2019 Community Health Needs Assessment Report

Primary Service Area

Jefferson & Switzerland Counties, Indiana
Trimble County, Kentucky

Prepared for:
King's Daughters' Health

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Table of Contents

Introduction

Project Overview

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the Primary Service Area of King's Daughters' 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 King's Daughters' 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.

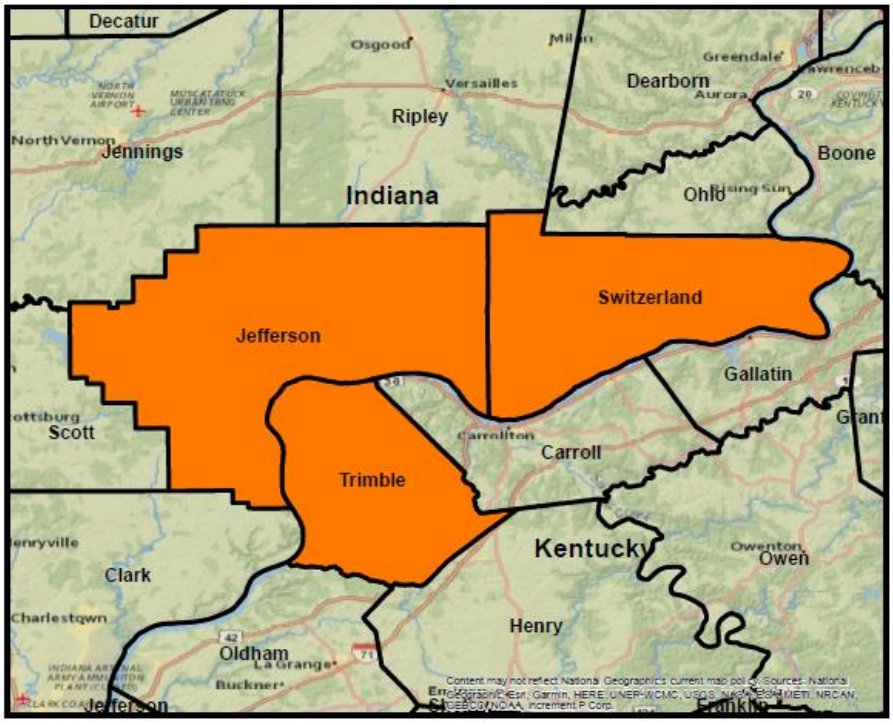
PRC Community Health Survey

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 King's Daughters' Health and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Primary Service Area" in this report) is defined as Jefferson and Switzerland counties in Indiana and Trimble County in Kentucky. This community definition, determined based on the counties of residence of recent patients of King's Daughters' Health, is illustrated in the following map.



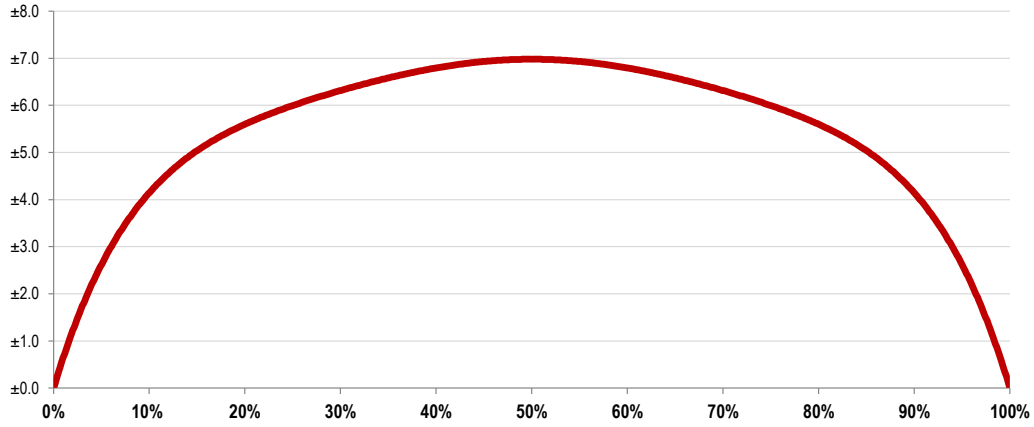
Sample Approach & Design

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 random sample of 200 individuals age 18 and older in the Primary Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Primary 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 200 respondents is ±6.9% at the 95 percent confidence level.

Expected Error Ranges for a Sample of 200 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 200 respondents answered a certain question with a "yes," it can be asserted that between 5.8% and 14.2% (10% ± 4.2%) 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 43.1% and 56.9% (50% ± 6.9%) of the total population would respond "yes" if asked this question.

Sample Characteristics

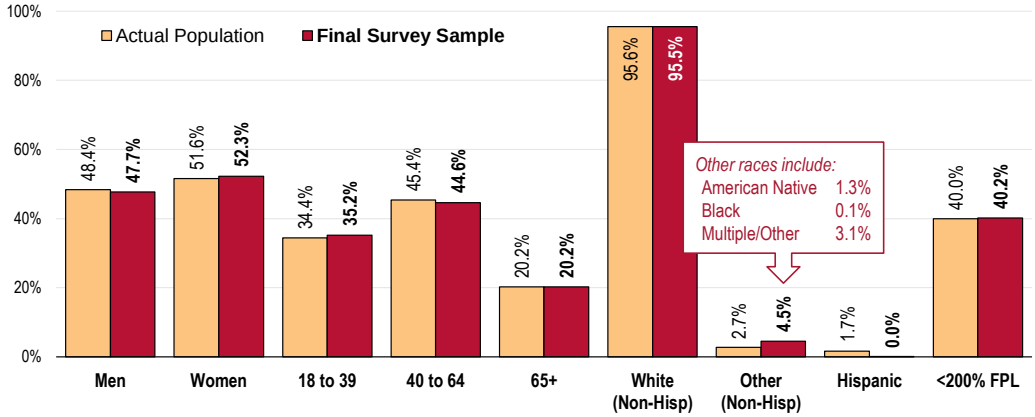
To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the 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 Primary 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

(Primary 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 King's Daughters' 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, 93 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	5
Other Health Providers	19
Social Services Providers	15
Other Community Leaders	49

Final participation included representatives of the organizations outlined below.

- Big Brothers Big Sisters
- Centerstone Madison
- Christian Academy of Madison
- City of Madison
- Cover Kids & Families- Community Action of Southern Indiana
- Eye Care Group
- Greater Madison Ministerial Association
- Hanover Town Council
- Healthy Communities Initiative of Jefferson County
- Jefferson Circuit Court
- Jefferson County Coroner's Office
- Jefferson County Court Services
- Jefferson County Government
- Jefferson County Health Department
- Jefferson County House of Hope
- Jefferson County Prosecutor's Office
- Jefferson County Sheriff's Office
- Jefferson County Transitional Services
- Jefferson County United Way
- Jefferson County WIC Program
- Jefferson County Youth Shelter
- King's Daughters' Health (KDH)
- King's Daughters' Health EMS
- King's Daughters' Home Care and Hospice
- La Casa Amiga- Ohio Valley Opportunities (OVO)

- LifeSpring Health Systems- Jefferson County Office
- LifeTime Resources, Inc.
- Madison Consolidated Schools (MCS)
- Madison Correctional Facility
- Madison FFA
- New Hope Services Inc.
- North Central District Health Department
- Prince of Peace Catholic Schools
- River Valley Resources, Inc.
- Rivertown Chiropractic
- Salvation Army Helping Hands Dental Clinic
- Second Stories, Inc.
- Southeastern Indiana Voices for Children, Inc.
- Switzerland County
- Switzerland County Sheriff's Office
- Switzerland County YMCA
- Town of Hanover

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 Primary Service Area were obtained from the following sources (specific citations are included with the 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

Benchmark Data

Indiana and Kentucky 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

King's Daughters' Health made its prior Community Health Needs Assessment (CHNA) report publicly available through 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, King's Daughters' 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. King's Daughters' 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 *A definition of the community served by the hospital facility*	8
Part V Section B Line 3b *Demographics of the community*	31
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	163
Part V Section B Line 3d *How data was obtained*	8
Part V Section B Line 3e *The significant health needs of the community*	16
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	17
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	11
Part V Section B Line 3i *The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)*	168

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); 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	• Lack of Health Insurance • Primary Care Physician Ratio
Cancer	• Leading Cause of Death • Cancer Deaths ○ Including Lung Cancer and Colorectal Cancer • Cancer Incidence ○ Including Lung Cancer and Colorectal Cancer • Female Breast Cancer Screening [Age 50-74] • Colorectal Cancer Screening [Age 50-75]
Diabetes	• Diabetes Deaths • Diabetes Prevalence • Kidney Disease Deaths • *Key Informants: Diabetes ranked as a top concern.*
Heart Disease & Stroke	• Leading Cause of Death • Heart Disease Deaths • Heart Disease Prevalence • Overall Cardiovascular Risk
Injury & Violence	• Unintentional Injury Deaths ○ Including Motor Vehicle Crash Deaths • Firearm-Related Deaths
Mental Health	• "Fair/Poor" Mental Health • Suicide Deaths • Mental Health Provider Ratio • *Key Informants: Mental health ranked as a top concern.*
Nutrition, Physical Activity & Weight	• Fruit/Vegetable Consumption • Overweight & Obesity [Adults] • Meeting Physical Activity Guidelines • Access to Recreation/Fitness Facilities • *Key Informants: Nutrition, physical activity, and weight ranked as a top concern.*

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Areas of Opportunity (continued)	
Respiratory Diseases	• Chronic Lower Respiratory Disease (CLRD) Deaths • Asthma Prevalence [Adults] • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Pneumonia/Influenza Deaths
Substance Abuse	• Cirrhosis/Liver Disease Deaths • *Key Informants: Substance abuse ranked as a top concern.*
Tobacco Use	• Cigarette Smoking Prevalence • Environmental Tobacco Smoke Exposure at Home ○ Including Among Nonsmokers • *Key Informants: Tobacco use ranked as a top concern.*

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment (see "Areas of Opportunity" above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. **Substance Abuse**
2. **Mental Health**
3. **Tobacco Use**
4. **Nutrition, Physical Activity & Weight**
5. **Diabetes**
6. **Heart Disease & Stroke**
7. **Cancer**
8. **Respiratory Diseases**
9. **Injury & Violence**
10. **Access to Healthcare Services**

Hospital Implementation Strategy

King's Daughters' Health will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the

development of the hospital's action plan to guide community health improvement efforts in the coming years.

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 Primary Service Area, grouped by health topic.

Reading the Summary Tables

In the following tables, Primary 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 columns to the right of the Primary Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2020 objectives. Again, symbols indicate whether Primary 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.

Social Determinants	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Linguistically Isolated Population (Percent)	0.3	1.8	1.3	4.4	
Population in Poverty (Percent)	15.2	14.6	18.3	14.6	
Children in Poverty (Percent)	22.3	20.4	24.7	20.3	
No High School Diploma (Age 25+, Percent)	13.4	11.7	14.8	12.7	
Unemployment Rate (Age 16+, Percent)	4.0	3.6	4.9	4.4	
% Worry/Stress Over Rent/Mortgage in Past Year	29.2			30.8	
% Low Health Literacy	21.3			23.3	
			better	similar	worse

Overall Health	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% "Fair/Poor" Overall Health	24.3	20.6	25.5	18.1	
			better	similar	worse

Access to Health Services	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	21.4	12.8	9.2	13.7	0.0
% Difficulty Accessing Healthcare in Past Year (Composite)	32.7			43.2	

Access to Health Services (continued)	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% Difficulty Finding Physician in Past Year	9.9			13.4	
% Difficulty Getting Appointment in Past Year	6.7			17.5	
% Cost Prevented Physician Visit in Past Year	11.6			15.4	
% Transportation Hindered Dr Visit in Past Year	5.8			8.3	
% Inconvenient Hrs Prevented Dr Visit in Past Year	9.4			12.5	
% Language/Culture Prevented Care in Past Year	0.0			1.2	
% Cost Prevented Getting Prescription in Past Year	17.7			14.9	
% Skipped Prescription Doses to Save Costs	16.0			15.3	
% Difficulty Getting Child's Healthcare in Past Year	4.1			5.6	
Primary Care Doctors per 100,000	50.3	75.9	74.0	87.8	
% Have a Specific Source of Ongoing Care	74.4			74.1	95.0
% Have Had Routine Checkup in Past Year	63.3	68.3	73.3	68.3	
% Child Has Had Checkup in Past Year	83.8			87.1	
% Two or More ER Visits in Past Year	10.2			9.3	
			better	similar	worse

Cancer	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	193.5	172.9	191.8	155.6	161.4
Lung Cancer (Age-Adjusted Death Rate)	64.8	48.8	60.5	38.5	45.5
Female Breast Cancer (Age-Adjusted Death Rate)	20.7	20.7	21.4	20.1	20.7
Colorectal Cancer (Age-Adjusted Death Rate)	23.0	15.4	16.8	13.9	14.5
Cancer Incidence Rate (All Sites)	505.7	447.0	509.9	483.8	
Female Breast Cancer Incidence Rate	114.6	121.7	125.0	124.7	
Prostate Cancer Incidence Rate	102.6	92.7	108.8	109.0	
Lung Cancer Incidence Rate	88.7	72.8	93.5	60.2	
Colorectal Cancer Incidence Rate	53.2	42.9	49.5	39.2	
% Cancer (Other Than Skin)	10.8	7.2	8.4	7.1	
% Skin Cancer	10.0	5.7	7.7	8.5	
% [Women 50-74] Mammogram in Past 2 Years	65.6	72.5	76.7	77.0	81.1
% [Women 21-65] Pap Smear in Past 3 Years	66.9	74.9	80.2	73.5	93.0
% [Age 50-75] Colorectal Cancer Screening	67.0	64.6	71.1	76.4	70.5
			better	similar	worse

Diabetes	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Diabetes (Age-Adjusted Death Rate)	34.6	26.5	28.1	21.3	20.5
% Diabetes/High Blood Sugar	26.9	11.8	12.9	13.3	
% Borderline/Pre-Diabetes	7.6	1.4	1.9	9.5	
Kidney Disease (Age-Adjusted Death Rate)	19.0	18.6	19.8	13.2	
			better	similar	worse

Heart Disease & Stroke	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	224.5	182.0	198.9	166.3	156.9
Stroke (Age-Adjusted Death Rate)	43.6	39.6	40.2	37.5	34.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	13.0			8.0	
% Stroke	5.5	3.6	4.7	4.7	
% Blood Pressure Checked in Past 2 Years	97.9			90.4	92.6
% Told Have High Blood Pressure (Ever)	42.0	35.2	39.4	37.0	26.9
% Cholesterol Checked in Past 5 Years	94.1	83.4	86.8	85.1	82.1
% Told Have High Cholesterol (Ever)	27.5			36.2	13.5

Heart Disease & Stroke (continued)	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% 1+ Cardiovascular Risk Factor	93.5			87.2	
			better	similar	worse

Infant Health & Family Planning	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Low Birthweight Births (Percent)	8.0	8.2	9.1	8.2	7.8
Infant Death Rate	6.4	7.3	6.7	5.8	6.0
Births to Adolescents Age 15 to 19 (Rate per 1,000)	38.8	38.9	48.4	36.6	
			better	similar	worse

Injury & Violence	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	61.5	52.7	70.0	46.7	36.4
Motor Vehicle Crashes (Age-Adjusted Death Rate)	20.3	12.3	17.9	11.4	12.4
[65+] Falls (Age-Adjusted Death Rate)	31.0	37.7	40.5	56.8	47.0
Firearm-Related Deaths (Age-Adjusted Death Rate)	19.3	14.3	16.3	11.6	9.3
Violent Crime Rate	34.1	419.1	224.9	384.8	
% Victim of Violent Crime in Past 5 Years	1.0			3.7	

Injury & Violence (continued)	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% Victim of Domestic Violence (Ever)	9.7			14.2	
			better	similar	worse

Mental Health	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	21.2			13.0	
% Diagnosed Depression	21.4	23.5	24.3	21.6	
% Symptoms of Chronic Depression (2+ Years)	26.1			31.4	
% Typical Day Is "Extremely/Very" Stressful	13.8			13.4	
Suicide (Age-Adjusted Death Rate)	24.1	15.4	16.9	13.6	10.2
Mental Health Providers per 100,000	70.1	149.9	203.2	202.8	
% Taking Rx/Receiving Mental Health Trtmt	16.7			13.9	
% Unable to Get Mental Health Svcs in Past Yr	0.8			6.8	
			better	similar	worse

Nutrition, Physical Activity & Weight	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% Food Insecure	30.7			27.9	
% 5+ Servings of Fruits/Vegetables per Day	24.2			33.5	
% "Very/Somewhat" Difficult to Buy Fresh Produce	21.1			22.1	
Population With Low Food Access (Percent)	7.1	25.3	18.0	22.4	
% No Leisure-Time Physical Activity	29.8	29.8	34.4	26.2	32.6
% Meeting Physical Activity Guidelines	10.5	17.2	16.8	22.8	20.1
Recreation/Fitness Facilities per 100,000	3.9	9.3	8.0	11.0	
% Healthy Weight (BMI 18.5-24.9)	13.1	30.2	30.7	30.3	33.9
% Overweight (BMI 25+)	86.2	68.0	67.8	67.8	
% Obese (BMI 30+)	54.4	33.6	34.3	32.8	30.5
% Child [Age 2-17] Physically Active 1+ Hours per Day	67.4			50.5	
			better	similar	worse

Oral Health	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% Have Dental Insurance	64.7			59.9	
% [Age 18+] Dental Visit in Past Year	62.3	61.9	61.8	59.7	49.0
% Child [Age 2-17] Dental Visit in Past Year	77.0			87.0	49.0
			better	similar	worse

Potentially Disabling Conditions	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% Activity Limitations	30.7	21.2	26.5	25.0	
Alzheimer's Disease (Age-Adjusted Death Rate)	18.8	34.4	35.0	30.2	
			better	similar	worse

Respiratory Diseases	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
CLRD (Age-Adjusted Death Rate)	72.9	55.1	65.0	41.0	
Pneumonia/Influenza (Age-Adjusted Death Rate)	17.4	13.4	18.2	14.3	
% [Adult] Currently Has Asthma	18.7	10.0	10.7	11.8	
% [Child 0-17] Currently Has Asthma	2.5			9.3	
% COPD (Lung Disease)	18.8	8.6	12.2	8.6	

Respiratory Diseases (continued)	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% [Age 65+] Flu Vaccine in Past Year	65.2	54.5	60.8	76.8	70.0
% [Age 65+] Pneumonia Vaccine Ever	69.8	73.8	74.4	82.7	90.0
			better	similar	worse

Sexual Health	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Chlamydia Incidence Rate	311.4	466.0	413.2	497.3	
Gonorrhea Incidence Rate	25.1	142.8	131.3	145.8	
HIV Prevalence Rate	99.1	195.7	179.6	362.3	
			better	similar	worse

Substance Abuse	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)	19.1	21.4	30.9	16.7	11.3
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	14.1	11.4	12.4	10.8	8.2
% Current Drinker	28.3	51.6	43.0	55.0	
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	11.6	16.6	15.8	20.0	24.4
% Excessive Drinker	11.6			22.5	25.4

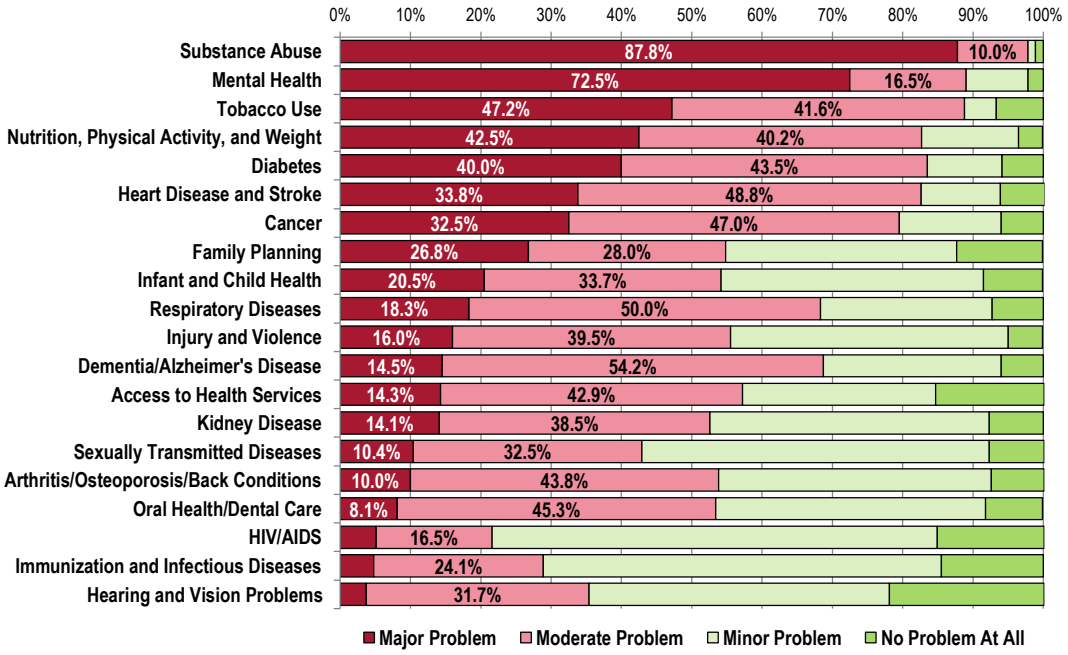
Substance Abuse (continued)	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% Drinking & Driving in Past Month	0.4	5.3	4.7	5.2	
% Illicit Drug Use in Past Month	0.9			2.5	7.1
% Ever Sought Help for Alcohol or Drug Problem	3.4			3.4	
% Personally Impacted by Substance Abuse	29.7			37.3	
			better	similar	worse

Tobacco Use	Primary Service Area	Primary Service Area vs. Benchmarks			
		vs. IN	vs. KY	vs. US	vs. HP2020
% Current Smoker	30.6	21.8	24.6	16.3	12.0
% Someone Smokes at Home	22.6			10.7	
% [Nonsmokers] Someone Smokes in the Home	10.2			4.0	
% [Household With Children] Someone Smokes in the Home	17.6			7.2	
			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 Primary Service Area, the focus of this Community Health Needs Assessment, encompasses 732.94 square miles and houses a total population of 51,607 residents, according to latest census estimates.

Total Population
(Estimated Population, 2013-2017)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Jefferson County (IN)	32,293	360.63	89.55
Switzerland County (IN)	10,617	220.66	48.11
Trimble County (KY)	8,697	151.65	57.35
Primary Service Area	51,607	732.94	70.41
Indiana	6,614,418	35,825.56	184.63
Kentucky	4,424,376	39,485.16	112.05
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

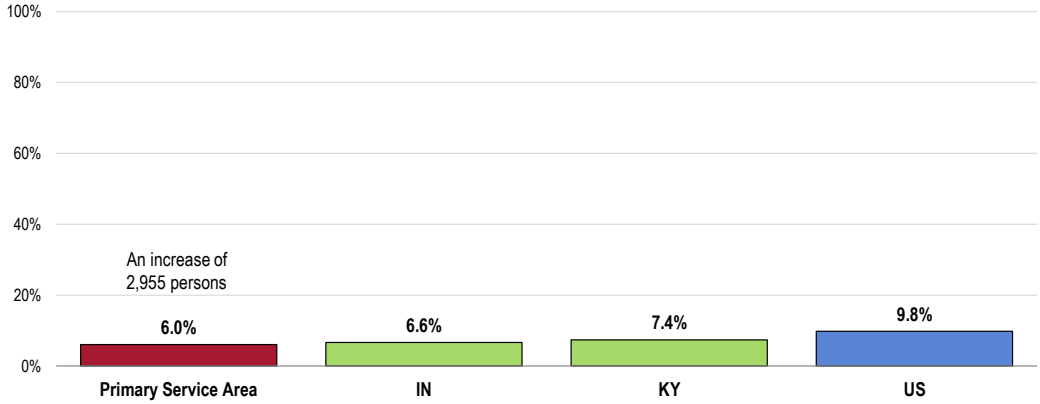
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of the Primary Service Area increased by almost 3,000 persons, or 6.0%.

- **BENCHMARK**: Lower than the Kentucky and national percentages.

Change in Total Population

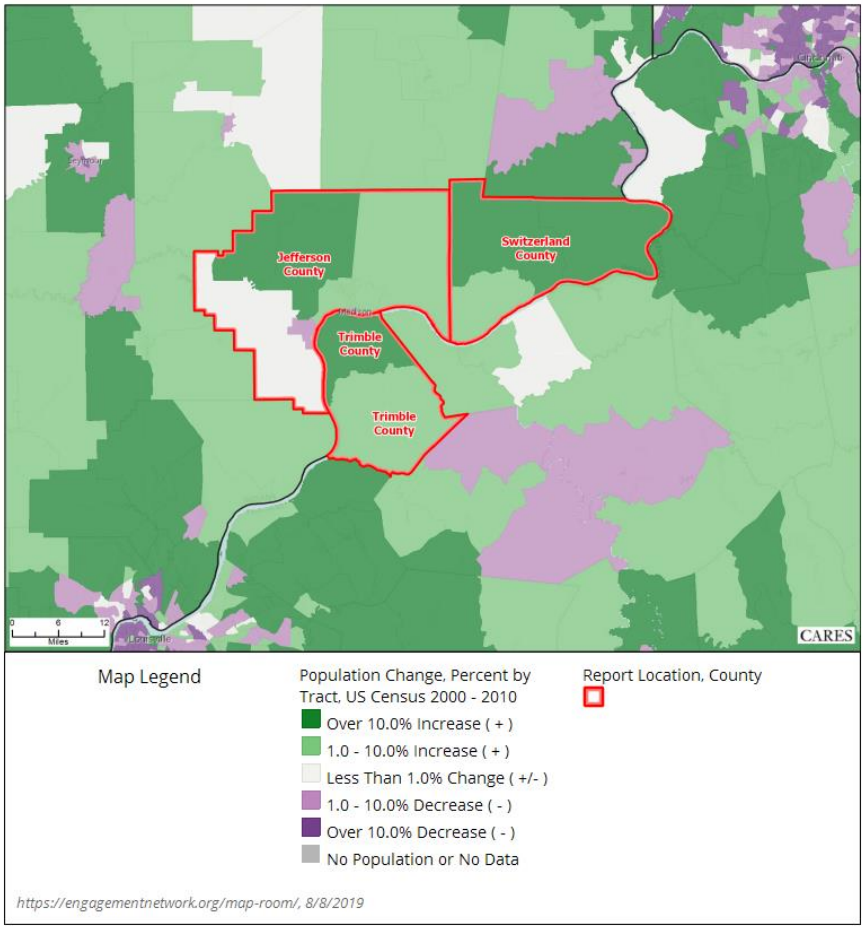
(Percentage Change Between 2000 and 2010)



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.



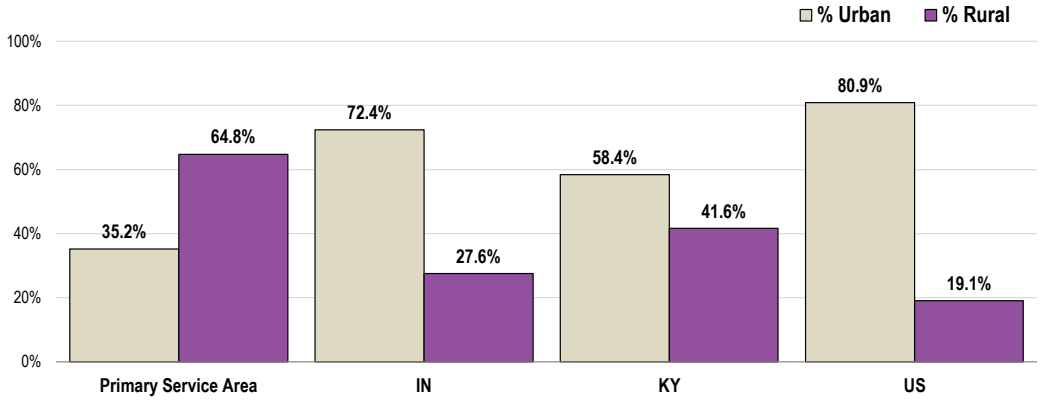
Urban/Rural Population

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 Primary Service Area is predominantly urban, with 35.2% of the population living in areas designated as urban.

- **BENCHMARK**: Significantly less urban than the state or national proportions.

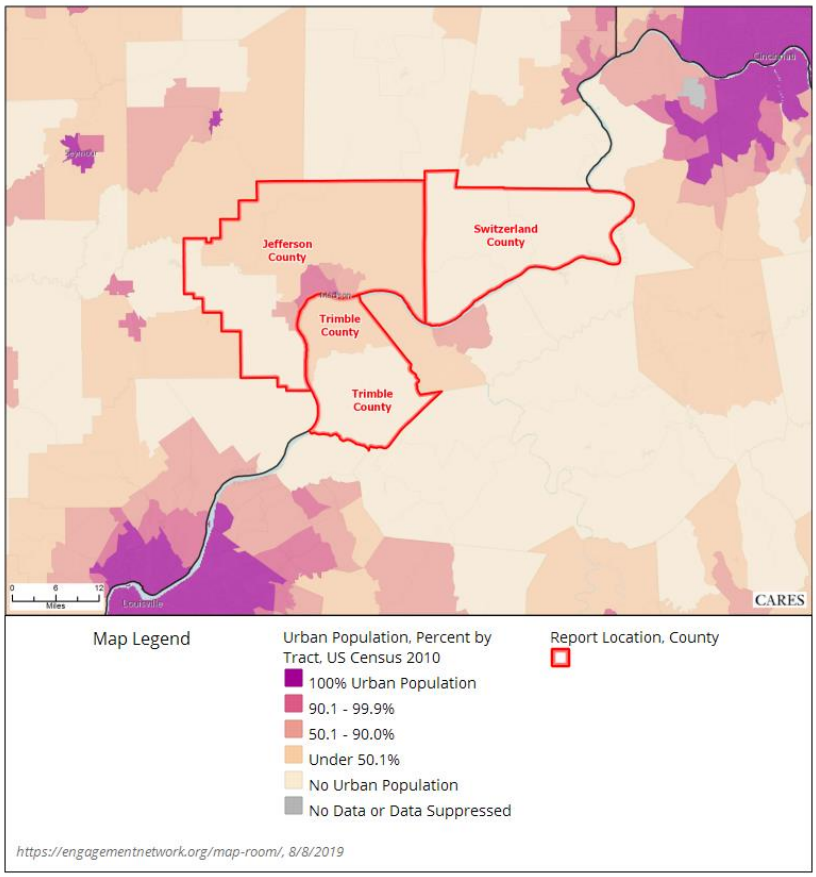
Urban and Rural Population
(2010)



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 Primary Service Area census tracts as of 2010.



