals, transportation, etc. More information needs to be available on where to find assistance and the steps to take. – Community Leader

Prevalence/Incidence

The percentage of the population that have this disease. – Community Leader

It just affects so many family members when someone has this problem. – Community Leader

I think it’s a problem in every community. It is a devastating disease that impacts entire families, not just the patient. – Community Leader

Many are affected. – Community Leader

This is an issue that a lot of families face. Education and support groups for caregivers is crucial. – Social Services Provider

Impact on Families/Caregivers

It was very hard to find support for our family when we had to put my Mom in a nursing home. I also think that when you do provide an educational training, it’s not always a good time for families. Trainings should be offered at different time in the day. – Other Health Provider

Help with the aged. – Community Leader

Taking care of family members with dementia requires a huge investment of time and energy. It is emotionally draining, and I do not know of adequate support networks for caregivers. – Community Leader

Access to Care/Services

Increase occurrence in our population and very few resources, facilities with knowledge and quality of life care. – Other Health Provider

In Osgood, only Manderly health care is organized to help. In Milan, also, there is Ripley Crossing. Public awareness is pretty low. – Community Leader

Contributing Factor

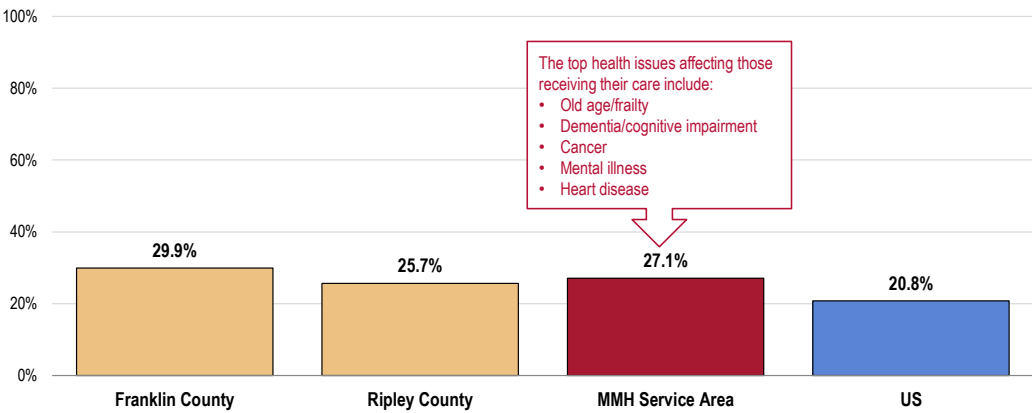
Because there is nothing you can do to prevent it or cure it. Also, aging population. – Community Leader

Caregiving

A total of 27.1% of MMH Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

- **BENCHMARK:** Well above the US figure.

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 111-112]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Immunization & Infectious Diseases

Hepatitis

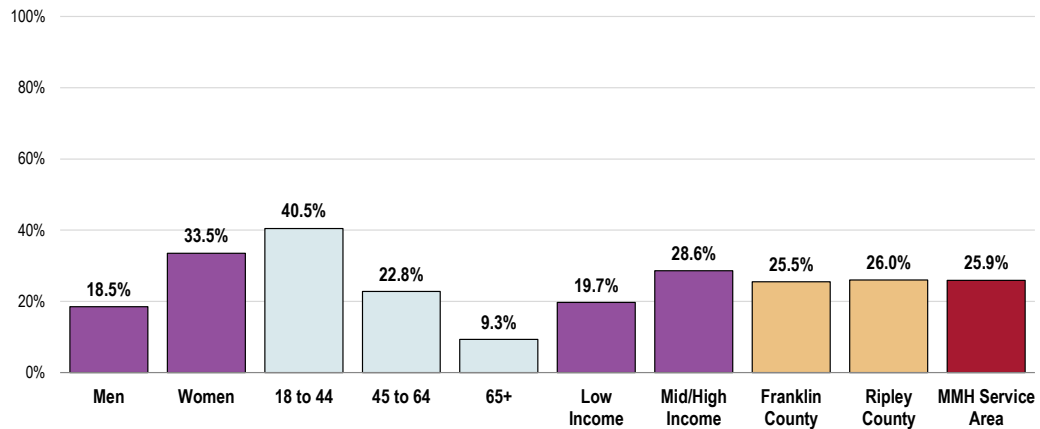
Hepatitis A/B

Hepatitis A is a liver infection caused by the hepatitis A virus and is highly contagious. The hepatitis A virus is most often spread through food or drink contaminated with the stool of someone with hepatitis A but can also be spread by close contact with an infected person.

A total of 25.9% of survey respondents have received the hepatitis A vaccine, which is completed after at least two and sometimes three doses are given.

- **DISPARITY:** The prevalence of vaccination decreases with age and is significantly lower among service area men than women.

Have Received the Hepatitis A Vaccination Series (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 305]

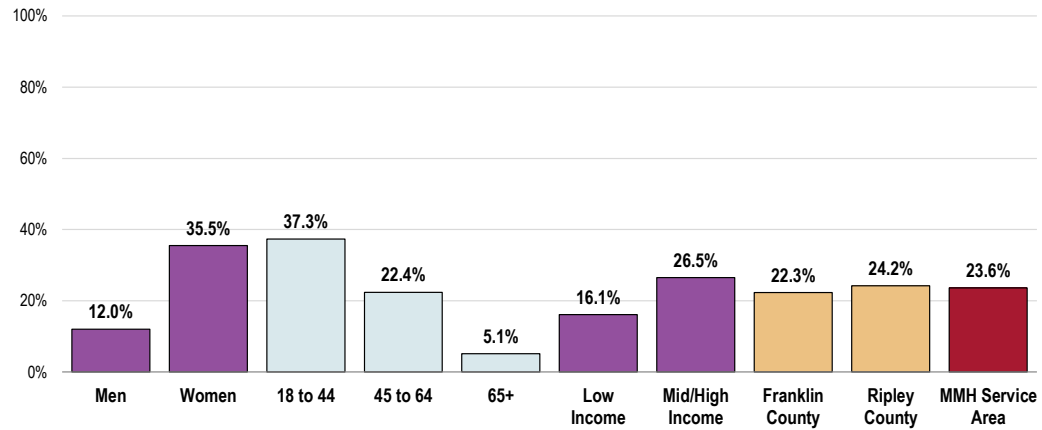
- Notes:
- Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - The hepatitis A vaccine is completed after at least two and sometimes three doses are given.

A total of 23.6% of survey respondents have received the hepatitis B vaccine, which is completed after at least two and sometimes three doses are given.

- **DISPARITY:** The vaccination series prevalence is much higher among women and young adults.

Hepatitis B is a liver infection caused by the hepatitis B virus, which causes inflammation of the liver. The hepatitis B virus is found in blood and certain body fluids and is spread when blood or body fluid from an infected person enters the body of a person who is not immune.

Have Received the Hepatitis B Vaccination Series (MMH Service Area, 2019)



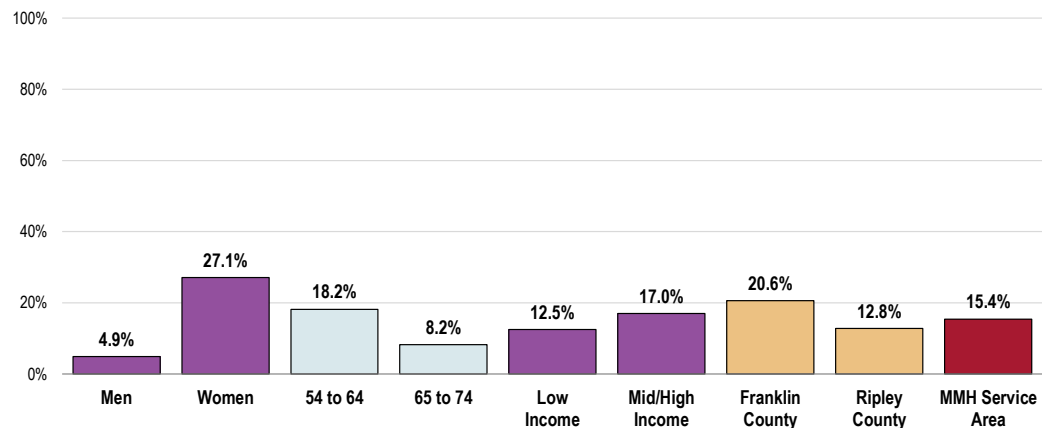
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 306]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • The hepatitis B vaccine is completed after at least two and sometimes three doses are given.

Hepatitis C

Among service area adults age 54 to 74, 15.4% have had their blood tested for hepatitis C.

- **DISPARITY:** The prevalence is lower among men and older adults.

Have Had Blood Tested for Hepatitis C (MMH Service Area Adults Age 54-74, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 316]
 Notes: • Asked of all respondents age 54 to 74.
 • 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 hepatitis C virus causes inflammation and damage to the liver. A person contracts this virus by coming into contact with blood or other bodily fluids from someone who is already infected with the virus. There is no vaccine to prevent the hepatitis C virus.

The CDC recommends that adults born during the years of 1945 through 1965 get tested for the hepatitis C virus.

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, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Awareness/Education

I think that many people in the area still believe false information about immunizations. – Community Leader

Prevalence/Incidence

Hospital acquired infections are on the rise. C. diff is a major problem. Can't clean a hospital bed. – Community Leader

Births



Birth Outcomes & Risks

Low-Weight Births

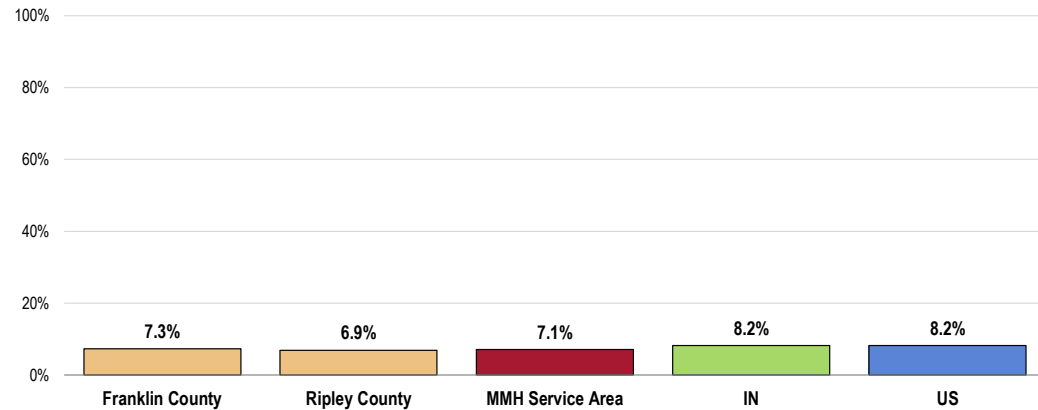
A total of 7.1% of 2006-2012 MMH Service Area births were low-weight.

- **BENCHMARK:** Better than the state and US percentages.

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

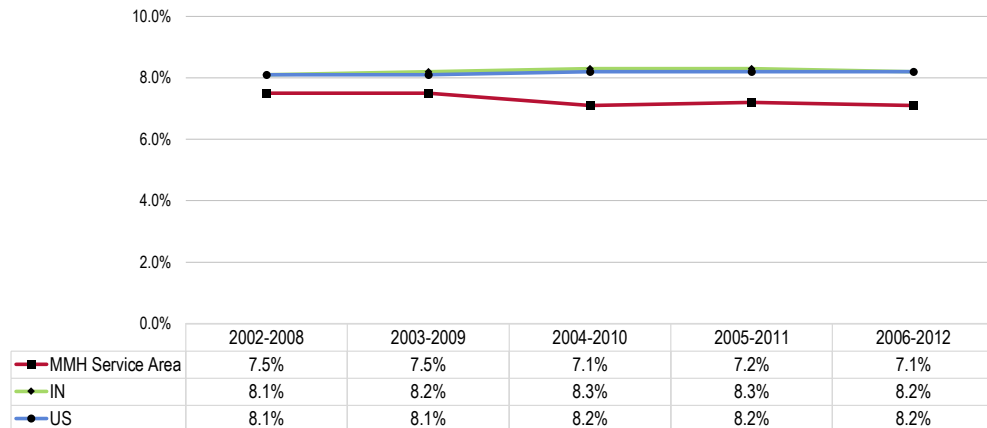
Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births (Percent of Live Births, 2006-2012) Healthy People 2020 = 7.8% or Lower



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
 - Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
- Note:
- 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-Weight Births (Percent of Live Births) Healthy People 2020 = 7.8% or Lower



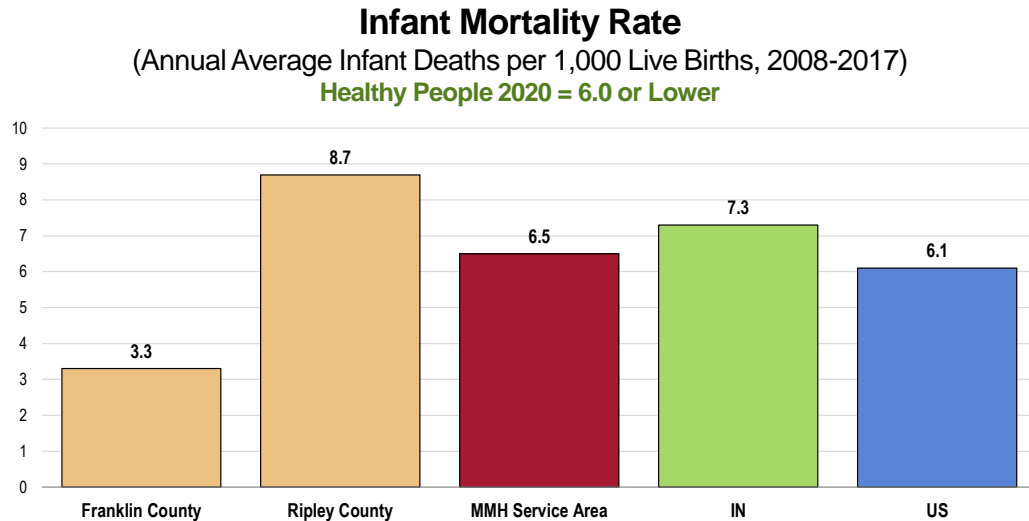
- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
 - Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
- Note:
- 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.

Infant Mortality

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

Between 2008 and 2017, there was an annual average of 6.5 infant deaths per 1,000 live births.

- **DISPARITY:** The mortality rate is much higher in Ripley County.

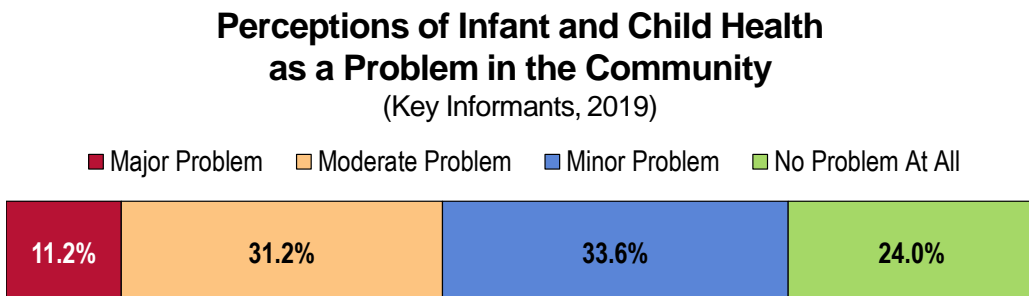


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2019.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]

Notes: • 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

Key informants taking part in an online survey generally characterized *Infant & Child Health* as a “minor problem” in the community, followed closely by “moderate problem” ratings.



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

Top Concerns

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

Contributing Factors

I work with students throughout the school system. Some of that time includes being in the cafeteria and seeing what the students pack and what they eat from the cafeteria menu. I am concerned because I know that the high processed food diet will lead to our children getting chronic diseases prematurely. Infant health – MMH dietitians offered a healthy eating class for newly pregnant women. It was called Baby Under construction and offered very basic, but healthy guidelines for new mothers to eat while pregnant. There was such a low response to this class, despite being a standing referral from the MD for all new moms, that we had to cancel the program. This could show that new mothers do not see the value in proper nutrition from the start. – Other Health Provider

Number of children born to mothers who smoke and take drugs. – Community Leader

There is a hunger problem in the area that is visible by the number of children on free or reduced lunch programs through the schools. The number of people using the Batesville Food pantry is rising. – Community Leader

Awareness/Education

Parenting needs to be taught. Usually if there is a class, the participants are the people who really don't need to be there. The people who need the help don't come. – Community Leader

Not enough awareness and outreach. – Community Leader

Infant Mortality

I don't have much experience in this area, but I have heard in meetings that Indiana's infant mortality rate is very poor. Also, it seems like with the opioid crisis the number of NAS infants is increasing. – Other Health Provider

Access to Care

Families not having insurance or means to pay for health costs. They may not be aware of free clinic. Children going to school when sick due to parents working. – Social Services Provider

Lack of Providers

Not many pediatric doctors in Brookville. – Community Leader

Affordable Care/Services

Lack of income for wellness checks. – Community Leader

Family Planning

Births to Adolescent Mothers

About Adolescent Births

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

Teen mothers:

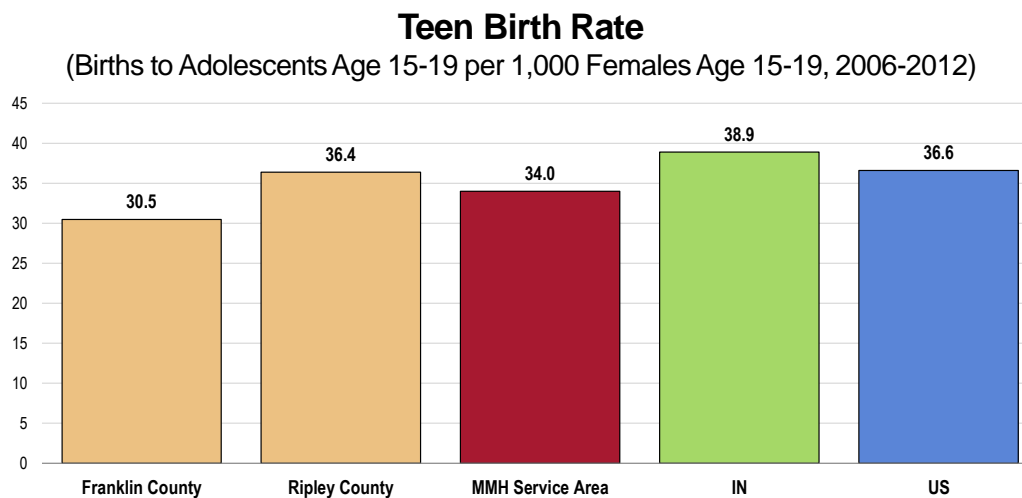
- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

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 were 34.0 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the MMH Service Area.

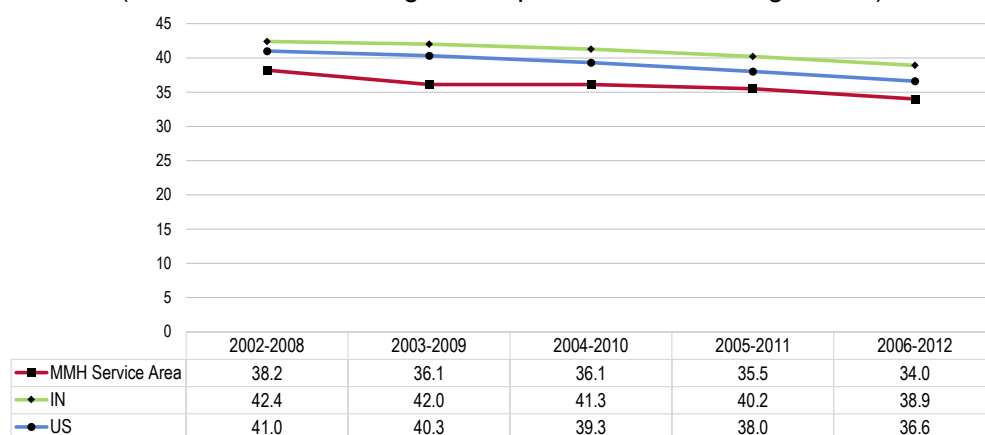


Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
• Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes: • 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.

Teen Birth Rate Trends

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19)



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System.
- Retrieved from Community Commons at <http://www.chna.org>.

Notes:

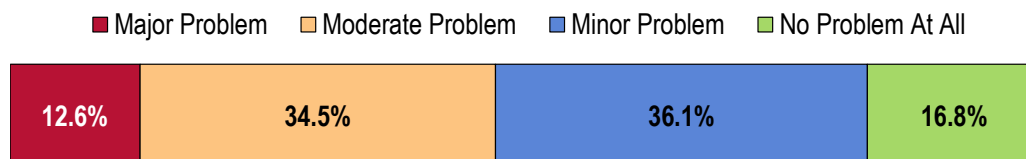
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the 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 (followed closely by “moderate problem” ratings).

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2019)



Sources:

- PRC Online Key Informant Survey, PRC, Inc.

Notes:

- Asked of all respondents.

Top Concerns

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

Contributing Factors

Community perceptions regarding birth control, etc. This impacts access to family planning that isn't driven by religious influences. – Social Services Provider

There many babies born into drug addicted families in our area. So, I think it would be good for someone to be available to speak to people about affordable contraception. Also, to prepare them for first time families. – Community Leader

The high number of single parent families. Families that need assistance to food, housing and medical treatment are easily seen to law enforcement offices as we respond to a host of calls to the public. – Community Leader

Too many people rely on someone else to take care of them. Planning could help. – Community Leader

Too many people who are living in poverty continue to have children they are unable to adequately feed. No one would build a house without a plan. No one should build a family without a plan. More education is necessary and birth control should be more readily available to those in need. – Public Health Representative

Awareness/Education

Not advertised, I often have people skirt around the subject when asking about it. Definitely a taboo subject. For youth and younger adults, they go to a major city nearby instead of local. – Other Health Provider

I believe more knowledge/education should be proactive in this area. – Community Leader

Young adults are sexually active and need better education. – Community Leader

Parenting and family assistance. – Community Leader

The culture does not usually plan families. – Community Leader

Hardly any well publicized or recognizable organizations that people relate to in Osgood. – Community Leader

Teen Pregnancy

Teen pregnancy, unexpected pregnancy and fetal drug exposure. – Physician

Seeing more teens pregnant and unsure of who the father is or lack of care in who the father is along with more teens reporting abortions. – Other Health Provider

Access to Care/Services

I think that there is a lack of availability when it comes to contraceptive methods, and that the subject is still considered fairly taboo. As a result, I think that many people in the community have difficulty getting the help, advice, and medicine that they need. – Community Leader

Prevalence/Incidence

I witness supervised visits on a daily basis. Situations where children are in situations where mom/dad are not capable of taking care of themselves much less a child. The situations are sad, and children are suffering. Grandparents are raising grandchildren. – Community Leader

Modifiable Health Risks



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)

Daily Recommendation of Fruits/Vegetables

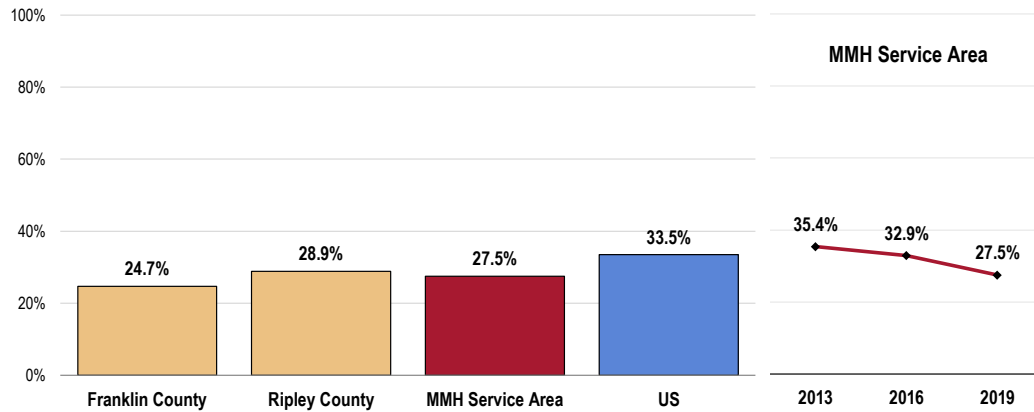
A total of 27.5% of MMH Service Area adults report eating five or more servings of fruits and/or vegetables per day.

- **BENCHMARK:** Below the national prevalence.
- **TREND:** Marks a statistically significant decrease since 2013.
- **DISPARITY:** The prevalence is notably low among adults in low-income households.

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.

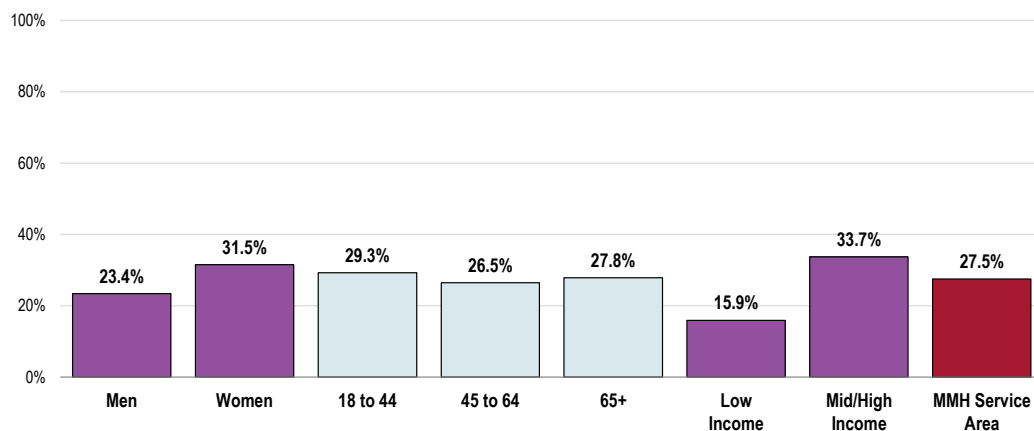
RELATED ISSUE:
See also *Food Access* in the *Social Determinants of Health* section of this report.