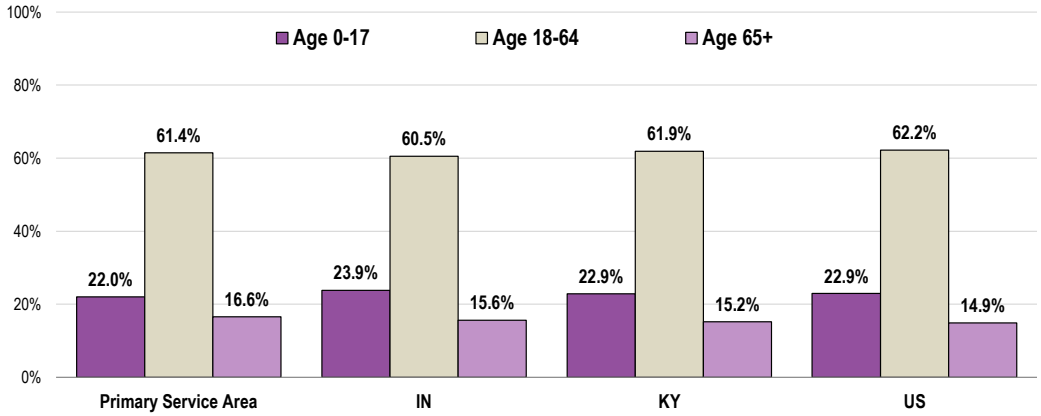
Age

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 Primary Service Area, 22.0% of the population are children age 0-17; another 61.4% are age 18 to 64, while 16.6% are age 65 and older.

- **BENCHMARK**: Statistically similar to state and national proportions.

Total Population by Age Groups, Percent
(2013-2017)

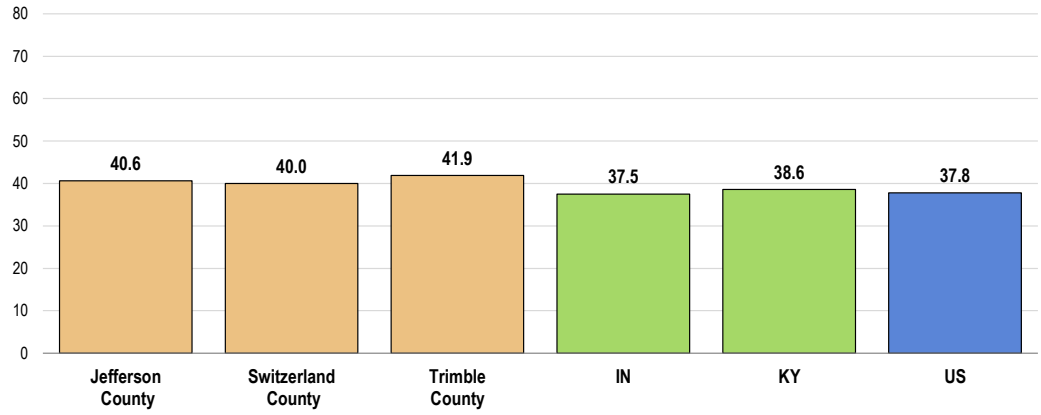


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at https://engagementnetwork.org.

Median Age

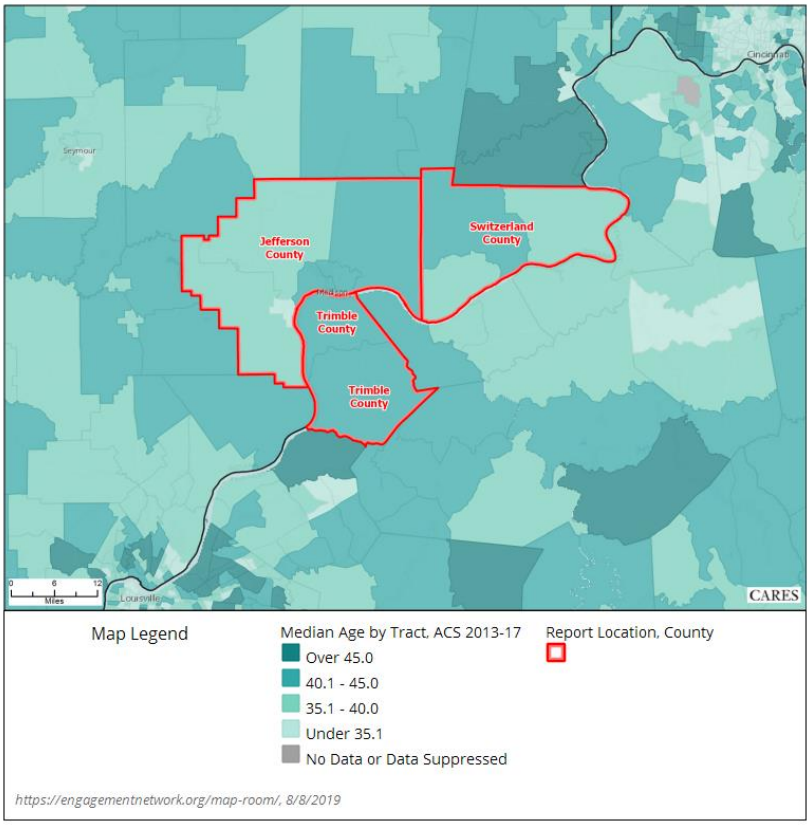
The Primary Service Area is "older" than the two states and the nation in that the median ages for the individual counties are higher.

Median Age
(2013-2017)



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 Primary Service Area, segmented by census tract.

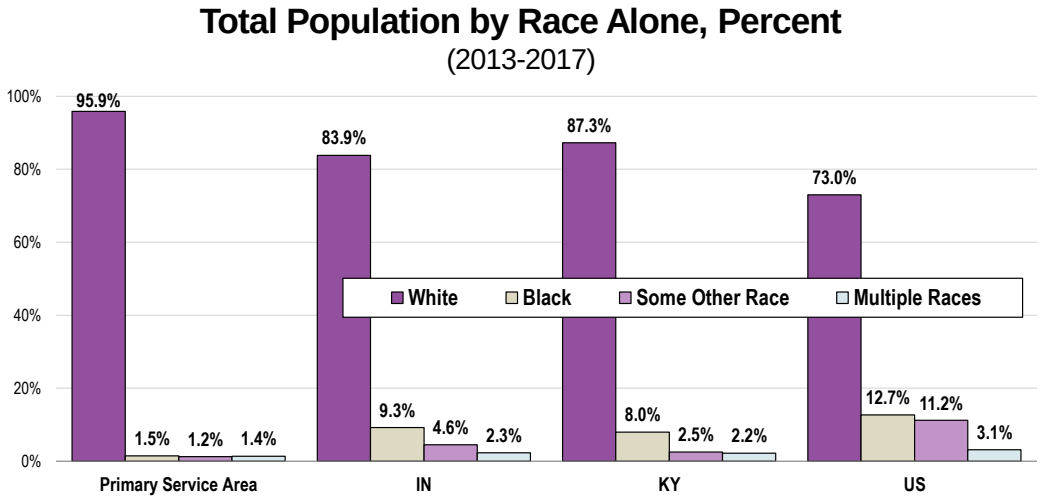


Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 95.9% of residents of the Primary Service Area are White and 1.5% are Black.

- **BENCHMARK**: Less diverse than state and (especially) national proportions.

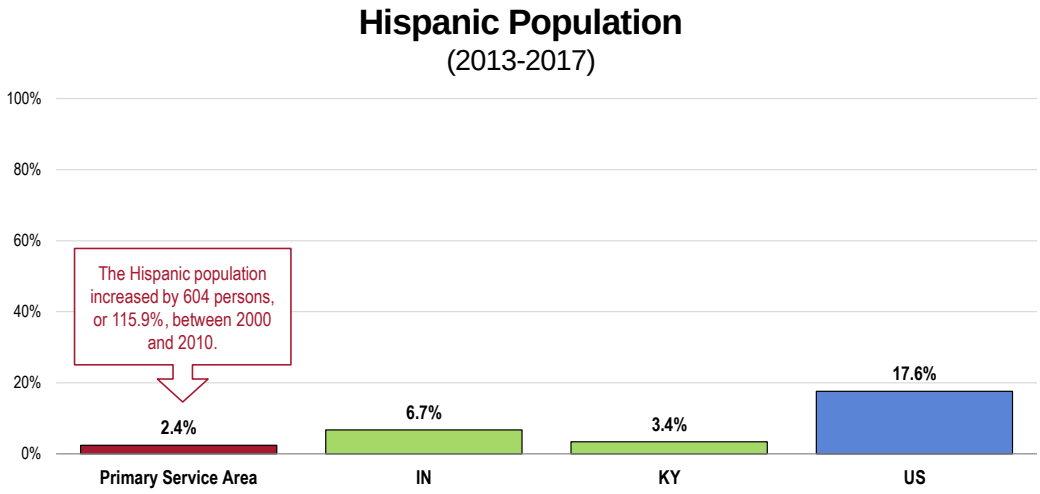


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at https://engagementnetwork.org.

Ethnicity

A total of 2.4% of Primary Service Area residents are Hispanic or Latino.

- **BENCHMARK**: Below state and (especially) national percentages.



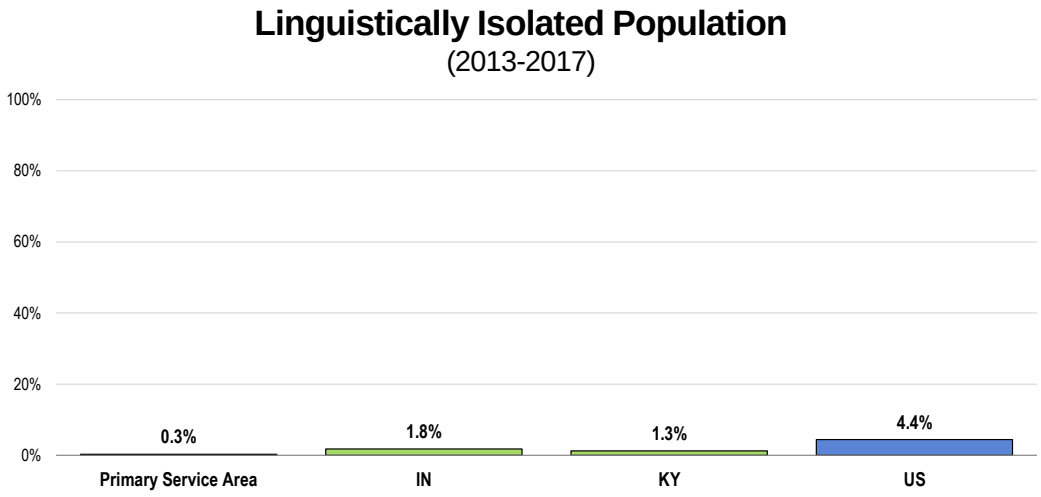
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at https://engagementnetwork.org.

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

A total of 0.3% of the Primary Service Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

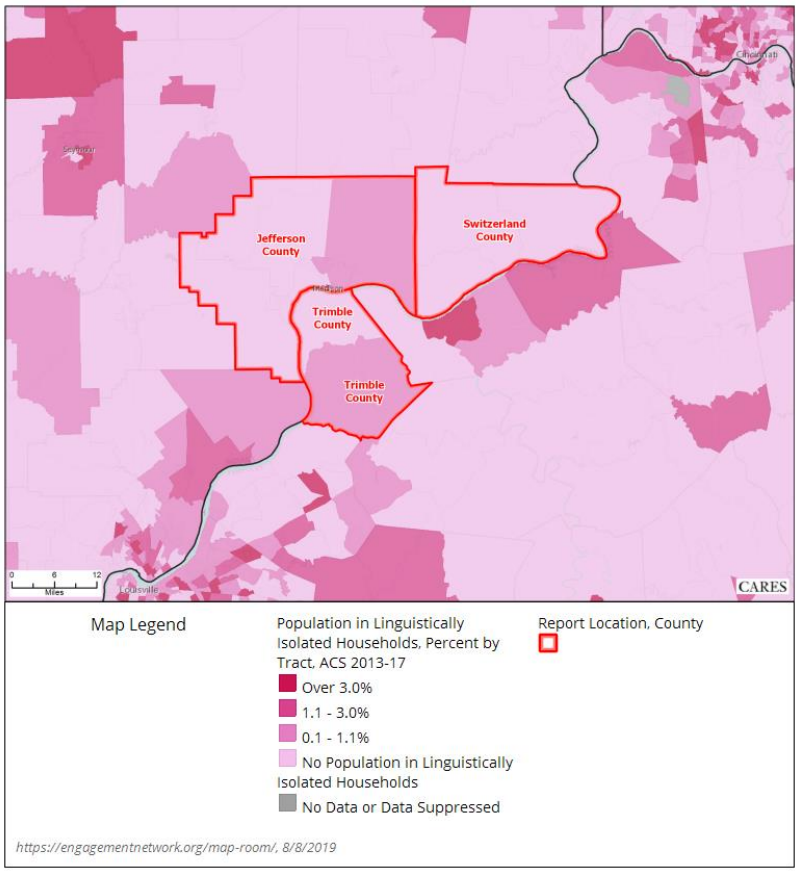
- **BENCHMARK**: Significantly more favorable than state or national proportions.



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 Primary 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

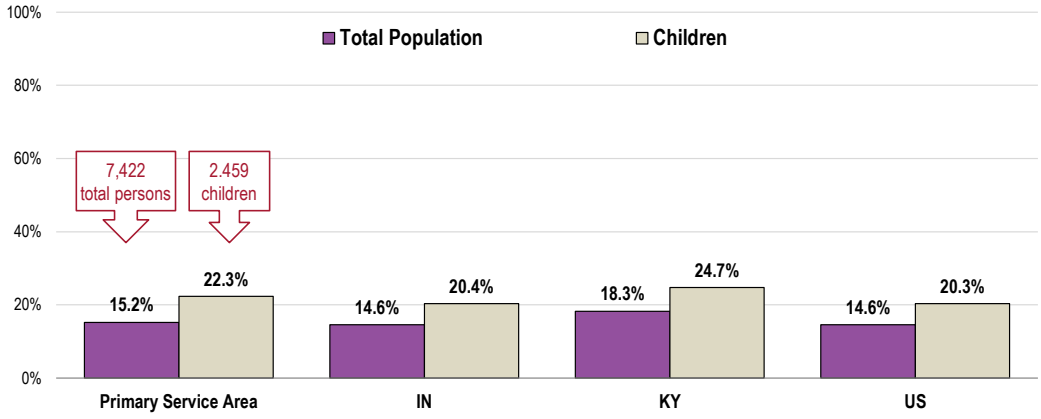
The latest census estimate shows 15.2% of the Primary Service Area total population living below the federal poverty level.

- **BENCHMARK**: Below the Kentucky percentage.

Among just children (ages 0 to 17), this percentage in the Primary Service Area is 22.3% (representing an estimated 2,459 children).

Population in Poverty

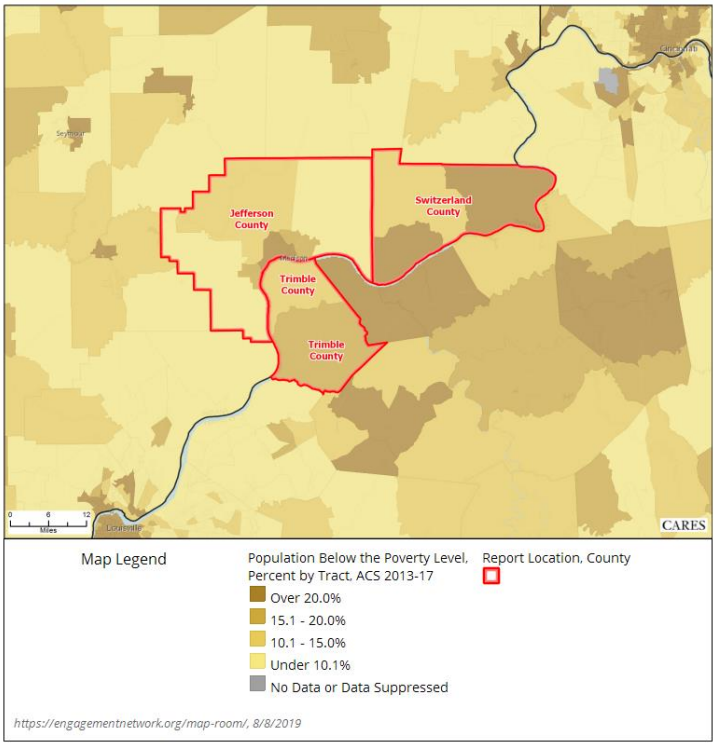
(Populations Living Below the Poverty Level; 2013-2017)

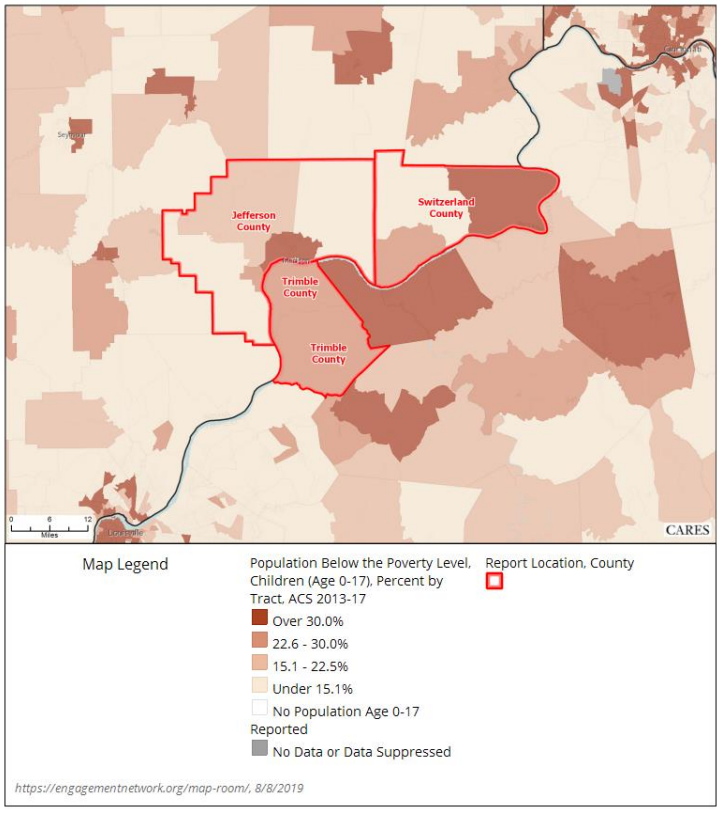


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2019 from CARES Engagement Network at https://engagementnetwork.org.

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

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





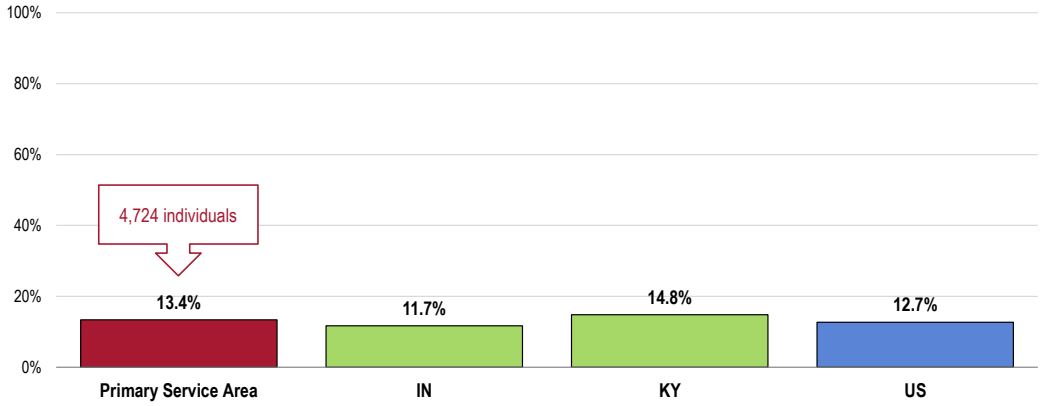
Education

Among the Primary Service Area population age 25 and older, an estimated 13.4% (over 4,500 people) do not have a high school education.

- **BENCHMARK**: No significant differences when compared against state and national percentages.

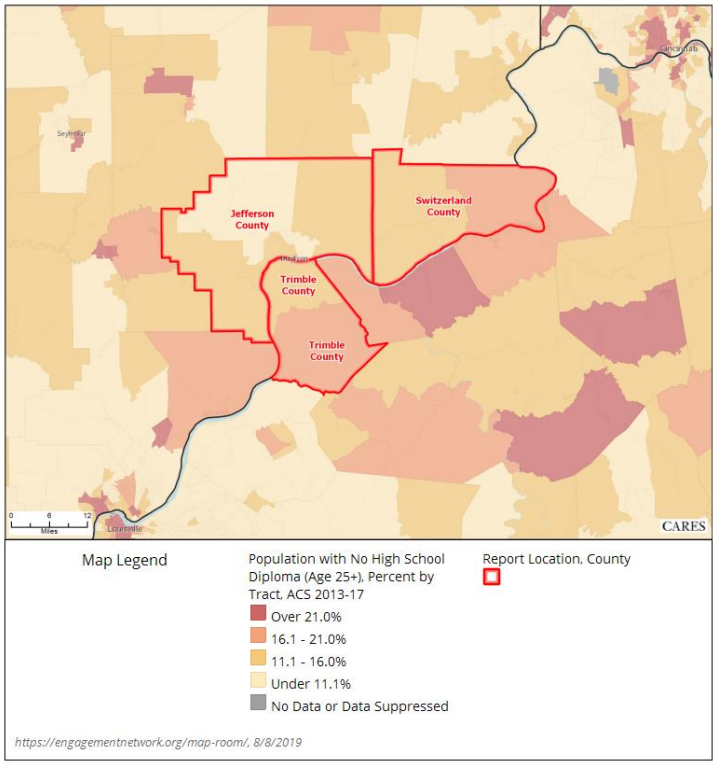
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2013-2017)



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

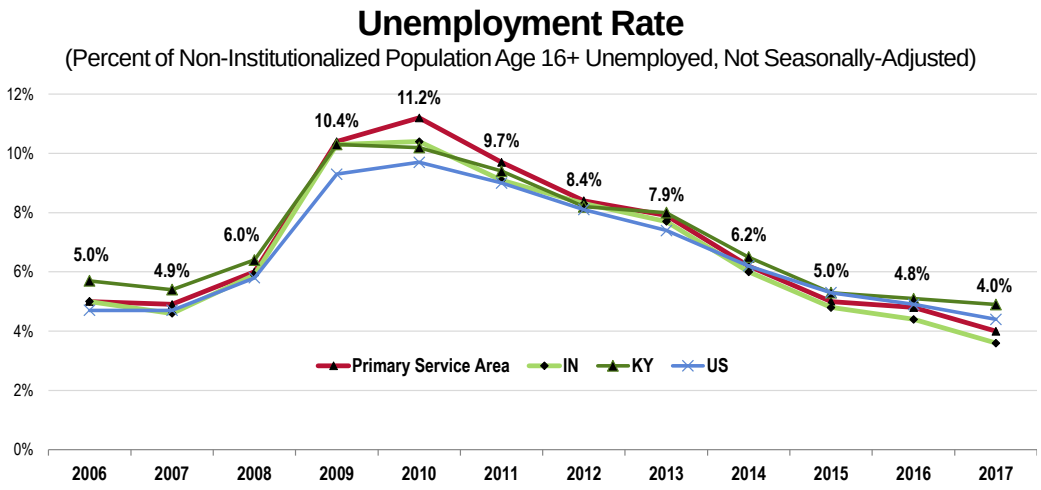
Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.



Employment

According to data derived from the US Department of Labor, the unemployment rate in the Primary Service Area as of 2017 was 4.0%.

- **BENCHMARK**: Significantly below the Kentucky rate for the same year.
- **TREND**: Well below half the 2010 rate.

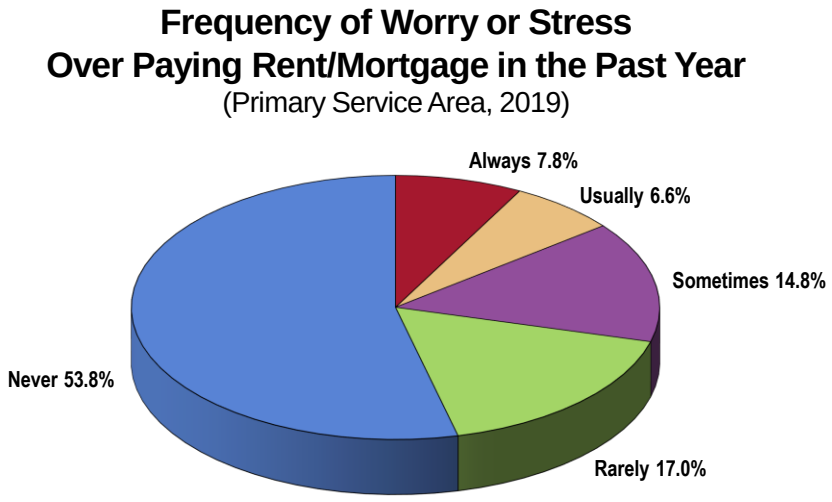


Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Retrieved September 2019 from CARES Engagement Network at https://engagementnetwork.org.

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.



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

Notes:
- Asked of all respondents.

However, a considerable share (29.2%) 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.

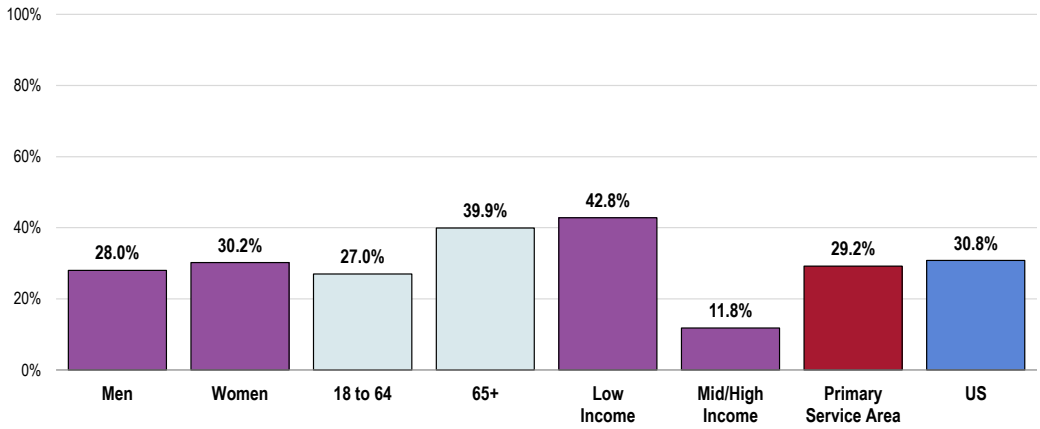
- **DISPARITY**: This prevalence is significantly high among low-income residents. Other differences by demographic characteristics are not statistically significant.

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.

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
(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 196]
- 2017 PRC National Health Survey, PRC, Inc.

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

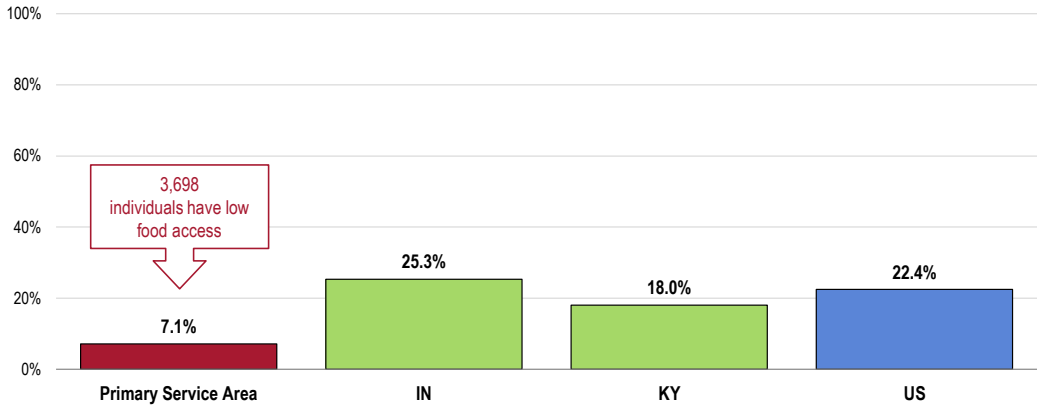
Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

US Department of Agriculture data show that 7.1% of the Primary Service Area population (representing almost 3,700 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

- **BENCHMARK**: Much more favorable than the Indiana, Kentucky, and US percentages.

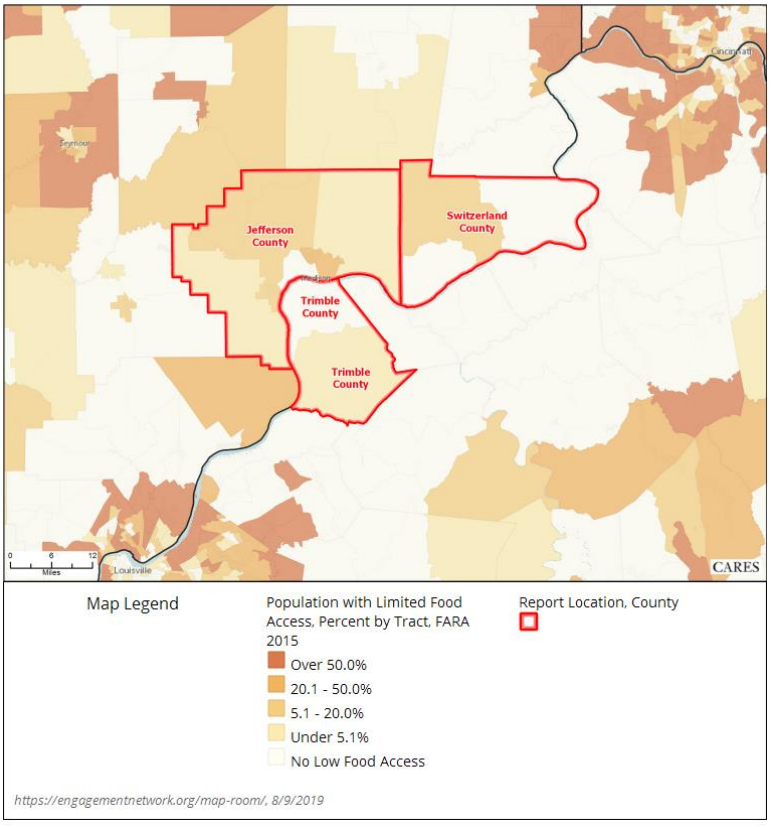
Population With Low Food Access

(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.



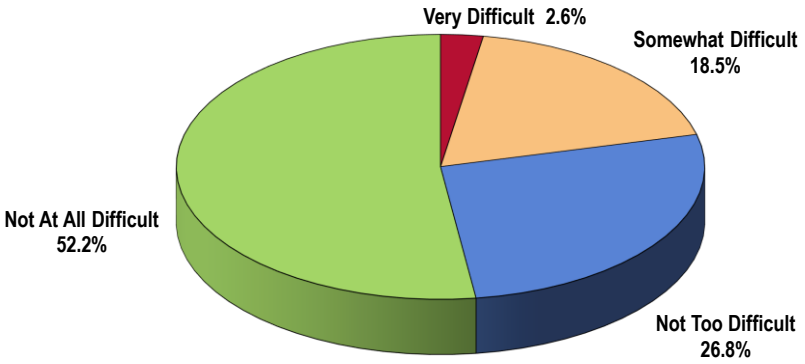
Difficulty Accessing Fresh Produce

Most Primary 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
(Primary Service Area, 2019)



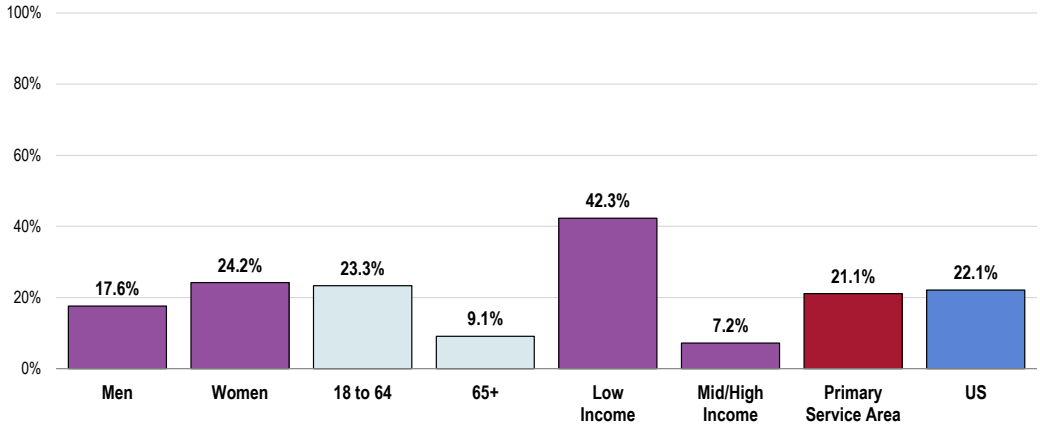
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 86]

Notes:
- Asked of all respondents.