Consume Five or More Servings of Fruits/Vegetables Per Day



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 148]
 - 2017 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
 - For this issue, respondents were asked to recall their food intake on the previous day.

Consume Five or More Servings of Fruits/Vegetables Per Day (MMH Service Area, 2019)



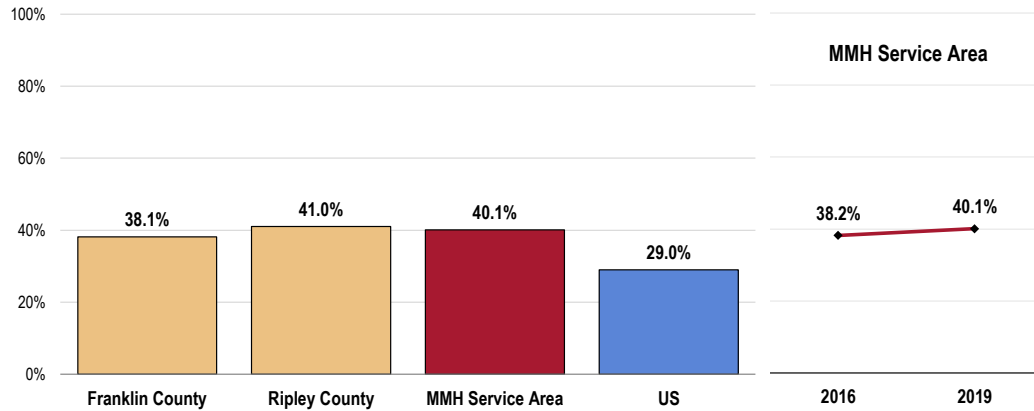
- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 148]
- Notes:
- Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal 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.

Sugar-Sweetened Beverages

A total of 40.1% of MMH Service Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

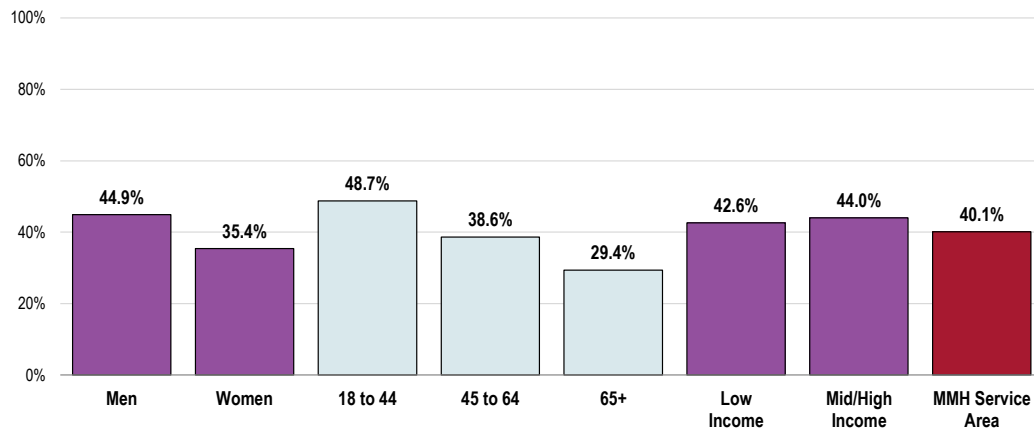
- **BENCHMARK:** Well above the US prevalence.
- **DISPARITY:** Sugar-sweetened beverage consumption correlates with age.

Had Seven or More Sugar-Sweetened Beverages in the Past Week



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 317]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Had Seven or More Sugar-Sweetened Beverages in the Past Week (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 317]
 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.

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, 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

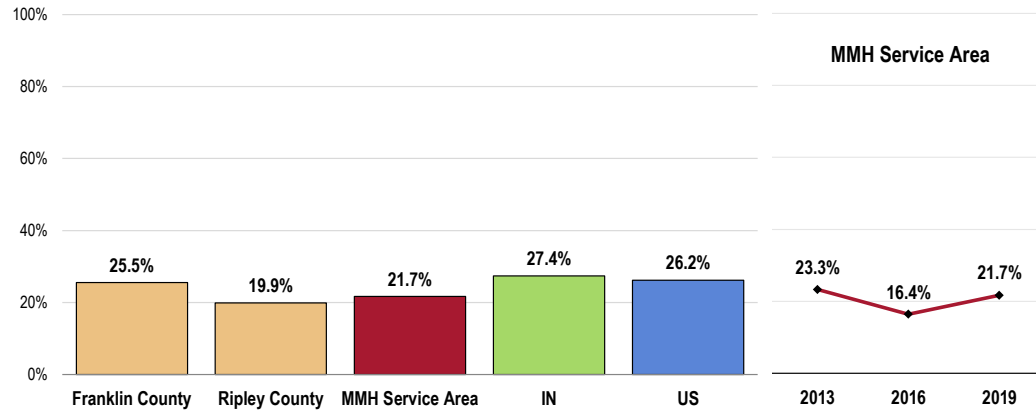
A total of 21.7% of MMH Service Area adults report no leisure-time physical activity in the past month.

- **BENCHMARK:** Better than the Indiana prevalence and satisfying the Healthy People 2020 objective.

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.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 = 32.6% or Lower



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 89]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, 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.

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>.

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

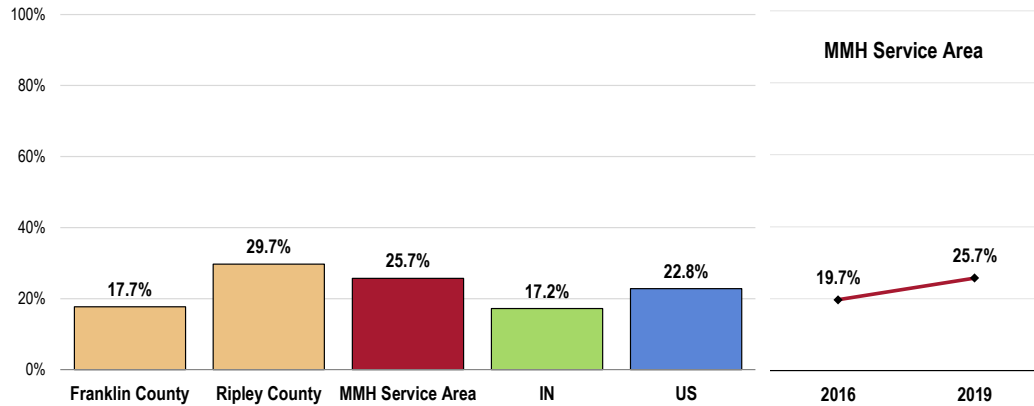
Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

A total of 25.7% of MMH Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

- **BENCHMARK:** Above the the Indiana figure; satisfies the Healthy People 2020 goal.
- **TREND:** Denotes a statistically significant increase since 2016.
- **DISPARITY:** Much lower in Franklin County. Lower among women, adults over 44, and those in low-income households.

Meets Physical Activity Recommendations

Healthy People 2020 = 20.1% or Higher

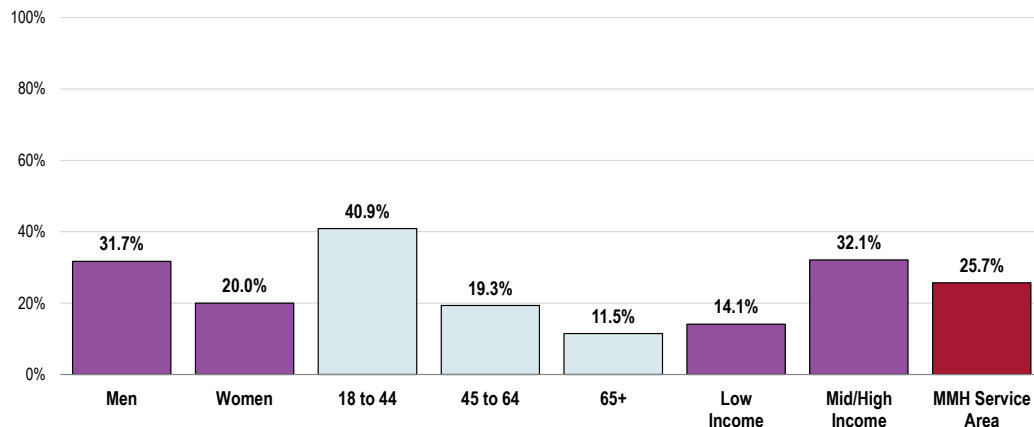


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 152]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2017 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-2.4]
 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 specifically designed to strengthen muscles at least twice per week.

Meets Physical Activity Recommendations

(MMH Service Area, 2019)

Healthy People 2020 = 20.1% or Higher



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 152]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-2.4]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

Recommended Levels of Physical Activity

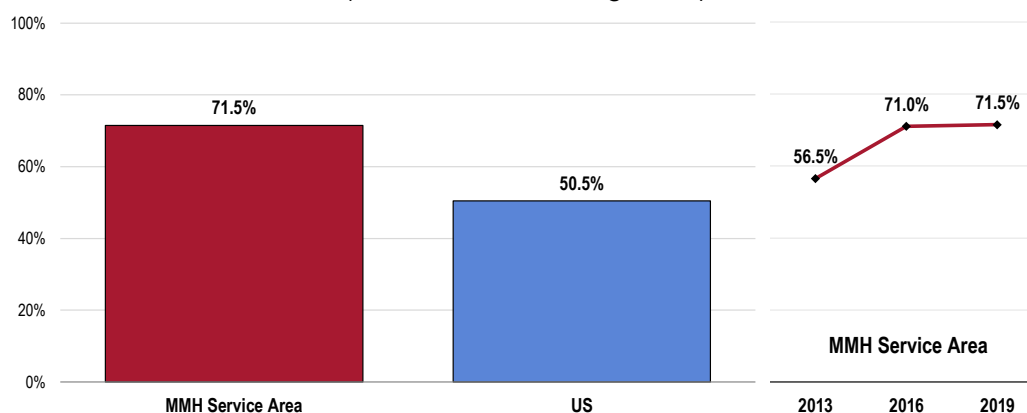
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

— 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, 71.5% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- **BENCHMARK:** Well above the US prevalence.
- **TREND:** Denotes a statistically significant increase from 2013 survey findings.

Child Is Physically Active for One or More Hours per Day (Parents of Children Age 2-17)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 124]

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children age 2-17 at home.

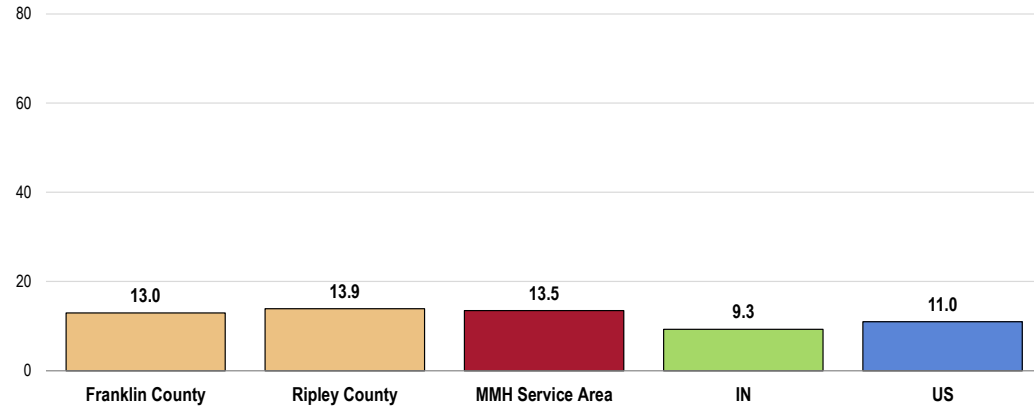
• Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

In 2016, there were 13.5 recreation/fitness facilities for every 100,000 population in the MMH Service Area.

- **BENCHMARK:** Better than the state and US rates.

Population With Recreation & Fitness Facility Access (Number of Recreation & Fitness Facilities per 100,000 Population, 2016)



Sources: • US Census Bureau, County Business Patterns. Additional data analysis by CARES.

• Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes: • Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which 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. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

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 (m^2). To estimate BMI using pounds and inches, use: $[\text{weight (pounds)}/\text{height squared (inches}^2)] \times 703$.

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

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

Adult Weight Status

| Classification of Overweight and Obesity by BMI | BMI (kg/m^2) |
|---|------------------|
| Underweight | <18.5 |
| Normal | 18.5 – 24.9 |
| Overweight | 25.0 – 29.9 |
| Obese | ≥ 30.0 |

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

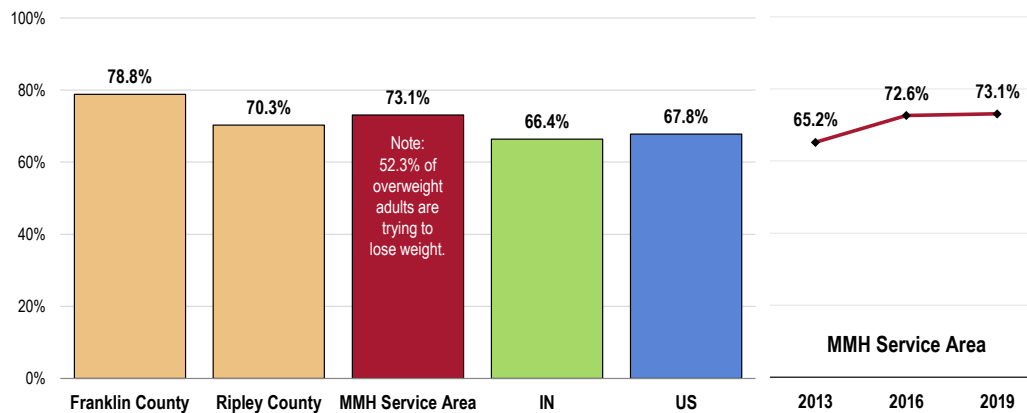
Overweight Status

Nearly three in four service area adults (73.1%) are overweight.

Here, "overweight" includes those respondents with a BMI value ≥ 25 .

- **BENCHMARK:** Worse than the Indiana and US prevalence.
- **TREND:** Marks a statistically significant increase since 2013.
- **DISPARITY:** Unfavorably high in Franklin County.

Prevalence of Total Overweight (Overweight and Obese)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 155, 191]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

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

Note that 29.8% of overweight adults have been given advice about their weight by a health professional in the past year (while most have not).

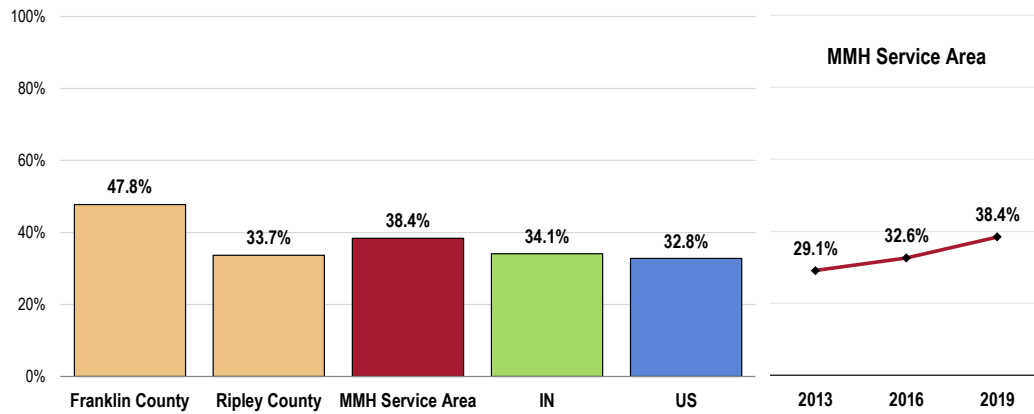
The overweight prevalence above includes 38.4% of MMH Service Area adults who are **obese**.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥ 30 .

- **BENCHMARK:** Above the US figure and failing to meet the Healthy People 2020 objective for obesity.
- **TREND:** Denotes a steady, significant increase since 2013.
- **DISPARITY:** Much higher in Franklin County. Over half of low-income adults in the service area are considered to be obese.

Prevalence of Obesity

Healthy People 2020 = 30.5% or Lower

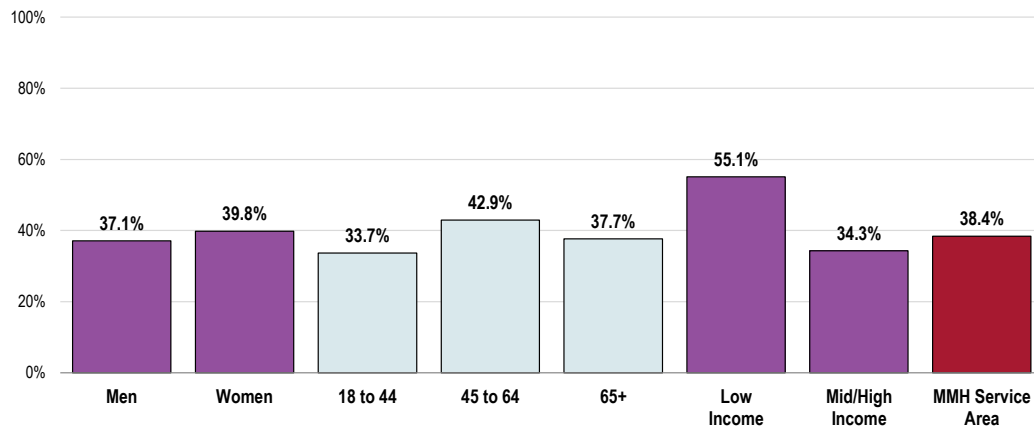


- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 154]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 - 2017 PRC National Health Survey, PRC, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity

(MMH Service Area, 2019)

Healthy People 2020 = 30.5% or Lower



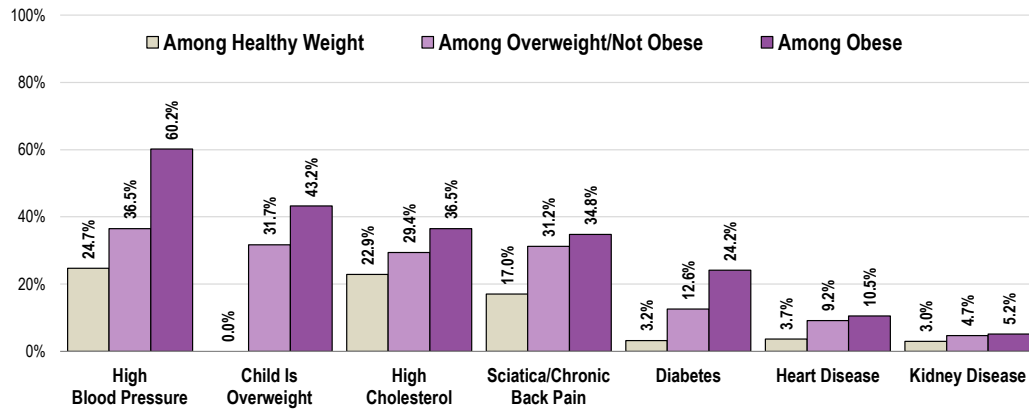
- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 154]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

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

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.

Relationship of Overweight With Other Health Issues
(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 154]
Notes: • Based on reported heights and weights, asked of all respondents.

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.

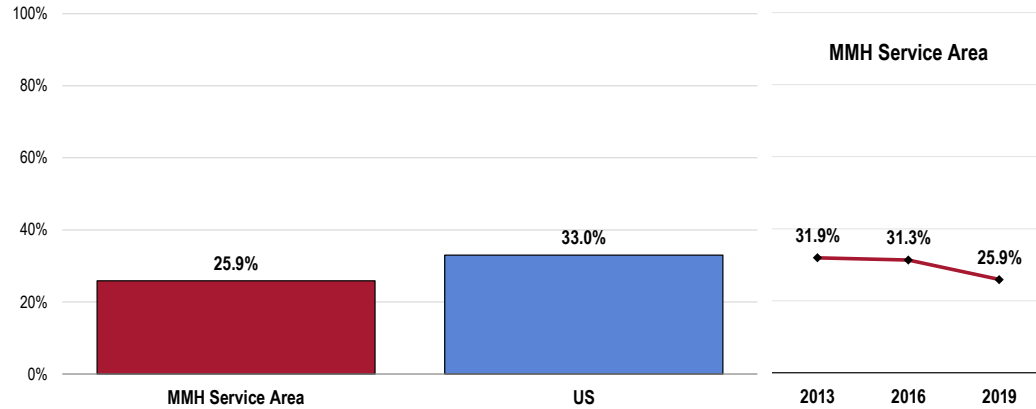
BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

— Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 25.9% of MMH Service Area children age 5 to 17 are overweight or obese ($\geq 85^{\text{th}}$ percentile).

Prevalence of Overweight in Children (Parents of Children Age 5-17)

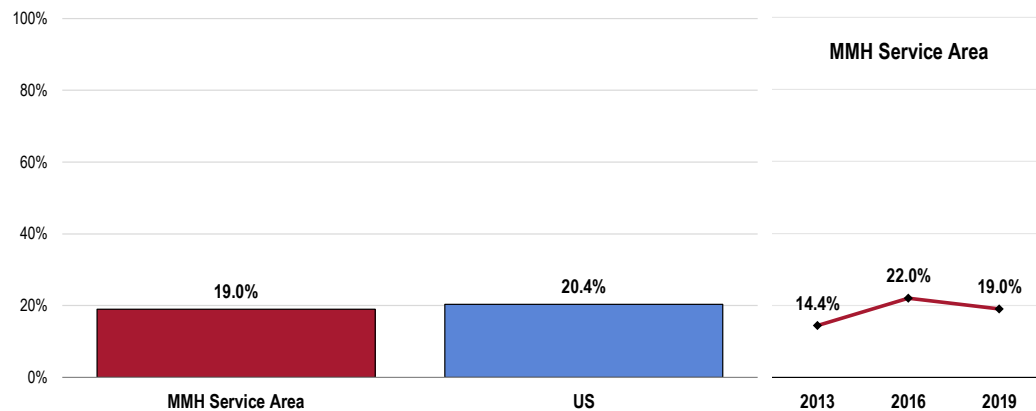


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 192]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

The childhood overweight prevalence above includes 19.0% of area children age 5 to 17 who are obese ($\geq 95^{\text{th}}$ percentile).

Prevalence of Obesity in Children (Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2020 = 14.5% or Lower



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 158]
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

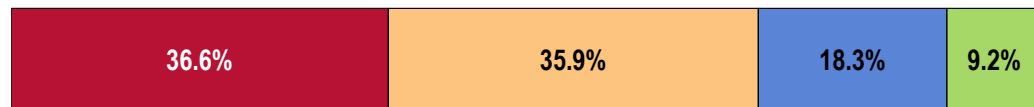
Key Informant Input: Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized **Nutrition, Physical Activity & Weight** as a “major problem” in the community, followed closely by “moderate problem” ratings.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Obesity

Simple, people weigh too much. – Physician

Obesity is a huge health problem. Despite access to farmer's markets and farm-to-table options, many are not taking advantage of this opportunity. While there is an abundance of healthy options to address this, most are not choosing to use resources. Many choose fast food and a sedentary lifestyle even though the health issues associated are well known. Children are of the most concern as they cannot control the food they are fed and the lifestyle that their family provides. – Other Health Provider

I just feel that more folks appear to be overweight. Folks are less active. Seems like healthy foods are more expensive. I also think time to exercise or prepare nutritious meals is not there. – Other Health Provider

Obese population in our area. – Other Health Provider

We live in an obesogenic culture; people do not have education on how to live a healthy lifestyle. Money to purchase the appropriate foods and motivation to follow that lifestyle. They will get nutrition-related chronic diseases, including obesity. – Other Health Provider

People are overweight and need encouragement to take part in healthy lifestyle. – Other Health Provider

Obesity is a significant challenge. Too many fast food options and a lot of people in the community are overweight. – Community Leader

People are overweight, sedentary, and have poor diets. – Physician

Prevalence of obesity and obesity-related chronic disease, accessibility to diet education, affordability of gym memberships and training. – Physician

Obesity is high in the area. – Community Leader

Overweight children and adults in the community. Lack of physical exercise. – Community Leader

Obesity leads to heart disease, diabetes and so many other physical, mental, and social ailments. Maybe nutrition programs exist but I'm not aware of anything. I would love to see the hospital sponsor events where the community can come together to get and be healthy together. Perhaps a partnership with the Y as part of a treatment plan. Parks with outdoor exercise equipment. I don't have children, so I don't know if MMH is involved with the schools and educating children about exercise, nutrition, and providing active programming. – Community Leader

Obesity is an issue and people refuse to address this problem. – Community Leader

Lifestyle

Discipline and desire to eat healthy and invest time in physical conditioning for exemplary health. – Community Leader

People just don't care. – Community Leader

Economic/work schedule demands, local food culture, restaurant choices all contribute to unhealthy eating options. Not all communities in Ripley and Franklin County are walkable or have good access to trails, green space, and indoor recreation space. Access is particularly limited for those with limited mobility, those in poverty, those who might not be comfortable running / walking / biking solo on trails or county roads. – Community Leader

Unhealthy eating habits and lack of regular exercise. – Community Leader

Unhealthy eating, not enough healthy food options in restaurants, excessive drinking, smoking, drug use, YMCA membership is expensive; would be great to have more options for physical activity. Maybe open up some buildings for walking at odd times of day. – Community Leader

We in general just like to eat, healthy or not. – Social Services Provider

Many people are food insecure, lead a poor lifestyle regarding physical activity and diet, leading to being overweight, and social determinants of health. – Social Services Provider

Busy lifestyles. – Other Health Provider

Awareness/Education

Education, motivation and sedentary lifestyle. – Physician

Education in schools related to the importance of overall health and wellness. Offering healthy, whole food options at school and teaching kids about their food source. I also think many educators in our community use recess and physical activity as punishment so workshops related to the importance of physical activity may need to be offered to teaching staff. We are lacking programs with a broader focus on overall health and self-care and getting to the underlying problems that often lead to overeating. – Community Leader

Education about what is truly healthy eating. School lunches could be more nutritious and use local fresh foods. Also, we live in a world that sits all day at work, at school, and when we go out with family/friends. – Other Health Provider

Lack of education and awareness. – Community Leader

I don't think there are enough support groups for people trying to lose weight. There are very few fun activities that involve physical exercise for adults available, and many health insurance companies do not cover weight loss related appointments with doctors or nutritionists. – Community Leader

Lack of education, lack of motivation and time constraints. – Other Health Provider

Access to Healthy Food

Lack of money to afford healthy foods or lack of knowledge on how to eat healthy and exercise. – Community Leader

Taking the time to eat healthy and exercise. – Community Leader

Prices of healthy food are expensive and not many people have time to prepare healthy meals. – Other Health Provider

The biggest challenge is the availability of the food and the knowledge of what people should be eating. Also, how to fix the food is an issue for some. Pantries often have canned goods filled with sodium and sugar. – Community Leader

Lack of enough healthy options in restaurants. Cost of healthy foods often makes them prohibitive for families with lower incomes. Children who spend all their time indoors playing video games and parents who allow them to do so. – Other Health Provider

Insufficient Physical Activity

Lack of motivation to eat healthy, get physical exercise and maintain healthy weight. – Community Leader

Many of us work in sedentary jobs where we sit all day with limited physical activities. There are opportunities to engage in physical activity but not sure the motivation is present. We have lots of fast food restaurants which contributes to obesity issues. – Community Leader

Changing a mindset locally. We are rather lazy and obese. We don't take care of ourselves and don't eat the right things. – Community Leader

There doesn't seem to be a culture that positively promotes and supports these things. Social activity in our community does not center around health and wellness; the most common center is alcohol. – Social Services Provider

Nutrition

It is an Indiana thing. Poor food choices, fast food convenience, no food fixed at home. – Community Leader

Caloric intake choices that exceed the caloric output of our citizens. Cultural normative acceptance of obesity has really picked up speed in our MALE population. Whereas I witness women being more proactive in their food-choice making, there is an, unfortunately, powerful regard for an obese man. The majority of powerful and wealthy public figures in Brookville have substantial BMIs. It seems like it's a kind of proof of success and entitlement; this is not acceptable for women at all, but it is for the men here. – Public Health Representative

Nutrition – All kinds of information and a lot of it is false! Need to teach people about real food. Eat to fuel your body and not your emotions. Teaching people how to cook with real food. That life skill is not being taught anymore in schools or in the home. Physical Activity – Teaching at a young age the importance of mobility, strength training and being active. Teaching adults that when you are in pain that avoiding using that muscle/joint is not going to make it feel better and heal faster – you need to move it and use it. So much you could teach about this. Weight—we are an overweight society. The low-income in our community are forced to buy foods that they can afford – processed foods. They don't always have the means to prepare food. We live in a fast-paced world and we reach for convenience food instead of planning ahead and food prepping. – Community Leader

Access to Care/Services

In my small community, there is no YMCA, only one small, privately-owned gym. There is a local grocery that sells fruit and vegetables to the public. Local groups have 3K and 5K runs for charitable organizations. – Community Leader

Affordable Care/Services

Lack of affordable facilities where families or their children can go to in the winter, when it is too cold to be outside doing physical activities. Most people know what they are supposed to do nutritionally but don't do it due to lack of self-control or for economic reasons. – Social Services Provider

Built Environment

It is a complex web of issues including a built environment that encourages overeating and lack of activity, decreasing cooking and nutrition knowledge, and a fast-paced lifestyle that leaves little time for exercise and sleep but plenty of time for stress and convenience eating. – Other Health Provider

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
- Crime
- Homicide
- 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.

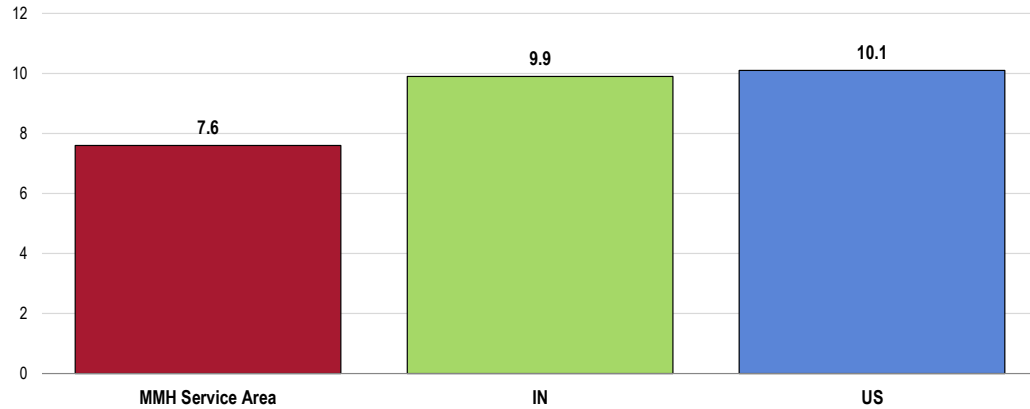
— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2008 and 2017, the MMH Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 7.6 deaths per 100,000 population.

- **BENCHMARK:** Below the state and national mortality rates.

Cirrhosis/Liver Disease: Age-Adjusted Mortality (2008-2017 Annual Average Deaths per 100,000 Population) Healthy People 2020 = 8.2 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 September 2019.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Alcohol Use

Excessive Drinking

A total of 25.2% of area adults are excessive drinkers (heavy and/or binge drinkers).

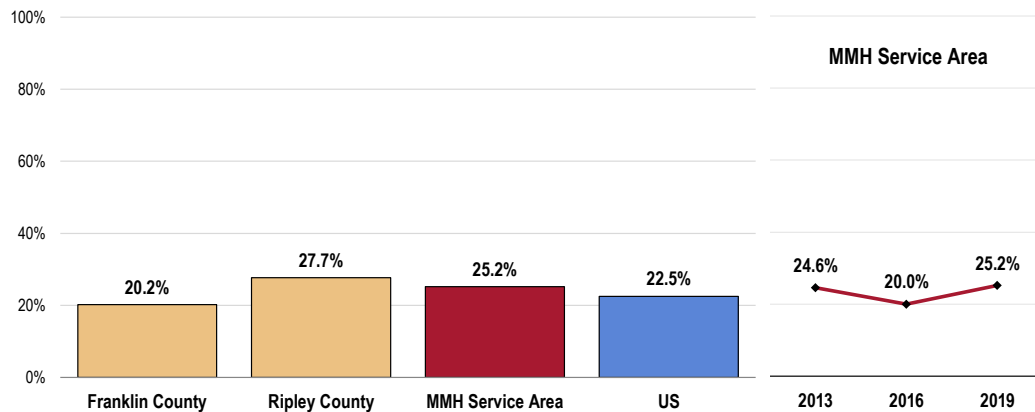
"Excessive drinking" includes heavy and/or binge drinkers:

- **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.

- **DISPARITY:** More often reported among service area men, young adults, and residents of upper-income households.

Excessive Drinkers

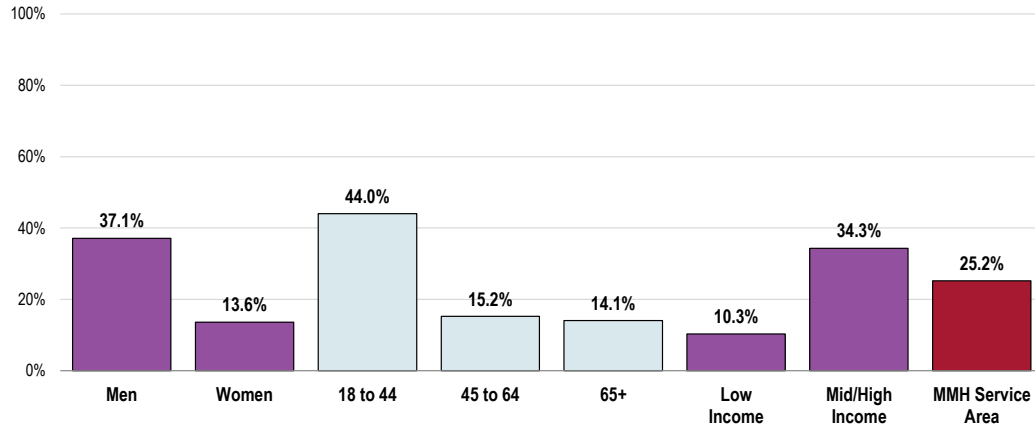
Healthy People 2020 = 25.4% or Lower



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 168]
• 2017 PRC National Health Survey, PRC, 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 Drinkers (MMH Service Area, 2019)

Healthy People 2020 = 25.4% or Lower



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 168]
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]

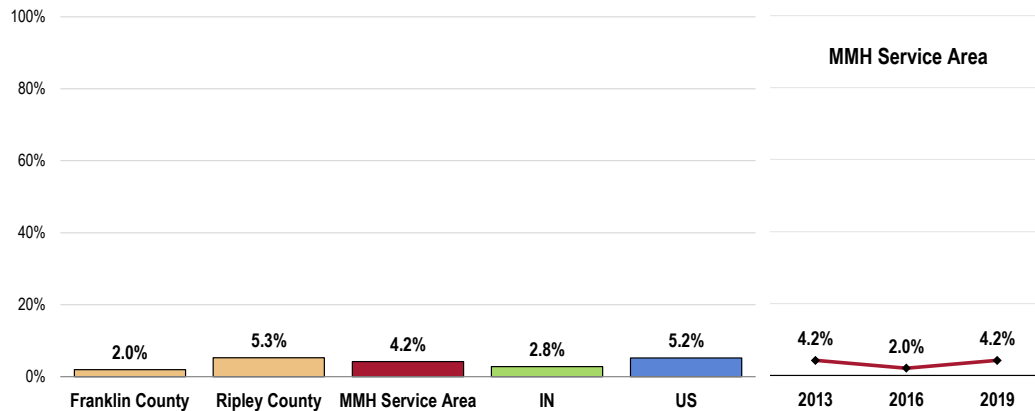
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes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

Drinking & Driving

A total of 4.2% of MMH Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

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



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 58]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Indiana data.
• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Age-Adjusted Unintentional Drug-Related Deaths

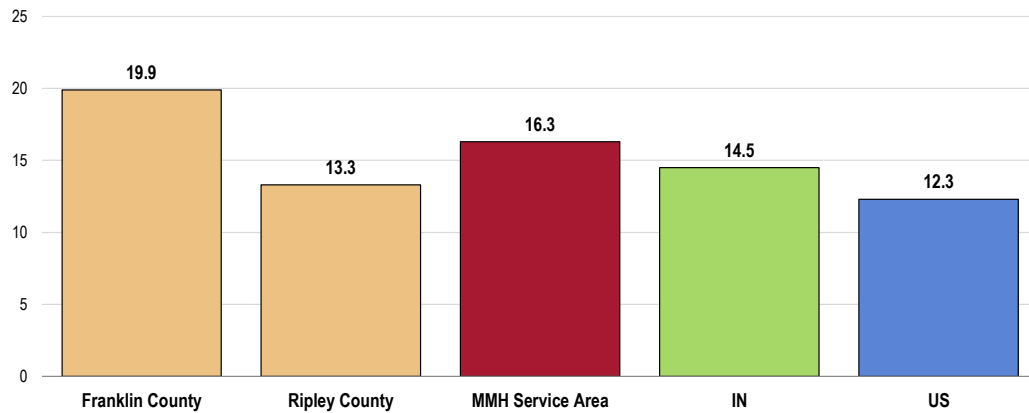
Between 2008 and 2017, there was an annual average age-adjusted unintentional drug-related mortality rate of 16.3 deaths per 100,000 population in the MMH Service Area.

- **BENCHMARK:** Worse than the US prevalence and failing to satisfy the Healthy People 2020 objective.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality

(2008-2017 Annual Average Deaths per 100,000 Population)

Healthy People 2020 = 11.3 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 September 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Illicit Drug Use

A total of 2.9% of service area adults acknowledge using an illicit drug in the past month.

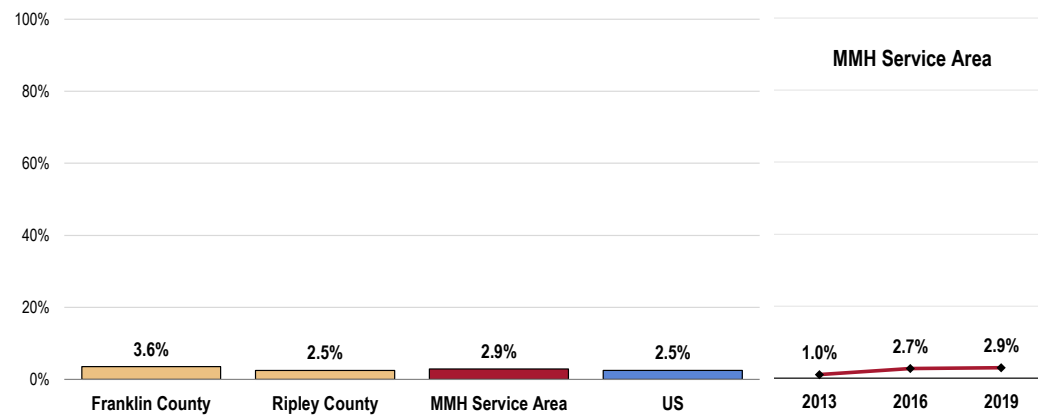
- **BENCHMARK:** Satisfies the Healthy People 2020 objective.
- **TREND:** Denotes a statistically significant increase since 2013.
- **DISPARITY:** The prevalence of illicit drug use decreases with age among survey respondents.

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Illicit Drug Use in the Past Month

Healthy People 2020 = 7.1% or Lower



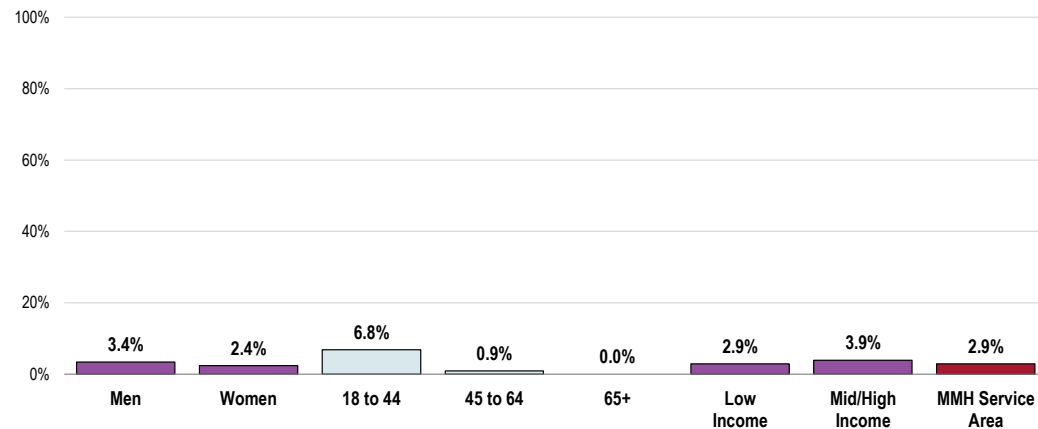
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 59]
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]

Notes: • Asked of all respondents.

Illicit Drug Use in the Past Month

(MMH Service Area, 2019)

Healthy People 2020 = 7.1% or Lower



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 59]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]

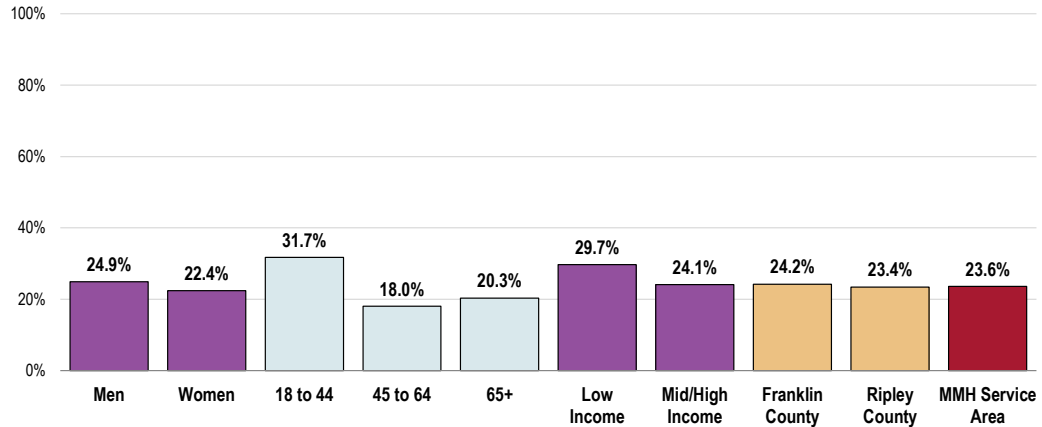
Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes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

Prescription Medication

Among the total sample of survey respondents, 23.6% report that they keep medication in a locked place so that no one else can access it.

- **DISPARITY:** Less often reported among adults age 45 and older in the service area.

Medications Are Kept in a Locked Place (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 302]

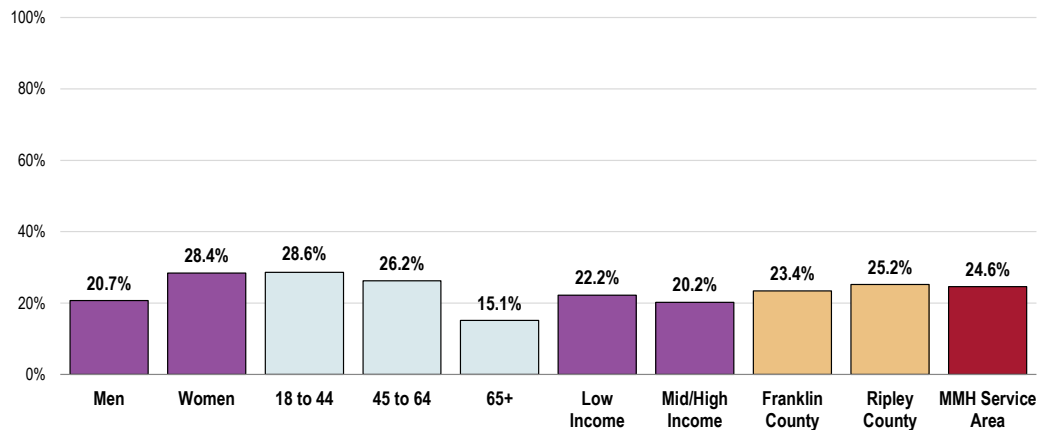
Notes: • Asked of all respondents.

• 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.

A total of 24.6% of MMH Service Area adults currently have prescriptions in the home that are expired or that they should no longer be taking.

- **DISPARITY:** More often reported among respondents under age 65.

Currently Have Expired or Unused Prescriptions in the Home (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 303]

Notes: • Asked of all respondents.

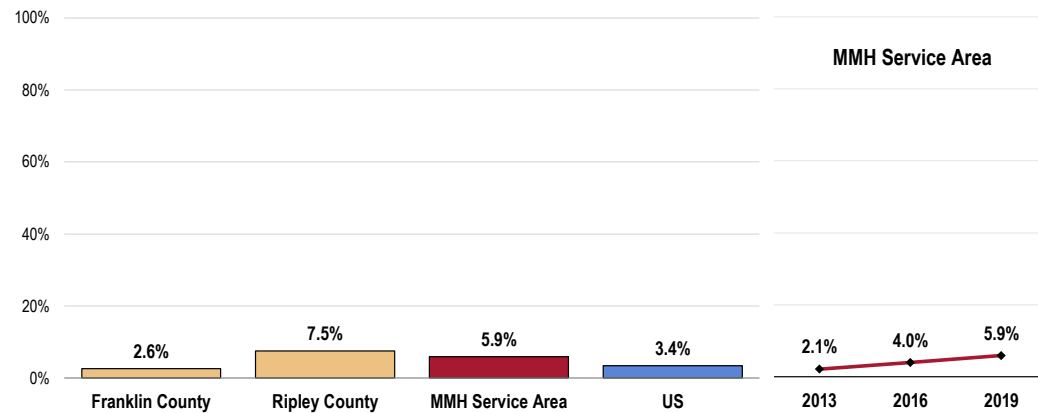
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty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

Alcohol & Drug Treatment

A total of 5.9% of MMH Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- **TREND:** Marks a steady, significant increase since 2013.
- **DISPARITY:** The prevalence is much higher in Ripley County.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



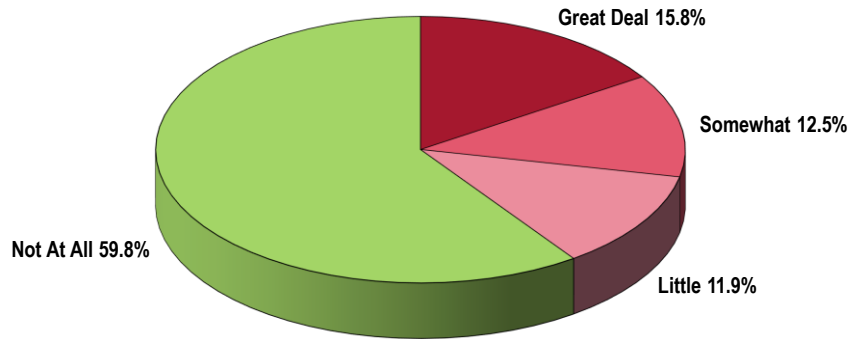
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 60]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Personal Impact From Substance Abuse

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

Most MMH Service Area residents' lives have not been negatively affected by substance abuse (either their own or someone else's).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's) (MMH Service Area, 2019)

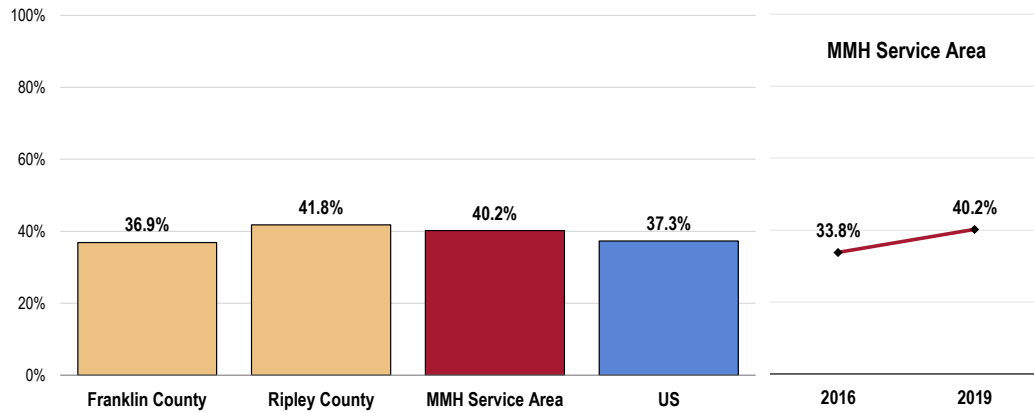


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 61]
Notes: • Asked of all respondents.

However, 40.2% have felt a personal impact to some degree (“a little,” “somewhat,” or “a great deal”).

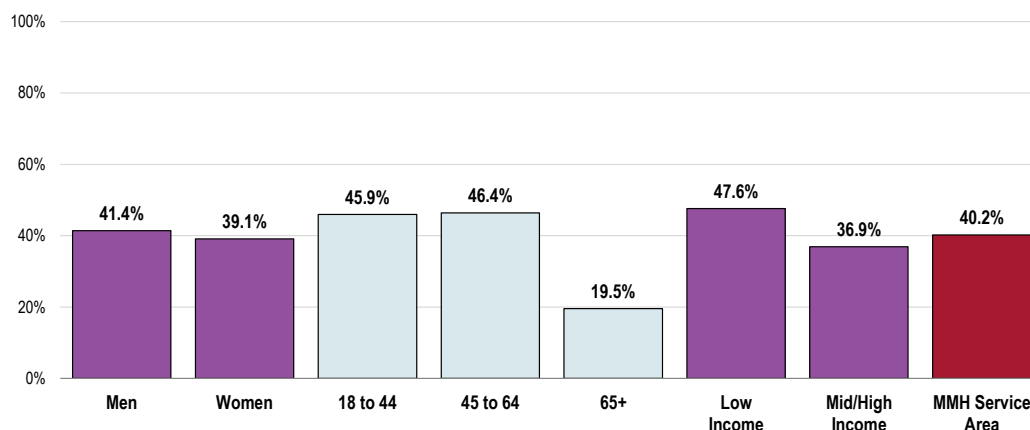
- **TREND:** Denotes a statistically significant increase since 2016.
- **DISPARITY:** Markedly higher among adults under age 65.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 195]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes response of “a great deal,” “somewhat,” and “a little.”