However, 21.1% of Primary Service Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

- **DISPARITY**: Significantly more common among adults under age 65, as well as among low-income residents (especially).

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 189]
- 2017 PRC National Health Survey, PRC, Inc.

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, three in 10 community residents (30.7%) are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

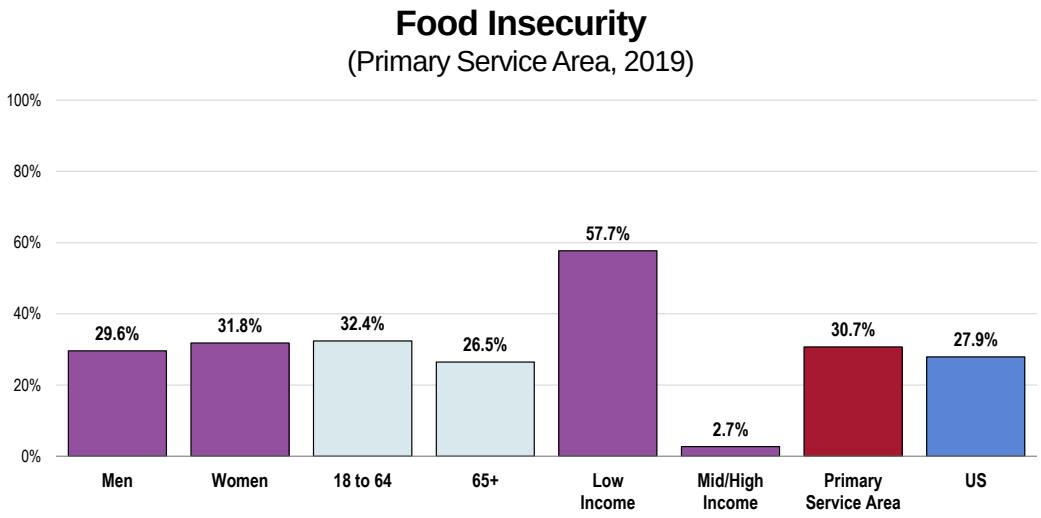
- **DISPARITY**: Notably high among those with lower incomes.

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.



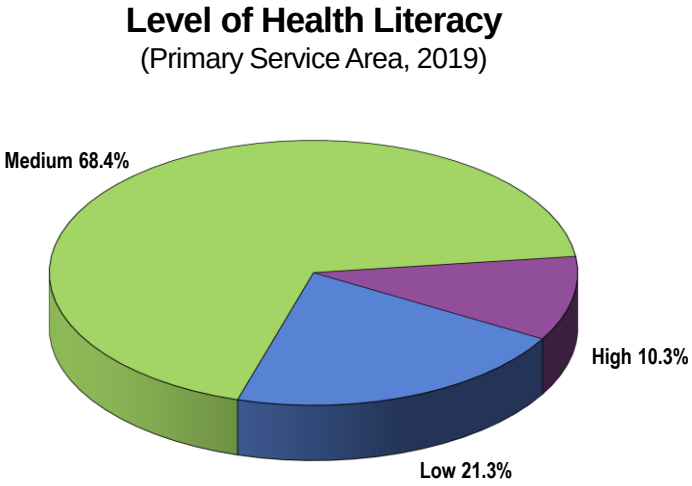
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 149]
- 2017 PRC National Health Survey, PRC, Inc.

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 Primary 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.



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

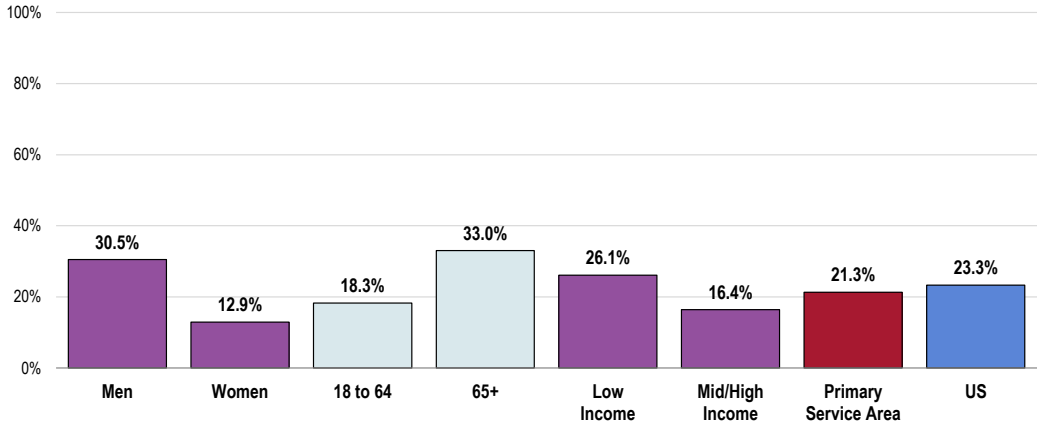
Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

A total of 21.3% are determined to have low health literacy.

- **DISPARITY**: Men and older adults are more likely to report low health literacy levels.

Low Health Literacy

(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 172]
- 2017 PRC National Health Survey, PRC, Inc.

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.

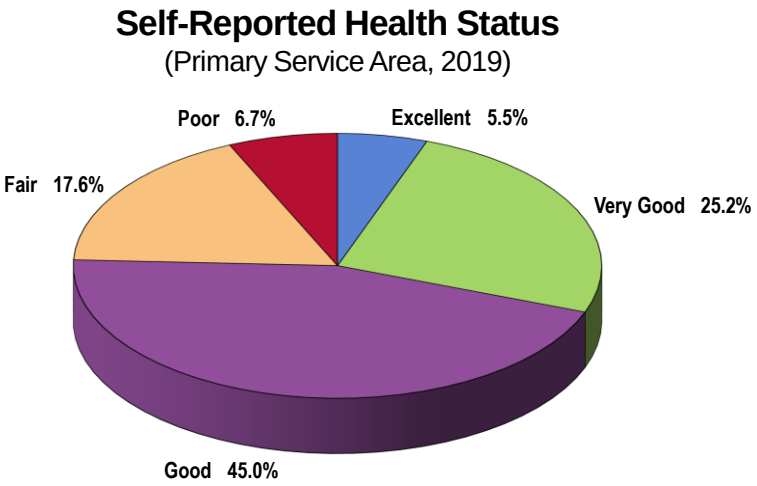
General Health Status

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

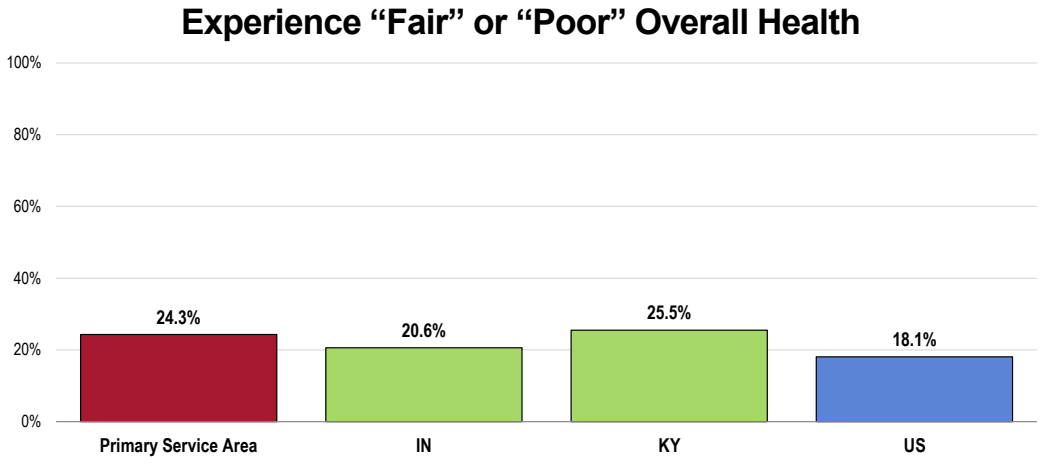


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 5]

Notes:
- Asked of all respondents.

However, 24.3% of Primary Service Area adults believe that their overall health is "fair" or "poor."

- **DISPARITY**: More evident among low-income residents.

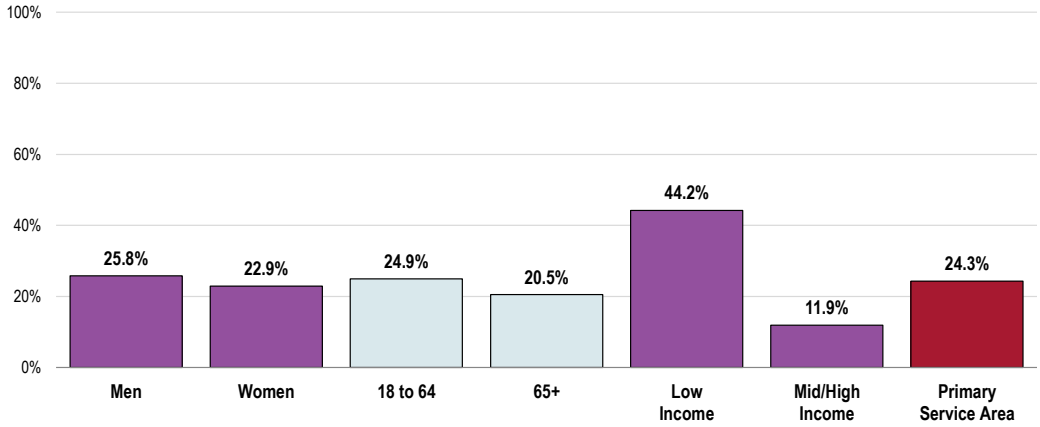


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 5]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health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

Notes:
- Asked of all respondents.

Experience "Fair" or "Poor" Overall Health

(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 5]

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

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:

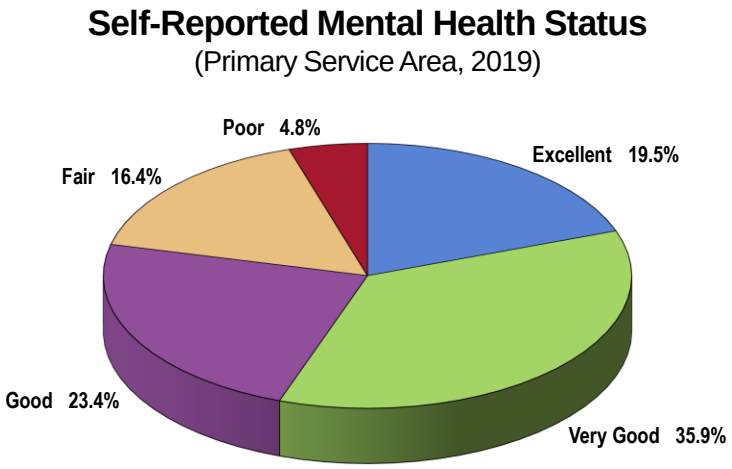
- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence 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

"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?"

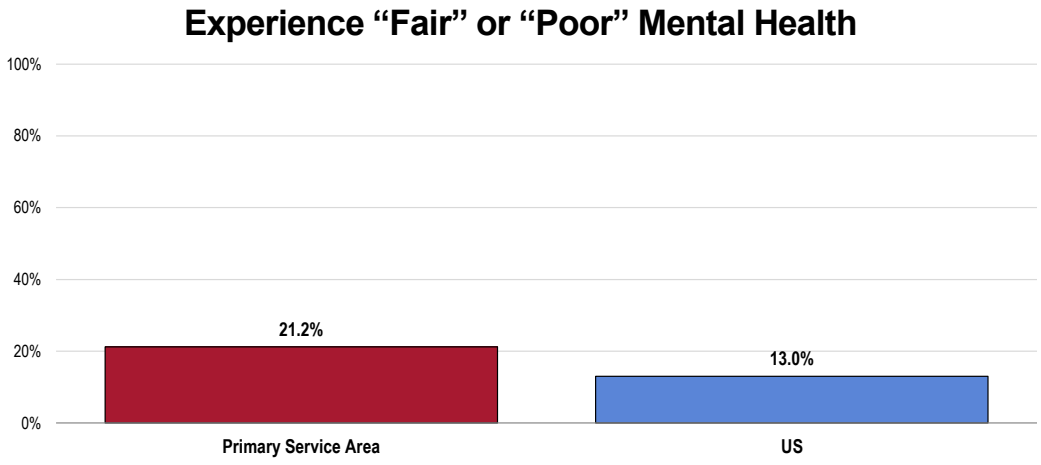
Most Primary Service Area adults rate their overall mental health favorably ("excellent," "very good," or "good").



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

However, 21.2% believe that their overall mental health is "fair" or "poor."

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



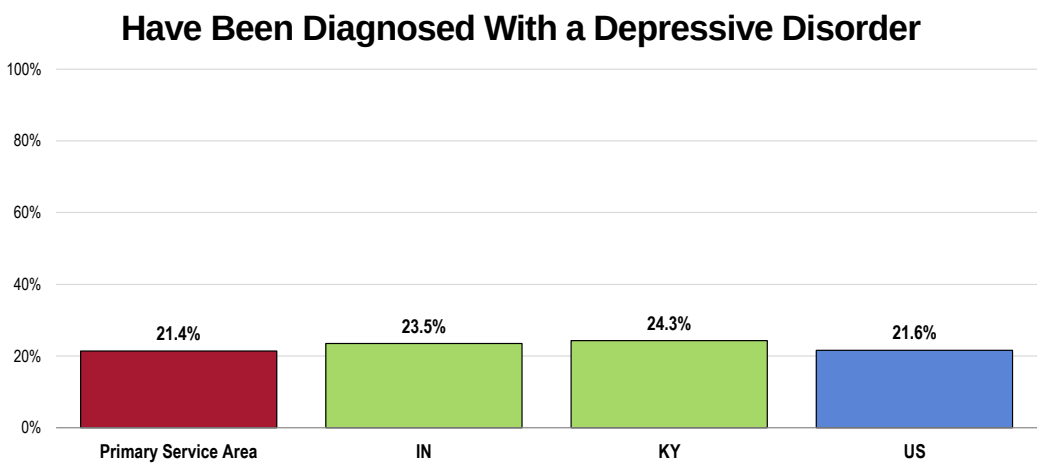
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 99]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Depression

Diagnosed Depression

A total of 21.4% of Primary Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- **BENCHMARK**: No significant differences to report (statistically similar to state and national percentages).



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): 2017 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.

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

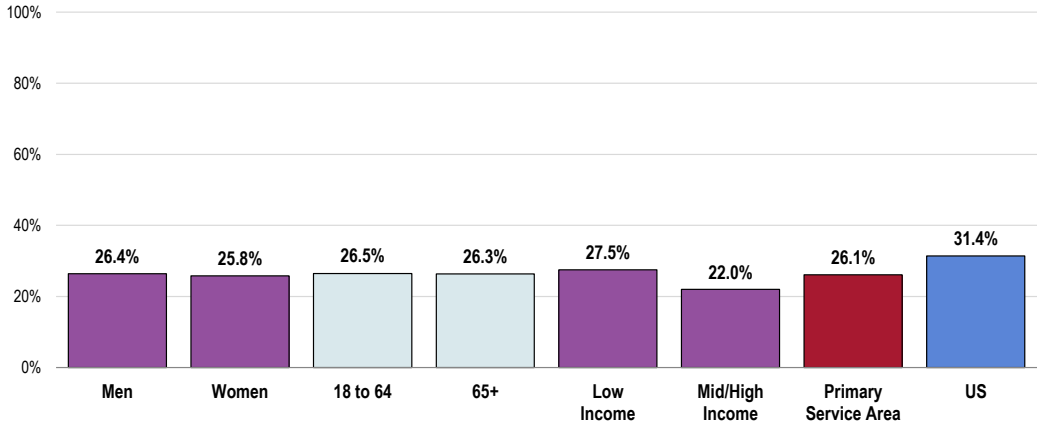
Symptoms of Chronic Depression

A total of 26.1% of Primary 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).

- **DISPARITY**: No significant differences to report.

Have Experienced Symptoms of Chronic Depression

(Primary Service Area, 2019)



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.
- 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

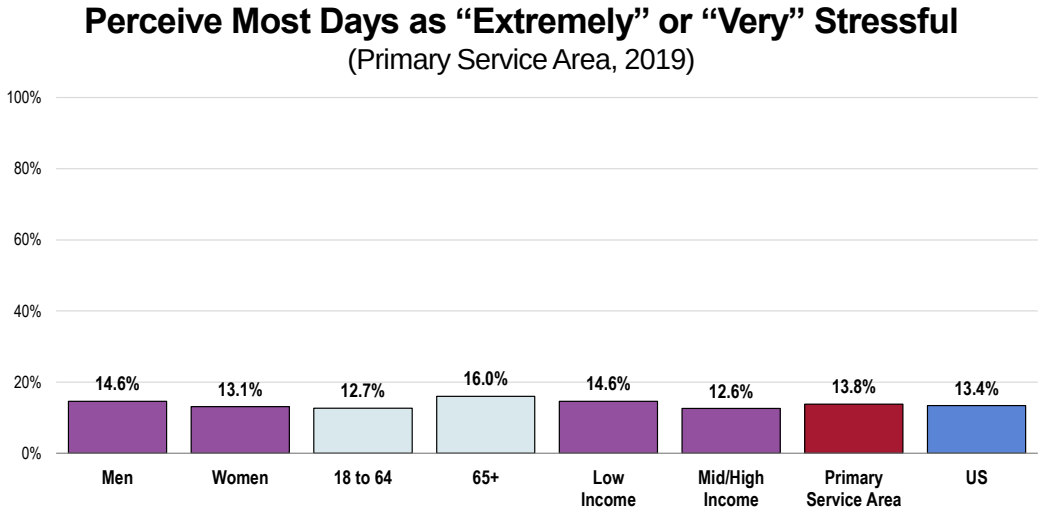
(Primary Service Area, 2019)

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

Notes:
- Asked of all respondents.

In contrast, 13.8% of Primary Service Area adults feel that most days for them are "very" or "extremely" stressful.

- **DISPARITY**: No statistically significant differences to report.



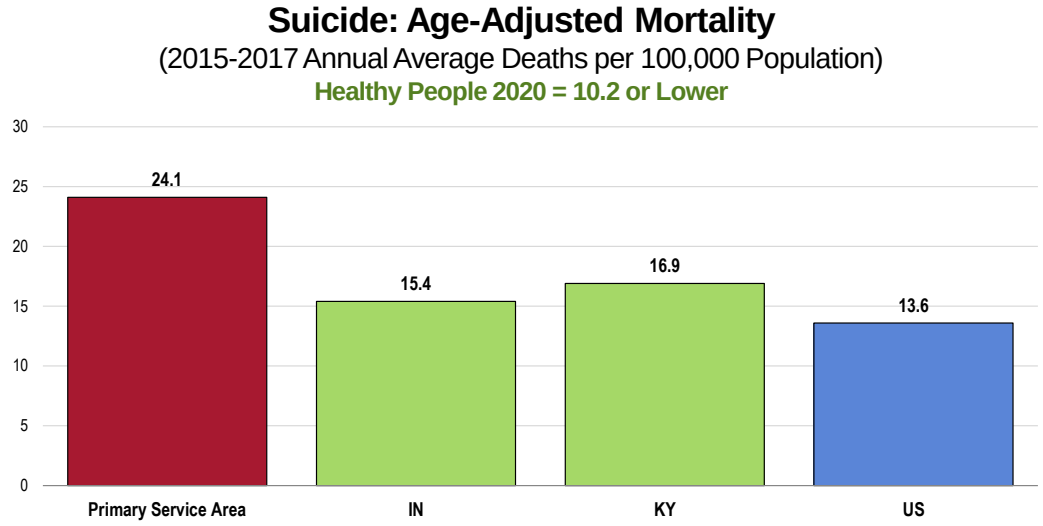
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 101]
- 2017 PRC National Health Survey, PRC, Inc.

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 2015 and 2017, there was an annual average age-adjusted suicide rate of 24.1 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Significantly above state and national rates. More than double the Healthy People 2020 objective.



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

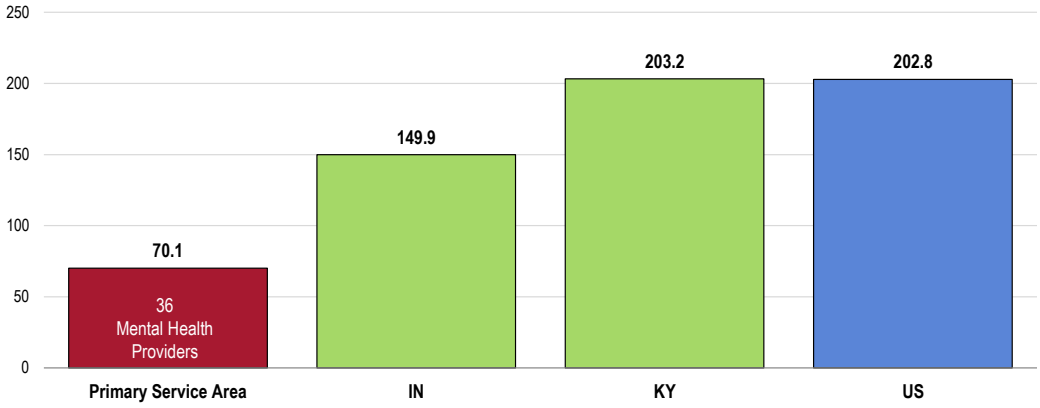
In the Primary Service Area in 2017, there were 36 mental health providers, translating to a rate of 70.1 providers for every 100,000 population.

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

- **BENCHMARK**: Well below the state and national rates.

Access to Mental Health Providers

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



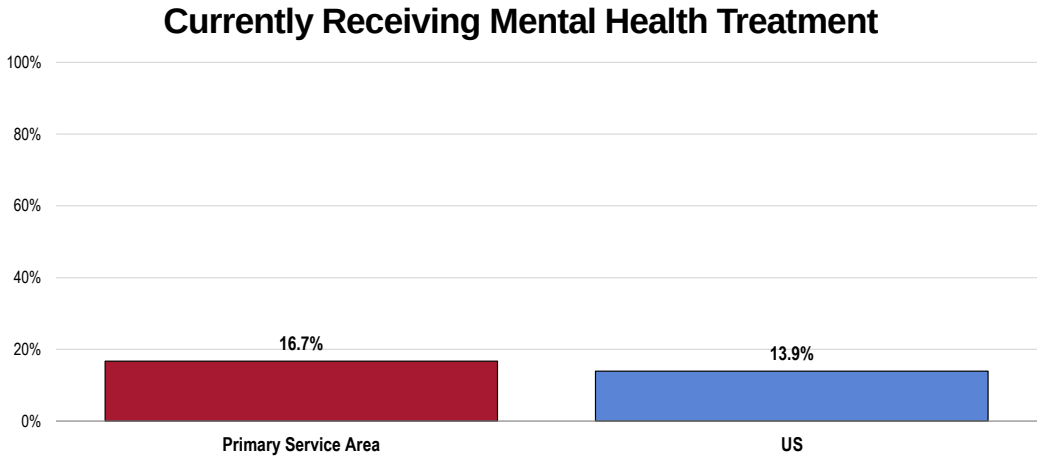
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Retrieved September 2019 from CARES Engagement Network at https://engagementnetwork.org.

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 16.7% 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.

- **BENCHMARK**: Statistically comparable to the US percentage.



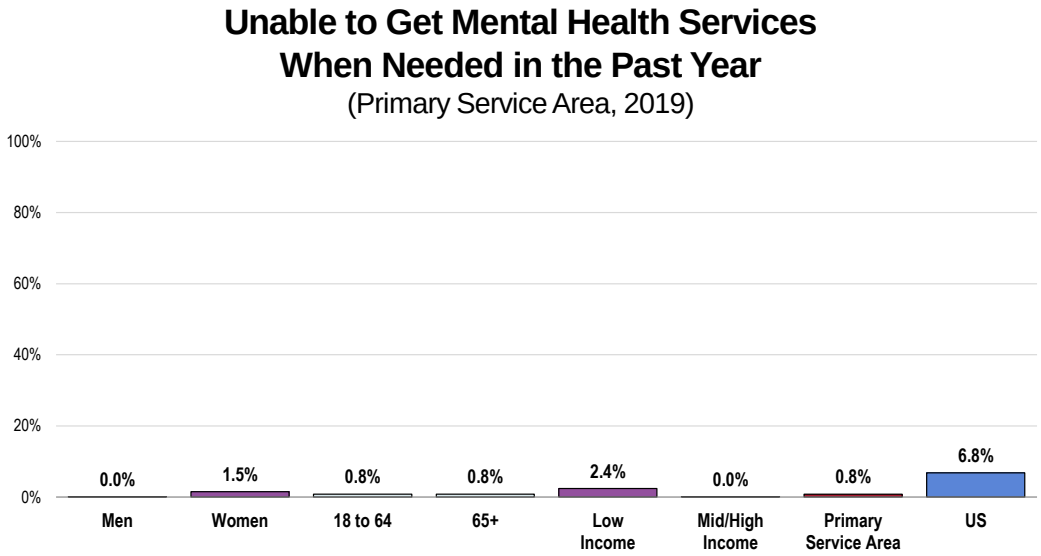
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 103]
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

Difficulty Accessing Mental Health Services

A total of 0.8% of Primary Service Area adults report a time in the past year when they needed mental health services but were not able to get them.

- **BENCHMARK**: Significantly more favorable than found nationally.

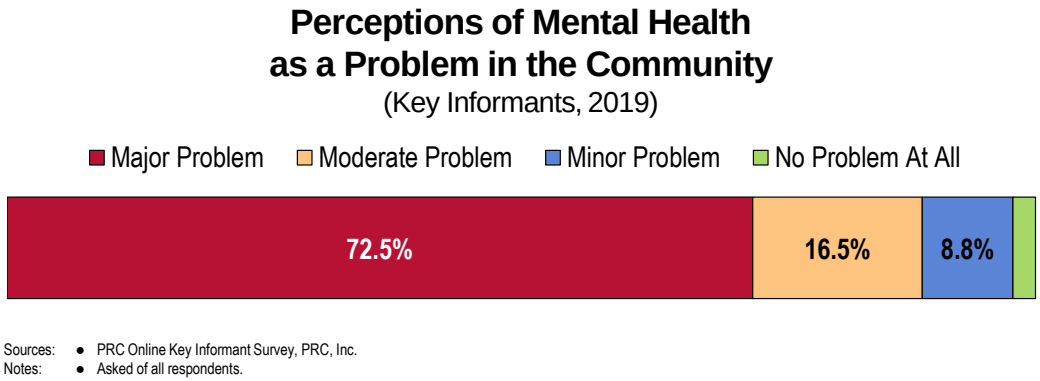


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2017 PRC National Health Survey, PRC, Inc.

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

More than seven in 10 key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.