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else) (MMH Service Area, 2019)

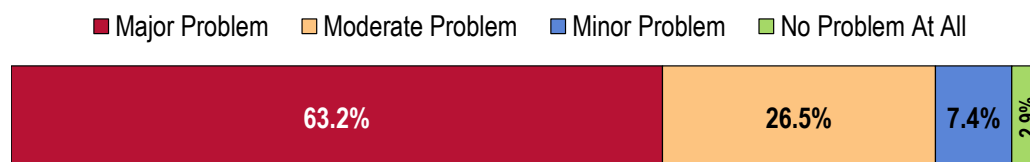


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 195]
 Notes: • Asked of all respondents.
 • Includes response of "a great deal," "somewhat," and "a little."
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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, 2019)



Sources: • PRC Online Key Informant Survey, PRC, 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

Access to care and treatment, early detection. – Other Health Provider

Very limited treatment and/or prevention services available in our communities. – Community Leader

Access and insurance. – Other Health Provider

While we have a program available it sounds like the process to start the program is lengthy due to insurance prior authorizations. Also, there is likely transportation or other social determinant of health issues preventing consistent attendance at appointments. – Other Health Provider

Access and privacy of identity. – Other Health Provider

Facility accepting them directly. – Other Health Provider

Again, limited resources available to people and it appears the population for this is getting younger. – Other Health Provider

Knowing where to turn for help. – Community Leader

We do not have an inpatient treatment facility in our community. – Other Health Provider

Local CMHC is never available to take new clients for IOP or individual counseling. Most inpatient treatments are far away from home. MAT program is not in Ripley County, so you have to drive to Greensburg or Lawrenceburg. – Other Health Provider

There are no local programs for detox or long-term treatment of any kind. Outpatient programs are not as effective as they could be and are difficult to access. No consistent outpatient treatment, high staff turnover, no programming, funding. – Other Health Provider

A clear-cut place to go. – Community Leader

Lack of services. Lack of coverage for payment of services. – Community Leader

People have to go out of town to get help and transportation could be a problem. – Community Leader

Having a place or home for people to go to with substance abuse. Like a rehab facility. – Community Leader

Lack of inpatient treatment options and lack of insurance coverage. – Other Health Provider

Lack of inpatient and outpatient facilities. – Community Leader

Treatment centers are not close. – Community Leader

Lack of skilled help. – Physician

Knowing where to go for help, not wanting help. Financial cost of getting help and being ashamed to seek treatment. – Community Leader

Inpatient/outpatient rehabilitation options. – Physician

There are not local detox facilities or many places for treatment. – Community Leader

Repeat offenders are sentenced 90 days to 1 year in jail, no treatment when they get out of jail, no follow-up. Why isn't there some kind of support or treatment center that they have to attend when they get out? Most offenders reoffend quickly, and the circle starts again. – Public Health Representative

Lack of law enforcement, budget. Treatment available and affordable. Education in general. – Community Leader

Oh my, there is no existing treatment in Osgood. – Community Leader

Lack of programs and resources, lack of housing for individuals struggling with substance abuse, social stigmas. – Other Health Provider

Access/availability seems to be the number one issue. I hear this all the time from people that want to quit their addiction. There are apparently so many folks that are in need there are not enough places to seek treatment. Also, I believe the cost of some programs are unattainable for some without insurance. – Community Leader

Access to adequate treatment options and a sustained support system. – Community Leader

Having the treatment centers available in the community and not having to send them to the city (Indy or Cincy). Treatment needs to be affordable; many substance abusers don't have health insurance and can't afford to pay out of pocket. Even with health insurance such as Medicaid, many facilities will not accept this form of payment. – Social Services Provider

Denial/Stigma

Getting the patient to accept the help available. – Community Leader

Stigma and recovery. – Community Leader

It's a small community. Not many youth will speak up. "If you see something, say something" statement needs to be utilized more here. Residents shouldn't be afraid to offer information. – Community Leader

I think that the stigma associated with substance abuse problems prevents most people from seeking help. Those with problems are not willing to risk the judgement they would get from the larger community if people found out they had a problem. – Community Leader

Transparency and being open/forthcoming with addiction and substance abuse problems. – Community Leader

Getting those who are abusing the substances to admit they have a problem and to seek help. Also, the problem is so large that there is no way our local law enforcement can keep up. We have even seen substance abuse issues make their way inside the county jail. – Community Leader

Coordination of all parties. – Community Leader

Stigma regarding addiction. Societal acceptance of substance abuse, specifically alcohol. Lack of Recovery residences. Transportation in the evening/weekend. – Social Services Provider

Patient motivation to stop. – Physician

Denial by individual or family that there is a problem. Also, hesitation due to embarrassment to admit there is a problem. – Social Services Provider

Small community and denial. – Community Leader

Ability to cope with being labeled as an abuser. – Community Leader

Stigma. Will people come forward for help in small community like ours knowing what the ramifications will be post treatment? Education, unsure of cost and insurance coverage, also what does treatment look like? In house, rehab from home. – Community Leader

Stigma, payer source, individuals not ready to change their behavior and social determinants. – Social Services Provider

Affordable Care/Services

Cost, location or treatment, and stigma around medicated assisted treatment. – Social Services Provider

No money to pay for it. – Community Leader

Cost and desire. – Community Leader

The greatest barrier to accessing care is the cost to run the program and the lack of reimbursement from Medicaid or commercial insurances to help cover the costs. – Community Leader

Money and accessibility. Desire for an individual to change. – Community Leader

Not many places to go and the costs to the person and the costs to the insurance plans. The problem is huge, and companies are struggling with being able to finance them. – Community Leader

Affordable, adaptable services. No outpatient work, no prep work, poorly designed. No through fare of patients. – Other Health Provider

Access to Care/Services

The availability of drugs, pain medicine poses a problem for an addictive personality. Once hooked it is very difficult to control the drive to have it. Treatment is available but not in every situation wanted. – Community Leader

The substances are cheaper than healthy food. – Other Health Provider

The barriers of substance abuse in the community are AVAILABILITY. Substance abuse is a lifelong challenge. Finding treatment that is affordable and long lasting. Once out of treatment, the long follow up and mentoring cannot occur in the area, town or neighborhood that subjects grew up in or lived.

Subjects will revert to the same old friends and ways that enabled them to become addicted in the first place. – Community Leader

Prevalence/Incidence

It's rampant in every community. – Public Health Representative

We know this continues to be a struggle; once we get a pulse on one drug another surfaces; without true 100% funding prevention on the front end, we will never be able to curb this. – Community Leader

Knowing the people. – Community Leader

Awareness/Education

I think that it is possibly that people are not aware of the resources available or are not ready to address their problem. – Other Health Provider

Education, I know the schools have some education materials, but it is not effective for all students. They choose to do what they want to do. Having more information available for those that do have a substance problem. Don't prescribe opioids. – Community Leader

Funding

Funding, detox, and long-term comprehensive supports. – Social Services Provider

Funding and lack of programs. – Community Leader

Lack of Providers

There is care coordination but not actual providers in the community i.e., licensed LCACs, more than one MAT, group therapy, or therapists are so hard to find and/or access. – Social Services Provider

No doctors local prescribe Subutex, methadone, etc. – Other Health Provider

Contributing Factors

High number of overdoses and drug related arrests. – Community Leader

This problem is not unique to only our community, but I do know overdose and substance usage (and abuse) is a problem. Kids start using likely due to home environment or peer pressure; adults abuse. I believe access to a holistic healthy life is a challenge aiding in substance abuse – lack of healthy lifestyle, mental status, physical health. This is a problem I don't think a lot of people like talking about because we don't want to believe it's a problem in our community. Local anti-drug agencies do a fairly good job in providing statistics. – Community Leader

To be honest we need to admit it is a problem here and it is bad. We need to embrace the problem and the problems it creates and then decide to face them head on. – Community Leader

Illicit drug use/alcohol abuse. – Public Health Representative

Again, culture change. Laws enforced more. Go after the dealers. School education. – Community Leader

Opioid crisis in the communities. Access to treatment by Franklin County residents. – Community Leader

The family unit has been broken—through divorce, single parents, grandparents raising their grandchildren. This area doesn't have a facility to have someone stay with their loved one's addiction problems, and the not-knowing of what to do if this happens and where to go for help. – Community Leader

There is a lot of concern about heroin, cocaine, and other drug use in high schools, neighborhoods, and communities in our counties. – Community Leader

Alcohol and drug dependencies are of major concern, but I have been fortunate to have never dealt with these problems in my family, yet I have seen how these addictions impact the immediate family, the community and beyond when the dependent does not seek and abide by treatment. – Community Leader

Prenatal exposure to substance abuse or "safer" medications to mitigate substance abuse – each month, several babies are born with substance dependency, and these kids are at high risk of developmental issues later in life. And the numbers are getting worse over time. – Physician

Impact on Families/Caregivers

Identifying families that need assistance, making connections, and building strong relationships to help them follow through with treatment options. – Community Leader

Lifestyle

I have no idea. But I know people continue to use. – Public Health Representative

Transportation

Transportation. – Other Health Provider

Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **alcohol** and **heroin/other opioids** as the most problematic substances abused in the community, followed by **methamphetamine/other amphetamines**, **prescription medications**, and **marijuana**.

| Problematic Substances as Identified by Key Informants | | | | |
|--|------------------|-------------------------|------------------------|----------------|
| | Most Problematic | Second-Most Problematic | Third-Most Problematic | Total Mentions |
| Alcohol | 35.4% | 16.5% | 22.8% | 59 |
| Heroin or Other Opioids | 32.9% | 24.1% | 12.7% | 55 |
| Methamphetamines or Other Amphetamines | 21.5% | 24.1% | 15.2% | 48 |
| Prescription Medications | 3.8% | 15.2% | 22.8% | 33 |
| Marijuana | 0.0% | 13.9% | 12.7% | 21 |
| Over-The-Counter Medications | 1.3% | 1.3% | 3.8% | 5 |
| Cocaine or Crack | 0.0% | 2.5% | 2.5% | 4 |
| Synthetic Drugs (e.g. Bath Salts, K2/Spice) | 0.0% | 0.0% | 2.5% | 2 |
| Inhalants | 1.3% | 0.0% | 1.3% | 2 |
| Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly) | 1.3% | 0.0% | 0.0% | 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.

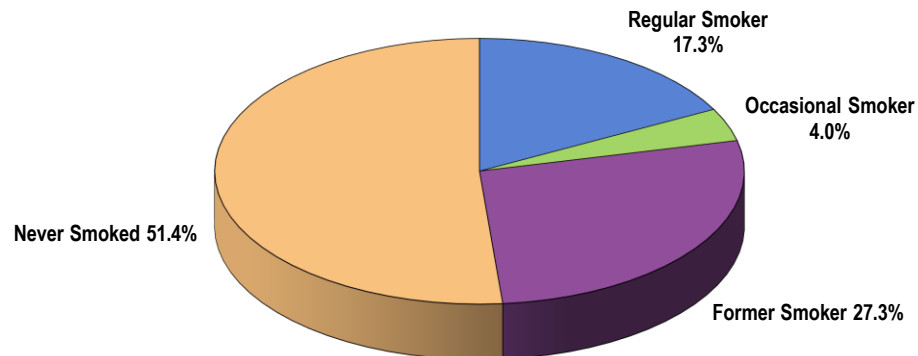
— Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 21.3% of MMH Service Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).

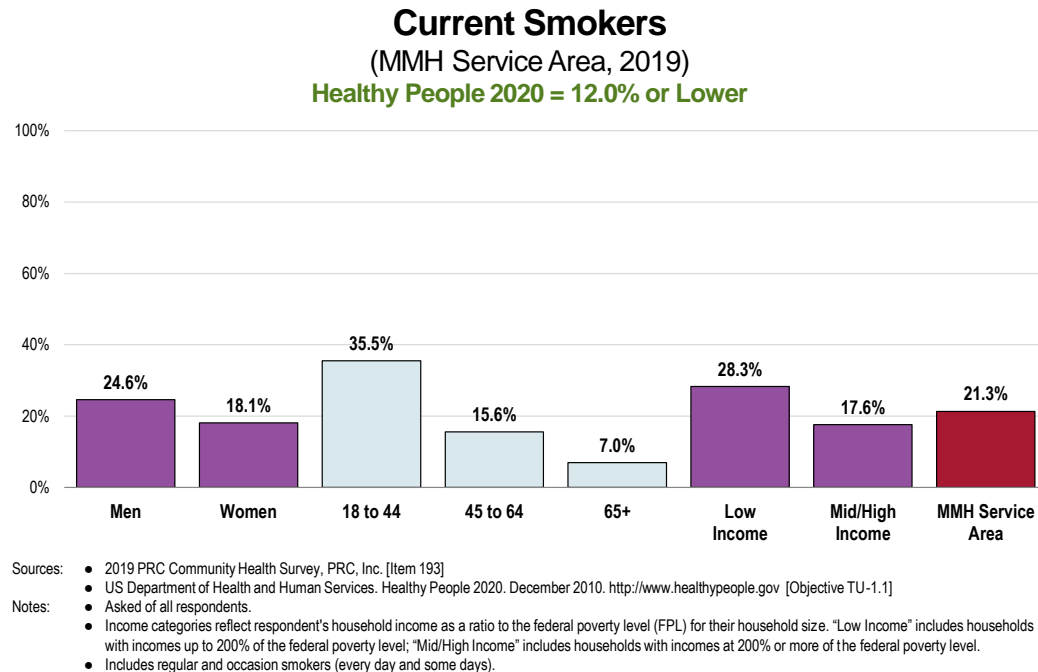
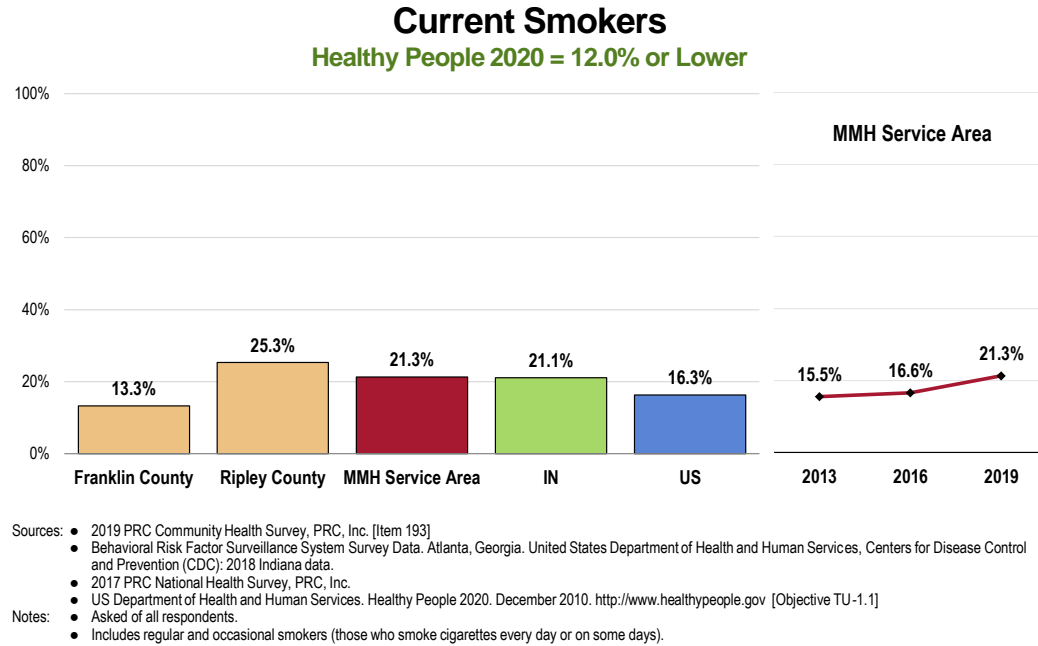
Cigarette Smoking Prevalence
(MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 159]
Notes: • Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the MMH Service Area.

- **BENCHMARK:** Higher than the national prevalence and far from meeting the Healthy People 2020 objective.
- **TREND:** Denotes a statistically significant increase from 2013 survey findings.
- **DISPARITY:** Much higher in Ripley County. The prevalence decreases with age and is especially high among low-income residents.

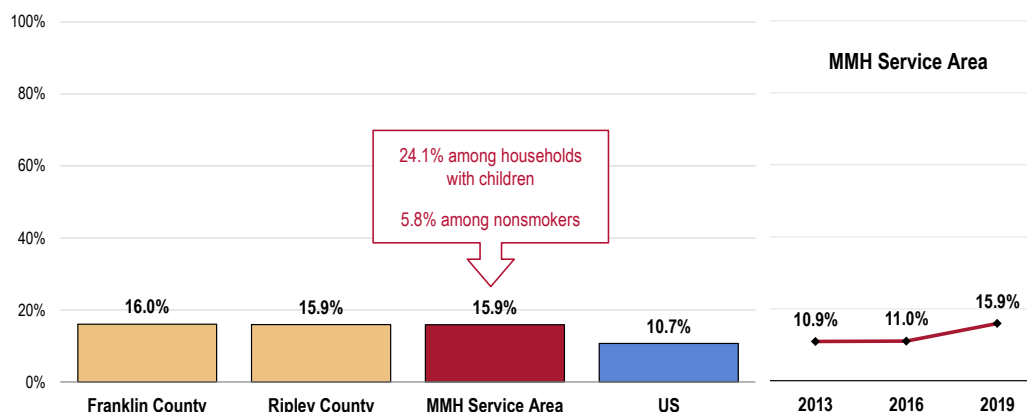


Environmental Tobacco Smoke

Among all surveyed households in the MMH Service Area, 15.9% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

- **BENCHMARK:** Well above the US prevalence.
- **TREND:** Marks a statistically significant increase since 2013.

Member of Household Smokes at Home



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 52, 161-162]
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

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.

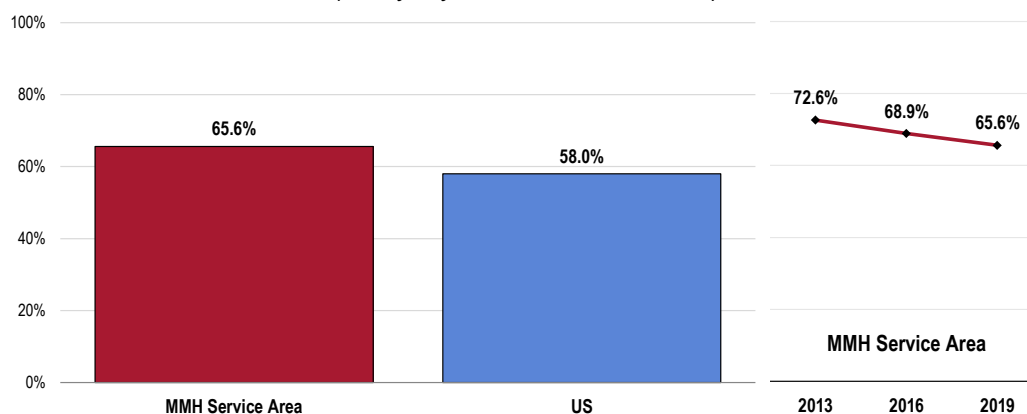
Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

— Healthy People 2020 (www.healthypeople.gov)

Nearly two in three regular and occasional smokers (65.6%) report that they received professional advice to quit smoking at least once in the past year.

- **TREND:** The decrease over time is not statistically significant.

Health Professional Advised Quitting Smoking in the Past Year (Everyday/Occasional Smokers)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 51]

• 2017 PRC National Health Survey, PRC, Inc.

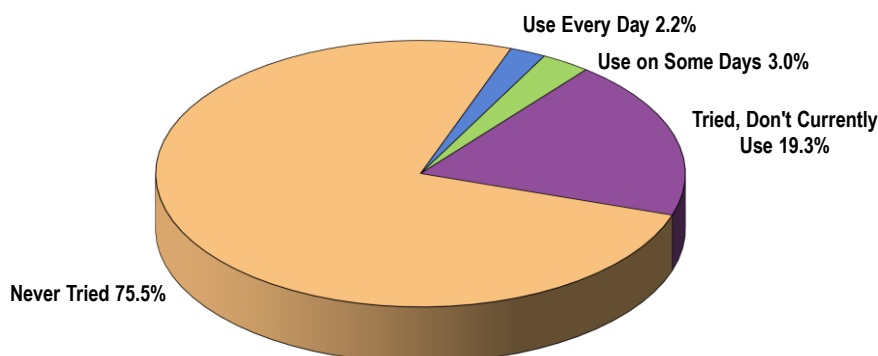
Notes: • Asked of respondents who smoke cigarettes, whether occasionally or every day.

Other Tobacco Use

Use of Vaping Products

Most MMH Service Area adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.

Use of Vaping Products (MMH Service Area, 2019)



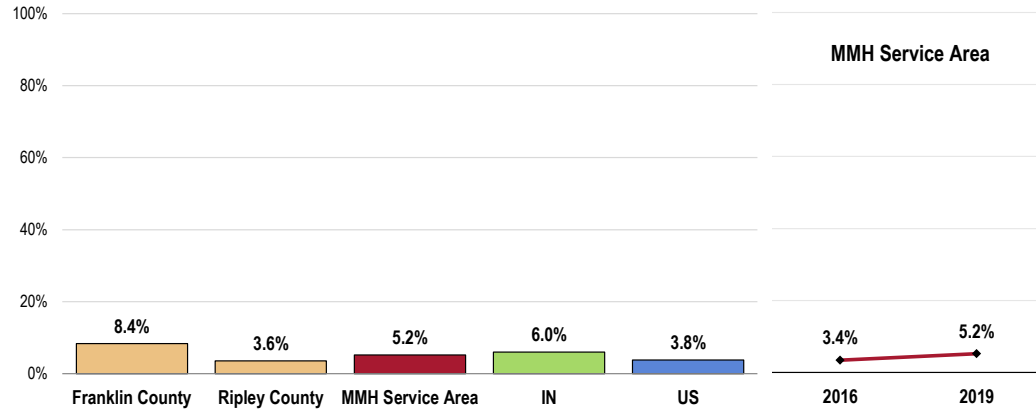
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 163]

Notes: • Asked of all respondents.

However, 5.2% currently use vaping products either regularly (every day) or occasionally (on some days).

- **DISPARITY:** Much higher prevalence in Franklin County. Use decreases with age and is notably higher among low-income adults.

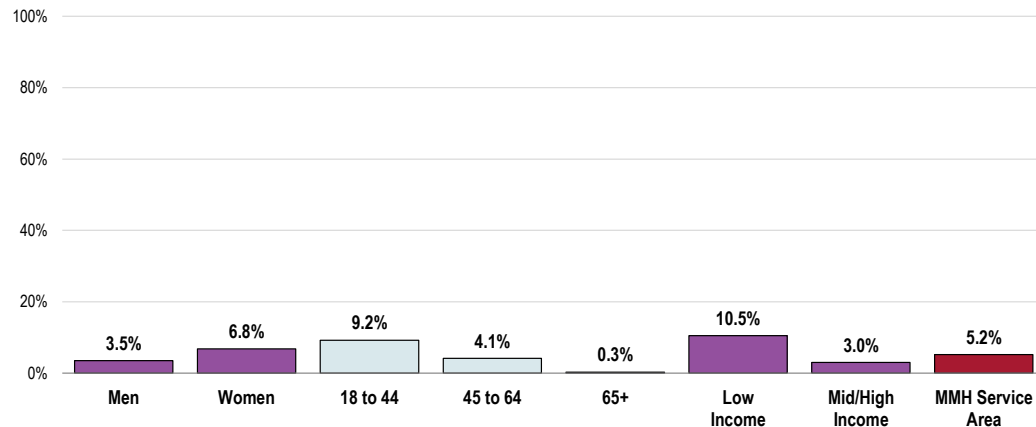
Currently Use Vaping Products (Every Day or on Some Days)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 194]
 • 2017 PRC National Health Survey, PRC, 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); 2017 Indiana data.

Notes: • Asked of all respondents.
 • Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Currently Use Vaping Products (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 194]
 • 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.
 • Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

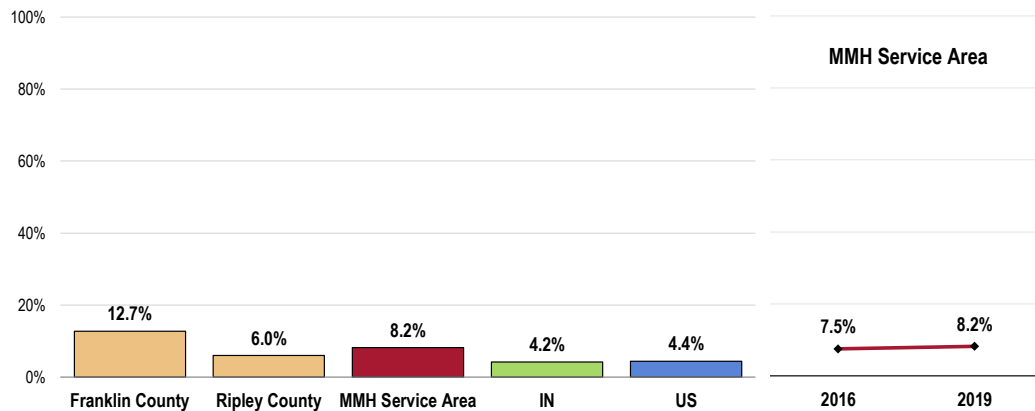
Smokeless Tobacco

A total of 8.2% of MMH Service Area adults use some type of smokeless tobacco every day or on some days.

- **BENCHMARK:** Much higher than state and national figures. Far from reaching the Healthy People 2020 objective.
- **DISPARITY:** Twice as high in Franklin County as in Ripley County.

Currently Use Smokeless Tobacco

Healthy People Goal = 0.2% or Lower



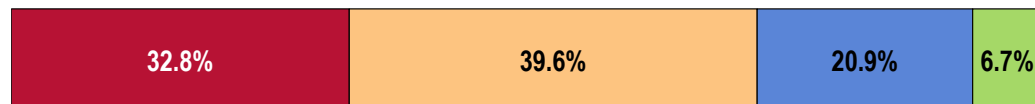
- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 301]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.2]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
- Notes:
- Reflects the total sample of respondents.
 - Smokeless tobacco includes chewing tobacco or snuff.

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, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



- Sources:
- PRC Online Key Informant Survey, PRC, Inc.
- Notes:
- Asked of all respondents.

Top Concerns

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

Prevalence/Incidence

We are a rural community where rates of smoking seem to have stayed stubbornly high. I also assume it's still a major problem due to the high rate of head and neck cancers we see. – Other Health Provider

Franklin County has a high number of smokers. – Community Leader

I know that Indiana has a very high percentage of tobacco users. – Community Leader

The amount of people using tobacco products. – Community Leader

Smoking rates in Franklin and Ripley counties above state and national averages per County Health Rankings; observed/anecdotal experience of people smoking more frequently here than other places I visit; cultural norms – still easy to see someone smoking in car with kids in back seat, smoking at a playground, etc. – Community Leader

Chewing and smoking is still common. Vaping is a problem. – Community Leader

Tobacco is normalized in Franklin County and not seen as a problem by most people. – Community Leader

It seems that there are a lot of people that smoke in our community. They are seen standing outside of businesses, smoking. Parents that smoke are likely to influence their children to smoke. – Community Leader

It is everywhere. – Other Health Provider

Too many people are addicted to tobacco use. – Community Leader

Prevalence of smoking cessation. – Physician

Still a fair number of people who smoke, even when they are experiencing health consequences. – Physician

Too many people don't take this addiction seriously and it is a gateway drug. I'm especially concerned about the increase in vaping and Juuling. – Public Health Representative

Many Hoosiers smoke, youth are vaping in even more numbers when we know it causes cancer and lung disease. – Social Services Provider

E-cigarettes

Vaping, e-cigarette use very high, low perception of risk. – Other Health Provider

There are now more ways to utilize tobacco. Vaping, e-cigarettes. I feel that more youth are utilizing these products. Also, these products are more addictive than cigarettes and smokeless tobacco. – Other Health Provider

The e-cigarettes have become popular with the young people. Tends to lead into other addictions. – Community Leader

Once again, it is a culture issue. Also, the new vape pens are out of control and there needs to be more testing and clinical studies done. Then education to follow the studies. Laws need to change to raise the age to purchase. – Community Leader

Vaping has truly become an epidemic. – Community Leader

Smokeless tobacco and Juuling, especially with our youth, is a huge problem. People perceive Juuling as a safe way to avoid tobacco, but the studies are showing that is not the case. – Social Services Provider

Vaping is a trend that does not “look” like tobacco but has much more serious consequences. Our students do not see vaping as true tobacco use. – Community Leader

Youth

Students view it as cool. Smokeless tobacco is a bigger issue than cigarettes. Vaping is a larger problem than either of the other items. – Community Leader

I see many times that people that are under the age 18 find themselves in a difficult spot. They want to quit but aren't old enough to get into some of the programs that are offered. Unless they get caught with tobacco by police officers. If they get caught, I've heard those programs are usually just box-checking type and don't seem to really help them figure out how to quit. These programs are often just about showing them how bad cigarettes or tobacco use is. – Community Leader

Schools are seeing increasing presence of vaping and e-cigarettes. Smokeless tobacco use is also prevalent in our community. This is generational in many families and it is hard to break the chain. – Community Leader

It is a habit that sometimes starts at an early age with some families and is permissible; not an illegal substance. – Social Services Provider

Contributing Factors

I believe it is a generational thing. Many children smoke or use tobacco products because their parents do. – Community Leader

Many start really young and is a generational habit. Vaping has increased the usage and made it more acceptable in public settings. Those in lower income households are frequently purchasing tobacco and vape products at the local gas stations. There is marketing to tell people to switch to vape as though this is healthier to do. Youth are doing it because it is trendy and then finding that the nicotine provides a buzz initially. This gets them hooked. Parents are allowing vaping as well. – Other Health Provider

Use by parents looked at by children as fine. – Community Leader

Birth issues. – Community Leader

Denial of risk. Family history. Societal acceptance. – Social Services Provider

People believe it is the lesser of all evils. Easy access especially to capes and dab pens and tobacco products in general. – Other Health Provider

Awareness/Education

People don't understand the side effects of tobacco use. – Community Leader

Ripley County Health Department failed to apply for state grants that were available for tobacco awareness. School resource officers are reporting epidemic conditions in our schools pertaining to vaping. – Community Leader

Comorbidities

Deaths due to lung cancer and heart disease. Refusal of local citizens to acknowledge the danger from smoking. – Community Leader

Lifestyle

The dangers are known. People continue to start smoking, and now vaping. – Public Health Representative

Sexual Health

HIV

About Human Immunodeficiency Virus (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.

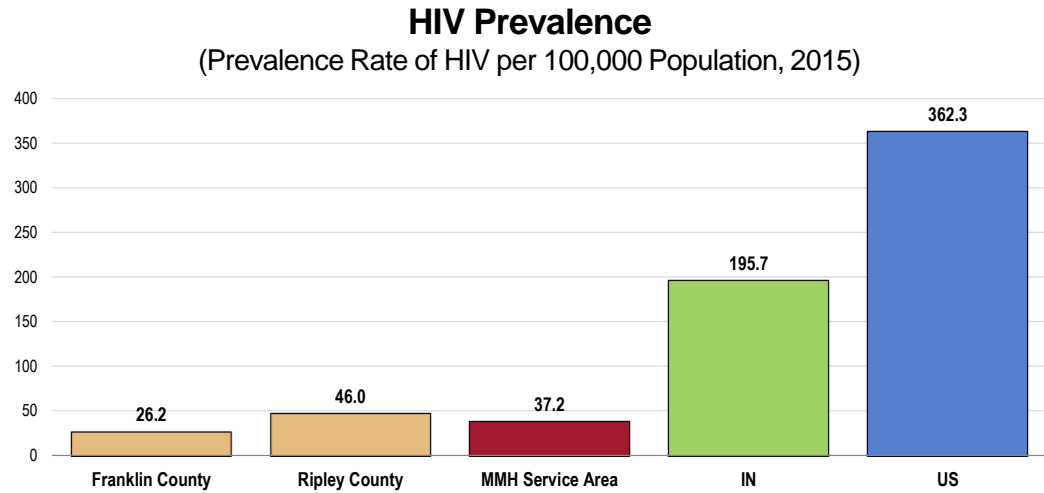
Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions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

— Healthy People 2020 (www.healthypeople.gov)

HIV Prevalence

In 2015, there was a prevalence of 37.2 HIV cases per 100,000 population in the area.

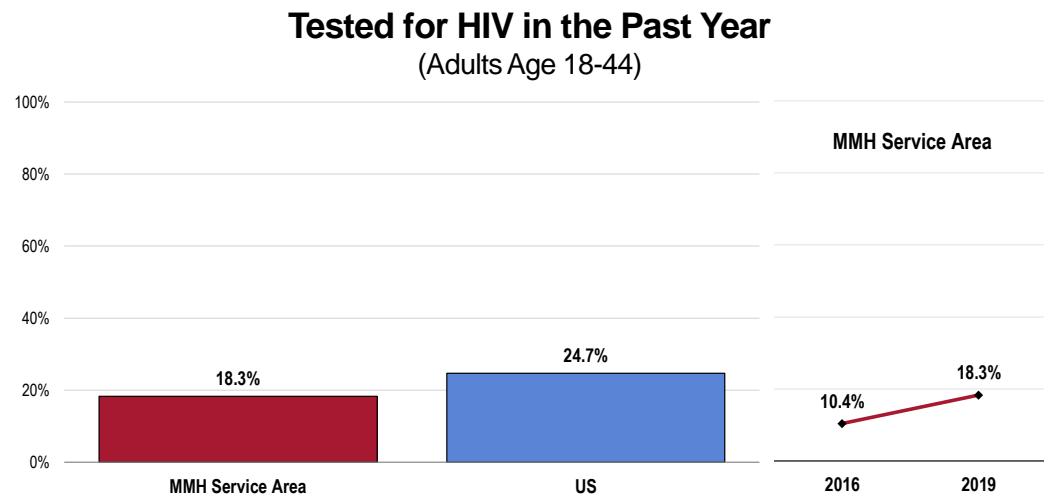
- **BENCHMARK:** Well below state and national rates.
- **DISPARITY:** Higher in Ripley County.



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
 • Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
 Notes: • This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

Among MMH Service Area adults age 18-44, 18.3% report that they have been tested for HIV in the past year.



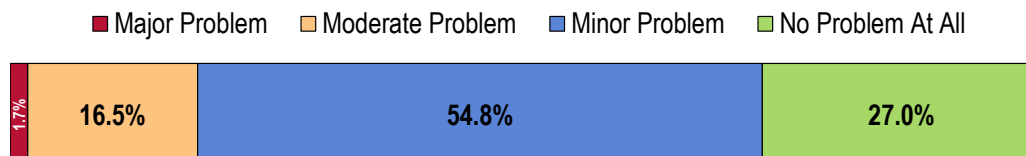
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 318]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Reflects respondents age 18 to 44.

Key Informant Input: HIV/AIDS

Over half of 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, 2019)



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

Top Concerns

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

Denial/Stigma

I listed this because I believe that this is also a taboo subject, and as a result, I think that people may have difficulty getting diagnosed or receiving treatment. I don't think the occurrence of HIV/AIDS is higher than other areas, but I do believe that it is a very stigmatized diagnosis, more so than in urban areas. – Community Leader

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

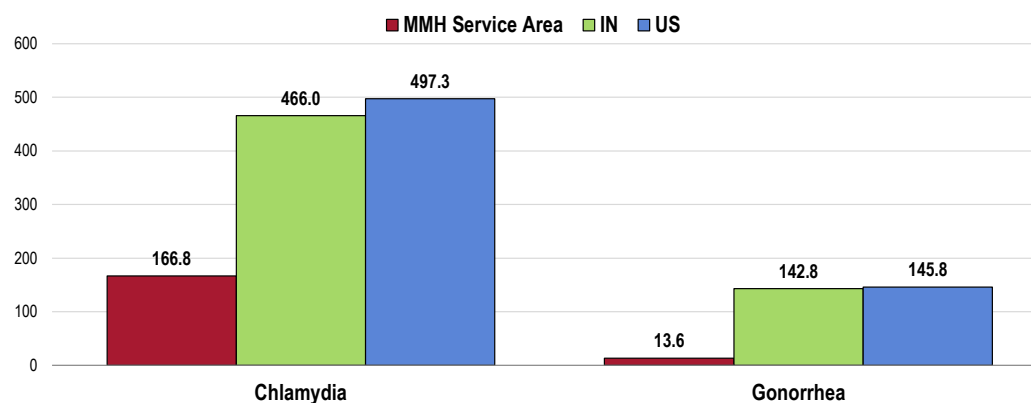
In 2016, the chlamydia incidence rate in the MMH Service Area was 166.8 cases per 100,000 population.

The area’s gonorrhea incidence rate in 2016 was 13.6 cases per 100,000 population.

- **BENCHMARK:** Both incidence rates fall well below the related state and US rates.
- **DISPARITY:** In both cases, the incidence rates are much higher in Ripley County (not shown).

Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2016)



Sources:

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes:

- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

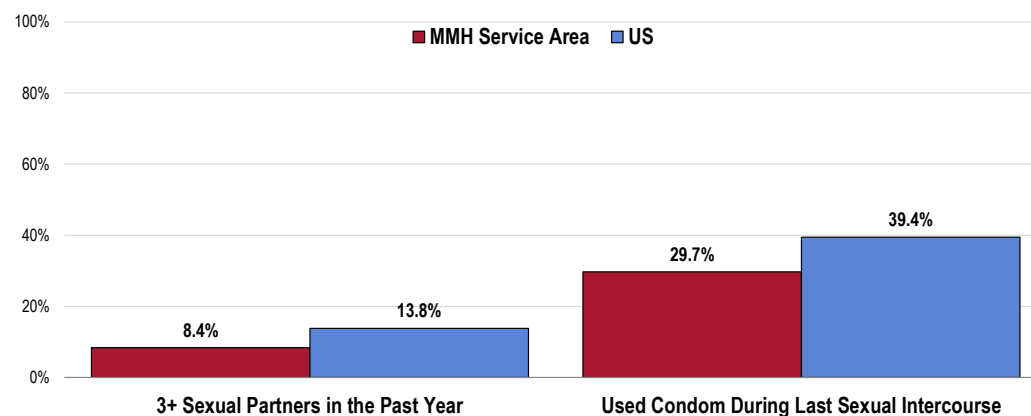
Safe Sexual Practices

Among unmarried MMH Service Area adults under the age of 65, the majority cites having one or no sexual partners in the past 12 months. However, 8.4% report three or more sexual partners in the past year.

A total of 29.7% of unmarried MMH Service Area adults age 18 to 64 report that a condom was used during their last sexual intercourse.

Sexual Risk

(Unmarried Adults Age 18-64)



Sources:

- 2019 PRC Community Health Survey, PRC, Inc. [Items 310-311]
- 2017 PRC National Health Survey, PRC, Inc.

Notes:

- Reflects unmarried respondents under the age of 65.

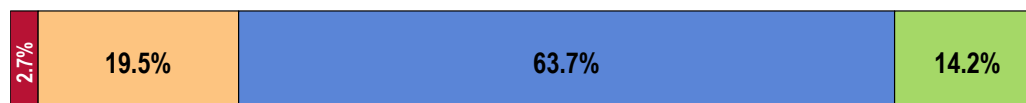
Key Informant Input: Sexually Transmitted Diseases

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, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Awareness/Education

I think there is a general lack of awareness about STDs and that people are not properly educated about what they can do to prevent STDs other than abstain from sex. – Community Leader

Access to Health Services

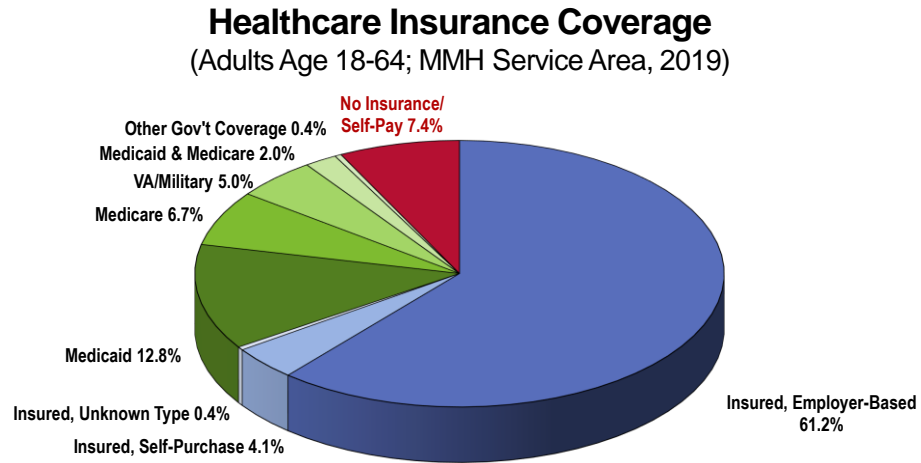


Health Insurance Coverage

Type of Healthcare Coverage

A total of 65.7% of MMH Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 26.9% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 169]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Among adults age 18 to 64, 7.4% report having no insurance coverage for healthcare expenses.

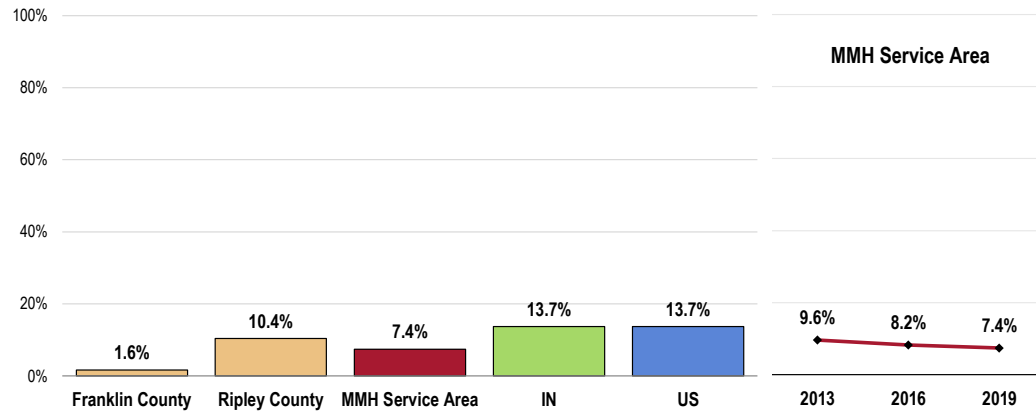
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

- **BENCHMARK:** Well below the Indiana and US figures. The Healthy People 2020 objective is universal coverage.
- **DISPARITY:** Lack of coverage is considerably worse in Ripley County. Adults age 18 to 44 and those in the higher income breakout are more likely to report being uninsured.

Lack of Healthcare Insurance Coverage

(Adults Age 18-64)

Healthy People 2020 = 0.0% (Universal Coverage)



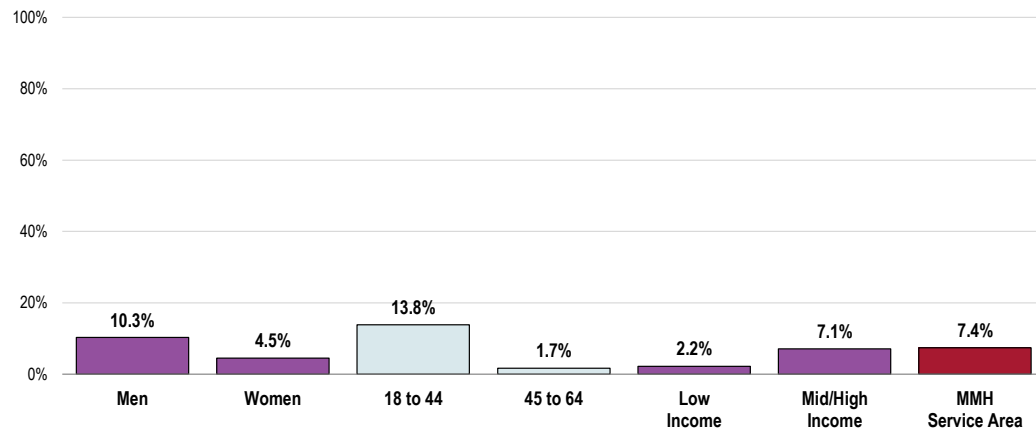
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 169]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, 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.

Lack of Healthcare Insurance Coverage

(Adults Age 18-64; MMH Service Area, 2019)

Healthy People 2020 = 0.0% (Universal Coverage)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 169]
 • 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 categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

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)

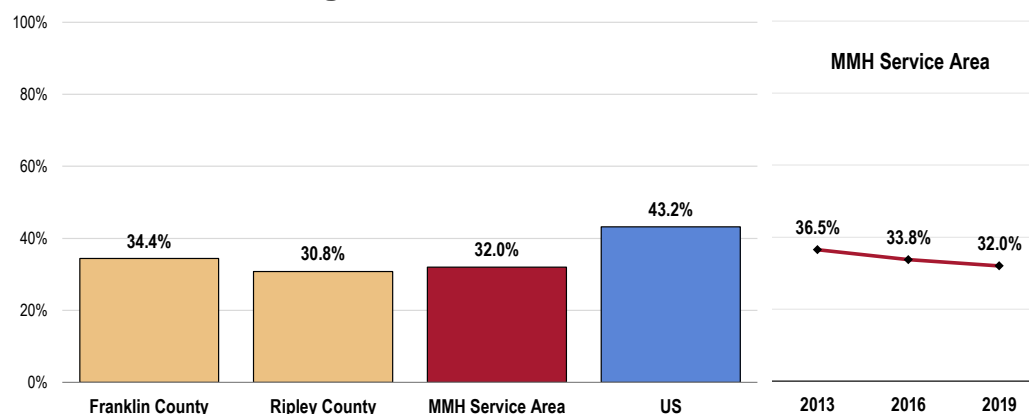
Difficulties Accessing Services

A total of 32.0% of MMH Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- **BENCHMARK:** Well below the national prevalence.
- **DISPARITY:** More often reported among adults age 45 to 64 and those in low-income households.

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

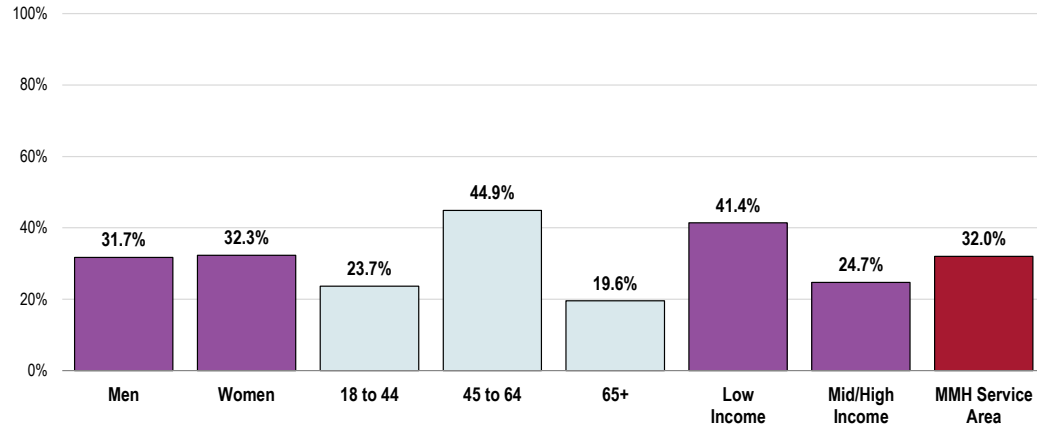
Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 171]
• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 171]

Notes: • Asked of all respondents.

• Percentage represents the proportion 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

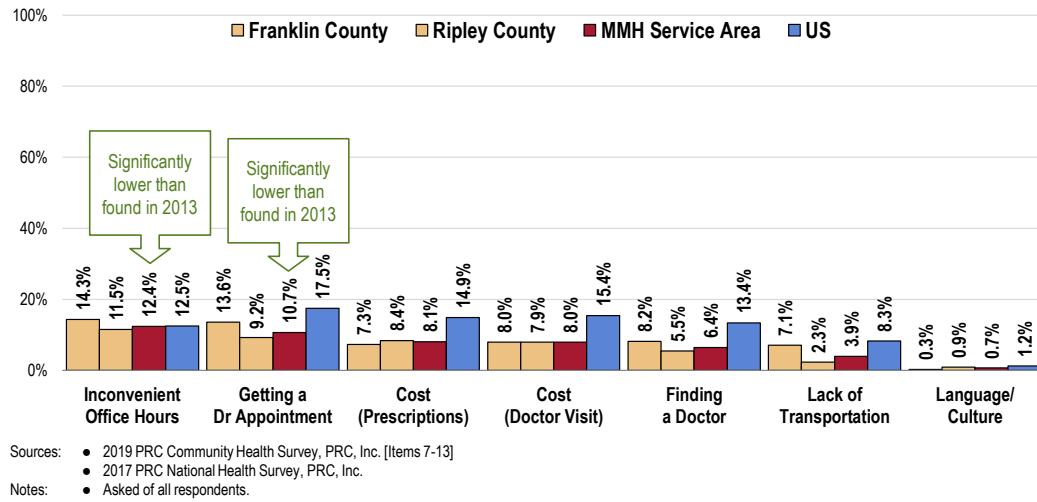
Of the tested barriers, inconvenient office hours and appointment availability impacted the greatest shares of MMH Service Area adults.

- **BENCHMARK:** The area fared better than national findings with regard to the barriers of **finding a physician, appointment availability, cost of care** as well as **prescriptions**, and lack of **transportation**.
- **TREND:** Significant decreases (improvements) were reported for the barriers of **appointment availability** and **inconvenient office hours**.
- **DISPARITY:** The barrier of transportation was more often reported in Franklin County.

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.

Barriers to Access Have Prevented Medical Care in the Past Year



Note also that 8.3% of MMH Service Area adults have skipped or reduced medication doses in the past year in order to stretch a prescription and save costs.

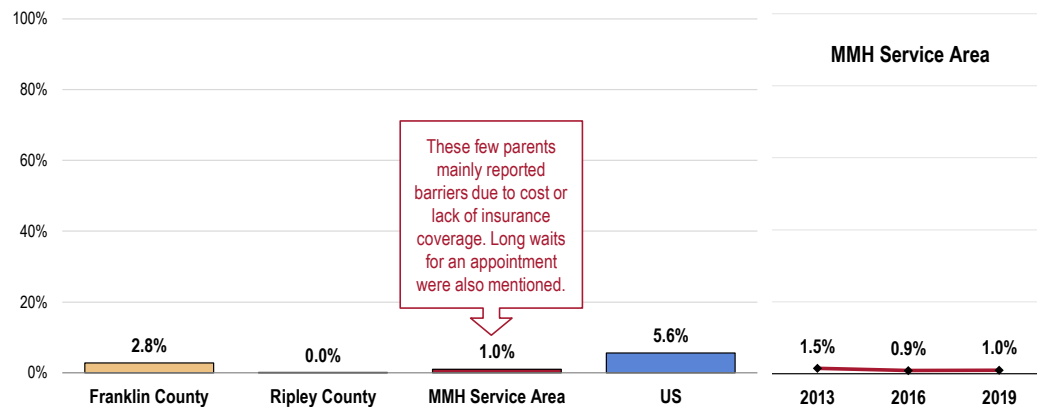
Accessing Healthcare for Children

A total of 1.0% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

- **BENCHMARK:** Well below the US figure.
- **DISPARITY:** None reported in Ripley County.

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.