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

The is probably the single-most critical challenge in our community, because of the lack of services for mental health. The mental health issues coupled with substance abuse is serious. — Community Leader

The mental health system is not working. The resources do not seem to have any long-term effect. Unfortunately, many of the people with mental health issues don't get the change of environment needed after treatment. Short-term treatment is just that Short-term and mental health issues are most frequently a lifelong issue. — Other Health Provider

This community has no inpatient resources for mental health. They have to use the resource of the ED and transported several hours away for inpatient mental health and then they do not have the resources for outpatient mental health for follow-up from inpatient. — Other Health Provider

Since the State Hospital was reorganized, many clients needing mental health services are unable to function well on their own. Some are homeless, some are vagrant, some cause alarm in the downtown. There are resources for them such as RVR, mental health providers, Salvation Army, but many are unable to recognize that they may need consistent care. — Community Leader

Mental health is a big challenge in our community. There is a lack of mental health clinics or in-house facilities available for suicidal or mentally ill individuals. This is especially prominent for younger individuals. Also, many self-medicate with illegal substances. — Community Leader

There is a major lack of mental health services in this community, and the number of people that need services is growing every day. We need to figure out a way to meet the needs of this population in crisis to ensure they are receiving appropriate follow-up & their needs are being met. — Social Services Provider

Individuals in need of treatment often struggle to receive timely treatment and effective treatment. There simply are not enough trained providers to meet the demands of the population. The primary modality by which mental health issues are treated is through weekly, individual therapy services with a trained service provider. The biggest issues lie with identifying a potential provider who 1) is in your area, 2) has availability for new clients, 3) has an open therapy time that you can attend, 4) either takes your insurance or has a fee schedule you can afford, and 5) has expertise in the area of mental health for which you are seeking services. I believe this is why our community is struggling with mental health. — Social Services Provider

Knowing where to send people for help as far as facilities. Making the community aware that opioids affect rich, poor and in between. We need a facility for these young people to get help. Addiction is a disease, sooner we realize it, the better off we can save a generation. — Community Leader

There are not any long-term care facilities or follow-up plans in place. Mental Illness can be seen in all our schools, but help is very hard to get and if help is granted then it is short-term. — Community Leader

There are not enough services and long waiting lists. Our current mental health providers are inadequately trained to deal with the crisis in our community. — Community Leader

Although there are several counselors in our area, there is no facility in town for mental health issues. — Community Leader

Lack of inpatient treatment facility, long wait times at facilities out of town, and lack of mental health counselors that live in our community. — Community Leader

Seeking help and not being prescribed a medication to just fix the problem. We need to actually evaluate mental illness before prescribing pills. — Community Leader

Finding access to appropriate care and places that will provide the type of care needed for the variety of insurances and people in our community. — Public Health Representative

The biggest challenge for people with mental health issues is access to appropriate services. — Social Services Provider

Lack of outpatient facilities for counseling and inpatient placement. — Other Health Provider

Lack of mental health care facilities and residential treatment facilities. — Community Leader

Inadequate services and no acute care. Mental health problems are exacerbated by drug and alcohol problems. — Other Health Provider

Limited mental health facilities in Jefferson County. — Public Health Representative

Access to local mental health services in a timely manner. — Physician

There are waiting lists and no long-term or short-term treatment facilities in our area. — Community Leader

Access to care and inpatient facilities. — Other Health Provider

Access to treatment is major barrier. — Community Leader

Access to care. — Other Health Provider

Not enough mental health treatment options available. — Community Leader

No local facility for treatment. — Community Leader

No resources. — Other Health Provider

Poor access to care. — Public Health Representative

Access. — Physician

Lack of Providers

We are a community with a mental health provider shortage. Closest inpatient treatment for acute emergency stays is at least an hour away. Community mental health providers cannot get and maintain therapists due to low pay and extreme stress that goes with the job. — Social Services Provider

Unfortunately, we do not have enough mental health professionals. We do not have affordable insurance. We do not have the education resources to teach people about mental health, so there is a stigma. — Community Leader

The biggest problem is that there is a shortage of providers in Jefferson County. It has a designation by the State of Indiana as a mental health desert. For many people, they do not have insurance or the proper insurance to access health care… There just are not enough trained caregivers and people have the right medical insurance, and the fact that mental health care is stigmatized. — Community Leader

People with mental health issues have extreme difficulty obtaining counseling/treatment. We have primarily two providers who accept government assistance. Private practitioners are too expensive for many people with these issues. People have to get on waiting lists and wait for months to get treatment. Many times, the treatment is too late. — Community Leader

The primary challenge we have in mental health is the caliber of candidates our rural area attracts. — Social Services Provider

Our community needs to have more access to mental health counselors and facilities that are able to help those having mental health issues. — Community Leader

Lack of mental health providers as well as lack of communication between community stakeholders who serve the same people. — Social Services Provider

Lack of available quality service providers and long wait times for new patients. — Social Services Provider

Access to mental health services, particularly psychiatry. Then finding services that will take a variety of insurances. — Other Health Provider

Not enough providers. Lack of knowledge. No alternatives/options, medication seems to be the only solution. — Community Leader

People without insurance sometimes have problems getting in for mental health counseling. — Public Health Representative

There are not enough providers. — Social Services Provider

Prevalence/Incidence

I work in law enforcement and also security at the hospital and see all too often people suffering from mental health issues. The issue is jails and emergency rooms aren't mental health care facilities and police officers and nurses aren't set up and trained for mental health issues. The whole country is seriously lacking when it comes to mental health care. — Community Leader

High suicide rate, lack of treatment providers. Lack of housing/residential treatment for mentally ill people. Mental health stigma in the community. — Community Leader

There is a large amount of mental illness in the community. Many are due to the substance abuse issues in the community. — Other Health Provider

Anxiety and depression disorders seem very prevalent and last I checked consist of three of the top ten medications for Medicaid. — Other Health Provider

High rate of suicide. Lack of access or knowledge of where to find counseling. — Physician

Alcohol/Drug Abuse

I think our area is high drug traffic area and leads to a lot of drug use. This, in turn, leads to mental health issues. Lack of inpatient care in this area. Local hospital not equipped to care for these patients. Lack of social workers in this area. — Other Health Provider

Because of my field of education, I see continued problems with drug use, depression, suicide attempts, self-harm in teenagers. — Community Leader

Drugs. — Social Services Provider

Denial/Stigma

Many people struggle with mental health issues, both openly and secretly. Mental health care is expensive and often delayed, not immediate enough. It needs to start younger in schools. — Community Leader

Stigma. High suicide rate for the county. Limit of licensed therapists in the county. Transportation to keep appointments, get medications. Many choose not to get services. — Social Services Provider

Support

Individuals that are not able to cope with their mental illness or do not have a support network to assist them with their mental illness. Some individuals are not able to care for themselves because of their illness and this creates a problem for the community. There is a need for residential care and secure mental health facilities in our community. With the only options for in patient care over an hour drive from our area, it creates a problem for these individuals and their families to get treatment. — Community Leader

Accountability for attending services. Access to services. Quality services. — Community Leader

Autism

Autism and anxiety are big issues in this community that lack support. We need to look into other communities that have become autism friendly. I think adapting some of their systems will help some of the other health needs. Children are being mistreated in this community because of their disability. — Community Leader

Awareness/Education

Mental health is a problem for the young and old. Education about mental health and where to get help are limited or non-existent. — Public Health Representative

Diagnosis/Treatment

> *Screening, follow-up appointments, medication management, transportation. — Social Services Provider*

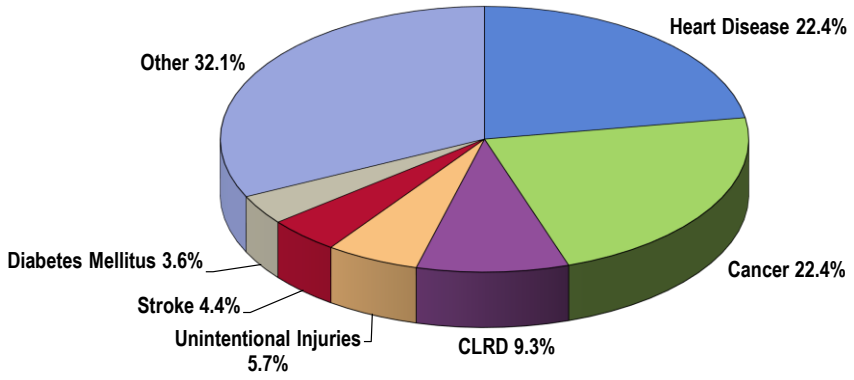
Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for approximately 45% of all deaths in the Primary Service Area between 2015 and 2017.

Leading Causes of Death
(Primary 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, Kentucky, 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 Primary Service Area.

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

Age-Adjusted Death Rates for Selected Causes

(2015-2017 Deaths per 100,000 Population)

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

	PSA	IN	KY	US	HP2020
Diseases of the Heart	224.5	182	198.9	166.3	156.9*
Malignant Neoplasms (Cancers)	193.5	172.9	191.8	155.6	161.4
Chronic Lower Respiratory Disease (CLRD)	72.9	55.1	65.0	41.9	n/a
Unintentional Injuries	61.5	52.7	70.0	46.7	36.4
Cerebrovascular Disease (Stroke)	43.6	39.6	40.2	37.5	34.8
Diabetes	34.6	26.5	28.1	21.3	20.5*
Intentional Self-Harm (Suicide)	24.1	15.4	16.9	13.6	10.2
Motor Vehicle Deaths	20.3	12.3	17.9	11.4	12.4
Firearm-Related	19.3	14.3	16.3	11.6	9.3
Unintentional Drug-Related Deaths	19.1	21.4	30.9	16.7	11.3
Kidney Disease	19.0	18.6	19.8	13.2	n/a
Alzheimer's Disease	18.8	34.4	35.0	30.2	n/a
Pneumonia/Influenza	17.4	13.4	18.2	14.3	n/a
Cirrhosis/Liver Disease	14.1	11.4	12.4	10.8	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.

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

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

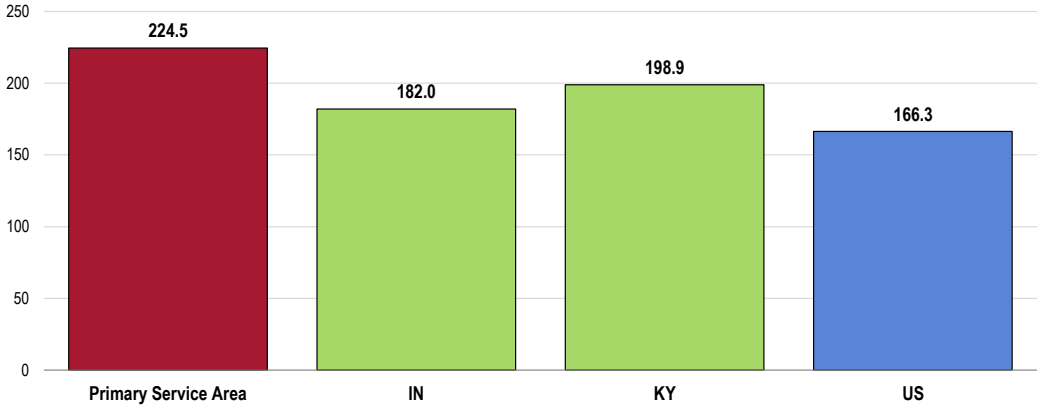
Between 2015 and 2017, there was an annual average age-adjusted heart disease mortality rate of 224.5 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Statistically above the Indiana and US rates; far from satisfying the related Healthy People 2020 objective.

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.

Stroke Deaths

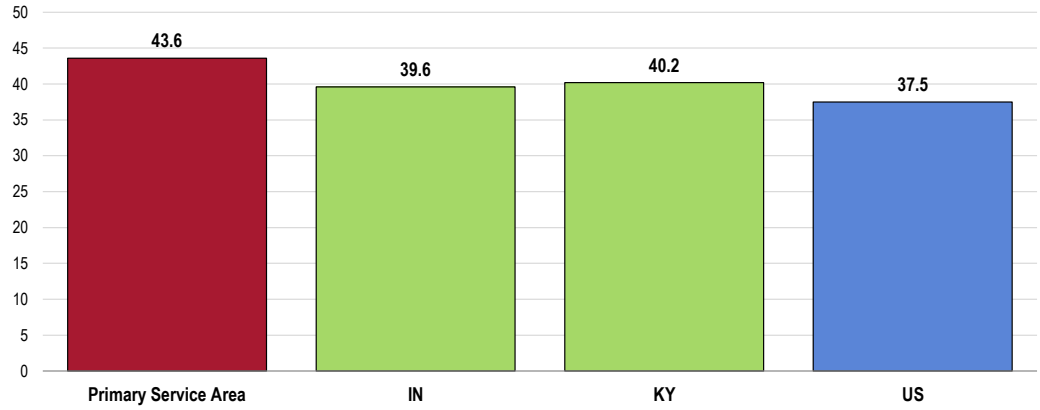
Between 2015 and 2017, there was an annual average age-adjusted stroke mortality rate of 43.6 deaths per 100,000 population in the Primary Service Area.

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

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]

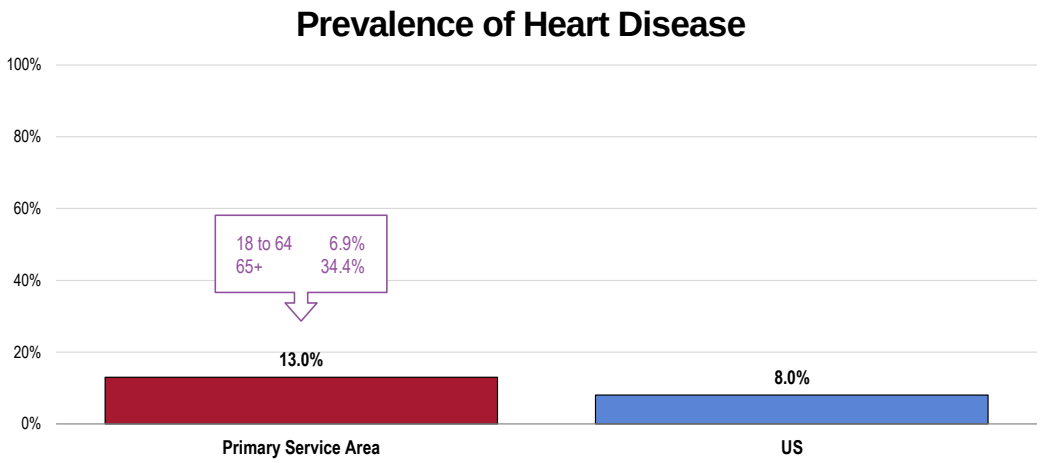
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 13.0% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

- **BENCHMARK**: Significantly higher than the national proportion.
- **DISPARITY**: Significantly higher among older adults.



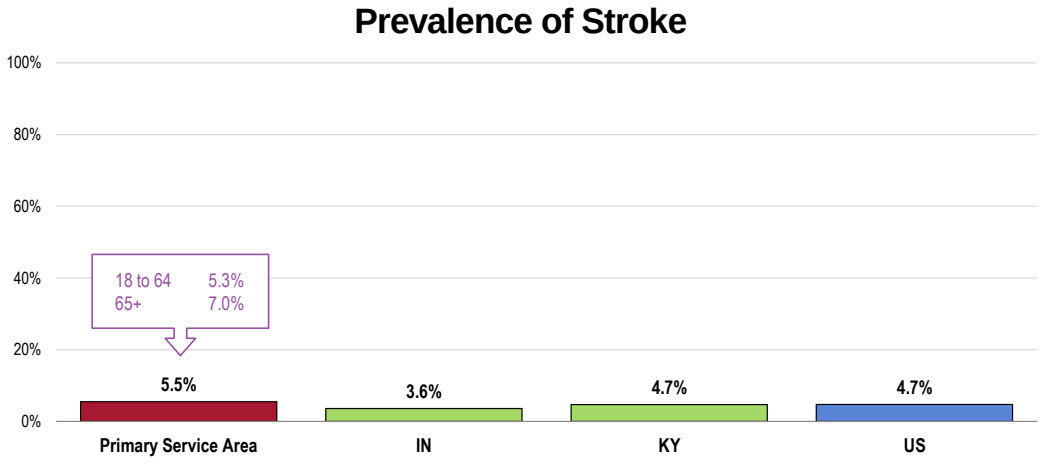
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 128]
- 2017 PRC National Health Survey, PRC, Inc.

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

Prevalence of Stroke

A total of 5.5% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- **BENCHMARK**: No statistically significant differences to report.



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): 2017 Indiana & Kentucky 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)

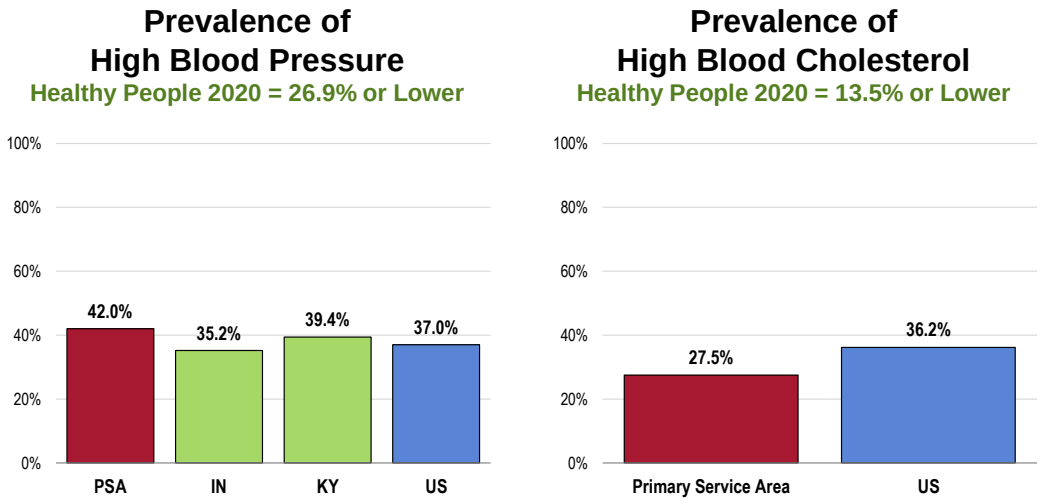
Blood Pressure & Cholesterol

A total of 42.0% of Primary Service Area adults have been told at some point that their blood pressure was high.

- **BENCHMARK**: Far from satisfying the related Healthy People 2020 objective.

A total of 27.5% of adults have been told by a health professional that their cholesterol level was high.

- **BENCHMARK**: More favorable than the national prevalence, though more than double the related Healthy People 2020 objective.



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 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 & Kentucky 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.

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

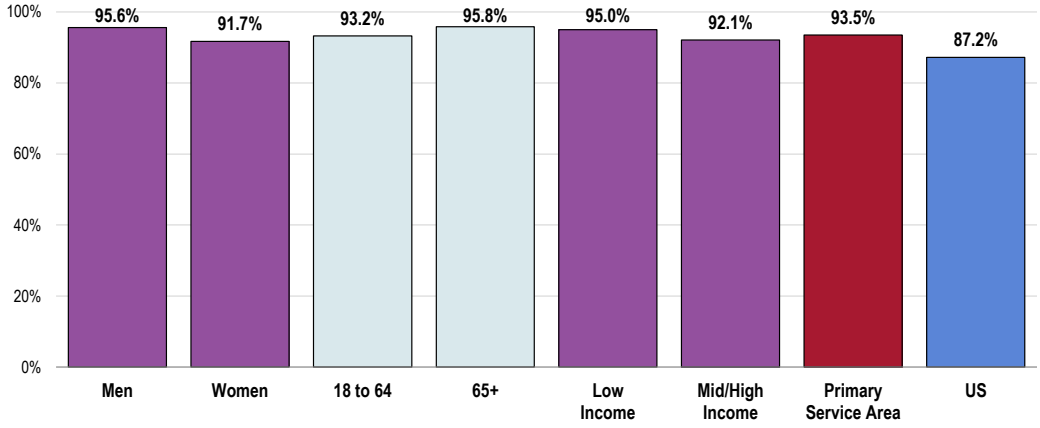
RELATED ISSUE:
See also *Nutrition*, *Physical Activity*, *Weight Status,* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

A total of 93.5% of Primary 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.

- **BENCHMARK**: Higher than the percentage found nationally.

Present One or More Cardiovascular Risks or Behaviors

(Primary Service Area, 2019)



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

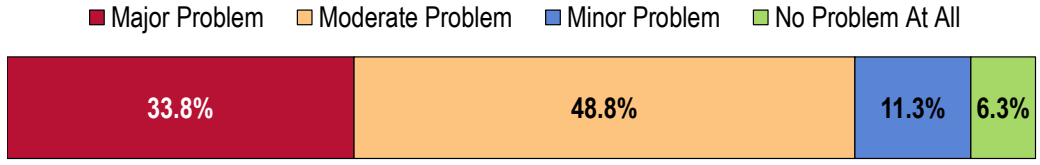
Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Income categories reflect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



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

> *Even young people are being affected by heart disease. Is there some underlying cause that is not being addressed. — Community Leader*
>
> *This is a chronic problem, and it is becoming more prevalent at a younger age. — Other Health Provider*
>
> *Heart disease and stroke affect many people in our community. — Community Leader*
>
> *I think heart disease and stroke impact many people. — Community Leader*

Because I have seen state statistics indicating this. — Community Leader

I see a lot of patients diagnosed with these problems. — Other Health Provider

Risk Factors

High levels of stress, addiction, and tobacco use contribute to this program. Lack of good paying jobs and affordable childcare contribute to stress and poor lifestyle choices that impact this problem. — Social Services Provider

Heredity, smoking, poor diet and minimal exercise. — Community Leader

Risk factors, poor access to care. — Public Health Representative

Poor health habits. — Physician

Access to Care/Services

Lack of wellness programs. Rural area and lots of smokers. Lack of education. Majority of residence here are lower socioeconomic status and cheaper foods tend to be the foods that are not good for us. — Other Health Provider

We do not have a cardiologist on staff 24/7. That is a major problem. — Community Leader

Not enough diagnosis/treatment facilities, i.e. surgeon. — Community Leader

Lifestyle

I believe the stroke and heart disease are linked to unhealthy lifestyles as well. Diet and exercise can help alleviate stress, which leads to stroke. — Community Leader

It was listed as a major problem in this area. I think overall health and habits plays a role. — Community Leader

Bad lifestyle habits including overweight, lack of exercise, and mainly poor diet and tobacco use. — Other Health Provider

Lack of Physical Activity

I believe heart disease and stroke are a problem in my community because there aren't many people getting outside to exercise, poor diet, and just not being informed of the causes and risk factors of the disease. — Community Leader

I believe that is because of an inactive lifestyle and the smoking problem. — Social Services Provider

Obesity

We have many people who are obese and smoke. We also have a major epidemic with methamphetamine and opioids. — Community Leader

Mainly because of the issues with obesity. It is not for lack of access to trails, sidewalks, etc. — Community Leader

Awareness/Education

Education, nutrition, lifestyle. — Other Health Provider

Cancer

About Cancer

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

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

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

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

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

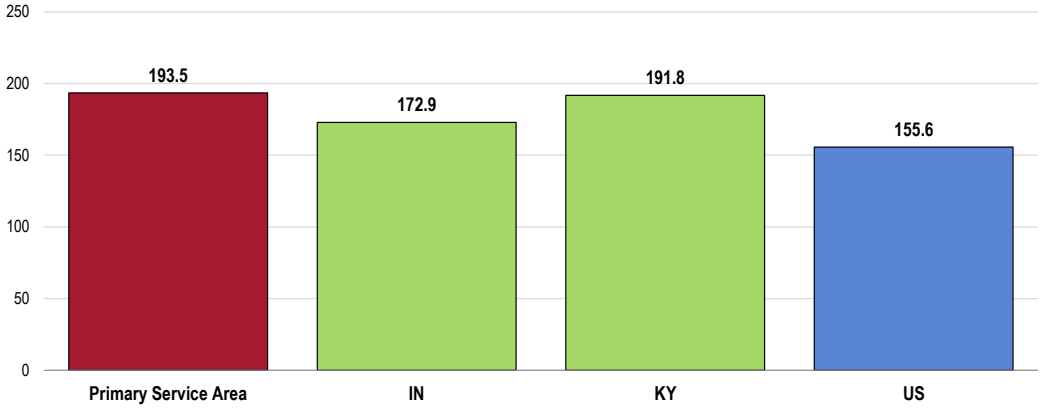
Between 2015 and 2017, there was an annual average age-adjusted cancer mortality rate of 193.5 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Above the US rate and the related Healthy People 2020 objective.

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.
- 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 Primary Service Area.

Other leading sites include breast cancer among women and colorectal cancer (both sexes).

BENCHMARKS: Based on 2015-2017 annual average age-adjusted cancer death rates by site, note the following unfavorable comparisons for the Primary Service Area:

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

Age-Adjusted Cancer Death Rates by Site

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

	PSA	IN	KY	US	HP2020
ALL CANCERS	193.5	172.9	191.8	155.6	161.4
Lung Cancer	64.8	48.8	60.5	38.5	45.5
Female Breast Cancer	20.7	20.7	21.4	20.1	20.7
Colorectal Cancer	23.0	15.4	16.8	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.

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

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

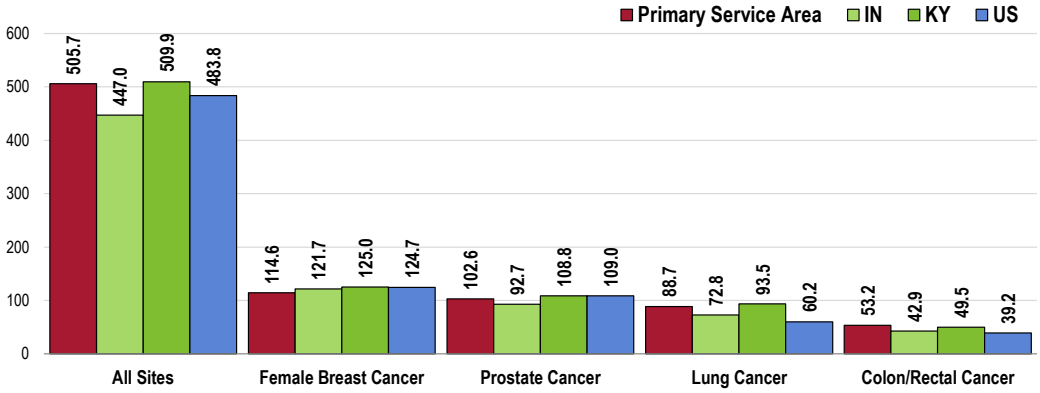
The highest cancer incidence rates are for breast cancer in women and prostate cancer in men.

BENCHMARKS: Based on 2015-2017 annual average incidence rates by site, note the following unfavorable comparisons for the Primary Service Area:

- **Lung Cancer**: Higher than the Indiana and national rates.
- **Colorectal Cancer**: Higher than the Indiana and national rates

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.

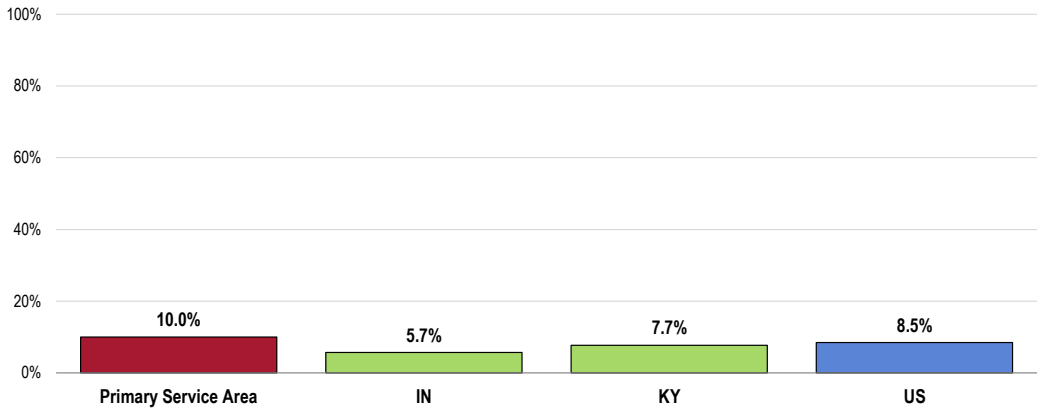
Prevalence of Cancer

Skin Cancer

One in 10 surveyed Primary Service Area adults (10.0%) report having been diagnosed with skin cancer.

- **BENCHMARK**: Statistically above the Indiana prevalence.

Prevalence of Skin Cancer



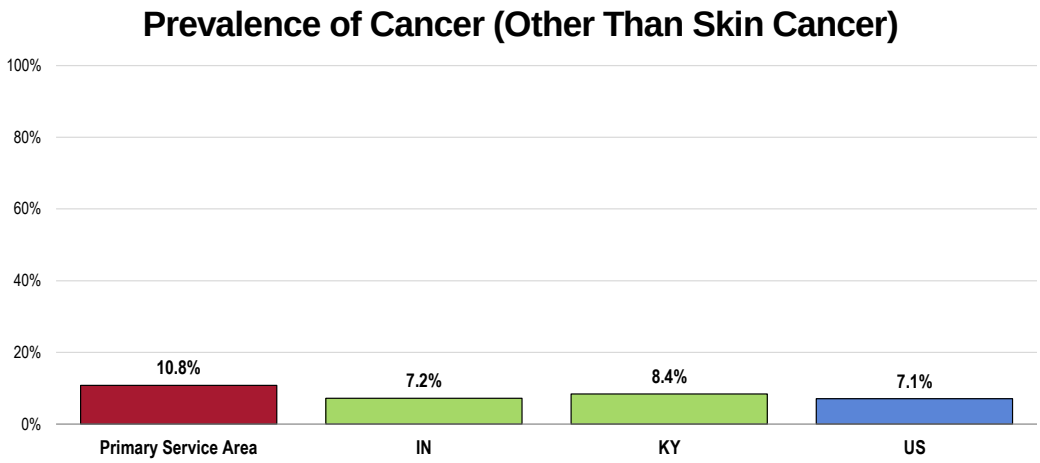
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 28]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health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

Notes:
- Asked of all respondents.

Other Cancers

A total of 10.8% of survey respondents have been diagnosed with some type of (non-skin) cancer.

- **BENCHMARK**: Not significantly different from state or national percentages.



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): 2017 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Risk

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

About Cancer Risk

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

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

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

Cancer Screenings

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

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

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 women age 50-74, 65.6% have had a mammogram within the past 2 years.

- **BENCHMARK**: Statistically below Kentucky and national screening levels; fails to satisfy the Healthy People 2020 objective.

Among Primary Service Area women age 21 to 65, 66.9% have had a Pap smear within the past 3 years.

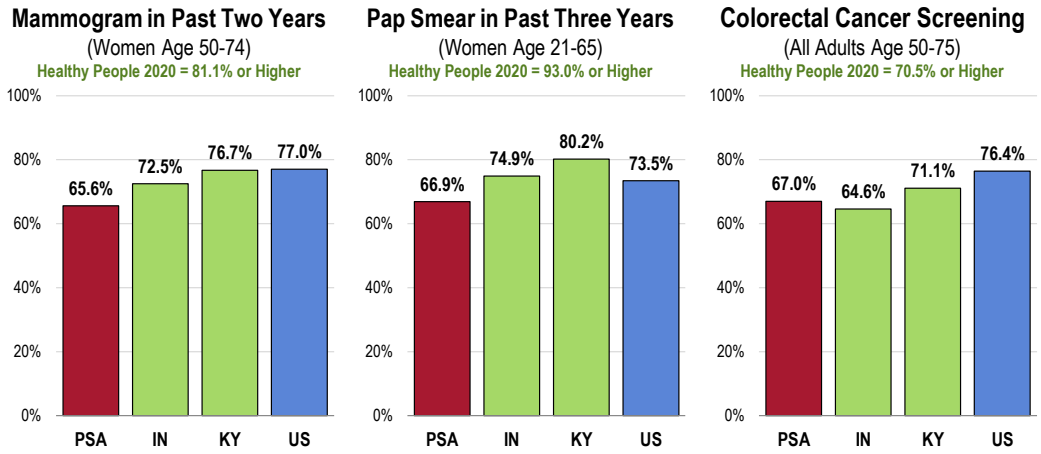
- **BENCHMARK**: Statistically below the Kentucky proportion; far from satisfying the Healthy People 2020 objective.

Among all adults age 50-75, 67.0% have had appropriate colorectal cancer screening.

- **BENCHMARK**: Statistically below the national proportion.

"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.

Cancer Screenings



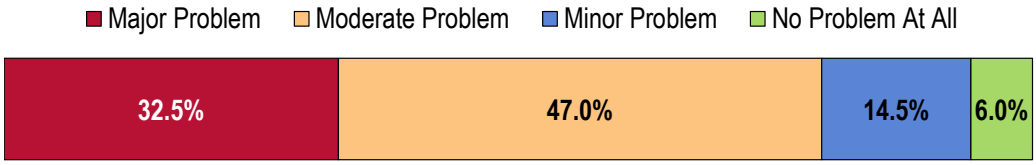
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 133, 134, 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Indiana & Kentucky data.
- 2017 PRC National 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.

Key Informant Input: Cancer

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

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

> *Very prevalent in our communities. Almost every family I know or have contact with has dealt with a close family member who is either fighting cancer or has died of cancer. — Social Services Provider*
>
> *I believe the Ohio Valley has a high cancer rate and may be linked to industry in our area. — Other Health Provider*

I believe it is a major problem everywhere. I know there is research being done every day to cure this issue, but I hope we can find a cure in our lifetime. I know that we have some resources in our community now, but still believe on more serious issues it would need to be handled in other places. I hope we can investigate locally what may be causing cancer issues in our region or area. — Community Leader

It appears Jefferson County has a high population with cancer diagnoses. — Public Health Representative

All families seem to have at least one member- and some have multiple- affected by this disease. — Community Leader

There are so many people in our community with cancer, it is widespread. — Community Leader

Prevalence of cancer is unreal. It's not IF you get it, it's WHEN. — Community Leader

Too many new cases reported. — Community Leader

There are many with the disease. — Community Leader

Risk Factors

I believe cancer is a major problem because of the consumption of unhealthy foods. There is also a lack of access to healthy foods. It seems to be a lifestyle passed down through generations. But, cancer is an issue throughout the US. — Community Leader

High incidence of smokers. Also adults, especially women, not getting yearly health evaluations. — Physician

Unhealthy lifestyles. Environment, power plants/chemical plants on the Ohio River. Aging population. — Other Health Provider

Genetics, limited access to healthy foods, limited access to treatment. — Community Leader

Risk factors are high. — Physician

Environmental Contributors

Concern about industry leaving toxins in the air, causing a higher percentage of breast cancer. Further, high use of tobacco products and Ohio Valley weather leading to pulmonary issues, such as lung cancer. — Community Leader

I see many people with cancer annually in my job. I feel having the power plant here and so close to Switzerland County in Kentucky, are major factors in the amount of cancer. — Other Health Provider

Due to environmental issues and genetics, cancer is prevalent in most families. — Social Services Provider

I believe cancer is a major problem in my community because there are many different environmental, and human-caused factors in the area that can contribute to the development of mutated (cancer) cells. There are also many behavioral factors that could contribute as well, such as addictive personality. — Community Leader

Access to Care/Services

Limited access to cancer treatment. Limited transportation. — Community Leader

Diagnosis/Treatment

Late diagnosis, poor access to care, many risk factors. — Public Health Representative

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)

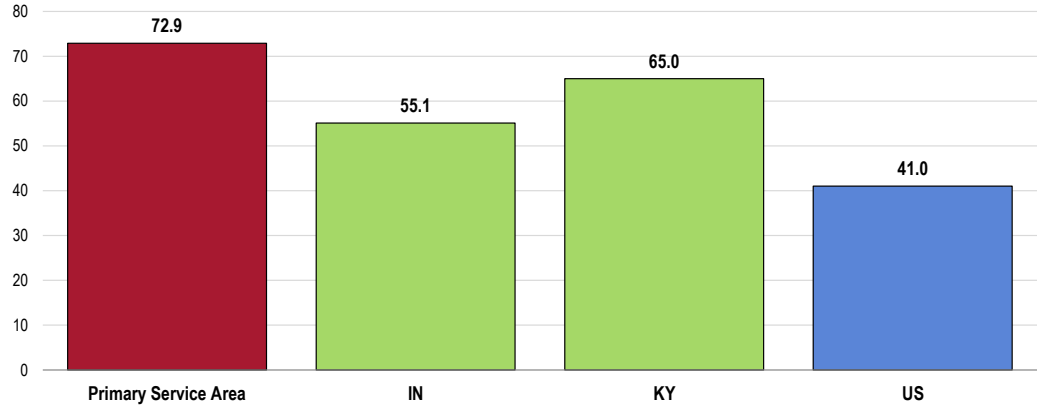
Note: Chronic lower respiratory disease (CLRD) includes lung diseases such as emphysema, chronic bronchitis, and asthma.