Had Trouble Obtaining Medical Care for Child in the Past Year (Parents of Children 0-17)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 118-119]
• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children 0 to 17 in the 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, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, PRC, 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

There is a severe lack of mental health services offered in the county. There are no practitioners in the county specially equipped to provide mental health care for farmers and their families. In addition, transportation is a huge problem for individuals and families who have an income but remain impoverished. Accessing maternal healthcare, pediatric care, and disease management is difficult for people spread across the county with limited access to transportation. Care is often sought outside the county. Addiction services for youth are a services, especially for youth are limited. The growing use of nicotine through vaping among youth will only exasperate the lack of access to care. – Public Health Representative

You can go to Minor care, but it is very difficult to get started with a doctor and then being able to get in to see your doctor, always pushed to minor care. No dental care coverage for those that can't pay. – Other Health Provider

Location. – Community Leader

Availability of access to mental health and substance abuse care. – Community Leader

Because Franklin County is rural, I think that the amount of time required for clients to get to emergency care is a huge problem if they are faced with a life-threatening emergency. – Community Leader

Adequate EMS service in Franklin County. – Community Leader

Pre-hospital emergency care has limited resources. – Community Leader

Insurance Issues

Limited insurance and resources to help obtain insurance along with limited providers accepting both. – Other Health Provider

Physical locations have improved; however, a majority of people do not have insurance so do not go or take their children for health care. – Community Leader

Transportation

It was a concern of both communities, until MMH opened its clinics in Franklin and throughout Ripley counties. However, seniors still worry about how they will get to their health care appointments. – Community Leader

People live in remote locations and are often unable or unwilling to travel for services. – Community Leader

Affordable Care/Services

Money. – Physician

Increasing amount of people without insurances. Affordability of health care as a whole is very concerning. Transparency of the cost of care. People avoid care as the costs are prohibitive. – Other Health Provider

Contributing Factors

High Poverty. Limited ability to get to and from other communities for healthcare appointments. Things like dental care, eyecare, and mental health are offered through the schools to support most needy students, but none of these options exist locally for adults who have no transportation. Use of FC transportation can cost around \$60 round trip. – Community Leader

Access to Providers

Shortage of providers accepting new patients. Patients often receive State insurances and cannot access care. – Other Health Provider

Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified behavioral health and substance abuse treatment as the most difficult to access in the community.

| Medical Care Difficult to Access as Identified by Key Informants | | | | |
|---|----------------|-----------------------|----------------------|----------------|
| | Most Difficult | Second-Most Difficult | Third-Most Difficult | Total Mentions |
| Behavioral Health | 50.0% | 27.3% | 0.0% | 8 |
| Substance Abuse Treatment | 40.0% | 27.3% | 9.1% | 8 |
| Specialty Care | 0.0% | 18.2% | 18.2% | 4 |
| Chronic Disease Care | 0.0% | 9.1% | 9.1% | 2 |
| Dental Care | 0.0% | 0.0% | 18.2% | 2 |
| Primary Care | 10.0% | 0.0% | 9.1% | 2 |
| Elder Care | 0.0% | 0.0% | 9.1% | 1 |

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

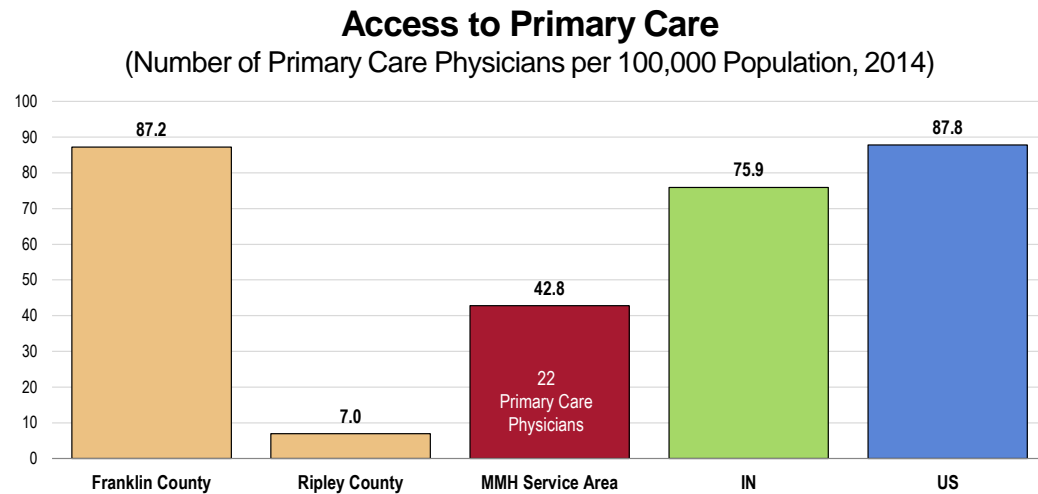
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

— Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

In 2014, there were 22 primary care physicians in the MMH Service Area, translating to a rate of 42.8 primary care physicians per 100,000 population.

- **BENCHMARK:** Notably lower than state and US access rates.
- **DISPARITY:** The rate is 12 times higher in Franklin County than in Ripley County.



Sources: • US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
 • Retrieved September 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes: • Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

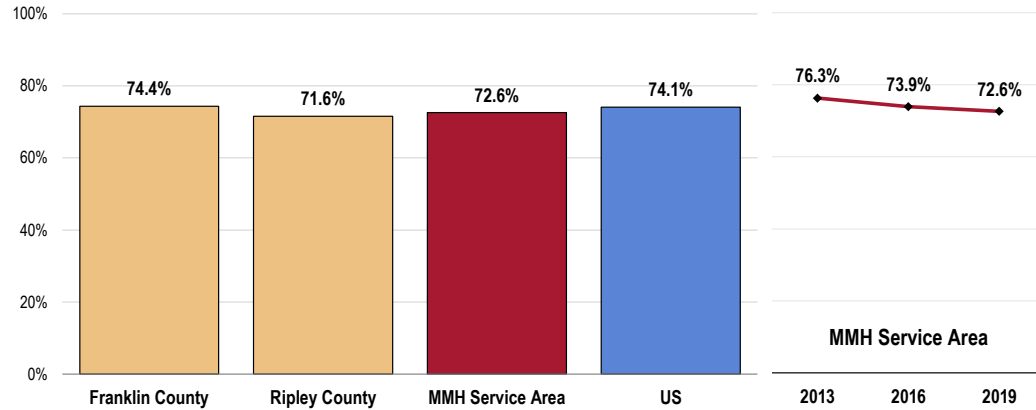
Specific Source of Ongoing Care

A total of 72.6% of MMH Service Area adults were determined to have a specific source of ongoing medical care.

- **BENCHMARK:** Fails to satisfy the Healthy People 2020 objective.

Have a Specific Source of Ongoing Medical Care

Healthy People 2020 = 95.0% or Higher



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 170]

• 2017 PRC National Health Survey, PRC, Inc.

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

Notes: • Asked of all respondents.

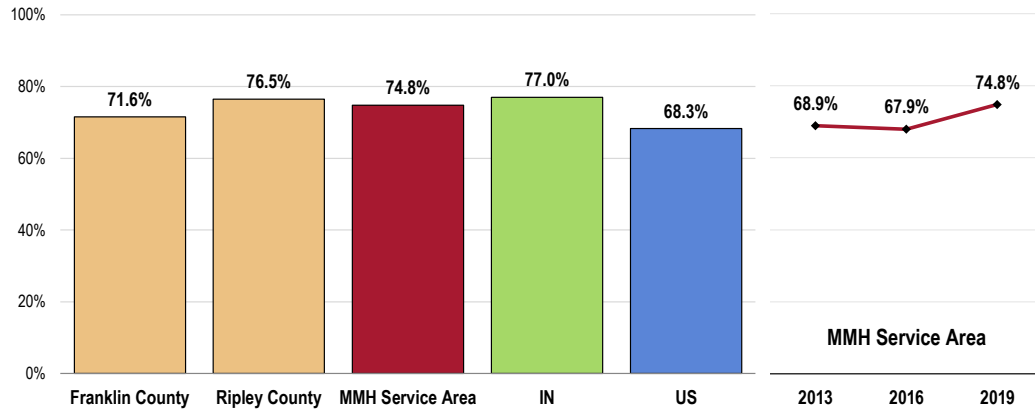
Utilization of Primary Care Services

Adults

Three in four adults (74.8%) visited a physician for a routine checkup in the past year.

- **BENCHMARK:** Higher than the US prevalence.
- **TREND:** Marks a statistically significant increase from previous survey findings.
- **DISPARITY:** The prevalence increases with age among survey respondents.

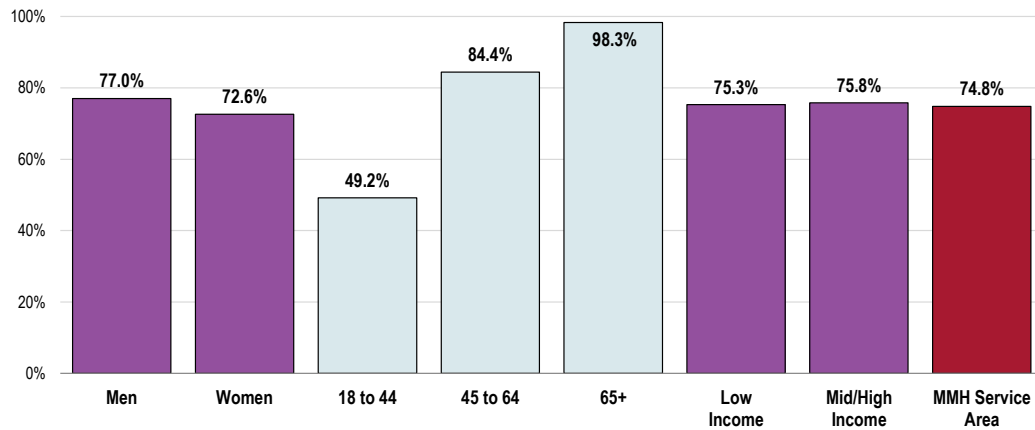
Have Visited a Physician for a Checkup in the Past Year



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 18]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year (MMH Service Area, 2019)

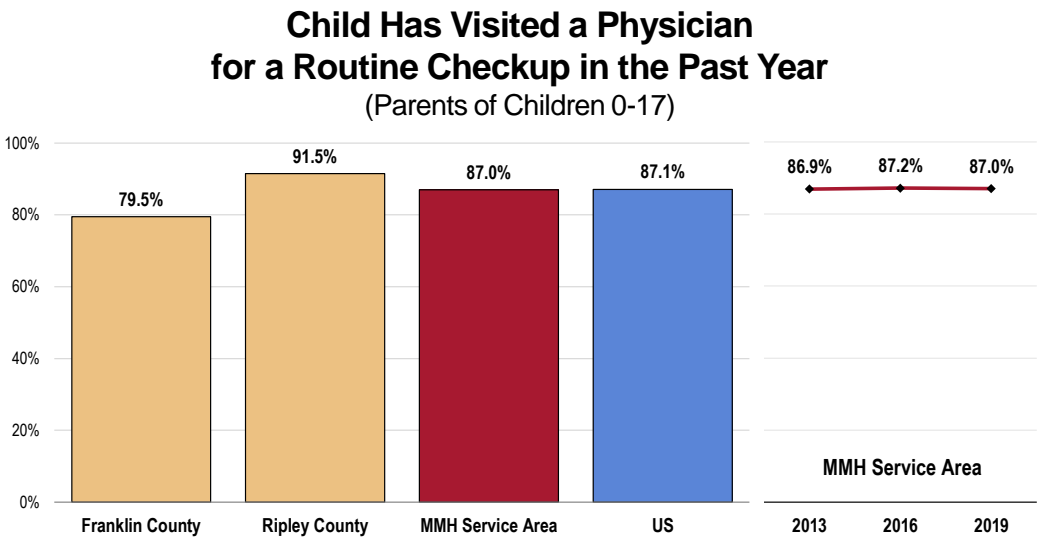


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 18]
 • Asked of all respondents.

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.

Children

Among surveyed parents, 87.0% report that their child has had a routine checkup in the past year.



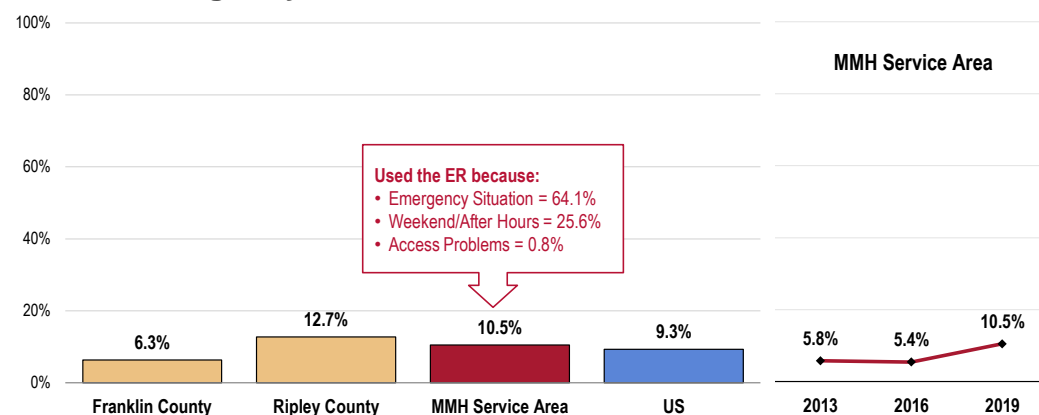
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 120]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 10.5% of MMH Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

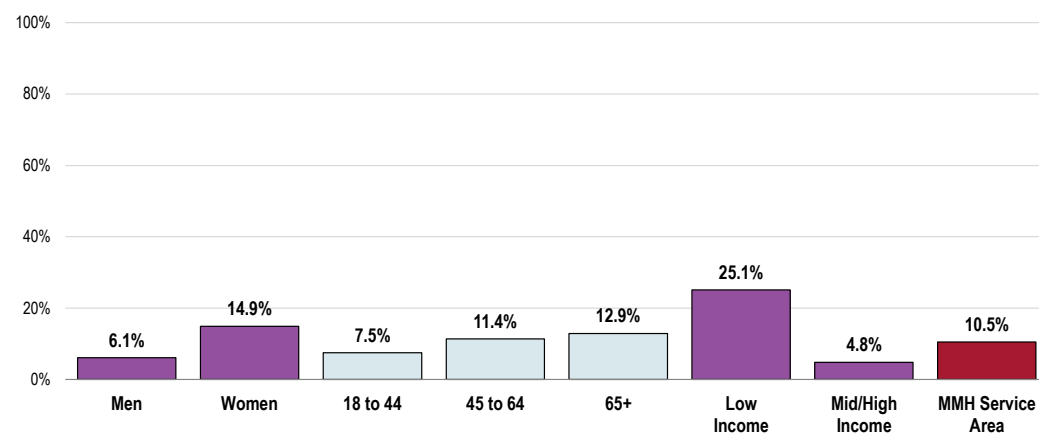
- **TREND:** Denotes a statistically significant increase from previous survey findings.
- **DISPARITY:** Twice as high in Ripley County as in Franklin County. Significantly high among women and residents in low-income households.

Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 22-23]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, 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.

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.

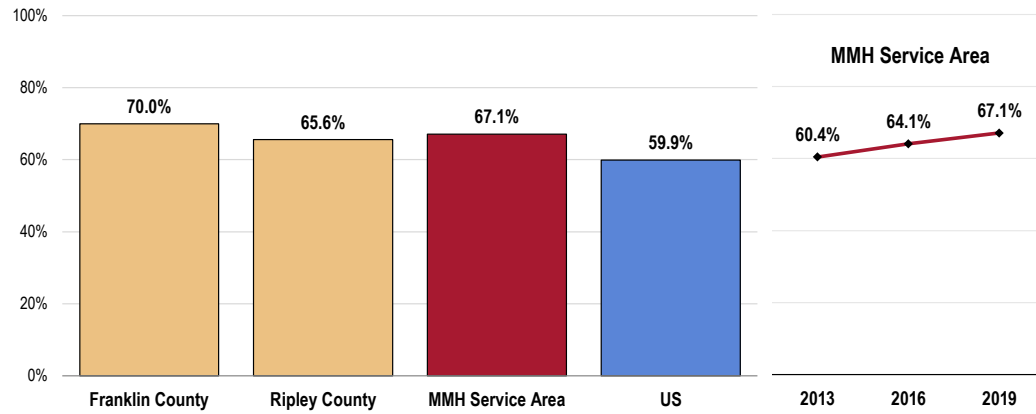
— Healthy People 2020 (www.healthypeople.gov)

Dental Insurance

Over two in three service area adults (67.1%) have dental insurance that covers all or part of their dental care costs.

- **BENCHMARK:** Above the US figure.
- **TREND:** Denotes a steady, significant increase since 2013.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 21]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Dental Care

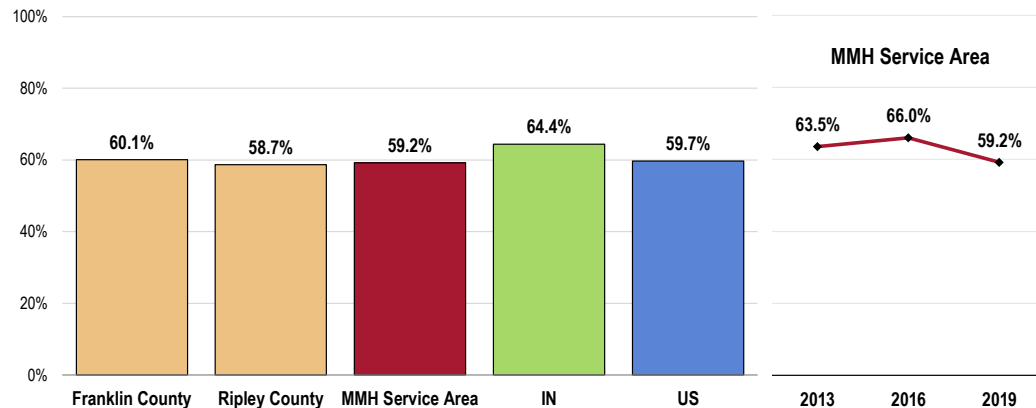
Adults

A total of 59.2% of area adults visited a dentist or dental clinic (for any reason) in the past year.

- **BENCHMARK:** Below the Indiana prevalence but satisfying the 2020 objective.
- **DISPARITY:** Less often reported among low-income residents and those without dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 = 49.0% or Higher

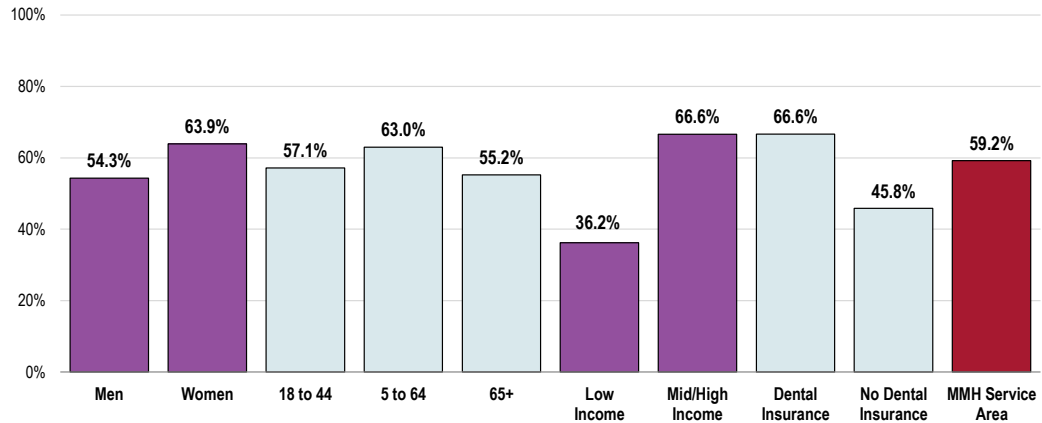


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 20]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2018 Indiana data.
 • 2017 PRC National Health Survey, PRC, 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.

Have Visited a Dentist or Dental Clinic Within the Past Year

(MMH Service Area, 2019)

Healthy People 2020 = 49.0% or Higher



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 20]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
- 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.

Children

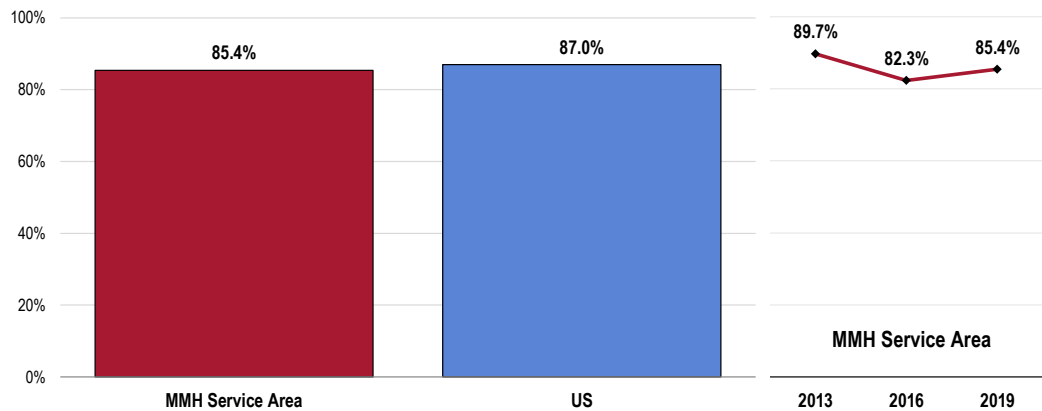
A total of 85.4% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- BENCHMARK:** Easily satisfies the Healthy People 2020 objective.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Parents of Children Age 2-17)

Healthy People 2020 = 49.0% or Higher



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 123]
 - 2017 PRC National Health Survey, PRC, 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 “minor problem” in the community.

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

Top Concerns

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

Insurance Issues

People without insurance can't afford for dental care resulting in tooth loss. Others go to Indianapolis where there are more affordable clinics. – Community Leader

Because many places of business do not offer insurance and people cannot afford it. – Community Leader

No dental insurance and no local programs to provide free check-ups and/or treatment. – Other Health Provider

Affordable Care/Services

Too costly, absolutely out of budget for swaths of the population. – Public Health Representative

Lack of affordable services. Expensive compared to surrounding areas. – Other Health Provider

Dental cost is expensive, and insurance doesn't cover very well. – Other Health Provider

Medicaid

So many children on Medicaid and so few providers willing to accept the insurance. – Other Health Provider

Awareness/Education

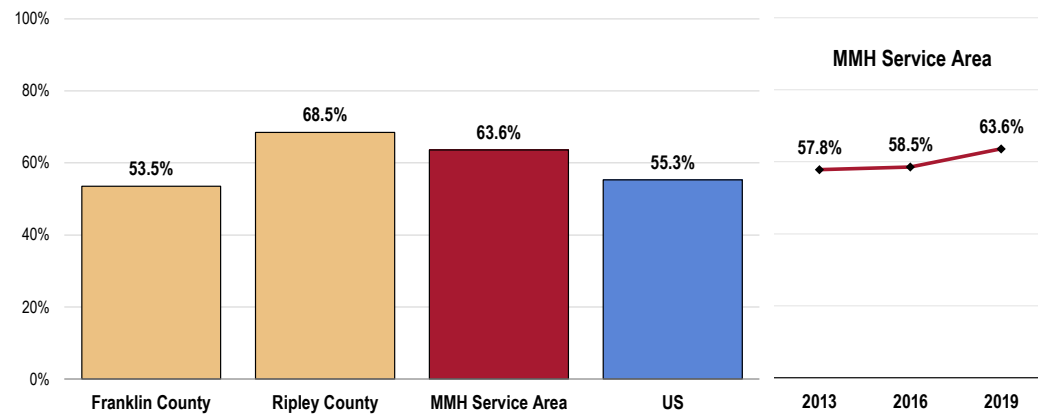
Awareness and education lacking. – Community Leader

Vision Care

A total of 63.6% of MMH Service Area residents had an eye exam in the past two years during which their pupils were dilated.

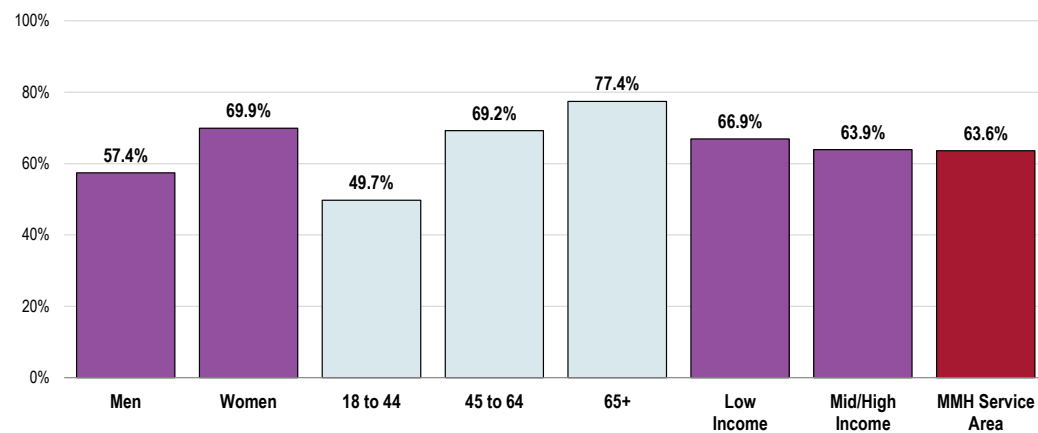
- **BENCHMARK:** Well above the US prevalence.
- **DISPARITY:** Much higher in Ripley County than in Franklin County. The prevalence increases with age and is much higher among service area women than men.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 19]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated (MMH Service Area, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 19]
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

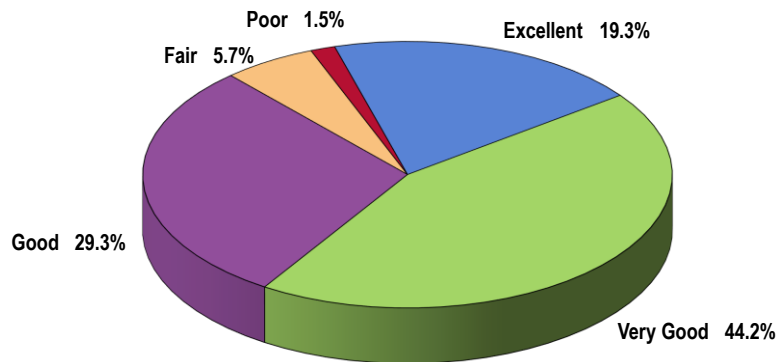


Perceptions of Local Healthcare Services

Most MMH Service Area adults rate the overall healthcare services available in their community as “excellent” or “very good.”

Rating of Overall Healthcare Services Available in the Community

(MMH Service Area, 2019)



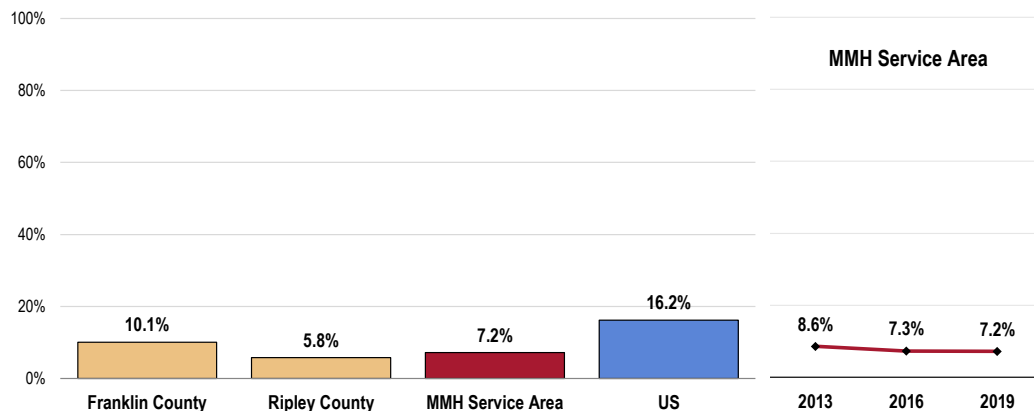
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 6]

Notes: • Asked of all respondents.

However, 7.2% of residents characterize local healthcare services as “fair” or “poor.”

- **BENCHMARK:** Less than half the national percentage.
- **DISPARITY:** Adults age 45 to 64 and those reporting access difficulties in the past year are more likely to be critical of local healthcare services.

Perceive Local Healthcare Services as “Fair/Poor”

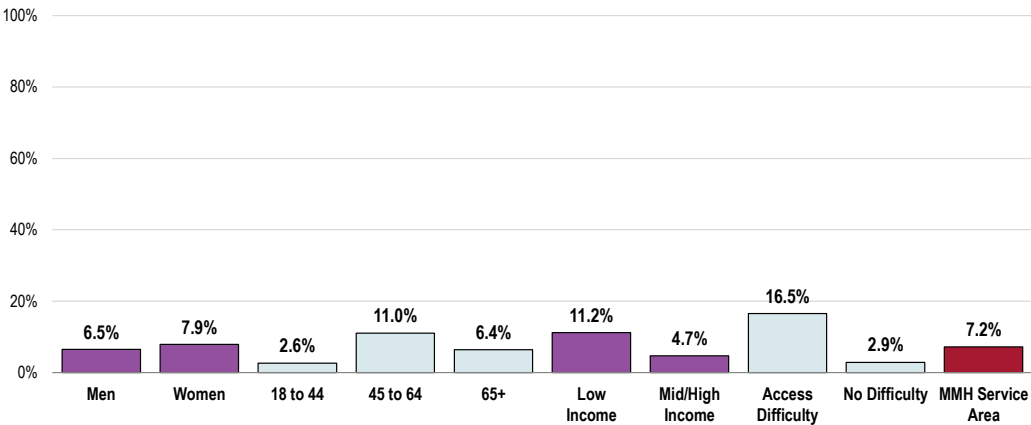


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 6]

• 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Perceive Local Healthcare Services as “Fair/Poor”
(MMH Service Area, 2019)

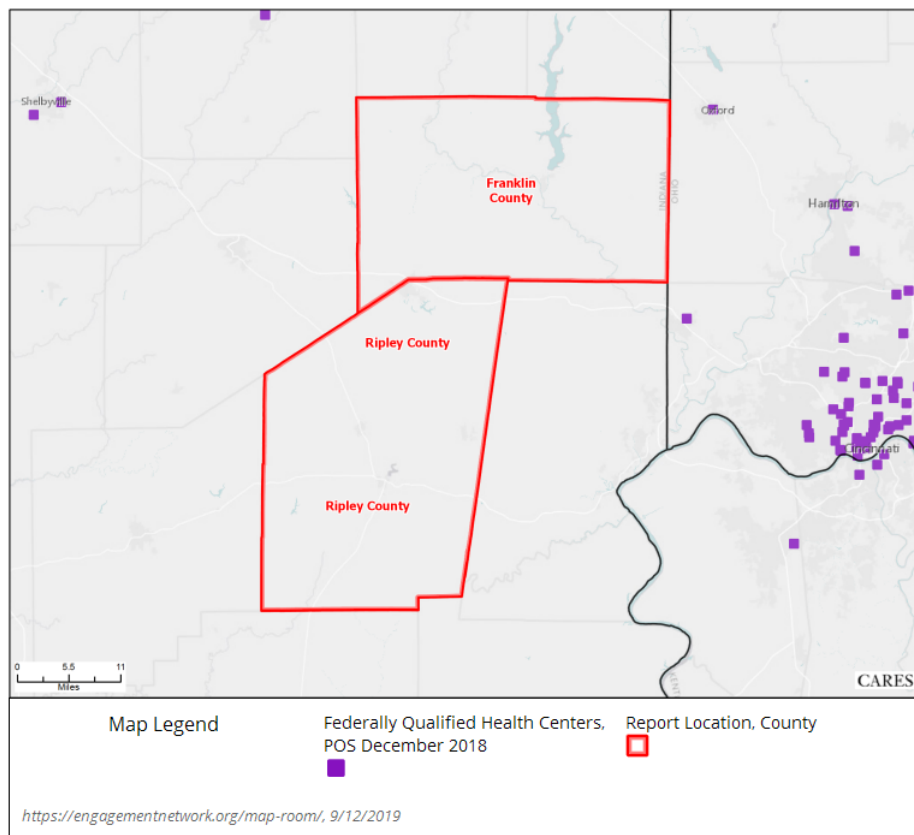


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Healthcare Resources & Facilities

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the MMH Service Area as of December 2018.



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access Problems

Catch-A-Ride
Child and Family Services
Community Mental Health Center
Dentist's Offices
Doctor's Offices
Franklin County Transportation
Free Clinic
Highpoint Health
Hospitals
Margaret Mary Health
Medications
One Community One Family
Osgood Primary Care
Pregnancy Center
Quest
School System
Southeastern Indiana Economic Opportunity Corporation (SIEOC)
Urgent Care
Volunteer Fire Department
Watch Center

Arthritis/Osteoporosis/Back Conditions

Anytime Fitness
Doctor's Offices
Margaret Mary Health
Massage Therapists
YMCA

Cancer

American Cancer Association
American Cancer Society
Batesville Memorial Public Library
Batesville Parks and Recreation
Breast Cancer Support Group
Cancer Center
Dearborn County Highpoint Health
Doctor's Offices
Get Real About Tobacco
Hansen Center

Highpoint Health
Home Care and Hospice
Hospitals
King's Daughters' Hospital
Lifetime Resources
Lifestream
Margaret Mary Health
Oncology Center
Preventative Programs
Relay for Life
Social Workers
Sororities
St. Andrews Health
St. Elizabeth
Support Groups
Think Pink

Chronic Kidney Disease

Batesville Dialysis Center
Davita Dialysis
Doctor's Offices

Dementia/Alzheimer's Disease

Alzheimer's Association
Alzheimer's Caregiver Support Group
Community Mental Health Center
Doctor's Offices
Health Care Facilities
Manderly Health
Margaret Mary Health
Ripley County Community Foundation
Ripley Crossing
Senior Living/Health Care Facilities
St. Andrews Health
The Waters of Batesville
Veterans of Cincinnati
Walk to End Alzheimer's

Diabetes

ADA.org
Care Coordinators

Diabetic Educators
 Doctor's Offices
 Farmer's Market
 George's Pharmacy
 Group Classes
 Live Well Now
 Margaret Mary Health
 Nutrition Services
 Online Resources
 Pharmaceutical Companies
 Purdue Extension
 Ripley County Board of Health
 Ripley County Court Services
 Ripley County EMS
 Southeastern Indiana Health Center
 Weight Watchers
 YMCA

Family Planning

Children's Health Care
 Churches
 CPS
 Crisis Pregnancy Hotline
 Doctor's Offices
 Health Department
 Margaret Mary Health
 Online Resources
 School System
 SEI Health Center

Heart Disease and Stroke

American Heart Association
 Care Coordinators
 Christ Hospital
 Churches
 City of Batesville Health City Investment
 Community Screenings
 Doctor's Offices
 Hospitals
 Live Well Now
 Margaret Mary Health
 Nursing Homes
 Ohio Heart Group
 Preventative Programs
 Telehealth
 WebMD
 YMCA

Infant and Child Health

Baby and Me Tobacco Free

Brookville Public Library
 Brookville United Methodist Church
 Children's Health Care
 Doctor's Offices
 Free Clinic
 Margaret Mary Health
 School System
 WebMD
 WIC

Injury and Violence

Adult Protective Services
 DCS
 Margaret Mary Health
 Police Department
 Safe Passage

Mental Health Issues

AA/NA
 Batesville Drug Coalition
 Behavioral Health Services
 Brookville
 Brookville Public Library
 Brookville United Methodist Church
 Centerstone
 Children's Health Care
 Children's Hospital
 Choices Emergency Response Team
 Christian Counseling
 Churches
 Cincinnati Children's Hospital
 Community Mental Health Center
 Community Mental Health Coalition
 Counseling Services
 Dearborn County Hospital Mental Health Services
 Detox Center
 Doctor's Offices
 Employer Assistance Program
 Faith-Based Organizations
 Franciscan Counseling
 Highpoint Hospital
 Hospitals
 Kings Daughter's Hospital
 Laurel Public Library
 Lifeworks Counseling
 Margaret Mary Health
 Mental Health Center
 Mental Health Services
 New Horizons

One Community One Family
Purdue Extension
Reid Memorial Hospital
Ripley County Court Services
School System
Social Workers
Urgent Care
Vocational Rehabilitation
YMCA
Young Life

Nutrition, Physical Activity, and Weight

5Ks/Neon Night Events
Anytime Fitness
Batesville Farmer's Market
Batesville Parks and Recreation
Community Mental Health Center
Dance Studio
Doctor's Offices
Farmer's Market
Fitness Centers/Gyms
Food Pantry
Girls on the Run
Grassroot Organizations
Healthy Steps
Heart Healthy Living
Jump in Style Gym
Koch Fitness
Live Well Now
Margaret Mary Health
Nutrition Services
Overeaters Anonymous
Parents Volunteering in Children's Sports
Parks and Recreation
Reclaim
School System
Total Package Gym
Turning Point Gym
Tyson Activity Center
Weight Watchers
YMCA

Oral Health/Dental Care

Care Credit
Dental School
Dentist's Offices
Free Clinic

Respiratory Diseases

American Cancer Association
Chronic Care Coordinators
County Health Nurses
DCMH/CRSM Pulmonary
Doctor's Offices
Educational Services
EMS
Margaret Mary Health
Smoking Cessation Programs
Tri-State Pulmonary Associates

Substance Abuse

AA/NA
Batesville Drug Coalition
Batesville Mental Health Clinic
Batesville Police Department
Batesville School System
Behavioral Health Addiction Services
Better Options
Brookville Police Department
Celebrate Recovery
Centerstone
Choices Emergency Response Team
Churches
Coalition Against Substance Abuse
Coalition for a Drug Free Batesville
Community Mental Health Center
Counseling Services
Court Services
Detox Center
Doctor's Offices
Drug Free Coalitions
Educational Services
Employer Assistance Program
Faith-Based Organizations
Franklin County Schools
Franklin County Sheriff's Department
Free Clinic
Highpoint Health
Hospitals
Law Enforcement
Legal System
Margaret Mary Health
National Hotline for Drug Use
Peer Groups
Peer Recovery Coaching Staff
Police Department
Prosecutor's Office

Public Transportation
Ripley County Drug Awareness Coalition (RCDAC)
Recover Out Loud
Ripley County Court Services
Ripley County Drug Coalition
SAMHSA National Hotline
School System
Sober Living Housing Providers
Social Workers
Stayin' Alive
Suboxone Clinic
Substance Abuse Programs
Support Groups
Treatment Centers
United Way
YMCA
Youthquake Initiatives

Tobacco Use

1-800-Quit Line
AA/NA
Baby and Me Tobacco Free
Batesville Drug Coalition
Choices Emergency Response Team
Coalition for a Drug Free Batesville
Community Mental Health Center
Doctor's Offices
Health Department
Healthy Families
Hospitals
Law Enforcement
Margaret Mary Health
Quit for Baby Program
Ripley County Drug Awareness Coalition (RCDAC)
Ripley County Court Services
Ripley County Health Department
School System
Smoking Cessation Programs
Stayin' Alive
Youthquake Initiatives

Appendix



Evaluation of Past Activities

Community Health Needs Implementation Plan

1. Focus on awareness and education.
2. Promote prevention and early detection.
3. Focus on access to wellness and preventive services.
4. Increase referrals and build resources.
5. Focus on modifiable risk factors.
6. Prevent re-admissions.
7. Utilize technology.
8. Reduce barriers.
9. Develop MMH team members as field experts.
10. Build partnerships.

| 2017-2018-2019 Community Health Needs Work Plan | | |
|--|---|--|
| Priority Number 1: Substance Abuse | | |
| OBJECTIVE | STRATEGY | PROGRESS REPORT |
| <p><i>Increase education and awareness among youth in each school in Franklin and Ripley counties.</i></p> <p><i>Offer each program in every school within Franklin and Ripley counties.</i></p> | <p>Focus on youth programming in the schools to address alcohol, tobacco, marijuana and other drugs.</p> <ul style="list-style-type: none"> • Alcohol EDU • Get Real about Tobacco • Marijuana Program • Generation Rx • Bounce • Hidden in Plain Site • Red Ribbon Grants • Neon Night • Family Fun Night | <p>Alcohol EDU is offered in Batesville and Oldenburg Academy and completed annually.</p> <p>Get Real About Tobacco reached 3,133 students.</p> <p>Marijuana Education reached 5,570 students.</p> <p>Generation Rx program reached 1,691 students.</p> <p>Bounce reached 1,869 students.</p> <p>Hidden in Plain Site reached 220 parents.</p> <p>Red Ribbon Grants were provided in 5 Franklin County schools for 2 years.</p> <p>The Neon Nights program was held in 2017 and 2018 and reached 910 people.</p> <p>Family Fun Night hosted each year in Osgood and has reached 1,689 people.</p> <p>Mentoring Successful Athletes was developed in 2017 and has reached 886 people.</p> <p>All these programs are in partnership with the local schools and with the local drug coalitions.</p> |
| <p><i>Increase the number of UDS kits provided throughout Franklin and Ripley counties.</i></p> | <p>Provide drug screening kits for home use.</p> <p>Expand the number of sites throughout service area.</p> | <p>We have expanded to 13 partners in Ripley and Franklin counties. Each year, the number of home drug kits provided has increased. In 2016, we provided 49 kits. In 2019 we have provided 527 to date with a total of 1,501 for the past three years.</p> |
| <p><i>Increase awareness of keeping medications secured.</i></p> | <p>Community education and awareness on medication storage and proper disposal.</p> <p>Lock box initiative.</p> | <p>3,639 people were reached with information on proper drug disposal in the past three years.</p> <p>In April 2017, we developed the Lock Box initiative with the MMH Foundation. To date, we have distributed more than 300 lock boxes.</p> |

| | | |
|--|---|---|
| <i>Increase the pounds of drugs disposed of properly.</i> | <p>Drug collection sites both permanent and temporary throughout Franklin and Ripley counties.</p> <p>Investigate other options for disposal.</p> | <p>Partnering with local police in Ripley and Franklin counties we have provided 4 permanent stations including one located just off the MMH main lobby. We have also co-hosted 13 take-back events at local businesses, school events such as football and basketball games, county fairs, and Senior Expo. In 2017, we removed 768.22 pounds of unused medications. In 2018, we increased to 839.8 pounds and in 2019 to date we have collected and destroyed over 895 pounds.</p> <p>In 2019, we found an alternative for homebound patients to destroy the medication in their home (Dispose RX). We recently started to provide kits to our Hospice families and Home Care patients. This was in partnership with the local drug coalitions. Additional, Detera disposal bags are now provided in OB and Same Day Surgery. This was provided in Partnership with Batesville Drug Free Coalition.</p> |
| <i>Decrease the number of opioid prescriptions and pills by 50% prescribed through MMH clinical areas.</i> | <p>Opioid guidelines in all clinical practice areas at MMH</p> <p>INSPECT report utilization and urine drug screen monitoring prior to prescribing.</p> | <p>MMH has focused on decreasing the number of prescriptions and the number of pills prescribed on discharge for our inpatient and ER.</p> <p>The number of pills and prescriptions 2017: 92,757 pills and 3,997 prescriptions 2018: 27,089 pills and 1,550 prescriptions 2019: 18,826 pills and 1,165 prescriptions (through October).</p> <p>Training has been provided to the medical providers. INSPECT and urine drug screen monitoring policies are in place.</p> |
| <i>All MMH clinical areas use the new pain scale.</i> | Utilize new pain scale | Completed in 2017. |
| <i>Increase the number of companies testing for drug abuse on hire and randomly.</i> | <p>Provide drug testing options to include urine, saliva and hair testing.</p> <p>Provide education on benefits of drug screening in the workplace.</p> | <p>Occupational Health has the option to provide drug screening using urine, saliva and hair. Most companies utilize urine. In the past three years, we have completed 6,245. We have also completed 1,048 medical reviews.</p> <p>Hosted three different panel discussion events in 2019 reaching 115 people.</p> |
| <i>Increase the number of high-risk patients screened for HIV and Hep C.</i> | <p>Develop additional opportunities for HIV and Hep C testing which includes counseling.</p> <p>Increase the sharps distribution sites and drop-off locations.</p> <p>Sharps project for public places.</p> | <p>A task force has been developed along with Ripley County Health Department to increase testing now that there is state funding to health departments to provide screenings.</p> <p>A long-standing program that provides sharps containers to the public, we now have 5 locations to drop off full containers and pick up empty containers. In the past three years, we have provided 1,377 sharps containers.</p> <p>A program was developed in 2018 to provide sharps disposal in public places. We have provided 212 sharps containers throughout Franklin and Ripley counties.</p> |
| <i>Early identification of the infant at risk for</i> | SEEK Survey implementation and referrals. | The SEEK survey was developed in 2018 and expanded in 2019 at MMH. To date, we have 109 referrals with 90 being in the first 3 quarters of 2019. |

| | | |
|--|--|---|
| <i>Neonatal Abstinence Syndrome (NAS).</i> | Continue prenatal urine drug screen testing. | MMH maternity department continues to provide urine drug screenings. 100% of all maternity patients are asked to complete a urine drug screen test on admission. If the mother refuses, the infant is then tested after birth. |
| <i>Initiate treatment options.</i> | Feasibility of Medication assisted treatment (MAT). | We are currently offering limited MAT services for patients enrolled and compliant in IOP. We utilize limited Subutex for expectant mothers in this program. Naltrexone for everyone else. We've had about 10. We will continue to investigate options to incorporate MAT with the Primary Care Providers. |
| | Focused education and follow-up program with mothers who test positive for drugs prenatally. | Patients who test positive prenatally are referred to the addiction's treatment program. Currently, mothers who have no criminal involvement but delivered at MMH are currently 37% of our IOP. We are also looking at implementing a new mother-specific peer support group, and our clinicals are getting advanced training in parenthood and substance abuse in November 2019. We will be adding an additional intensive parenting therapy course in January 2020. |
| | Initiate the implementation of outpatient addiction counseling services. | We currently offer outpatient addictions treatment at Batesville and Brookville, and an IOP in Versailles. We are also developing an IOP in Brookville. |
| | Cultivate a "one call" partnership with inpatient facility. | We had a one call partnership with Mercy but the collaborative ended July 2019. |

Priority Number 2: Nutrition, Physical Activity & Weight

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <i>Develop local community initiatives using results-based accountability.</i> | Develop an action-based community task force in Osgood. | In 2018, we developed an Osgood community partnership. Unfortunately, the participation was more from interested organizations and not local community members. There was little participation and was stopped at the end of 2018. |
| | Develop an action-based community task force in Brookville. | Planned to initiate in 2019 but because of limited resources and the outcome in Osgood it was not pursued. |
| <i>Increase opportunities for the community to learn about cooking and meal preparation.</i> | Teaching Kitchen. Cooking workshops. | The teaching kitchen is currently under study and looking at other possible alternatives. Four community workshops have been scheduled for 2019. Cooking Made Easy: 33 attended. Power of Food: 43 attended. Ready, Set, Cook: 18 attended. Holiday Open House is scheduled for December. |
| | Expand website to provide interactive features such as recipes, videos etc. | Planned for 2018 but was delayed with the launching of a new website for MMH. Content has been compiled which includes recipes, blog posts and tip sheets to launch later this year or early 2020. |
| <i>Increase % who received advice about weight in the past year from 23.8% to 26.2%.</i> | Develop an Adult Obesity Primary Care Model. | Planned for 2019 but has not been initiated at this time. |
| | Certify at least one RD as a CDR Board Certified Specialist in Obesity and Weight Management. | One registered dietitian will sit for the exam later this year. |

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| | Determine interest of primary care providers to obtain certification through American Board of Obesity Medicine. | This was explored in 2019 with no providers currently interested in obtaining this certification. |
| | Expand HMR locations. | HMR was closed December 2018. |
| | Expand Slim Down Now locations. | We have provided 11 programs and 311 people have participated in the last three years. |
| | IBT provided in each physician office to include: Osgood, MAC, MMPC, Brookville and Milan. Prescreen patients to better identify who is eligible for IBT. | Intensive Behavioral Therapy (IBT) is offered in all primary care offices to the Medicare population. Options to increase referrals continue to be pursued with the new EHR. In the past three years, we have had 1,993 visits with 1,012 being in the first three quarters of 2019. |
| | Develop a web-based weight management program utilizing wireless scales. | Initial feasibility for this program started in 2019. |
| | Provide low cost alternatives to individual appointments. | Group medical appointments which reduces a patient expense was developed in 2018. 21 people participated. Other disease-specific classes were developed including a monthly demonstration at the local food pantry. |
| <i>Increase programming with an activity or nutrition component to all schools within Franklin and Ripley counties.</i> | GOTR The First Tee Farm Fit School gardens (indoor and outdoor) | In partnership with the local schools, the Girls on the Run program continues to impact local girls. We are in our 15 th year. Each year, there are two program sessions held with a 5K event for each. In 2017, 513 girls served and 1,439 attended the 5K. In 2018, 566 girls served and 1,525 attended the 5K. In 2019, 515 girls served and 1,434 attended the 5K. The First Tee Program has reached 1,963 students. Farm Fit has reached 1,590 students. We have 15 school gardens (indoor and outdoor) |
| <i>Development of a Pediatric Obesity Primary Care Model</i> | Develop a pediatric obesity task force. Nutrition Services staff to be trained in pediatric obesity treatment. Referral process for children ages 2-18 with BMI percentile >85 th to nutrition services. | This was not pursued however; a staff member has completed the pre-work in pediatric obesity treatment and will be certified in 2020. |
| | Increase number of pregnant women enrolled in Baby Under Construction. | Participation in this program continued to fall across 2017-2019, with the decision to ultimately discontinue the program in 2019. Information discussed in the class was made available on the MMH website. |
| <i>Increase access to healthy food options.</i> | Offer mid-week market. | The Outpatient Clinic and Oncology Center is the site for the mid-week market starting in July and running through August. |
| | Explore competitive pricing options in MMH cafeteria (ie. healthy options cost less). | Initially targeted for 2019 but has not been developed at this time. |
| | Nutrition and calorie information to promote healthy choices in MMH cafeteria. | In June 2018, the Eat Well, Live Well initiative was rolled out to the cafeteria. All menu items are labeled with a calorie and color designation. It also includes a large screen promoting the meal items and other signage in the cafeteria. |

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| | Work with local restaurants(non-chain) to promote and label healthy options. | In January 2019, Izzy's at Hillcrest debuted a quinoa bowl developed in partnership with MMH dietitians. |
| <i>Increase the percent of locally grown food purchased for the cafeteria to at least 10% of our produce volume from the local growers.</i> | Financially support Farmer Training Initiative (3- year commitment). | MMH has made a financial contribution annually to support ongoing efforts to train local farmers. |
| | Offer fresh locally sourced produce in MMH Cafe | The cafeteria continues to purchase and offer fresh locally sourced produce. Each year, a farmers' market luncheon is held where only local fresh produce is prepared and served. |
| <i>Improve the nutrition status of the elderly and medically complex.</i> | Develop a Malnutrition Care Model. | In late 2018, a Malnutrition Care Model was developed. This model included education materials at discharge, post discharge phone calls and the option of complimentary outpatient visits with a dietitian. 107 patients with malnutrition have been provided with education material. We have not had any participate in the additional visits. |
| | Implement a nutrition care plan at discharge if malnutrition is diagnosed. | |
| | Screen malnourished and/or elderly patients for food insecurity. | In late 2019, a proposal developed to increase screening of patients in inpatient/outpatient setting. |
| | Home Care follow up for patients with malnutrition by nutrition services. | Initially targeted for 2019 but plan not developed at this time. Will evaluate in 2020. |
| <i>Increase the number who meets physical activity recommendations from 19.7% to 23%.</i> | Increase referrals to Progressive Exercise/Medical Exercise or other exercises programs. | A total of 1,769 sessions have been held in the past three years reaching 90 people. |
| | Incorporate the use of lifestyle prescription pads in primary/acute care. | Not implemented. We will continue to evaluate this in the future. |
| | Walking Club Program | There 70 members in the walking club which utilize indoor walking "tracks" in the local schools during the winter months. |
| | Neon Night | Neon Night was held in 2017 and 2018 and reached 910 people. We made the decision not to offer in 2019. |
| | Walk with a Doc initiative | Initially targeted for 2019 but determined not feasible to implement at this time. |
| | Feasibility Study for bike program. | Initially targeted for 2017 but determined not feasible at this time. |