Between 2015 and 2017, there was an annual average age-adjusted CLRD mortality rate of 72.9 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Significantly above the Indiana and US rates.

CLRD: Age-Adjusted Mortality

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



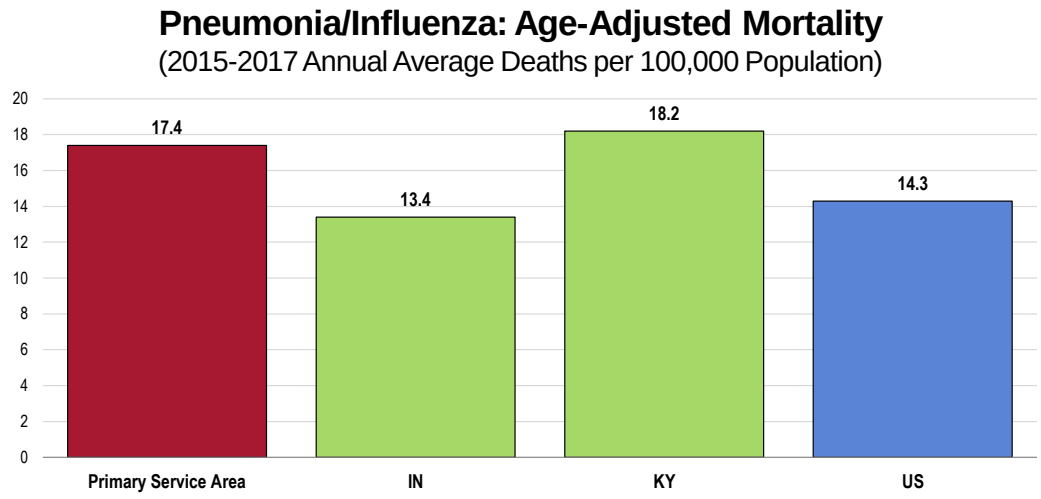
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.

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.

Pneumonia/Influenza Deaths

Between 2015 and 2017, the Primary Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 17.4 deaths per 100,000 population.

- **BENCHMARK**: Significantly above the Indiana and US rates.



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)

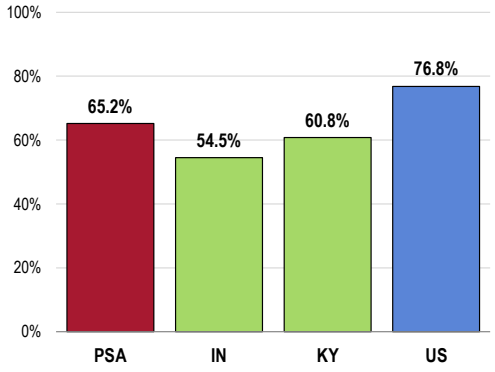
Among Primary Service Area adults age 65 and older, 65.2% received a flu vaccination within the past year.

- **BENCHMARK**: No significant differences to report.

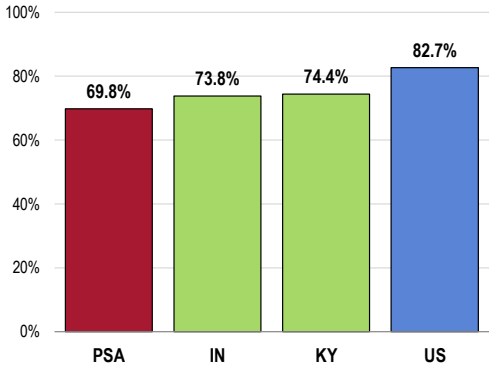
Among Primary Service Area adults age 65 and older, 69.8% have received a pneumonia vaccination at some point in their lives.

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

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): 2017 Indiana & Kentucky 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

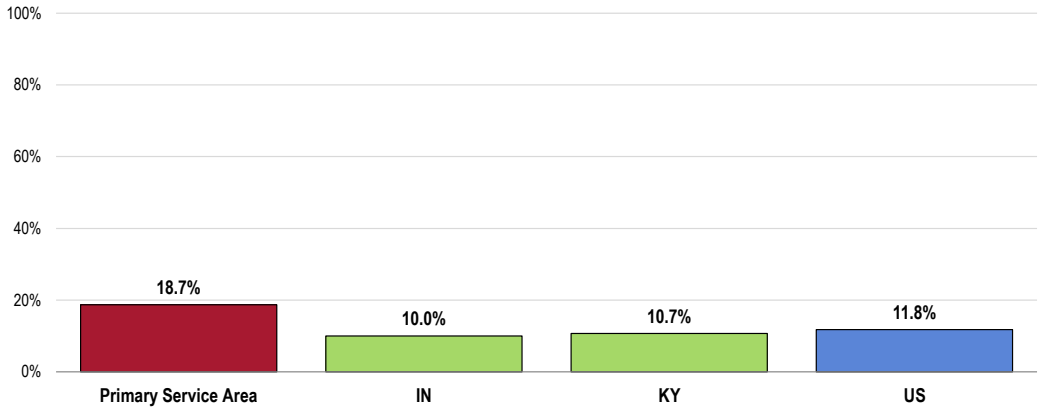
Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

.

A total of 18.7% of Primary Service Area adults currently suffer from asthma.

- **BENCHMARK**: Above state and national percentages.
- **DISPARITY**: More prevalent among low-income residents.

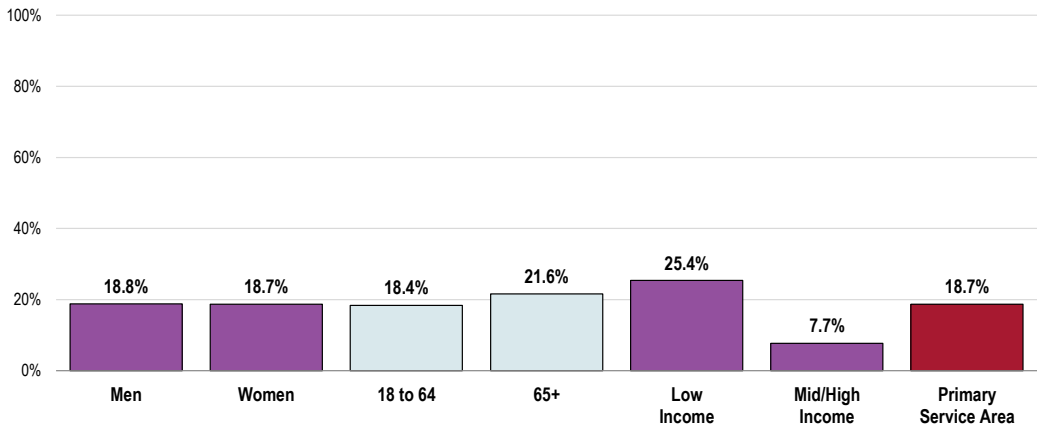
Prevalence of Asthma



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): 2017 Indiana & Kentucky 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
(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 138]

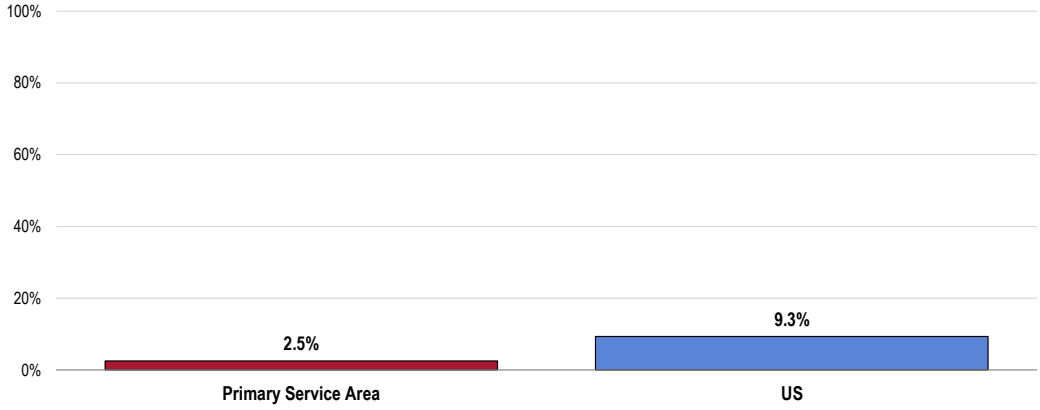
Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with 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 Primary Service Area children under age 18, 2.5% currently have asthma.

- **BENCHMARK**: Significantly below the national finding.

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.

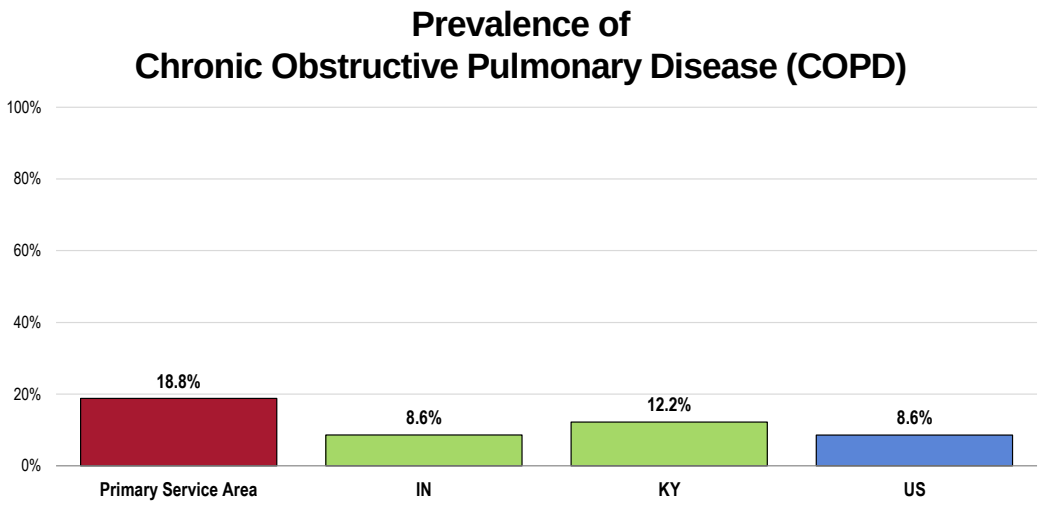
Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

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

A total of 18.8% of Primary Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- **BENCHMARK**: Significantly above state and national proportions.

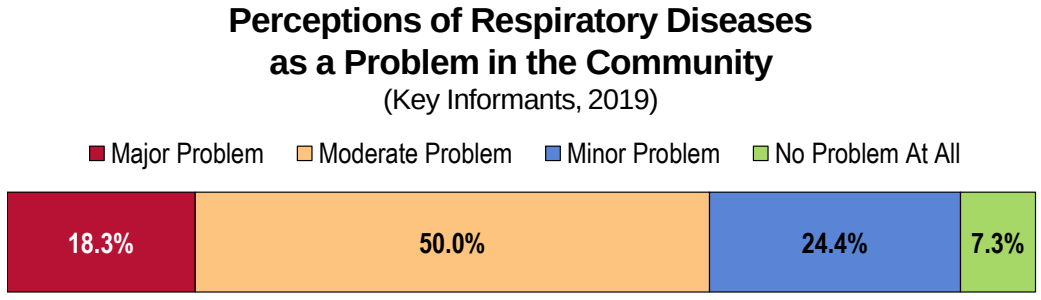


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

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



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:

Environmental Contributors

Living on the Ohio River and near power plants, makes the air not as healthy as some places. It is humid throughout the summer months making it hard for people with COPD. Being a farming community, a lot of people either smoke or used to smoke. — Other Health Provider

I believe respiratory diseases are a problem in my community because of pollution from factories, the geography of the area, and the weather in the area. — Community Leader

We live in the River Valley. Smoking and substance abuse. — Community Leader

Because we live in the Ohio River Valley. — Community Leader

Pollution and smoking. — Community Leader

Ohio Valley. — Other Health Provider

Tobacco Use

Cigarettes, drugs, e-cigarettes/vaping all add to respiratory issues. People with COPD, difficulties breathing, weight issues, smoking/oxygen incidents. — Social Services Provider

[Smoking and obesity are] why we have respiratory problems in our community. — Community Leader

Tobacco use rate is very high. Lack of exercise. Poor air quality. — Other Health Provider

Aging Population

Aging population and the area environment play a major role in this problem. — Other Health Provider

Disease Management

COPD is a disease that is hard to manage at home and causes re-hospitalization. Medications are difficult for patients to purchase. — Other Health Provider

Lack of Physical Activity

Lack of exercise, environment and smoking or history of smoking. — Community Leader

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

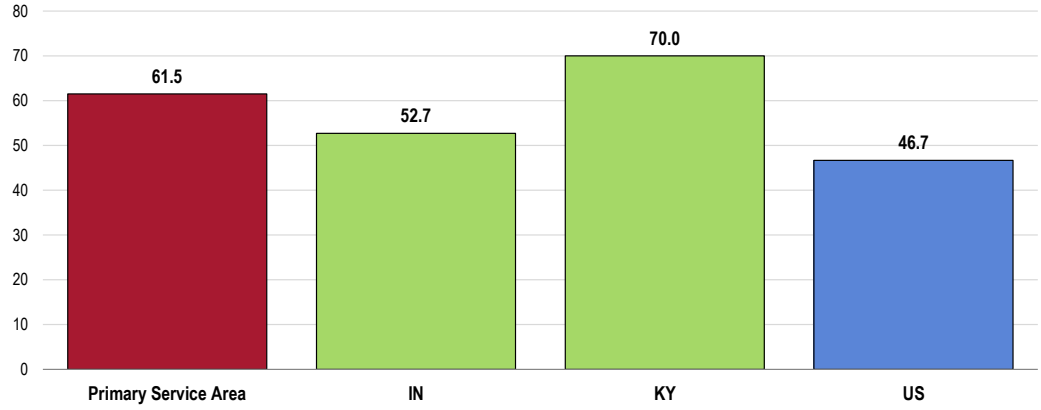
Between 2015 and 2017, there was an annual average age-adjusted unintentional injury mortality rate of 61.5 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Significantly above the US finding. Far from satisfying the related Healthy People 2020 objective.

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.

Leading Causes of Unintentional Injury Deaths

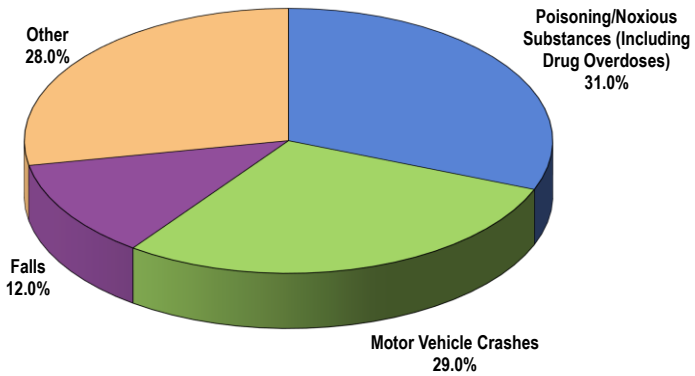
RELATED ISSUE:

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

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

Leading Causes of Unintentional Injury Deaths

(Primary 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).

Violent Crime

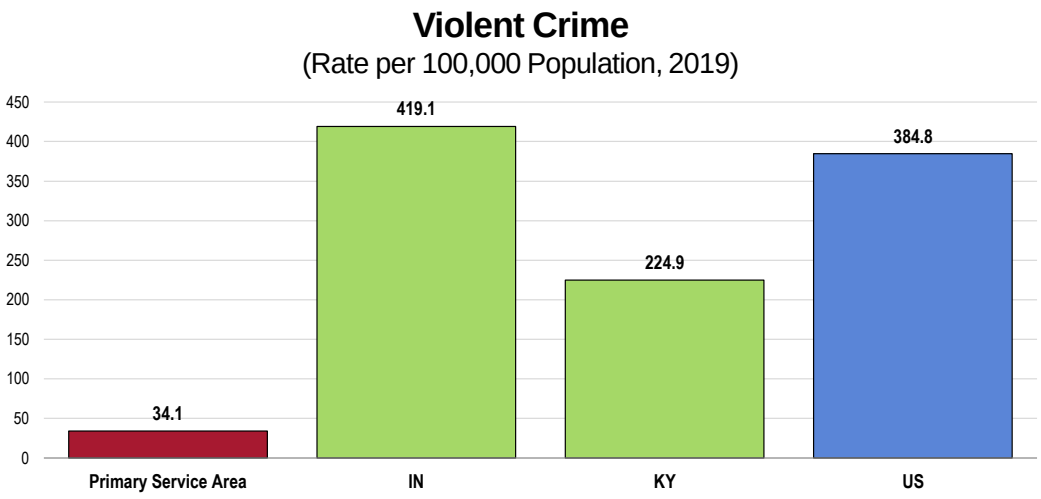
Violent Crime Rates

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

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

In 2019, there were a reported 34.1 violent crimes per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Notably lower than the state and national rates.



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.

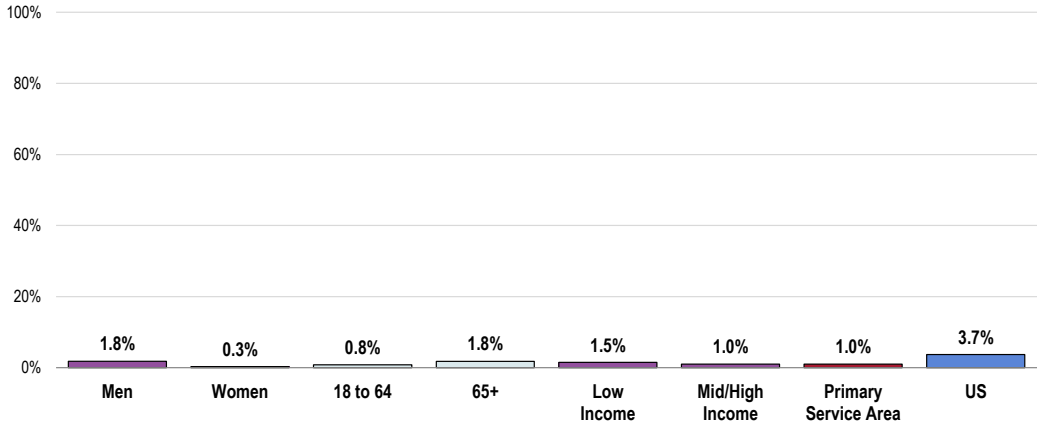
Community Violence

A total of 1.0% of surveyed Primary Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

- **BENCHMARK**: Statistically more favorable than the national proportion.

Victim of a Violent Crime in the Past Five Years

(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 46]
- 2017 PRC National Health Survey, PRC, Inc.

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

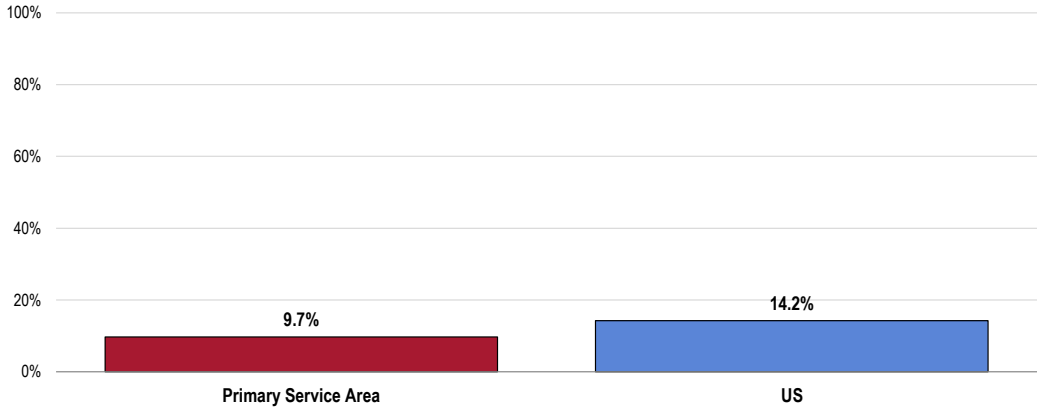
A total of 9.7% of Primary Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

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."

- **BENCHMARK**: Statistically similar to the US percentage.

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.

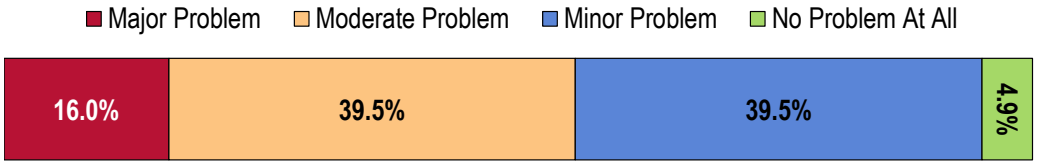
Notes:
- Asked of all respondents.

Key Informant Input: Injury & Violence

Key informants taking part in an online survey characterized *Injury & Violence* as a "moderate problem" equally as often 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:

Alcohol/Drug Abuse

Increase drug problem is affecting this issue. — Other Health Provider

We have a lot of substance abuse and poverty. — Community Leader

Simply based around the drug use in our community. — Community Leader

Domestic Violence

Domestic violence has become an increasing issue in our community. The amount of substance abuse and addiction problems in our community, as well as the number of people who are living in high-stress situations creates more violence, aggression, domestic violence, and "survival mode" behaviors. — Social Services Provider

I believe that violence is a major problem because of the number of injuries caused by domestic disturbances that involve substance abuse. Substance abuse is a huge concern for our area. — Community Leader

Much domestic abuse, may be caused by poverty and drug abuse. — Community Leader

Mental Illness

Our community has recently a history of suicide and suicide attempts. There are articles in the paper regarding domestic abuse. A horrible recent story was that of a 5-year-old who was sexually assaulted by the man her mom lives with and the mom was late to an appointment for the 5-year-old because the 12-year-old sister thought she may have been impregnated by the same man. Also, violence is part of the fall out of substance abuse, of which there is a problem in this county. — Community Leader

Mental Illness, substance abuse, community culture of tolerated incivility. — Other Health Provider

Access to Care/Services

Limited resources available. — Social Services Provider

Prevalence/Incidence

The increasing incidence. — Other Health Provider

Diabetes

About Diabetes

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

Diabetes mellitus:

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

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

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

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

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

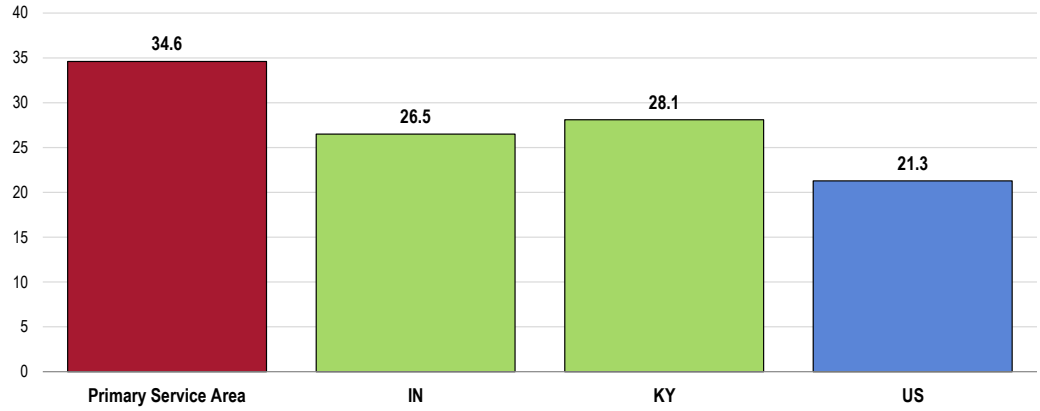
Between 2015 and 2017, there was an annual average age-adjusted diabetes mortality rate of 34.6 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Statistically higher than state and national rates; fails to satisfy the related Healthy People 2020 objective.

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]

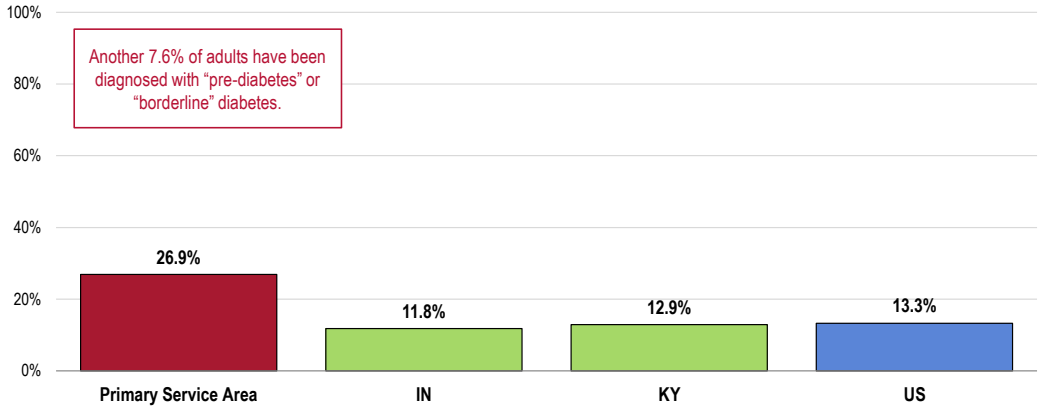
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

A total of 26.9% of Primary Service Area adults report having been diagnosed with diabetes.

- **BENCHMARK**: More than double the state and national percentages.
- **DISPARITY**: Low-income residents report a particularly high prevalence.

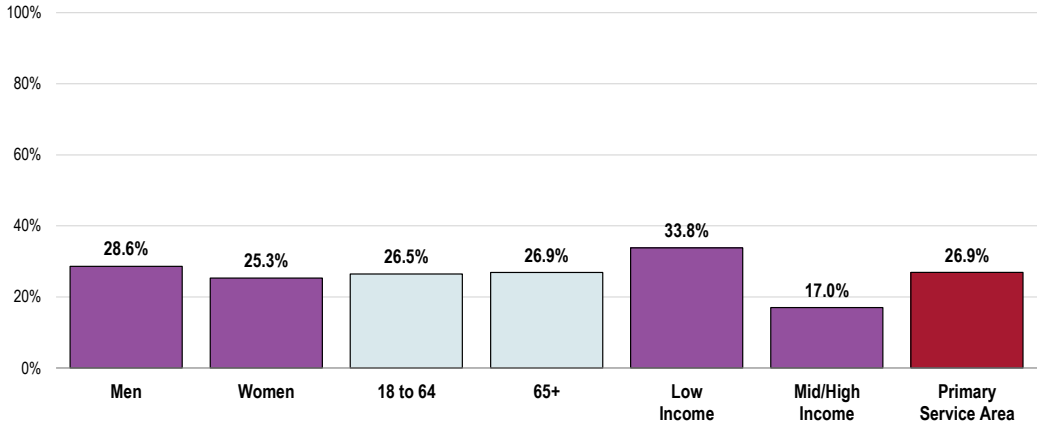
Prevalence of Diabetes



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): 2017 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(Primary Service Area, 2019)

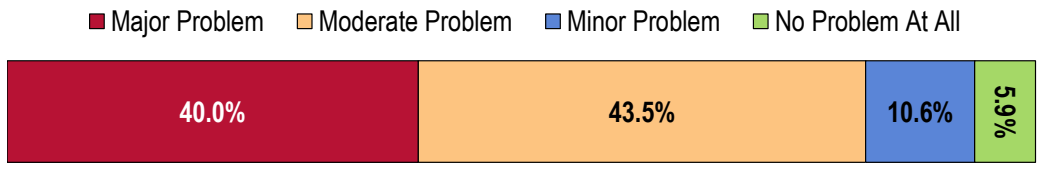


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal 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

Key informants taking part in an online survey characterized *Diabetes* as a "moderate problem" slightly more often than a "major problem" in the community.

Perceptions of Diabetes 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:

Awareness/Education

> *I think the lack of education about living with diabetes and the lack of affordable healthy food is the biggest issue here. However, I want to say that even though people lack the education and the healthy food, it is available. I know Purdue Extension Office offers a "living with diabetes" class. But it is not attended nearly as well as it should be. I think sometimes people are willfully ignorant. — Community Leader*
>
> *Seeking help and becoming educated on dealing with diabetes. — Community Leader*
>
> *Usually just go to their family doctor and that's all they know. — Community Leader*

Education and medications and supplies. — Physician

No one to teach. — Other Health Provider

Nutrition/Access to Healthy Food

Eating well and exercise. The area also has a low educational attainment rate, which is also a hindrance. The lack of a downtown grocery story in Madison with fresh fruits and vegetables would be another challenge, as well as for the outlying areas. The hospital has a diabetes center and nutritionists available, which is very helpful. — Community Leader

Access to affordable, healthy food, education on how to manage diabetes, poverty impacts a persons ability to eat right. No cheap fast food choices that are healthy. — Social Services Provider

The access to the nutritional food needed for the diet. — Community Leader

I know many people with diabetes, and the options for healthy restaurants in this area are limited. Overall health and diet is a challenge in this community. — Community Leader

Poor eating habits and obesity. — Other Health Provider

Access to Medications/Supplies

The cost of diabetes medications and supplies are costly, and the majority of our community has insufficient resources to cover the cost. — Other Health Provider

The cost of medications and insulin. — Community Leader

Obtaining medications and supplies to help manage their disease. — Other Health Provider

Paying for medication and support programs. — Community Leader

Disease Management

Challenge for people with diabetes includes ability to follow an appropriate diet. I read about the increase price of insulin. I know many people who have diabetes, who don't seem to be able to make healthy choices and having medical issues related to diabetes. — Social Services Provider

Poor compliance with preventative measures, especially diet and exercise. — Other Health Provider

Level of compliance with treatment. — Other Health Provider

Patient engagement to adhere to plan of care to manage their diabetes. — Other Health Provider

Lifestyle

Once again, the biggest challenge for people with diabetes is an unhealthy lifestyle, particularly with food consumption and lack of exercise. Also, the lack of and the cost of healthy food choices. But, mostly the lack of desire to change. — Community Leader

Junk food diets, obesity, and physical inactivity. These all stem from mindset from youth. Youth need to be targeted. — Physician

Sticking to a diet and exercise program. Testing their blood sugars properly and promptly. Being able to afford their insulin. — Other Health Provider

Obesity

We have great part of our community that is obese. — Social Services Provider

Obesity and poor nutrition. — Community Leader

Obesity and lack of physical activity. — Physician

Access to Care/Services

Access to care, poor diet and somewhat of a food desert. — Public Health Representative

Access to medical care in emergency situations. — Community Leader

Cost is a barrier to access. — Community Leader

Prevalence/Incidence

Many people in Madison suffer from diabetes. I see it all the time when I'm out in town and am concerned about their wellbeing. — Community Leader

Lack of Physical Activity

Besides Madison's downtown, the rest of the community isn't very walkable. We have too many residents overweight with Type 2 diabetes. — Community Leader

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.