Priority Number 3: Heart Disease & Stroke

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <i>Focus on modifiable risk factors.</i> | See Nutrition, Physical Activity and Obesity and Tobacco Strategies | |
| <i>Increase the number of wellness visits completed each year.</i> | Complete annual wellness visits and refer to appropriate resources to promote health and preventative services. | We have increased the number of Medicare wellness visits which includes referral to appropriate resources. In 2017, we completed 805. In 2018, we completed 825. As of third quarter 2019, a total of 1,586 has been completed. |

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| <i>Increase the numbers screened. 100% with abnormal screening results are referred to their PCP or health coach as appropriate.</i> | Expand vascular screening. Expand student athletic screenings. Expand cholesterol/blood pressure screenings. Refer all screening participants back to PCP following standardized screening guidelines. Develop health coaching program related to heart disease and stroke for referral purposes. | We have not been able to increase the number of vascular screenings due to staff resources. In the past three years, 87 people have been screened. Student screenings are no longer offered through MMH but have been continued through Giving Hearts a Hand (GHH). MMH has a team member on the GHH Board of Directors and the efforts continue in our service area. Cholesterol/blood pressure screenings continue throughout Franklin and Ripley counties. In the past three years, 509 people have participated and referred for ongoing management back to their Primary Care Provider. However, a coaching program was not developed. |
| <i>Increase access to cardiology specialists.</i> | Implement tele-cardiology services. | Tele-cardiology services are currently offered in Brookville and Osgood. |
| | Implement tele-cardiology consult services for MS/SCA and ER. | Not implemented. |
| <i>Increase education and awareness of heart disease and stroke.</i> | Annual community-based educational event. | 203 people were reached and provided heart and stroke awareness and education by the cardiac rehab team. |
| | FAST and stroke prevention focus at health fairs | Over the past three years, all health fairs had a focus on stroke prevention. A total of 1,567 people were reached. |
| <i>Implement Million Hearts campaign.</i> | Million Hearts Campaign Control Group | Participation in a control group was started in 2017. |
| <i>Complete feasibility study.</i> | Explore the integration of a cardiology NP to develop programming (patient education/care) for COPD and CHF patients. | Not implemented but still in consideration if determined feasible. |
| <i>Meet criteria for D2D2B times for facility transferring in to PCI facility (< 120 minutes).</i> | Chest Pain Network. | MMH continues to be in the Christ Hospital Chest Pain Network. In 2017, we had 23 patients and an average time of 116 minutes. In 2018, we had 20 patients and an average time of 107 minutes. In 2019 YTD, we have had 11 patients and an average time 125 minutes. |
| <i>Complete Stroke Ready Joint Commission Certification</i> | Stroke Ready Certification. | Initial certification was in 2017 and recertified in August 2019 as an Acute Stroke Ready Hospital. MMH meets stringent standards set by the Joint Commission by standardizing our methods of clinical care centered on evidence-based guidelines for patients with stroke. |
| <i>Compliance with Stroke Guidelines</i> | Track EMS compliance with stroke guidelines. | ER and the medical director assist with education, complete audit and review and update protocols as needed. |
| <i>Increase usage of Telestroke services.</i> | Continue to utilize TeleStroke | Through the ER, TeleStroke has been utilized five times. |
| <i>CPR and AED training throughout Ripley and Franklin counties.</i> | Offer CPR and AED. | In the past three years, 1,425 people have been CPR and AED trained. Additionally, MMH team members are trained every other year. |

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| <p><i>Increase access for new patients to the Phase 2 of the Cardiac Rehab program.</i></p> | <p>Move toward an independent Phase 3 Cardiac Rehab program provided by the YMCA.</p> | <p>The specific program at the Y is the Healthy Heart class which is offered 2x per week. Approximately, 15-20 patients have utilized this program at the Y since 2017. Most of our Phase 3 "graduates" have opted in the cardiac rehab onsite for their maintenance program.</p> <p>Over the last three years, we have had 256 patients referred and receive an initial assessment in the Phase 2 Cardiac Rehab Program.</p> <p>To date there has not been an analysis of the bundled payments for cardiology services.</p> <p>Data has been collected including referrals, class attendance and retention. Additionally, cardiac rehab has collected data to show compliance with AACVPR program certification performance measures. Educational reviews with medical staff include CHF and PAD/PVD in relation to potential referrals. In 2019 and going into 2020, a secure video conferencing system can be used for regular educational programs.</p> |
| | <p>Increase referrals to Cardiac Rehab Phase 2 program</p> | |
| | <p>Analyze impact of change to "bundled" payments for Cardiology services.</p> | |
| | <p>Track outcome data to promote program.</p> <p>Provide education offering to medical staff.</p> | |
| <p><i>Decrease re-admission rate (Indiana State comparison)</i></p> | <p>ACO Participation – SHO2 Focus on CHF to improve quality of life and reduce overall healthcare spend. (2,621 Medicare Beneficiaries)</p> | <p>Care coordination and chronic care management focuses on any patient with chronic conditions which includes those with CHF. A total of 2012 CCM episodes since 2017.</p> |
| | <p>TCM Program – provide transitional care management for discharged inpatients.</p> | <p>Currently offer TCM through coordinated efforts between Med-Surg and Care Coordination.</p> |
| | <p>Implementation and participation in MACRA/MIPS quality program.</p> | <p>Implemented and continued participation since 2017.</p> |
| | <p>NP located in nursing home.</p> | <p>NP was placed in The Waters Nursing Home from 2017-2019. It was determined that this was not sustainable however there was an improvement in avoidable ER visits thru this model.</p> |

Priority Number 4: Diabetes

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <p><i>Increase the percent of non-diabetics who have had a blood glucose tested in the past three years to 55.0%. (Early detection)</i></p> <p><i>Reduce the proportion of the diabetic population with an A1C value greater than 9% ACO #27.</i></p> | <p>Expand A1c and glucose screening throughout Ripley and Franklin counties with a special focus in Franklin County.</p> | <p>We continue to offer A1c and glucose screenings and have expanded beyond Batesville, into Brookville, Osgood and Milan. In the past three years, 331 people have been screened.</p> <p>In 2019, we have also implemented a monitoring tool to target educational and monitoring efforts for all patients in the primary care offices who have A1c over 9%.</p> |

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| <i>Focus on modifiable risk factors.</i> | See Nutrition, Physical Activity and Obesity Strategies | |
| | Develop and implement a diabetes prevention program. | In 2017, MMH and the YMCA investigated the program and decided the length of the program was a barrier to success. It was determined for anyone diagnosed with pre-diabetes; we would recommend medical nutrition therapy. |
| <i>Increase the number of wellness visits completed each year.</i> | Complete annual wellness visits and refer to appropriate resources to promote health and preventative services. | We have increased the number of Medicare wellness visits which includes referral to appropriate resources. In 2017, we completed 805. In 2018, we completed 825. As of third quarter 2019, a total of 1,586 has been completed. |
| <i>Increase Diabetes Care educational services to each MMH primary care office.</i> | Provide diabetes education services in PCP offices. | The Diabetes Care nurses now see patients in the Batesville, Brookville and Milan offices. We plan to expand to Osgood in 2020. To date, we have seen 91 patients in the offices. |
| | Recruit endocrinologist. | Recruiting efforts continue. Since 2018, we have had three potential candidates. The last onsite visit with a potential candidate was in October 2019. |
| | Advanced training to mid-level provider to support diabetes care program. | Initially targeted for 2018 but not yet implemented. |
| | Expand service line to include Continuous Glucose Monitoring and Pump Therapy. | Initially targeted for 2019 but not yet implemented. Plan to secure endocrinologist before developing the new service lines. Diabetes Care team has had some training and will be able to develop this program with an endocrinologist. |
| <i>Enhance and drive population health efforts to include health registries.</i> | Cerner HealtheIntent Population Health platform implementation. | In 2019, we have also implemented a monitoring tool from healthy registries. We will be able to target educational and monitoring efforts for all patients in the primary care offices who have A1c over 9%. |
| | Develop and implement Chronic Care Management for those with diabetes. | Chronic Care Management is offered through the care coordinators. We have begun discussion on how to involve the Diabetes Care team for those who have diabetes. |

Priority Number 5: Cancer

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <i>Develop and initiate a lung cancer screening program.</i> <i>Increase the number of lung cancer screenings (Low Dose CT) Target 25/annually</i> | Develop and promote screening criteria, as well as build a screening tool to determine eligible patients within the PCP offices. | Completed in 2017. |
| | Provide Low Dose CT following recommended standards of care. | The following Low Dose CT have been completed following recommended standards of care. 2017-33 new screenings 2018- 27 new screenings, 14 repeat screenings 2019- 44 new screenings, 35 repeat screenings |
| | Implement Tobacco Cessation Program | Referral to Quit Line utilized for all patients |
| | Awareness campaign. | An awareness campaign was developed. 8,909 individual mailings. Of those contacted, 52 individuals received a lung cancer screening. 33 were existing MMH patients and 19 were pure prospects (no prior encounters with MMH). |

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| | Develop assistance programs for those without insurance. | A financial assistance program is available for anyone needing services who meet the criteria developed. |
| <p><i>Increase the percent that have had a colorectal screening (FOBT and/or colonoscopy). ACO #19</i></p> <p><i>Improve the return rate for FOBT.</i></p> | Expand FOBT screening throughout Ripley and Franklin counties with a special focus in Franklin County. | Averaging about 60 tests each year. Kits are provided to more patients but there is a low return rate. |
| | Promote screening by colonoscopy in the PCP offices through identification of those who meet criteria. | Marketing efforts for colonoscopies which included the screening guidelines reached 1,753 individuals. |
| | Promote screening by colonoscopy through workplace wellness programs. | Initially targeted for 2019 and to date has not been implemented. |
| | Educational and awareness event annually in RC and FC. | In March 2017 and 2018, we have hosted an awareness campaign reaching 1,275 people through the efforts. |
| | Patient Portal Reminders at age 50. | Not completed at this time. |
| <i>Increase the percent who have had a prostate screening with digital exam.</i> | Expand PSA screening throughout Ripley and Franklin counties with a special focus in Franklin County. | 187 men who meet the criteria have been screened and referred as appropriate from the prostate screening which includes a digital exam by a physician and a blood draw. |
| <p><i>Increase the percent who have had a mammogram to meet HP 2020 target of 81.1%. ACO #20</i></p> | Promote free mammogram screenings to those who meet the financial criteria. | MMH promotes free mammograms through Southeast Indiana Health Center and our community outreach. We have provided 14 free screening mammograms and 10 diagnostic mammograms in the past three years. |
| | Promote mammogram in the PCP offices through identification of those who meet criteria. | Mammograms are addressed during the Medicare Wellness visit. Additionally, marketing efforts for mammograms which included the screening guidelines reached 8,337 individuals. |
| | Patient Portal Reminders. | Not completed at this time. |
| | Promote mammogram screening through workplace wellness programs. | Initially targeted for 2019 and to date has not been implemented. |
| | Educational and awareness event annually in RC and FC. | Think Pink has been hosted each of the three years, reaching over 760 women. We have had several powerful stories shared where this evening has prompted them to have a mammogram. In 2018, one woman was diagnosed with cancer and underwent treatment following a mammogram scheduled at Think Pink. MMH also supports the Pink PJ party in Brookville and has reached 160 women. |
| <i>Increase the percent of women who have had a cervical screening in the past 3 years.</i> | Promote free cervical screenings to those who meet the financial criteria. | In 2017 and 2018, MMH partnered with SEIHC to host scheduled screenings. We reached 28 people. It was determined that SEIHC can reach more by offering screenings during routine visits instead of a specialty clinic. In 2019, the screenings were provided through SEIHC and MMH helps support the cost of the labs |
| <i>Increase the number vaccinated with HPV vaccine</i> | HPV Showing | Hosted in 2017 and reached 31 people. |
| | Provide HPV vaccine through school clinics and offer during routine vaccine visits | Each year we have increased the number of HPV vaccines provided through school clinics and during routine vacation visits. 2017: 290, 2018: 292 and to date 2019, 384. |

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| | Promote cervical screenings in the PCP offices through identification of those who meet criteria. | Promoted during routine wellness visits for those who meet the criteria. |
| <i>Improve compliance to treatment.</i> | Revise and update Nurse navigation program to focus on proactive efforts versus reactive efforts. | The official role of the Nurse Navigator started in the third quarter of 2018. Pre-planning sessions were implemented on bi-weekly. For patients referred to UC Health, we are connected to their Nurse Navigators for better continuity of care. We establish regular teleconferences to provide updates on mutual patients. We set up the ability to remote into specific tumor boards at UC Health when MMH patients were being presented. |
| <i>Increase enrollment in survivorship program</i> | Revise survivorship program | In the latter part of 2017, a nurse practitioner was hired and responsible for the survivorship visits. In 2018, pre-planning sessions were implemented and held bi-weekly to identify patients who would be completing their curative treatment regimen and to ensure the survivorship visit was scheduled. |
| | Develop care plans for weight reduction for cancer patients in remission with BMI >30. | Cancer patients were offered a free healthy eating program starting in September 2018. To date 19 patients have participated in the 10-class program and had an average weight loss of a 5% to 2.5% and correlated with the number of classes attended. |
| | Implement exercise component to survivorship program. | The survivorship programs continue to be in development and plan to exercise in the future. |
| <i>Develop Palliative Care Program</i> | Feasibility study and implementation of a Palliative Care program | Initially targeted for 2018. Feasibility for a Palliative Care program continues for future program development. |

Priority Number 6: Mental Health

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <i>Decrease the amount of perceived days as being "Extremely" or "Very" Stressful.</i> | Stress Management Series | A three-part series hosted annually has reached 38 individuals. Nine additional people took the booklets and completed a self-study. |
| <i>Increase the number of referrals to behavioral health.</i> | Depression screening in PCP office with referral to behavioral health services | Depression screening is ongoing within the PCP offices. |
| <i>Increase the number of appointments for behavioral health care services</i> | Increase behavioral health services in satellite locations, Brookville and Osgood | Initiated in late 2017, and in 2018 behavioral health had 932 visits. In 2019 through October, they have had 3,089. Brookville has a full-time LCSW and a part-time Psychiatrist in Osgood. |
| <i>Suicide prevention and ensuring proper nursing home placement.</i> | PAS Level 1 completed prior to discharge and PAS Level 2 Assessment completed within 5 business days from time of notification | Implemented in 2018, 361 PAS Level 1 assessments completed and 13 PAS Level 2. |
| <i>Develop Autism Hub</i> | Implement an Autism Early Evaluation Hub Determine need for Autism follow-up services and resources. | Developed in late 2017, we have evaluated 46 pediatric patients. We continue to partner with Riley to develop needed resources. |

Priority Number 7: Tobacco Use

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <i>Reduce the number of current smokers and prevent youth from starting.</i> | Tobacco prevention programs in the schools. | Get Real About Tobacco is offered to every school in Franklin and Ripley counties. In the past three years, 3,133 students have participated in the program. |
| | Promote American Cancer Society Freshstart group program for face-to-face smoking cessation counseling. | Smoking cessation is provided to inpatients and to patients coming in for stress testing as appropriate. We have not seen the need to increase the number of facilitators at this time due to lack of enrollment in classes. All areas continue to promote counseling and the Quit Line for cessation efforts. In 2017, the focus was on implementing tobacco-free environments. A task team was formed to develop a community presentation for local groups. 25 people were reached. The following moved forward with implementing tobacco-free environments: Franklin County Antique Machinery Club Brookville Town Park Franklin County Fairgrounds Franklin County Park Pocket Park-Franklin Co Community Foundation Park Franklin County 4H Fair |
| | Train additional smoking cessation facilitators. | |
| | Partner with Ripley County Health Department to seek grant opportunities to fund local cessation efforts/program. | |
| | Evaluate inpatients and outpatients (for cardiac diagnostic testing) for potential referral need. | |
| <i>Implement tobacco use assessment and cessation interventions. ACO #17</i> | Implement tobacco use assessment and referral in physician offices. Develop PCP tobacco counseling visits (99406 and 99407). | Initially targeted for 2018 but not implemented fully. Tobacco and vaping habits are assessed in the EHR. Quit Now is used as a referral source. |
| <i>Increase the number of referrals to the quit line.</i> | Promote Quit Line | 25 referrals made to Quit Line. |
| <i>100% of pregnant women who smoke are referred into program.</i> | Apply for grant money to continue the Baby & Me Tobacco Free program or to implement similar program. | MMH applied for and received the Baby & Me Tobacco Free grant funding in 2018. The program was developed and implemented. A referral process is in place. A marketing campaign was launched. 25 mothers have been referred with one successfully completing the program and four currently active. Recently began to partner with Decatur County Memorial Hospital, High Point Health and Kings Daughters Hospital to reach a larger service area. |
| | Baby and Me Tobacco Free Program or similar program development and implementation | |
| | Referral process into program | |

Priority Number 8: Respiratory Disease

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <i>Increase the percentage of adults who are vaccinated against respiratory diseases to include both influenza (from 58.9% to 62%) and pneumococcal (from 63.6 to 70% for those over 65 years of age. ACO #14 and #15</i> | Expand access to influenza and pneumococcal vaccines | Offered in all primary care offices and in the inpatient areas. Additionally, Occupational Health and Wellness provides onsite clinics at local schools and businesses for influenza. |
| | Expand access to vaccinations with VFC and adult programs. | Vaccines for Children was expanded to Brookville in late 2018 and will be expanded to Milan in December 2019. |

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| <i>Increase access to specialty services.</i> | Pulmonary Services in Batesville. | TriState Pulmonary is in Batesville 2 days a month. This has not increased due to commitment to other clinics in Ohio. The need continues to exist for services. Pulmonary Services receive, on average, 20 referrals a month from Primary Care offices. |
| | Expand Sleep Medicine Services at MMH. | Dr. Kanagarajan continues to do 1 day a month seeing between 20-26 patients a month. In August 2019, NP Miranda Miller started coming every Friday. She went from seeing 25-30 patients a month to 59. Sleep Medicine receives on average 10 referrals a month from primary care. Total Sleep studies have increased each year since 2016. In 2016, 392 sleep lab studies completed. 2017 and 2018, increased to 467 and 562 respectfully. Year to date in October, 568 have been completed. |
| <i>Develop a pulmonary health screening program</i> | Promote pulmonary health awareness and screening at local health fair/festivals. | Lung screenings are provided in primary care with potential referral to the lung screening program. |
| <i>Increase referrals to Pulmonary Rehab program.</i> | Work in partnership with TriState Pulmonary Associates to provide education offering to medical staff. Referral from screening program. Track outcome data to promote program. | Referrals from our primary care providers to pulmonology have increased significantly. Additionally, there are efforts to develop a secure video conferencing system for a monthly education program between our medical director and pulmonary rehab patients. |
| <i>Enhance and drive population health efforts to include health registries.</i> | Cerner HealtheIntent Population Health platform implementation. | In progress and includes other conditions such as diabetes. |

Priority Number 9: Access to Healthcare Services

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
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| <i>Increase the points of care within our communities by expanding our geographic site reach.</i> | Expansion Osgood Health Center to include minor care, lab services and imaging. | Complete. |
| | New facility in Milan. | Complete. |
| <i>Develop Workplace Clinic Model</i> | Implementation plan for a workplace clinic model | Batesville Tool and Die Health and Wellness Clinic doors opened in August 2018. A total of 3,788 appointments through October 2019. |
| <i>Improve the availability and access to specialty care in our community. (ACO #4)</i> | Add specialty services to satellite locations in Brookville and Osgood. <ul style="list-style-type: none"> Pediatrics Rheumatology Increase orthopedic coverage. Determine need to add specialty services at satellite locations: OB | Pediatrics and OB are now available in Brookville. Orthopedic services were expanded in May 2019 with an office in the Physician Center. |
| <i>Increase the number of active medical providers.</i> | Physician Recruitment Plan | Since 2017, we have added 18 new Providers. Including: 1 in OB/GYN, 2 in Oncology, 2 in Orthopedics, 8 in Primary Care, 2 in Behavioral Health and 3 in Anesthesiology. |

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| <i>Increase the number of students who mentor at MMH.</i> | Develop a model to enhance physician integration through internships, mentorships and career development opportunities. | Since 2017, we have had a total of 39 rotations. In 2018 the rotations were lower because of the medical record implementation and we accepted less into the program that year. |
| <i>Increase the number of tele-health visits.</i> | Implement telehealth <ul style="list-style-type: none"> • MMH Team members • SISIC • Franklin County Schools • General Community • Employers | A pilot program was developed in 2018 with South Ripley Schools. 49 students utilized telehealth in the school year. In October 2019, we have expanded to include Batesville, and Milan schools. We will continue to work with additional schools in the future. MMH team members and family have utilized telehealth services a total of 367 visits (Feb 2017-Nov. 2019). Batesville Tool & Die has utilized 16 visits since implemented. |
| <i>Complete feasibility for PAC.</i> | Implement a multi-disciplinary team to focus on Post Acute Care (PAC) program for improved access, patient outcomes and reduction in healthcare spend related to SNF's. | A multi-disciplinary team has been developed and initially planning and discovery took place in the Fall of 2019. PAC will be focused on in 2020. |
| <i>Complete feasibility for PACE.</i> | Explore requirements for the development of a PACE program (Program for the All-inclusive Care for the Elderly). | Determined not feasible. |
| <i>Provide needed healthcare services for those without insurance/underinsured.</i> | Charity Care Plan | MMH offers a financial assistance program to those in need. |
| <i>Determine need of retail pharmacy services.</i> | Complete feasibility of Retail Pharmacy | Preliminary feasibility was initiated by pharmacy but determined not financially feasible at this time. |
| <i>Determine need and feasibility of a transportation initiative.</i> | Complete feasibility study. | Completed study and implemented MMHealth Rides in 2018 serving both Ripley and Franklin counties. MMHealth Rides provides transportation to or from any MMH location. Over 174 Fast Passes have been provided under the Medicare Waiver. Over 2,000 trips have been provided to those who needed transportation. |
| <i>Increase enrollment into health insurance plans.</i> | Provide education and assistance with enrollment into healthcare plans. | Claim Aid was implemented in July 2017 and the referrals and applications have increased each year. Since July 2017, there were 8,371 referrals, 1,735 applications and 1,520 enrollments. |

Priority Number 10: Injury & Violence

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
|---|--|---|
| <i>Maintain the percent of children who utilize an age-appropriate vehicle restraint system at 97% or higher.</i> | Certified car seat station. | Each year, car seat inspections and the number of car seats provided has grown. In the last three years, we provided 148 inspections and provided 90 car seats to families in need. |
| | Ensure all new mothers have an approved car seat prior to discharge. | Education on the car seat inspections is included in each maternity packet. The information stresses to the new parents the importance of having their car seat inspected and fitted. |

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| | Host community event such as booster bash and car seat check points. | In 2017, we have hosted a community event with Napoleon State Bank and promoted car seats and booster seats. |
| <i>Increase the number of bike safety presentations.</i> | Bike safety presentations were completed in every school system in Franklin and Ripley counties. | In the past three years, we have taught 2,149 students the importance of wearing helmets. Many of the schools also have assisted in bike helmet sales to the parents following the presentations. |
| <i>Increase the number of bike helmets provided to the community.</i> | Bike helmet sales at MMH and through community events. Stress importance of adults being role models. | We have sold or donated over 1,048 bike helmets in the past three years. |
| <i>Increase the access to Narcan</i> | Narcan program for law enforcement to include training and kits. | MMH has worked with local law enforcement to provide Narcan to officers. 260 doses have been provided. In 2019, the Ripley County Health Department received funding for Narcan and now provides Narcan for officers in RC. Our ER Medical Director and the ER along with CHI assists with training and support. |
| <i>Increase support services for families with opioid addictions</i> | Narcan program for high-risk family and individuals to include training and kit. | Since April 2017, MMH provided 1,380 face shields with rescue breathing education to our community. In the past three years, 1,425 people have been CPR and AED trained. Additionally, MMH team members are trained every other year. |
| | Provide CPR training and rescue breathing. | |

Priority Number 11: Oral Health

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
|--|---|--|
| <i>Improve overall dental hygiene to have a positive impact on health.</i> | Support SEIHC efforts to move towards a component of dental services. | Dental program launched in 2019 at SEIHC. MMH provided support in the implementation. |
| | Promote interventions to reduce tooth decay such as brushing, flossing and fluoride use with school age children. | Initially targeted for 2019. Upon investigation with local schools, several varying services in place. At this time, additional efforts not required. Oral health not identified as a community need in 2019 report. |

Priority Number 12: Dementia

| OBJECTIVE | STRATEGY | PROGRESS REPORT |
|--|--|--|
| <i>Increase the support and resources for the caregivers/family.</i> | Palliative Care program for those afflicted with Dementia and Alzheimer's. | Initially targeted for 2019. Feasibility for a Palliative Care program continues for future program development. |
| | Education series on dementia. | Not implemented. |
| <i>Increase the number of people who are assisted with advance directives forms and information.</i> | Assist patients and family with advance directives. Provide education and awareness about the need for Advance Directives. | Social Services have helped 76 patients with Advance Directives. |

| Priority Number 13: Potentially Disabling Conditions | | |
|---|--|--|
| OBJECTIVE | STRATEGY | PROGRESS REPORT |
| <i>Implement preventive initiatives in the workforce.</i> | Assessment and early invention of back strains in the workplace. | Initially targeted for 2019, not fully implemented. Basic ergonomic program is available along with training program through PT. |
| | Ergonomics Program to include proper lifting and stretching. | |