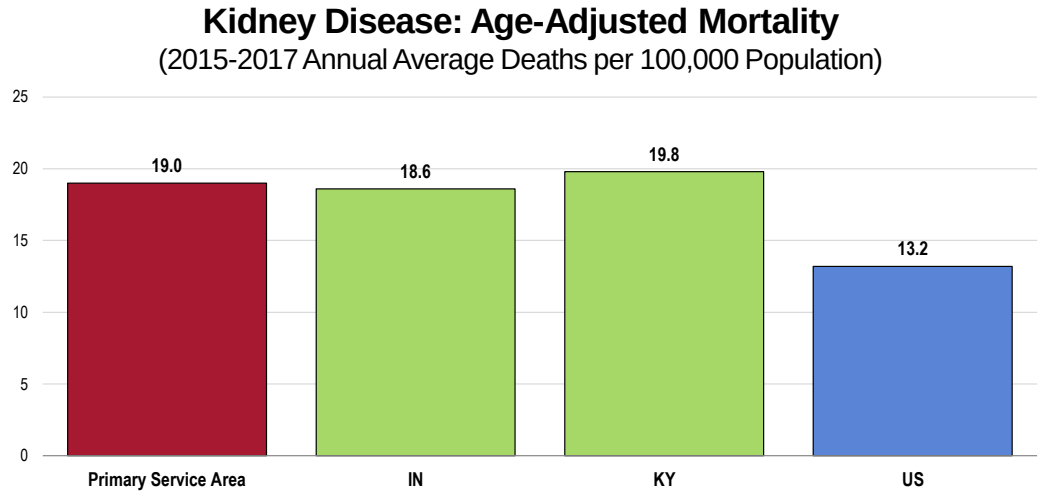
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes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

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2015 and 2017, there was an annual average age-adjusted kidney disease mortality rate of 19.0 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Significantly above the national rate.



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.

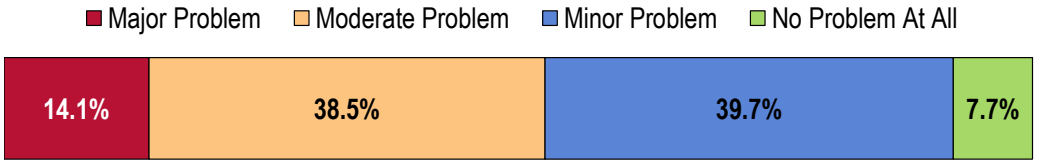
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Kidney Disease

Key informants taking part in an online survey characterized *Kidney Disease* as a "minor problem" slightly more often than a "moderate problem" in the community.

Perceptions of Kidney 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:

Access to Care/Services

We need a kidney and renal specialist on staff. — Community Leader

Our dialysis centers are full. We sometimes have to transfer people to other facilities for renal problems. — Other Health Provider

There is only part-time medical coverage at KDH through First Urology, and this creates an exodus to other communities for healthcare. — Community Leader

Lifestyle

I feel the majority of people eat what they want, when they want. This is a huge stress on vital organs. When people get diabetes mellitus, this just adds to the renal issues. — Other Health Provider

Lifestyle, which increases incidence of high blood pressure and diabetes. — Other Health Provider

Prevalence/Incidence

I say this because the parking lot at dialysis is always full and I hear many families I work with talk about this disease. — Social Services Provider

Many people in our community are receiving dialysis. I see this getting worse in the future with all the drug use. — Other Health Provider

Comorbidities

Due to a lot of chronic health issues. Deficiency of wellness programs in rural areas. — Other Health Provider

Potentially Disabling Conditions

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.

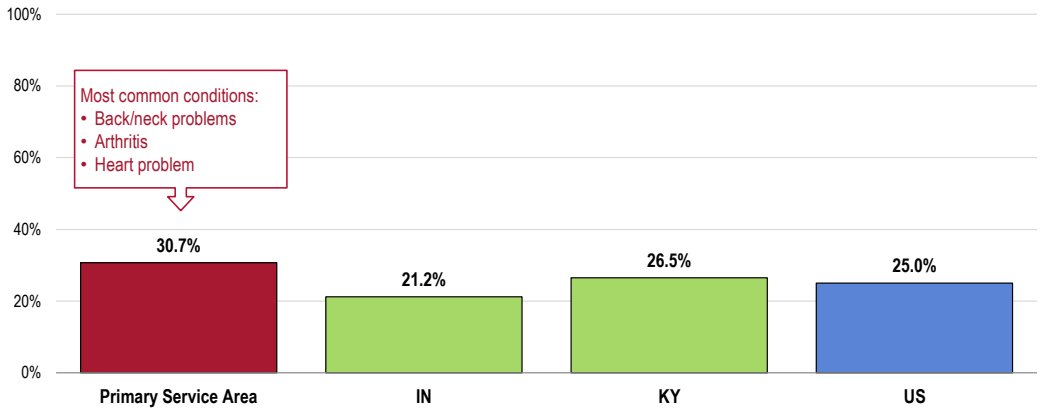
- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **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 30.7% of Primary Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

- **BENCHMARK**: Statistically higher than the Indiana prevalence.
- **DISPARITY**: This prevalence is higher among low-income residents.

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

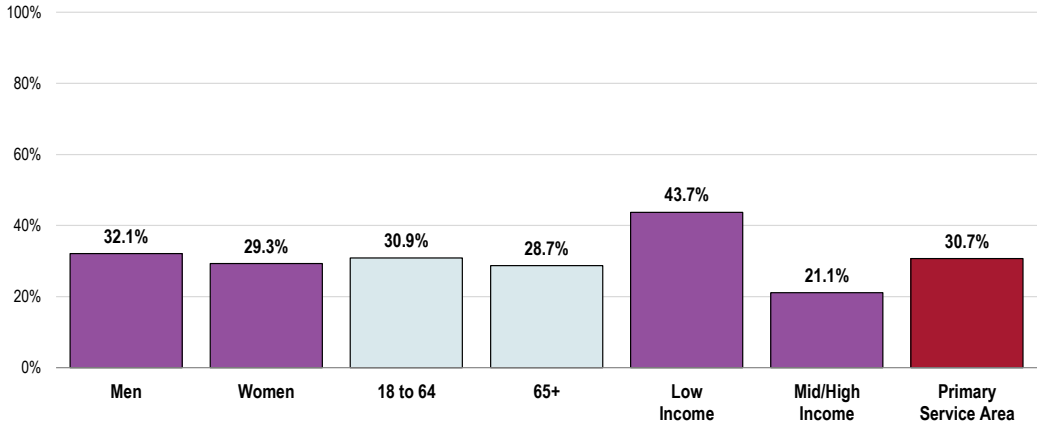


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 109-110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

(Primary 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.

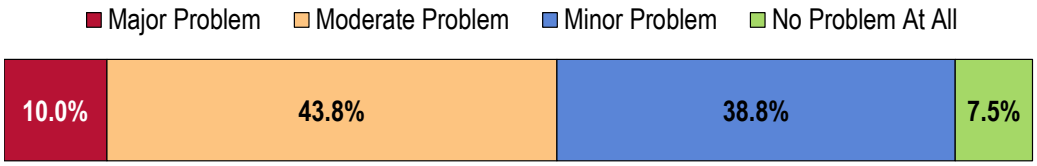
— Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

Key informants taking part in an online survey most often characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a "moderate 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

> *Many individuals in the community suffer from back problems, and many of these are on disability for issues that contribute to back problems. — Community Leader*
>
> *As a home health nurse, I see many joint replacements. Many clients are overweight and never exercise, putting undue stress on joints. — Other Health Provider*
>
> *Lots of people have back problems. — Community Leader*

Access to Care/Services

> *The wait time to get an appointment to see a physician in this area is sometimes over a month. The community has only one orthopedic physician, and most people do not want to have follow-up or diagnostic treatment by a nurse practitioner. One physician to cover several counties is not enough. — Community Leader*

Aging Population

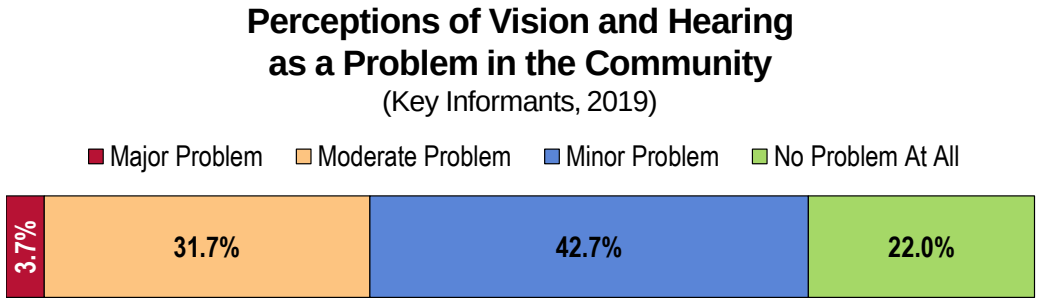
> *It seems that most people over 55 have significant back problems. There are a very large number of joint replacements. — Physician*

Alcohol/Drug Abuse

> *I believe the back injuries started as a way to seek opioids from their physicians, and now we have a substance abuse problem in the community with lots of people on disability for back issues. — Other Health Provider*

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.



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

> *Those with disabilities do not have a lot of services available in the community or programs they can attend. — Community Leader*

Awareness/Education

> *I believe they are a problem in my community because people aren't well informed on how to take care of their ears and eyes. They are also not well-informed in what the causes of poor vision and hearing loss are. — 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.

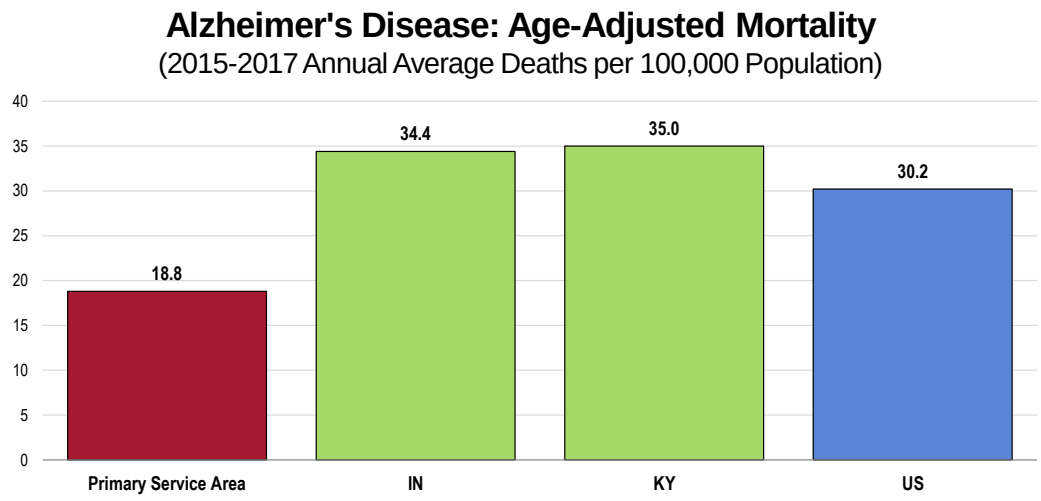
Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat 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 18.8 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Significantly below the state and national rates.

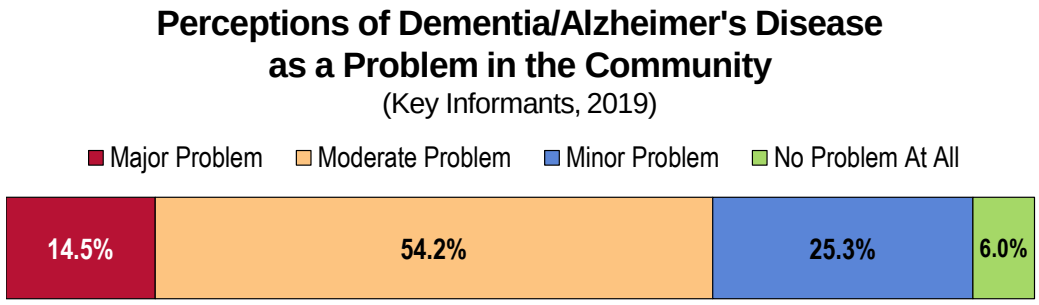


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2019.

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

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



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:

Impact on Families/Caregivers

I think this impacts many people in their families as they attempt to provide elder care to their loved ones. However, resources, understanding, and the financial burden of this task really takes a toll on families. — Community Leader

Dementia and Alzheimer's disease affects not just the individuals suffering, but also their families. Our community has a high prevalence. — Community Leader

I talk to a lot of adults taking care of their elderly family members who have these diseases. — Social Services Provider

Need support groups for families. — Community Leader

Access to Care/Services

You cannot get in to see a Neurologist locally; patients have to wait weeks to months to be seen. — Other Health Provider

I don't know of any physician or facility who specializes in dementia or Alzheimer's. — Community Leader

Lack of treatment. A nursing care facility is a long-term solution. There is no care for the family nor the individual to receive help. — Community Leader

Aging Population

In our community, there is a considerable population of individuals in the age range related to this terrible disease. I have no idea why it is a major problem, but it is. — Community Leader

We have a major aging community. — Social Services Provider

Prevalence/Incidence

In my context, I have known many people with dementia. It seems to affect a number of people, and the resources are limited. — Community Leader

I have encountered many families who have a loved on affected by this disease. We also have clients who seem to be affected and have no one to advocate on their behalf. — Community Leader

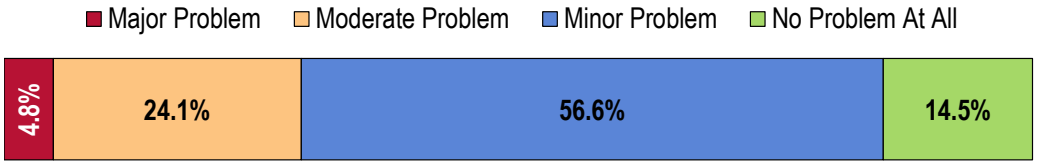
Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

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

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 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

> *We do not have easily accessible services or good advertising, so that those in need know where to go. — Community Leader*

Affordable Care/Services

> *Immunization is expensive, and we have a significant population needing health insurance. — Community Leader*

Births

Birth Outcomes & Risks

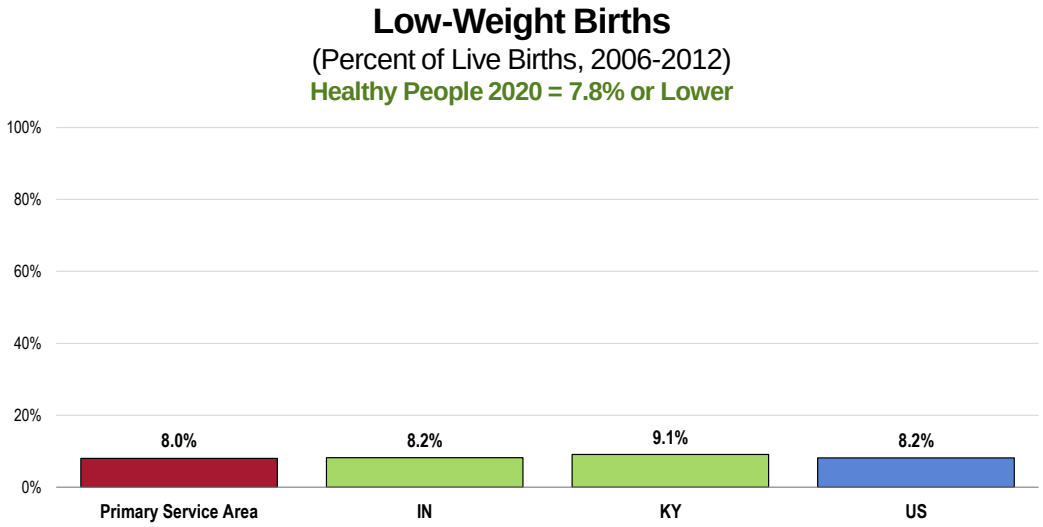
Low-Weight Births

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

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

A total of 8.0% of 2006-2012 Primary Service Area births were low-weight.

- **BENCHMARK**: Statistically similar to state and national percentages.



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.

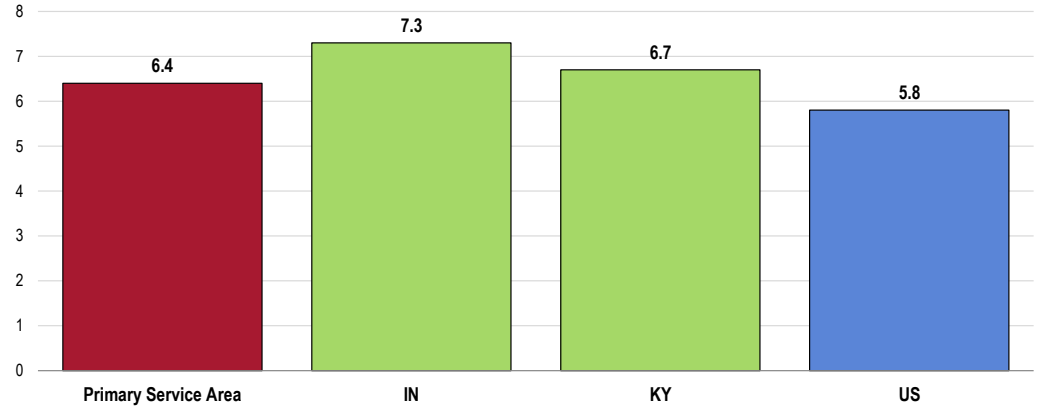
Between 2015 and 2017, there was an annual average of 6.4 infant deaths per 1,000 live births.

- **BENCHMARK**: No significant differences to report.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2015-2017)

Healthy People 2020 = 6.0 or Lower



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]

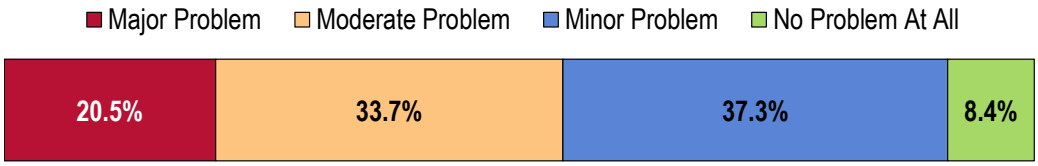
Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Key Informant Input: Infant & Child Health

Key informants taking part in an online survey characterized *Infant & Child Health* as a "minor problem" slightly more often than a "moderate problem" in the community.

Perceptions of Infant and Child 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:

Substance Use During Pregnancy

> *Because too many children start out life unhealthy when their mother is on drugs. We have too many children with rotten teeth. Too many obese children. Too many expectant mothers smoking during their pregnancies. All of this will catch up to these children. Who knows what the long-term effects of being born addicted to drugs is? — Community Leader*
>
> *A large percentage of children are born with drugs in their system. CHINS cases in Jefferson County have drastically increased over the past few years. — Community Leader*

[Smoking during pregnancy] leads to children who may be born underweight or have other health issues. There are also a number of expected mothers who are doing drugs during the development of their child. Some babies have to be detoxed before they can even go home. — Community Leader

Rate of infant/child health problems, especially related to substance abuse. — Community Leader

We have a lot of infants born drug-addicted. — Community Leader

There are a high number of infants born that are drug-exposed. — Community Leader

We have babies born addicted to meth and opioids. — Community Leader

Prevalence/Incidence

I think developmental delays is also a major issue in our community, and resources are limited. — Community Leader

Neonatal Abstinence Syndrome, because I would estimate a quarter of all babies born in our community have been exposed to some illicit substance one or more times while in utero. — Other Health Provider

In terms of the work we do within the public school setting, the number of young children in need of services is increasing in number and intensity. — Social Services Provider

Affordable Care/Services

We see many families who cannot afford to take their child to the doctor (who don't have transportation or in some cases), who do not bother to take their children to the doctor. These families need to have access to care and need to understand when healthcare may be to crucial to the life of the infant or child. Getting into a clinic or getting and established health care provider is difficult in our rural community. — Community Leader

Affordable health insurance is a problem in our community, and many parents do not take their children for well checks, or have the money for healthy meals, or have adequate childcare resources. — Community Leader

Child Abuse

Child abuse and neglect is a serious issue in our community. Many of the services available to our children through the system are inefficient and not at all based on outcomes, but rather looking at a checklist as to if a service is done or not- never at how efficient it is or if it's helping. — Social Services Provider

The increasing incidence of abuse is sickening, and this community must take an unfavorable stand to deal with these monsters. — Other Health Provider

Access to Care/Services

Only one hospital in the area with limited resources for infant and child health. Also, few pediatric doctors. — Community Leader

Poor Parenting

I know that parenting has gone downhill in our community and our country. Many grandparents raise their grandchildren due to drug use, divorce or kids have children too young. We need to continue to push the message for young adults to be responsible in their choices. This will take our entire community and I know the schools can help. The infant birth rate with mothers who have been using drugs is way too high. It is scary. We have to have better parenting to stop the cycle. — Community Leader

Family Planning

Births to Adolescent Mothers

About Adolescent Births

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

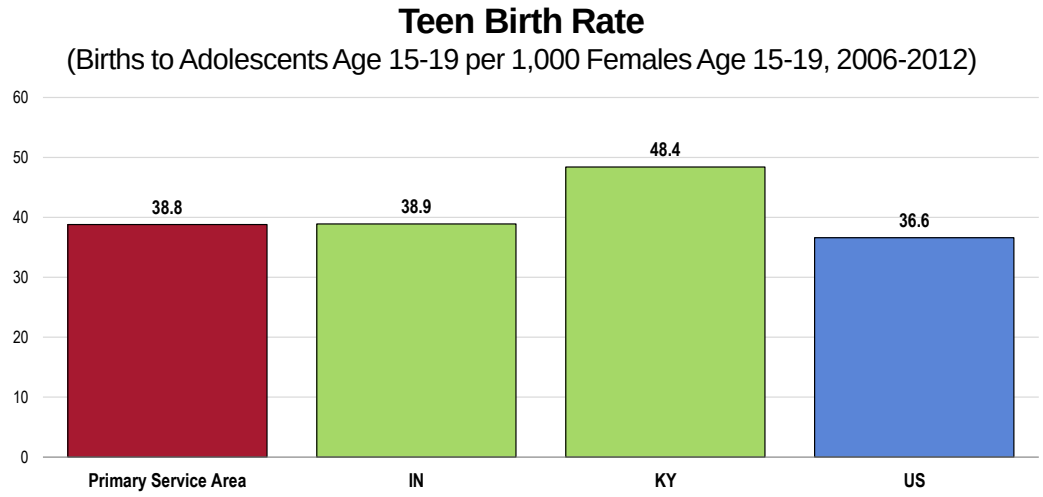
- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

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 38.8 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Primary Service Area.

- **BENCHMARK**: Statistically below the Kentucky rate.

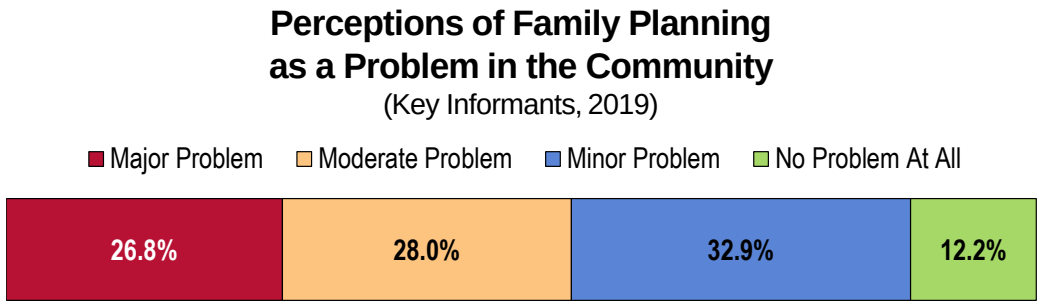


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Retrieved September 2019 from CARES Engagement Network at https://engagementnetwork.org.

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.

Key Informant Input: Family Planning

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



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

No Planned Parenthood in Jefferson County. Nowhere to receive free birth control. Majority of children born to single mothers. — Public Health Representative

I believe women's health has fallen through the cracks, and there are no Planned Parenthood facilities for 50 miles. Women need more low-cost options in the community. — Community Leader

Uninsured individuals or individuals that don't have insurance that KDH accepts have to leave town to receive birth control. This can become a transportation issue and then result in unplanned pregnancies. — Public Health Representative

There is very little access to free birth control, and we have many families living in poverty. — Social Services Provider

There is not a Planned Parenthood. The WIC office is all the way out in Hanover. — Community Leader

We don't have family planning services at all. — Community Leader

Because there is no Planned Parenthood in our community. — Community Leader

There is no easy access to birth control. — Community Leader

Awareness/Education

I feel like there are not enough educational resources in our communities about safe sex, especially for young people and teenagers. Safe sex, in regards to how to prevent pregnancy and the contraction and spread of STIs, is not adequately discussed in school in my personal experience. I believe this is one of the reasons for teen pregnancies in the area, as teenagers are going to have sex regardless of how many abstinence programs they sit through in school. I believe it is important to give them, along with young families, the necessary information regarding sex and pregnancy so that there can be informed choices and the knowledge on how to prevent unwanted pregnancies. — Community Leader

It is the lack of family planning. The education for this should target teens and early adults. — Other Health Provider

Socioeconomic Status

Jefferson County is a rural county with an under-educated population. It is not unusual to see families with three or more children, and you wonder how are the parents able to support the family. — Community Leader

At Southwestern, over 50% of the students are on the government lunch plan. — Other Health Provider

Teen Pregnancy

> *The number of teen pregnancies and unexpected pregnancies seems to be on a rise. — Community Leader*
>
> *Underage pregnancy. — Physician*

Unplanned Pregnancies

> *Quite honestly, people who are unable to care for themselves should not be reproducing. Offering free vasectomies/tubals. — Other Health Provider*
>
> *Unwanted pregnancies. Child Protective Services caseload. — Other Health Provider*

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 24.2% of Primary Service Area adults report eating five or more servings of fruits and/or vegetables per day.

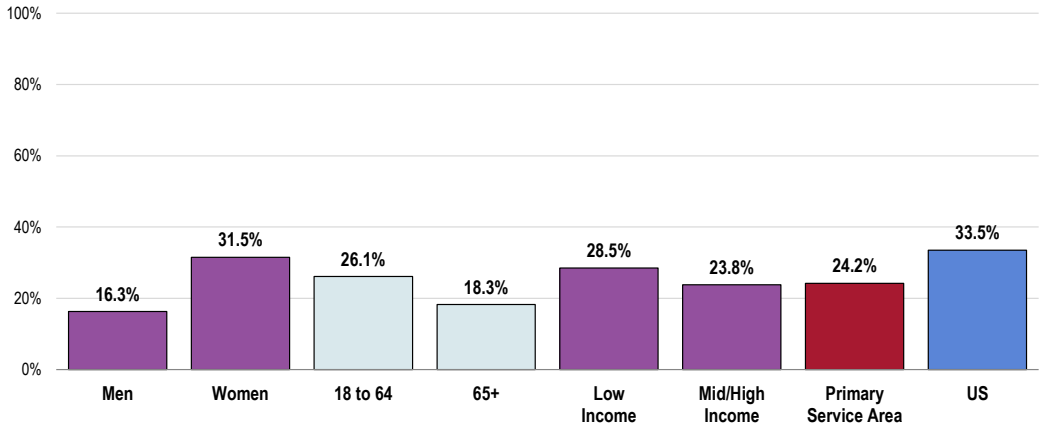
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

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

- **BENCHMARK**: Less favorable than found nationally.
- **DISPARITY**: Less common among men.

Consume Five or More Servings of Fruits/Vegetables Per Day

(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 148]
- 2017 PRC National Health Survey, PRC, Inc.

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.

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

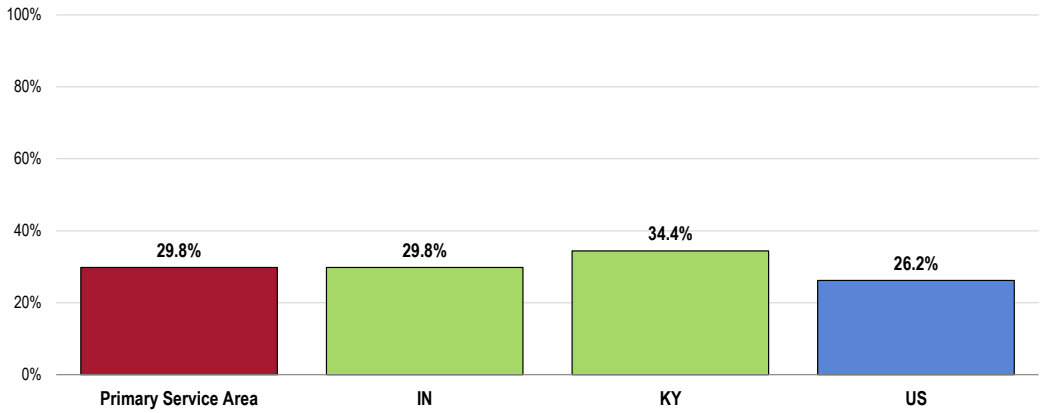
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

A total of 29.8% of Primary Service Area adults report no leisure-time physical activity in the past month.

- **BENCHMARK**: Not significantly different from state or national proportions.

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): 2017 Indiana & Kentucky 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.

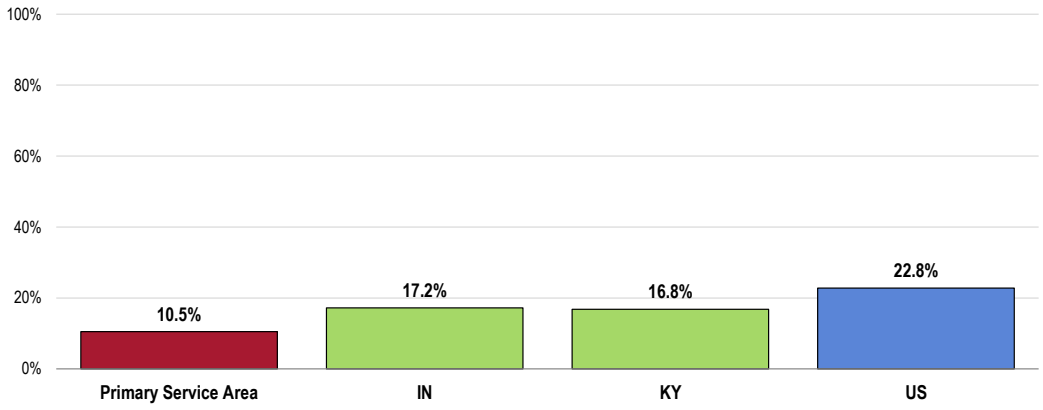
Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

A total of 10.5 % of Primary Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

- **BENCHMARK**: Significantly lower than state and national percentages; also far from satisfying the related Healthy People 2020 objective.

Meets Physical Activity Recommendations

Healthy People 2020 = 20.1% or Higher



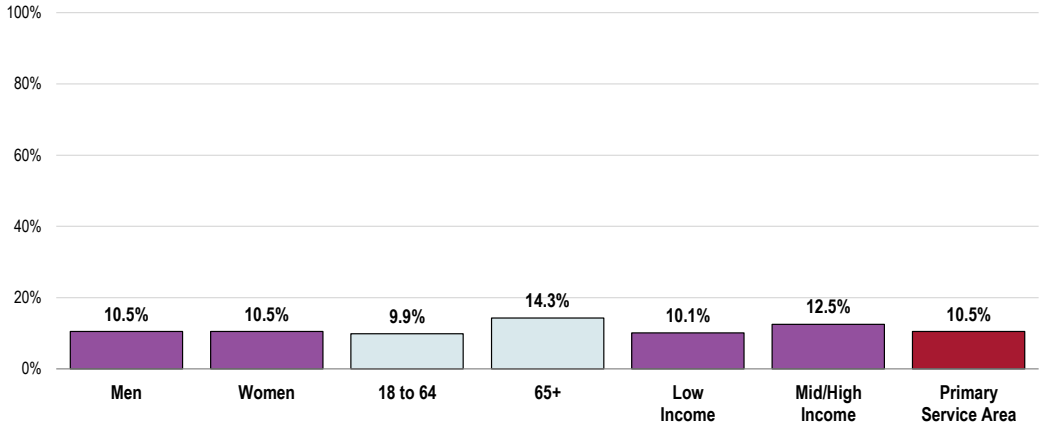
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 152]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health 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

(Primary 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

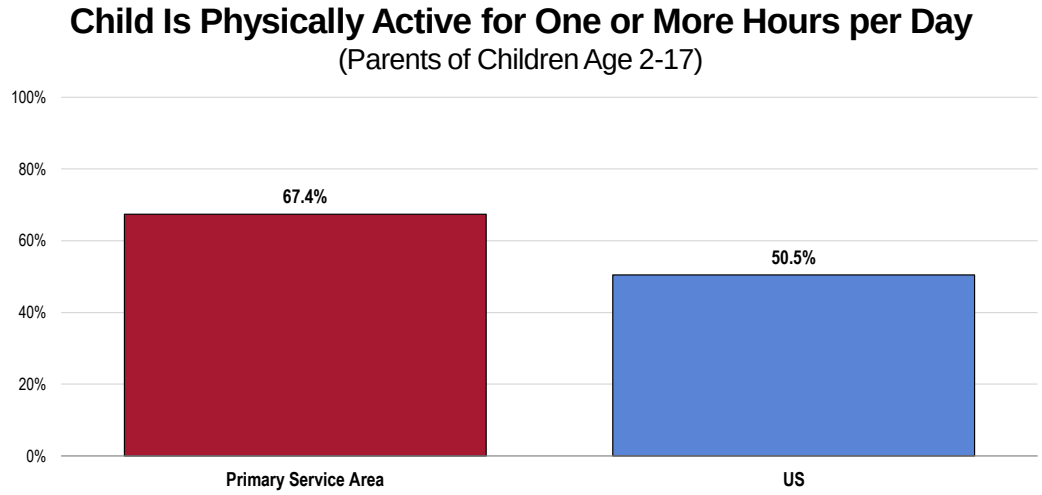
Recommended Levels of Physical Activity

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 Primary Service Area children age 2 to 17, 67.4% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- **BENCHMARK**: Statistically above the prevalence found nationally.



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 3.9 recreation/fitness facilities for every 100,000 population in the Primary Service Area.

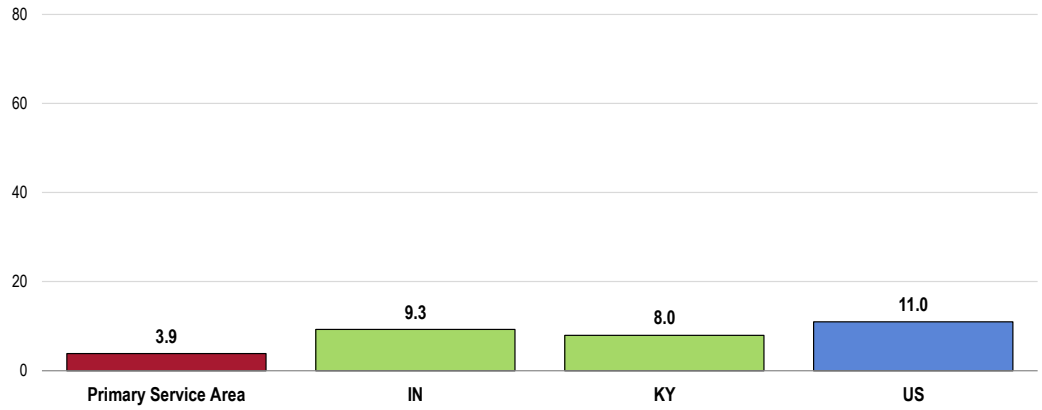
Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

- **BENCHMARK**: Notably below the state and national 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: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥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 ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

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

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

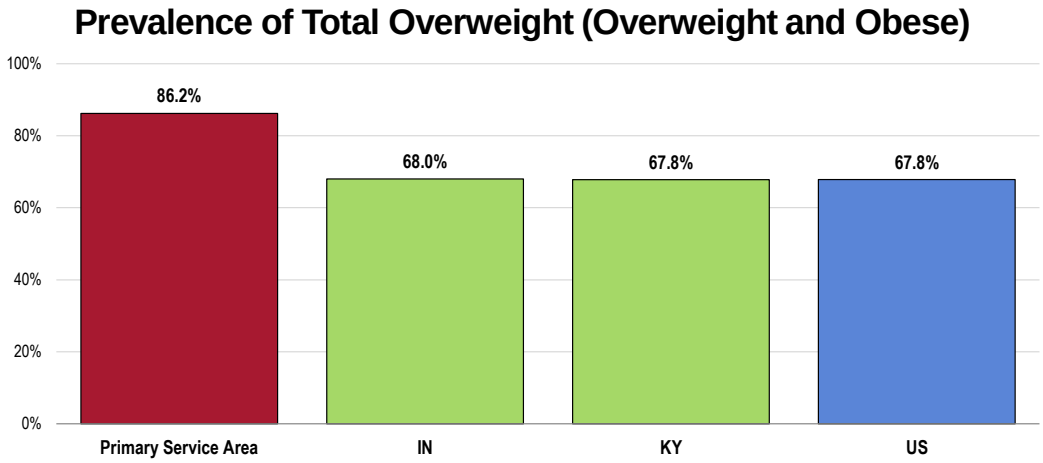
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

Overweight Status

More than eight in 10 Primary Service Area adults (86.2%) are overweight.

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

- **BENCHMARK**: Notably above state and national percentages.



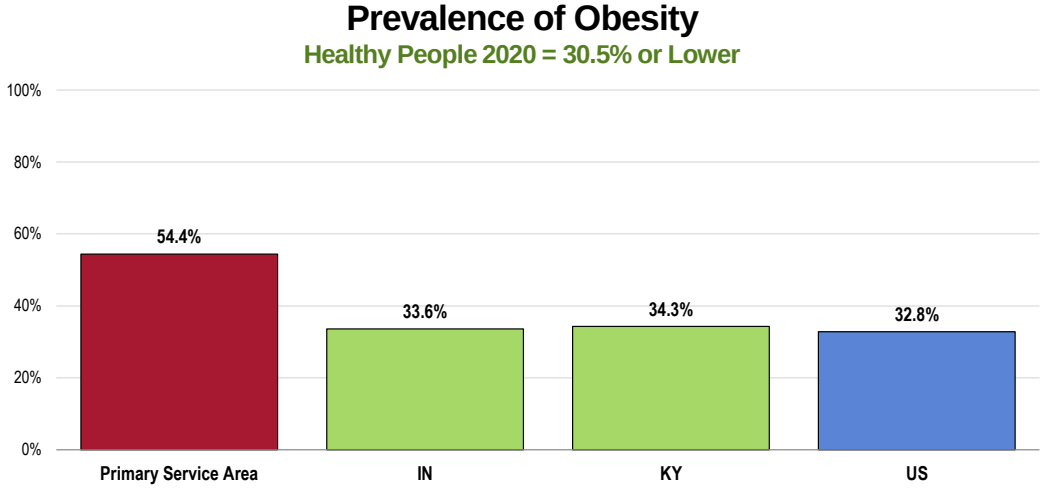
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 191]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health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

The overweight prevalence above includes 54.4% of Primary Service Area adults who are obese.

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

- **BENCHMARK**: Notably above state and national percentages. Fails to satisfy the related Healthy People 2020 objective.



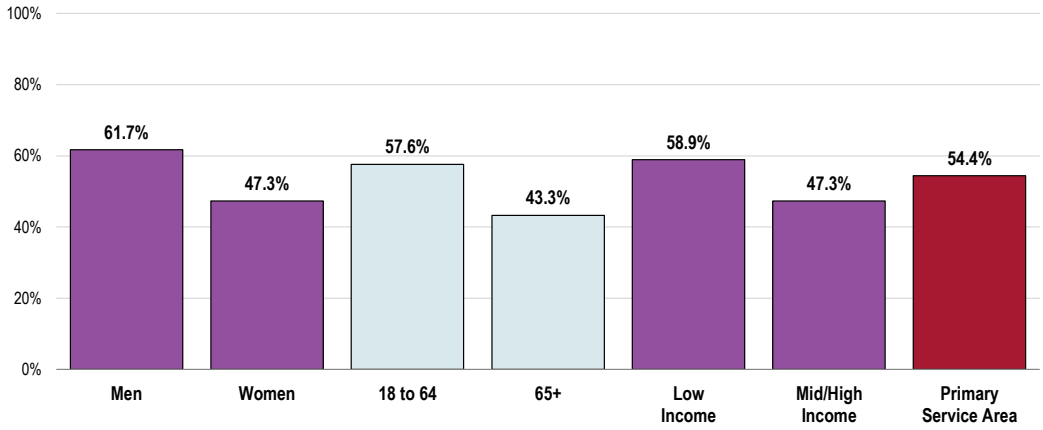
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 154]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health 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

(Primary 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]

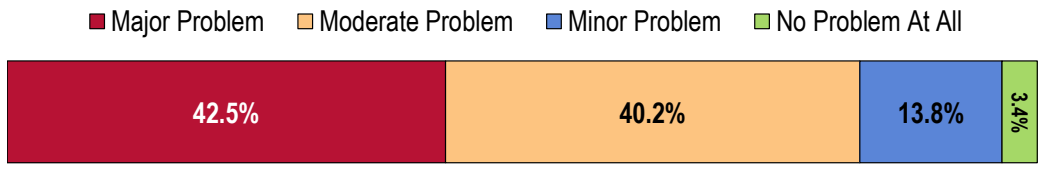
Notes:
- Based on reported heights and weights, asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High 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.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants taking part in an online survey characterized *Nutrition, Physical Activity & Weight* as a "major problem" slightly more often than a "moderate problem" in the community.

Perceptions of Nutrition, Physical Activity, and Weight 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:

Obesity

> *I see many obese people in Madison. I believe that the number is increasing because of the food we are giving to the younger kids. I feel that the physical education classes at school have been lenient towards children in the past few years also. — Community Leader*

People are overweight and having difficulties with making dietary changes. We all tend to be more sedentary. More weight issues/physical problems happening to younger children. Fast food is too easy to get. Many people also don't know about ways of eating more healthy versus processed foods. — Social Services Provider

There is a large obesity problem with children, adolescents, and adults. Eating healthy is problematic because of the low wages and the high cost of healthy foods. — Community Leader

Many overweight people. Portion sizes are too large. Too much fast food for children. — Other Health Provider

Obesity is a major issue. Access to reasonably priced healthy fast food items would help as well as employer-based exercise for employees half an hour each day. — Social Services Provider

Obesity, lack of healthy fast food options in the community. — Public Health Representative

Obesity is a problem for all ages. We see it younger and younger. — Community Leader

Entire families are obese, including children. This is a massive future problem. — Community Leader

Lack of Physical Activity

The communities of Madison and Hanover are not set up to promote walking. There appears not be be an ordinance to require sidewalks or lighting. Crosswalks at key intersections are missing and where they do exist, motorists ignore people in crosswalks. Access to affordable fresh fruit and vegetables is poor, especially out in the county or in downtown Madison. While there are some walking trails in Madison, they are not connected well to neighborhoods or to each other. — Community Leader

This is a problem mainly because people just don't like to exercise. We have plenty of paid facilities (Fit for the King, Anytime Fitness, Planet Fitness, Hanover College) and free facilities (sidewalks, trails, etc.), but some people do not see it as an issue in their life. — Community Leader

Probably many answers to this question. Gaming/Screen culture. Fast food culture, no one has time to cook anymore, much more eating out instead of preparing balanced meals at home. Drug addiction. — Community Leader

Our community does not have bike trails which are needed. There are limited activities for youth and they get in trouble for biking and skateboarding downtown. — Community Leader

This has been an item that the community has been trying to focus. We have multiple gyms, but need to find ways to keep people motivated. — Community Leader

Lack of desire to be physically active. — Other Health Provider

Lifestyle

Mindset. Lifelong habits. There are plenty of opportunities to go to gyms, go outside such as Riverwalk and Clifty Park, but one has to be willing. There doesn't seem to be much public nutritional program opportunities. — Physician

I see the desire to change their lifestyle. Lack of nutritional health and exercise also create issues with mental health. So, it is all inter-related. We can always provide more education, but creating that desire to change is difficult. — Community Leader

People choose poor lifestyle habits such as poor nutrition, lack of physical activity and being overweight. — Other Health Provider

Individual engagement for a healthy lifestyle. — Other Health Provider

Basic lifestyle choices. — Physician

Access to Healthy Food

Access to healthy foods and gym memberships, but then they also need the motivation to pick the right lifestyle measures to improve health. Too much text time in our society, need for more club sports perhaps. — Physician

Lack of access to grocery stores and the cost of healthy food is too expensive for some families. Junk food is always cheaper. — Community Leader

Bad food is much cheaper than healthier options. Few sidewalks exist on Madison's hilltop. Schools don't require physical education like they used to. — Community Leader

Access to healthy foods in the downtown area. Nutrition knowledge, health problems that already limit their physical activity. — Public Health Representative

Nutrition

> *The biggest challenge related to this topic is access to information regarding nutrition and the motivation for people to participate. — Social Services Provider*
>
> *Preference for sugary foods, food additives, cultural habits, TV, lack of sufficient education about nutrition and preparing healthy foods. There are educational opportunities available, but don't often reach or appeal to those who need it most. Poor self-esteem. — Community Leader*
>
> *Minimal nutrition/weight loss resources for the average citizen. Even with plenty of indoor and outdoor exercise opportunities in our community, many people do not utilize them. Need more bike lanes and sidewalks. — Other Health Provider*
>
> *Lack of healthy eating options when eating out. — Physician*

Access to Care/Services

> *Poor access to care, lack of parks and facilities, poor diet. — Public Health Representative*

Aging Population

> *Aging community. — Social Services Provider*

Awareness/Education

> *Education and determination. Even when people know what they should be doing, they don't always comply. It is very difficult to stick with a nutrition and exercise program and some people just want to do it. — 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

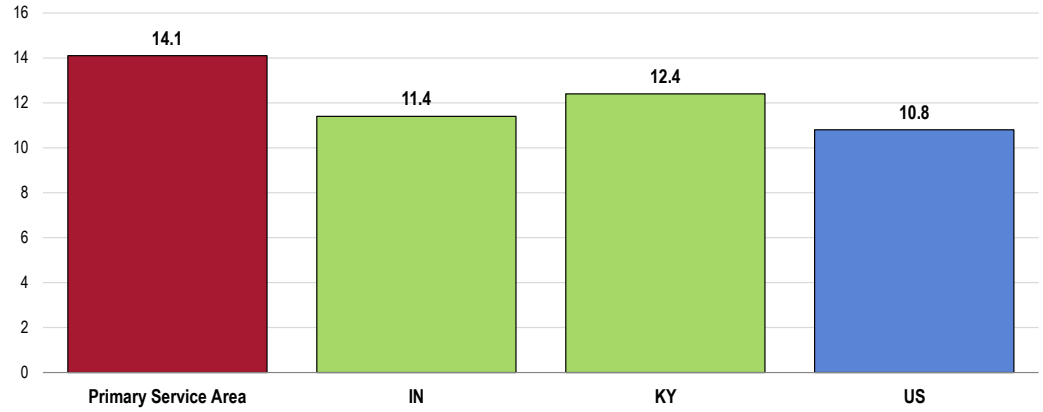
Between 2015 and 2017, the Primary Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 14.1 deaths per 100,000 population.

- **BENCHMARK**: Statistically above the Indiana and US rates; fails to satisfy the related Healthy People 2020 objective.

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2015-2017 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

"**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.

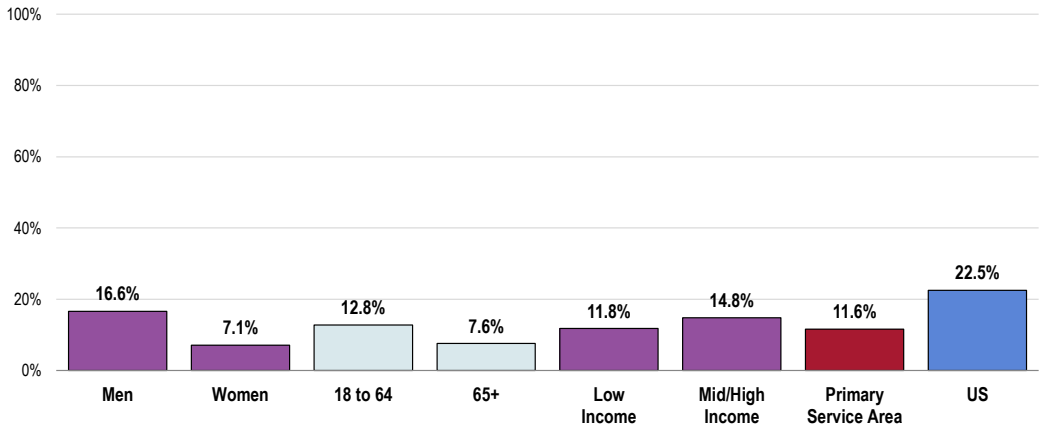
A total of 11.6% of area adults are excessive drinkers (heavy and/or binge drinkers).

- **BENCHMARK**: More favorable than the US prevalence; satisfies the Healthy People 2020 objective.

Excessive Drinkers

(Primary Service Area, 2019)

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]

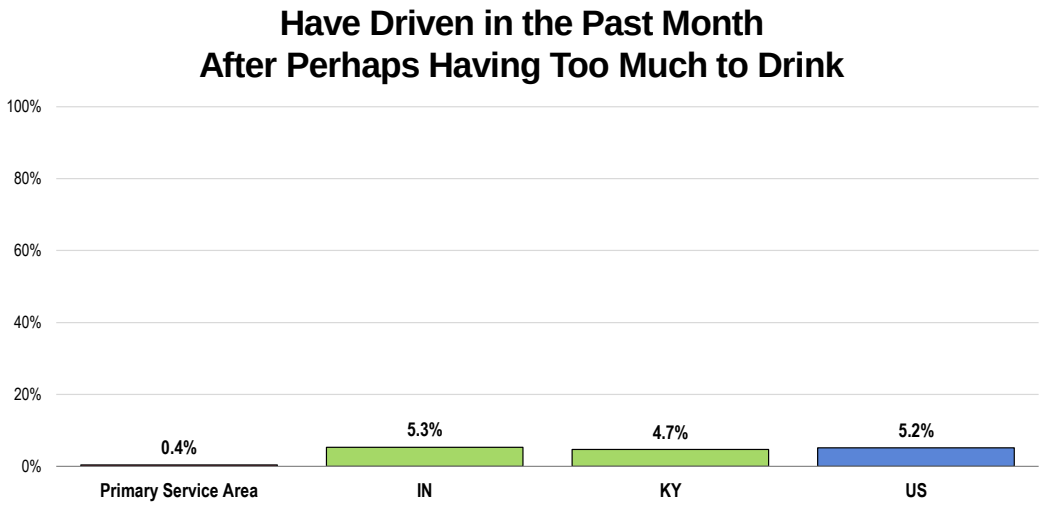
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes 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 0.4% of Primary 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.

- **BENCHMARK**: Notably below the state and national percentages.



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): 2016 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Age-Adjusted Unintentional Drug-Related Deaths

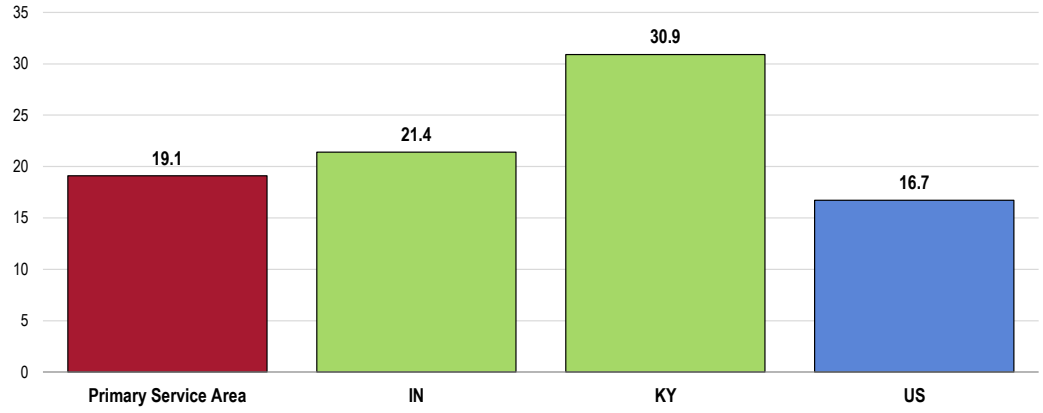
Between 2015 and 2017, there was an annual average age-adjusted unintentional drug-related mortality rate of 19.1 deaths per 100,000 population in the Primary Service Area.

- **BENCHMARK**: More favorable than the Kentucky rate, though it fails to satisfy the related Healthy People 2020 objective.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality

(2015-2017 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

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.

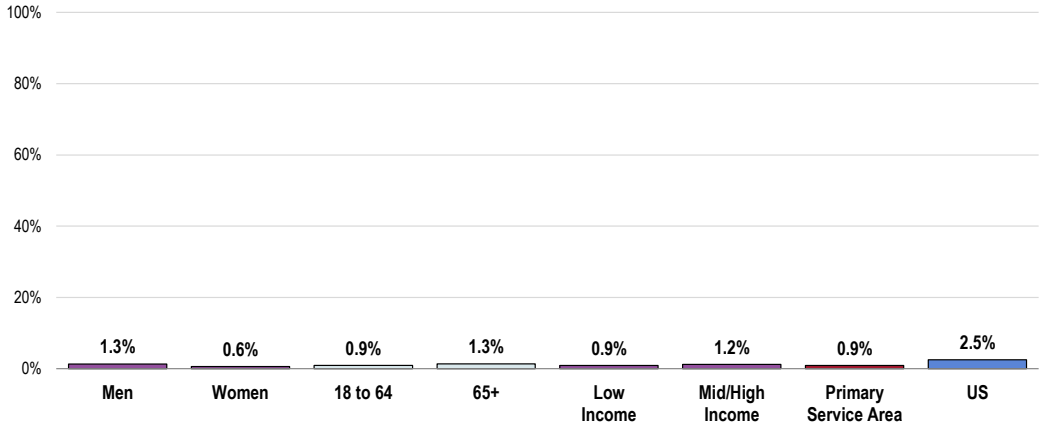
A total of 0.9% of Primary Service Area adults acknowledge using an illicit drug in the past month.

- **BENCHMARK**: Satisfies the related Healthy People 2020 objective.

Illicit Drug Use in the Past Month

(Primary Service Area, 2019)

Healthy People 2020 = 7.1% or Lower



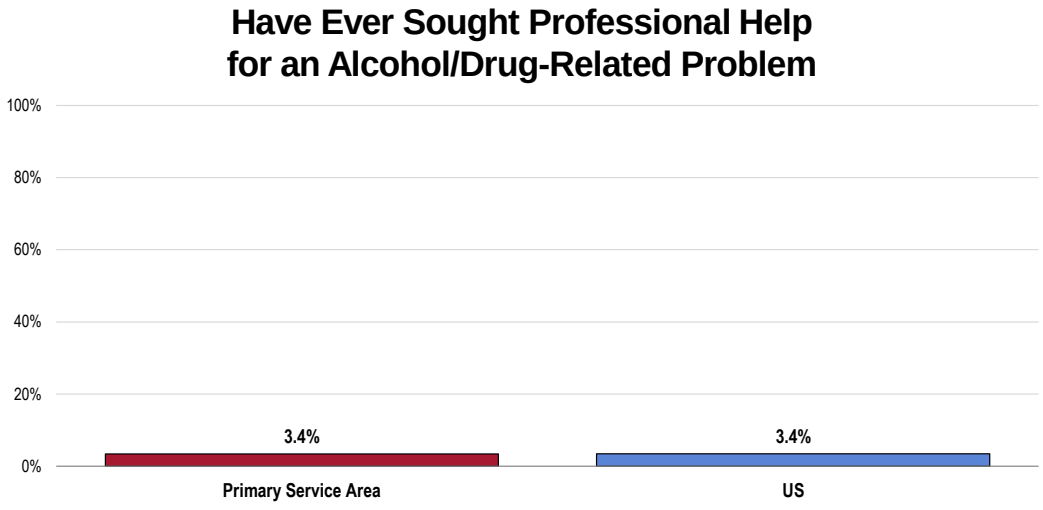
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 59]
- 2017 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.
- 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 3.4% of Primary Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- **BENCHMARK**: Matches the national prevalence.



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 60]
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

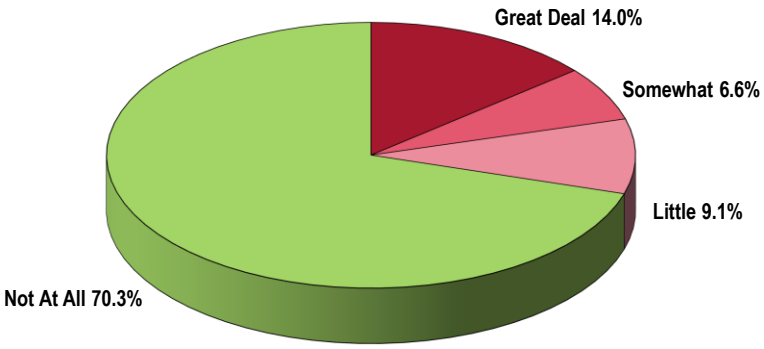
Personal Impact From Substance Abuse

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 Primary Service Area residents' lives have <u>not</u> 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)

(Primary Service Area, 2019)



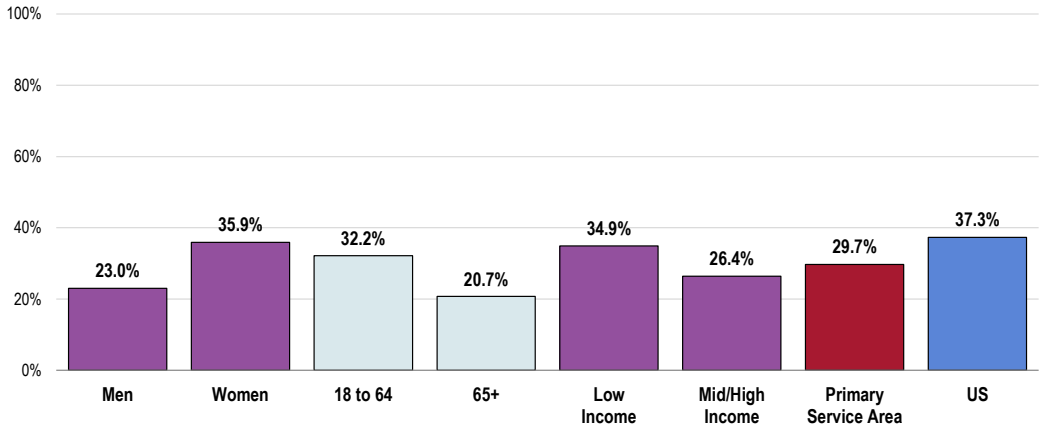
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 61]
Notes: • Asked of all respondents.

However, 29.7% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

- **BENCHMARK**: More favorable than the US finding.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

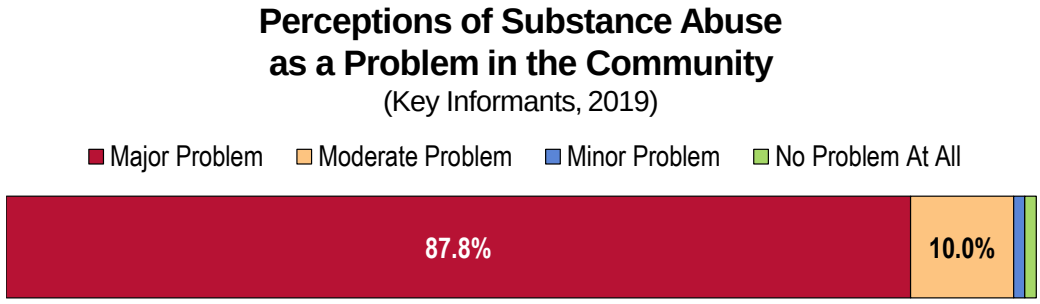
(Primary Service Area, 2019)



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."
• 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

More than eight in 10 key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.



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

We do not have sufficient services in our area for substance abuse. Much of the treatment is done through mental health agencies, whether through the court on the civil side or the criminal side. Community Corrections does a good job in managing the clients; however, our corrections team can only be as good as the providers they have available to them. We have seen many clients pass drug screens through probation/corrections and pass the program, graduating out of it, while we see them fail screens or continue to struggle with addiction/use in DCS cases (or vice versa). The lack of transparency and working together in our community also negatively affects this process. A shortage of inpatient rehab facilities affects us, as well as a waitlist for the halfway houses here. — Social Services Provider

The lack of substance abuse in the local community is like the lack of mental health help/assistance. The lack of substance abuse victims and mental health victims have no choice but to go the local medical hospitals who aren't setup to deal with these kinds of issues. Any person, administrator or politician that doesn't think these topics are an issue should spend just a few hours in the local emergency room. — Community Leader

There is no treatment center relatively close. By the time you find a driver and a treatment center with openings, it is usually the next day. By this time, the individual has changed their mind. Also, using a drug to try to combat another drug addiction is ludicrous. Education is also a barrier. I guess I should say lack of education is a barrier. Some don't realize the harm they are inflicting not only on themselves but others. Many individuals don't take the abuse seriously because they have no consequences that mean anything. They are slapped on the wrist and put back out on the street over and over. If we had a mandatory treatment stay at a treatment center, maybe that would help them make the choice to not abuse substances. We would also need help for these individuals after the stay. Access to affordable counseling. — Community Leader

In my opinion, the greatest barriers related to accessing needed substance abuse treatment are transportation and that in-patient facilities are all located out of the county. — Community Leader

No inpatient treatment facility. I am told there are waiting lists for out-of-town treatment options, and many are expensive or have insurance requirements. — Other Health Provider

Treatment centers are somewhat far from this community, unadvertised support groups. — Other Health Provider

Lack of residential treatment. Lack of effective interventions/treatment for meth use. No research on best practices on how to treat. — Community Leader

There really is no substance abuse program in this county. If they are wanting inpatient, they have to travel several hours away for treatment and then again will not have the follow-up care needed. — Other Health Provider

There does not appear to be a complete cycle treatment cycle and lack of consequences for substance abuse. Individuals use the substance treatment facilities to avoid consequences instead of getting help. — Community Leader

Not enough services. Not enough options available for people who want to quit. People who are using, don't necessarily want to quit. Counselors and helpers are stretched too thin. Parental denial in many cases. — Other Health Provider

Facilities themselves. It is not realist to think those who need immediate treatment will drive themselves since the majority do not have transportation. — Community Leader

There are no local in-patient programs. These programs are very costly, and we do not have the professional expertise or financial resources to start an in-patient program. Grants are available, but are they sustainable? — Community Leader

Problem begins with law enforcement, to treatment facilities, to re-entering society. — Community Leader

Once again, treatment is not long-term. Also, broken families and lack of family support at home. — Community Leader

We do not have enough resources to deal with our growing substance abuse crisis. — Community Leader

There is no real substance abuse treatment in our community. There are mandated IOP programs through the courts, but I have not seen any of these programs be successful. Other than NA and AA programs, I do not see any other programs available in our community. — Social Services Provider

Methamphetamine abuse has destroyed the lives of many of our citizens. Access to treatment is a barrier that continues to make it difficult for people to recovery. Again, stress, poverty, social anxiety all add to the increased use of substances. — Social Services Provider

Lack of inpatient beds that admit patients long enough to be effective, and in some cases a lack of willingness to pursue treatment. — Physician

Programs are lacking. — Community Leader

Availability of resources and unwillingness of patients to stay in programs. — Other Health Provider

No treatment facilities in Jefferson County. — Public Health Representative

No facility close to here. Have to drive over an hour to get help. — Other Health Provider

Unable to decide on a location for a facility. — Physician

No inpatient centers to go and get clean close to here. — Other Health Provider

No treatment in area, more access to drugs than treatment. — Public Health Representative

Lack of inpatient treatment facility. — Community Leader

Needed inpatient rehab facility. Ready access to street drugs. — Community Leader

Getting the people to the facility. — Community Leader

Lack of available options and long waiting lists. — Community Leader

Lack of programs and treatment availability. — Social Services Provider

Lack of treatment. — Other Health Provider

Access. — Other Health Provider

Denial/Stigma

I feel the greatest barrier is the lack of desire to find treatment. There continues to be a stigma related to substance abuse- this is true in health care, just as it is in the community-at-large. However, I feel most people who could benefit from treatment are not ready to stop using yet. — Other Health Provider

It's hard to know where to start with this. Perception: too many people think abusers are just weak and they need to toughen up. That's a problem. Treatment: we don't have treatment options in Madison. Police: I doubt they have all the tools and resources to find and prosecute dealers. Education: the community needs to be educated on this topic so we all understand the costs of doing nothing. — Community Leader

Lack of understanding by the community and lack of treatment facilities. — Community Leader

Apathy on the part of addicts. An unlimited supply of controlled medications on the street. — Community Leader

The greatest barrier is people being willing to participate in substance abuse treatment. — Social Services Provider

Person is unsure if they want to quit using drugs. Influences from peers and environment to keep using. High rate of drug use and legal issues that involve alcohol/drugs in some way. — Social Services Provider

Drug addicts who don't seek treatment. They seek treatment only after they overdose. — Other Health Provider

Unwilling people. — Social Services Provider

Prevalence/Incidence

In my opinion, we don't know exactly what we are fighting. Opioid use is greater in surrounding counties, but meth appears to be the problem in our county. It would be nice to have an idea of the percentage of the population that is abusing drugs and the type of drugs being abused. This lack of knowledge leads into the issue of what type of treatment facilities do we need. There is a firm belief that there needs to be a treatment facility in Jefferson County, but the question is what type of facility that should be. — Community Leader

Suboxone is a highly prevalent drug in our area. We have many people buying and selling this on our streets, including children. — Social Services Provider

Substance abuse continues to be a huge issue, and I'm very worried about the future of our community and children if this continues. — Social Services Provider

There are also many people in my community that use narcotics. We have multiple drug busts a week, and many people are starting to smoke weed. — Community Leader

We are seeing a large increase in the amount of substance abuse in our community. As an educator, we are seeing more students impacted by drugs or drug exposed. — Community Leader

We are overrun with substance abuse in this county. Just look at the jail population issues. — Community Leader

There are a smaller percentage of people involved, but it is a glaring problem. — Physician

Alcoholism. — Community Leader

Easy Access

Not only our community, but drugs are so readily available to everyone that this a growing problem. I think that offering classes to teach in our schools to educate children on the effects of drug use might be a partial solution. — Community Leader

Products are easy to come by. Still young resources after penal discipline; for example, half-way houses don't have much space to support those coming out of prison. — Community Leader

The availability of drugs to people. — Community Leader

We have none. Drugs are so easy to get in the area. — Other Health Provider

Cost/Funding

The availability of comprehensive treatment in rural settings; need increase funding and inter-community coordination for viable regional options. Also need for recovery coaches who can help integrate the patients back into the community. — Physician

The greatest barriers are money, inability to commit to treatment, and the stigma around getting help. — Community Leader

Cost. — Other Health Provider

Lack of Providers

Lack of providers, treatment facilities, and supportive services. — Social Services Provider

Not having any providers other than support groups. — Public Health Representative

Too few providers. — Community Leader

Socioeconomic Status

Homelessness. This population is growing due to substance abuse issues and mental health issues. — Community Leader

Economic insecurity has led to an increase in drug use. — Community Leader

Awareness/Education

> *Need more education and supportive programs. — Physician*

Disease Management

> *People minimize the problem and fail to comply with treatment. Conventional rehab is only 20-30% successful. — Other Health Provider*

Parenting

> *Higher standards by parents. Being more involved with their children's lives. Let's teach parents how to parent, but it will help when kids stop having kids so early. It is all about education. I know that is not an easy solution, but we need to continue as a group to work together — Community Leader*

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **methamphetamine/ other amphetamines** as the most problematic substance abused in the community, followed by **heroin/other opioids**, **alcohol**, and **prescription medications**.

Problematic Substances as Identified by Key Informants

	Most Problematic	Second-Most Problematic	Third-Most Problematic	**Total Mentions**
Methamphetamines or Other Amphetamines	52.3%	29.2%	6.3%	**57**
Heroin or Other Opioids	24.6%	29.2%	18.8%	**47**
Alcohol	7.7%	10.8%	34.4%	**34**
Prescription Medications	9.2%	16.9%	12.5%	**25**
Marijuana	3.1%	4.6%	15.6%	**15**
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	3.1%	7.8%	**7**
Cocaine or Crack	3.1%	1.5%	3.1%	**5**
Over-The-Counter Medications	0.0%	3.1%	0.0%	**2**
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	1.5%	0.0%	**1**
Steroids	0.0%	0.0%	1.6%	**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).

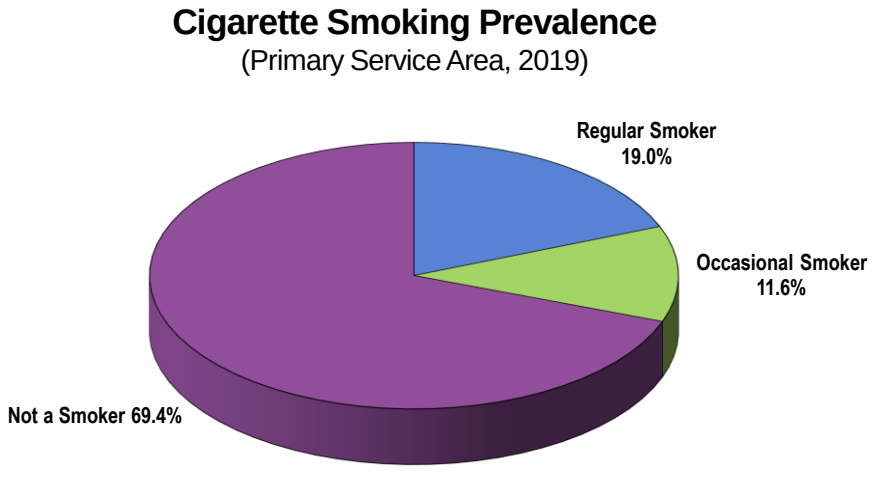
Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

— Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

Three in 10 Primary Service Area adults (30.6%) currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



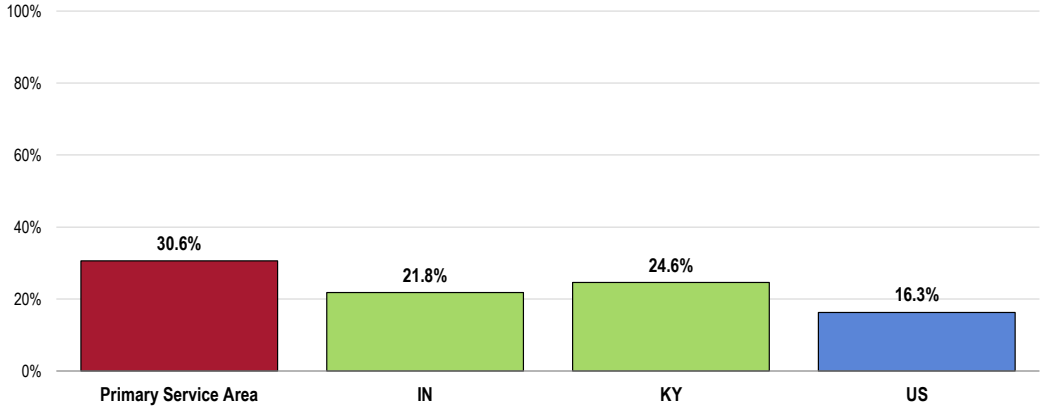
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 49]
Notes: • Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the Primary Service Area.

- **BENCHMARK**: Above the Indiana and US percentages; far from satisfying the related Healthy People 2020 objective.
- **DISPARITY**: Statistically less common among older adults.

Current Smokers

Healthy People 2020 = 12.0% or Lower



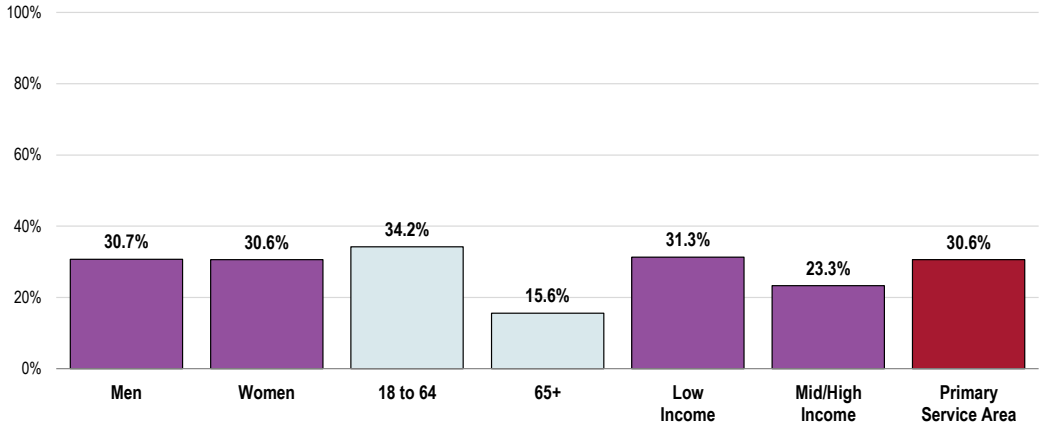
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 193]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers

(Primary Service Area, 2019)

Healthy People 2020 = 12.0% or Lower



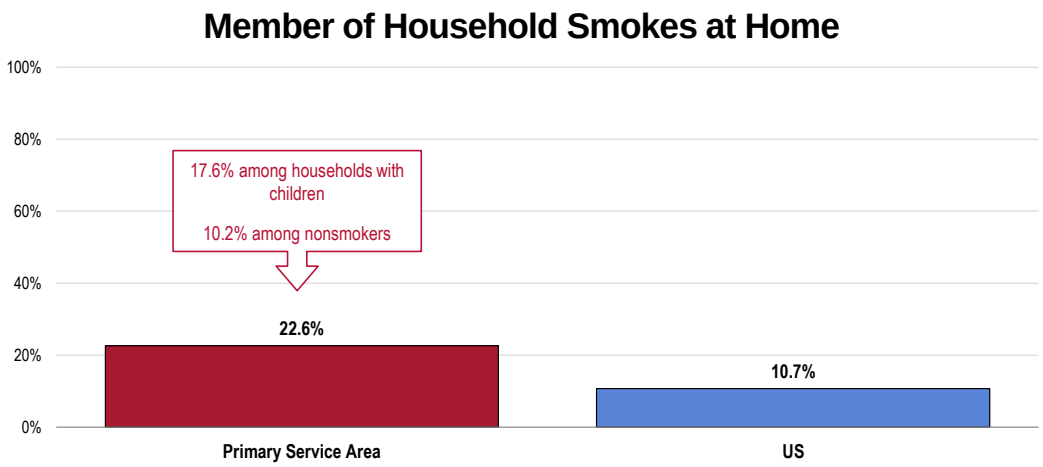
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 193]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

Among all surveyed households in the Primary Service Area, 22.6% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

- **BENCHMARK**: More than double the national prevalence.

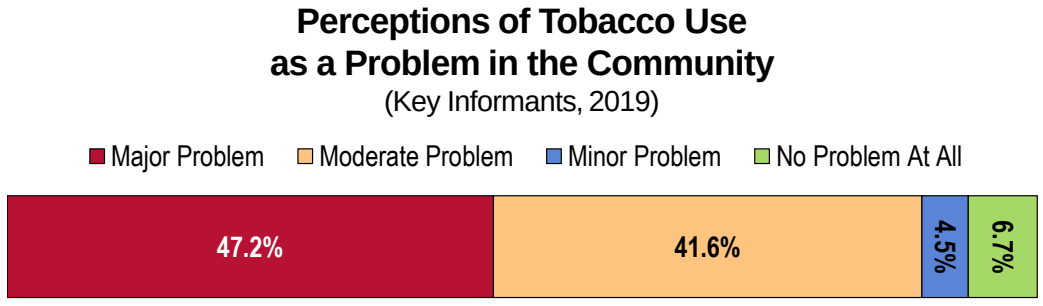


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 52, 161-162]
- 2017 PRC National Health Survey, PRC, Inc.

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.

Key Informant Input: Tobacco Use

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



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

Lots people still smoke, and more are starting to vape. Vape is a major problem with many of young people in our community that are still in school. — Community Leader

Again, being a farming community, many people smoke. Smoking is detrimental to the circulatory system causing a multitude of health issues including respiratory and cardiac problems. — Other Health Provider

Because the statistics show this. It's hard to believe so many people still smoke and vape… Young children are vaping. — Community Leader

Our community continues to fall above the state and national average for tobacco use. Vaping is a huge growing concern for our area youth. And cigarette butt litter is a massive problem in our community. — Other Health Provider

There are many smokers in this community. Also the younger teenagers in my age group are becoming more and more addictive towards Juuls and vaporized products of that category. — Community Leader

Tobacco use is being used by all age groups, and vaping/electronic cigarettes are at extremely high levels in the schools. — Community Leader

Major problem in Jefferson, Switzerland and Trimble Counties. — Community Leader

We have too many people, including teens, smoking. — Community Leader

Way too many people smoke and chew, thus cancer prevails. — Community Leader

High rate of tobacco use. Resistance to change. Poor lifestyle choices. — Other Health Provider

See too many residents purchasing tobacco products. — Community Leader

Tobacco locally grown and is viewed as acceptable. — Other Health Provider

Number of people who smoke including youth. — Social Services Provider

There is a high percentage of people smoking, vaping, etc. — Social Services Provider

E-Cigarettes/Vaping

The use of electronic cigarettes among teens and young adults is a major problem. I am not sure how these underage individuals are purchasing these items, but they are. Many don't believe or are not knowledgeable of the effect of these on their bodies. Many think since they are vapor and not smoke that they cannot be harmful. Electronic cigarettes are hard to monitor with teens. They are so compact that they can be hidden in pockets at school. — Community Leader

Even as tobacco use has diminished in the area, it has just been replaced with a new nicotine delivery system and I don't believe we know just how much the side effects will have on the users. — Other Health Provider

Many youth continue to start each week and will suffer a lifetime of health consequences because of it. Vaping is seen everywhere and very few realize its hazards. — Community Leader

Vaping is the issue because people still think it's better than smoking cigarettes. — Community Leader

High incidence of teen smoking and vaping. — Physician

Addiction

Difficult to break the habit. Kids get started, and it becomes too tough to quit. Tobacco has historically been a major income producing crop for this area and nearby Kentucky. — Community Leader

Many people get addicted at a young age and continue to use later in life. — Community Leader

Patients not wanting to quit, and it affects all healthcare. — Other Health Provider

Easy Access

> *Agriculture in our area includes growing tobacco, so a cash crop leads to more people using it. Further, we are seeing a huge problem in our schools with vaping. — Community Leader*
>
> *Tobacco is too accessible. — Community Leader*
>
> *The access. — Community Leader*

Cultural Norms

> *Jefferson County is a tobacco-growing county, which makes it difficult to talk about in some circles. — Community Leader*
>
> *Societal norm, being exposed to folks who smoke and family history of growing tobacco. — Public Health Representative*

Smoking During Pregnancy

> *Over 27% of pregnant women smoke. People use smoking as a way to reduce stress. — Public Health Representative*
>
> *High percentage of maternal smoking rates. — Other Health Provider*

Poverty

> *I see about 450 food insecure families each month. Approximately 30% have one or more family members who smoke. I also observe a large number of adolescents and young adults smoking and vaping. — Community Leader*

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)

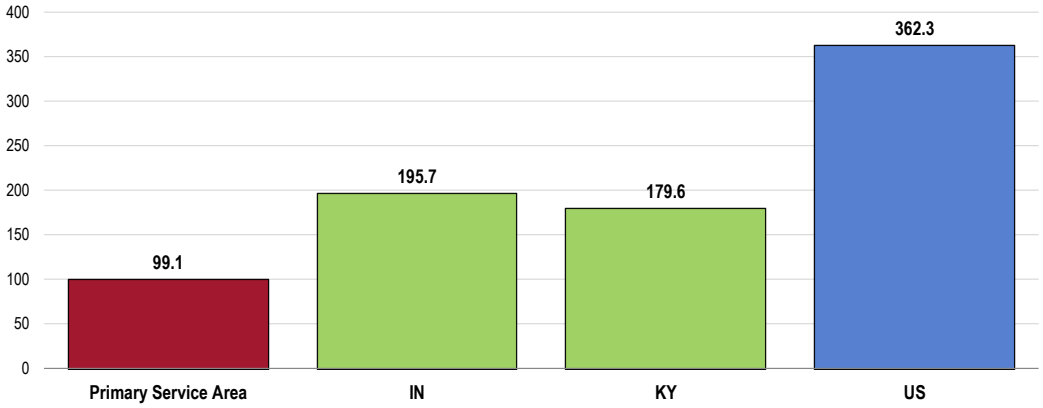
HIV Prevalence

In 2015, there was a prevalence of 99.1 HIV cases per 100,000 population in the Primary Service Area.

- **BENCHMARK**: Notably lower than state and national percentages.

HIV Prevalence

(Prevalence Rate of HIV per 100,000 Population, 2015)



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.

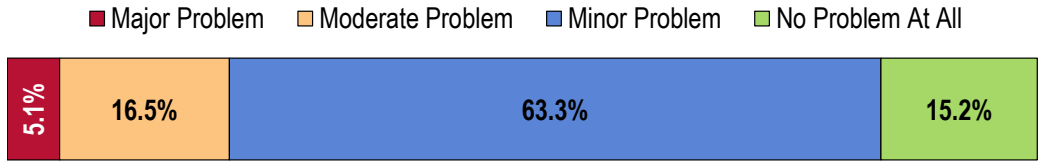
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Key Informant Input: HIV/AIDS

Key informants taking part in an online survey largely 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

> *It seems our community has a problem acknowledging these types of problems exist in our community. Consequently, people with these issues are discouraged from coming forward (stigma, etc. related to ignorance about these type of health problems.) And, there are significantly limited resources to assist individuals with these problems. — Community Leader*

Prevalence/Incidence

> *In 2014, there was an HIV outbreak in a neighboring county, and it has been a problem in surrounding areas. Part of this has been proven to be because of the sharing of used, unclean needles in relation to the community's drug problem. I think practices of unsafe sex because of lack of education has also contributed to the issue. — 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

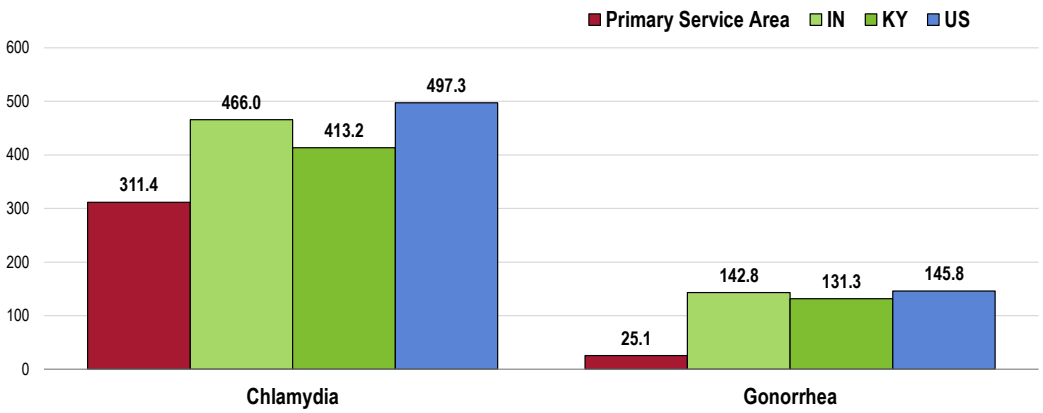
In 2016, the chlamydia incidence rate in the Primary Service Area was 311.4 cases per 100,000 population.

The Primary Service Area gonorrhea incidence rate in 2016 was 25.1 cases per 100,000 population.

- **BENCHMARK**: Each rate is well below its related state and national rates.

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.

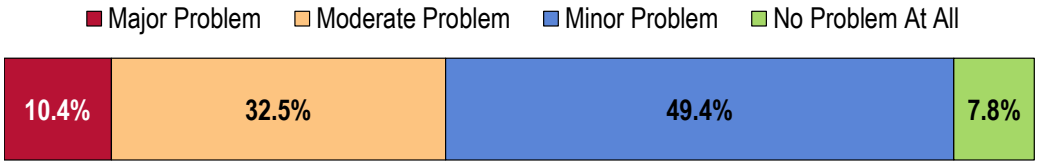
Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexually Transmitted Diseases

Almost half 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)



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:

Alcohol/Drug Abuse

> *Drugs and alcohol use. High incidence of STD's in our youth. — Other Health Provider*

Awareness/Education

> *Lack of education and no Planned Parenthood services. Lack of acknowledgement of these problems. Stigma associated. — Community Leader*

Cultural Norms

> *Because modesty is no longer valued, promiscuity has been de-stigmatized, and people who wish to teach abstinence to teens are mocked. Also because drug addiction is so rampant and sex is a commodity — the trade of sex for drugs is common, often drug addicts have had countless sexual partners — Community Leader*

Access to Health Services

Health Insurance Coverage

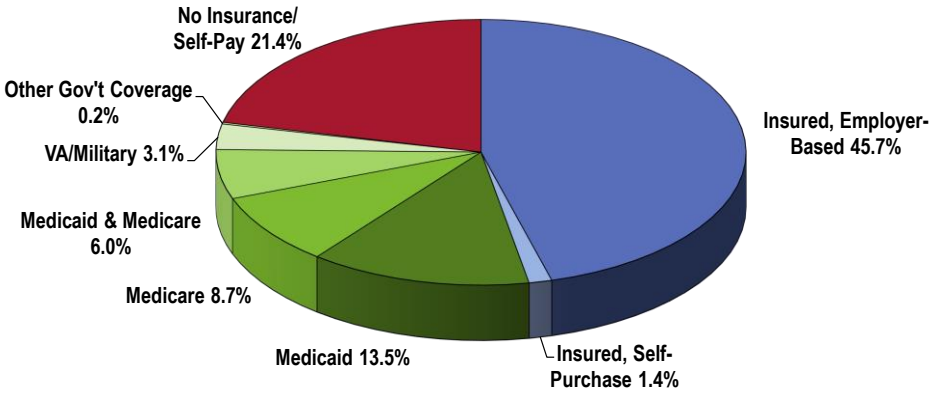
Type of Healthcare Coverage

A total of 47.1% of Primary Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 31.5% 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.

Healthcare Insurance Coverage

(Adults Age 18-64; Primary Service Area, 2019)



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, 21.4% report having no insurance coverage for healthcare expenses.

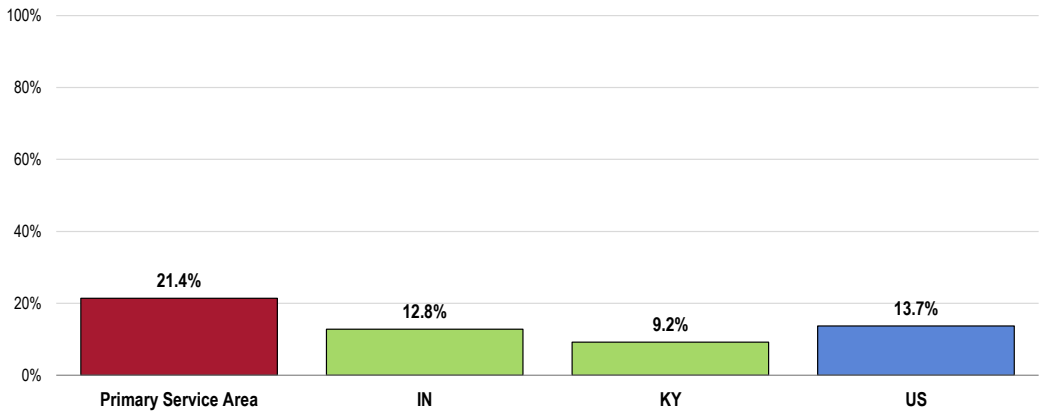
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

- **BENCHMARK**: The uninsured prevalence is far higher than state or national percentages. The Healthy People 2020 objective is universal coverage.

Lack of Healthcare Insurance Coverage

(Adults Age 18-64)

Healthy People 2020 = 0.0% (Universal Coverage)



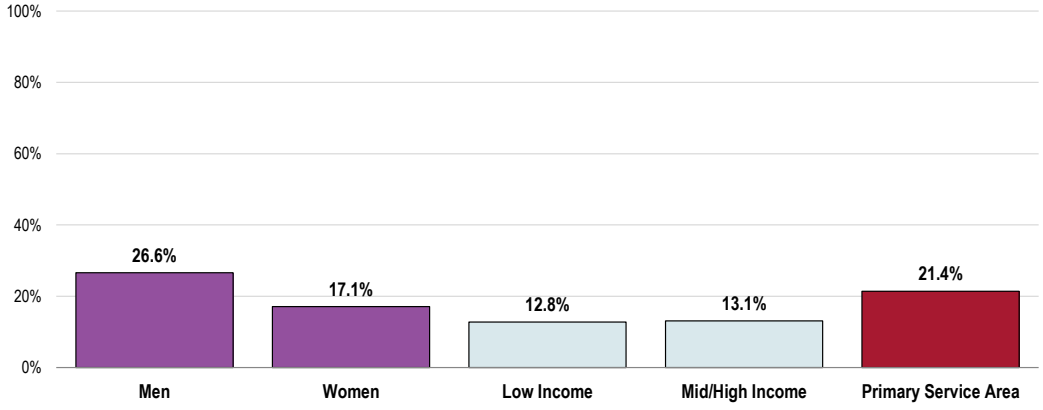
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 169]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health 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; Primary 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

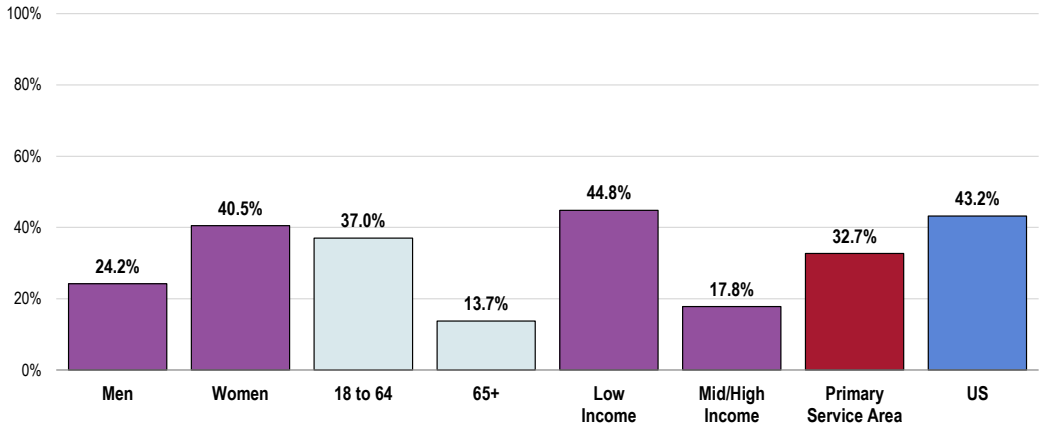
This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

A total of 32.7% of Primary Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- **BENCHMARK**: Lower than found nationally.
- **DISPARITY**: Significantly more common among women, adults under age 65, and low-income residents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(Primary Service Area, 2019)



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.
- 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

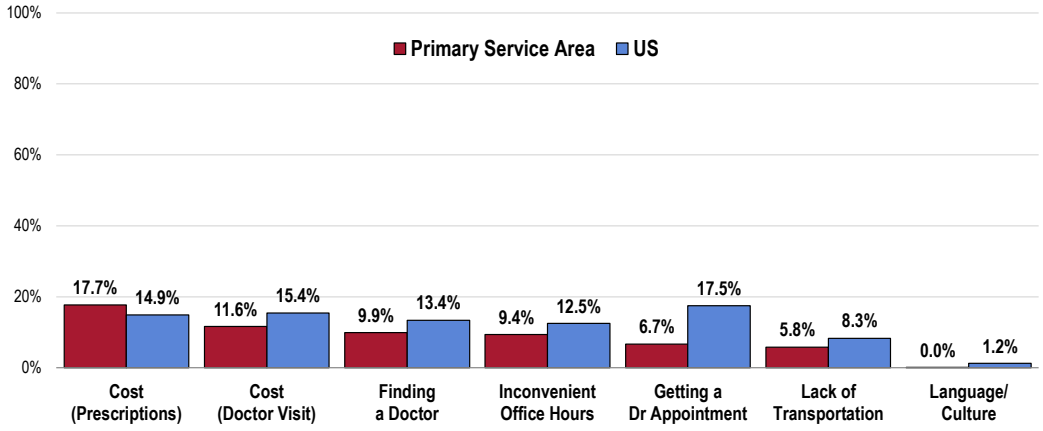
To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, cost of prescriptions impacted the greatest share of Primary Service Area adults.

- **BENCHMARK**: The prevalence of those reporting difficulty **getting an appointment** is significantly below the national proportion. Note that none of the Primary Service Area respondents reported **language/cultural barriers**.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 7-13]
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Note also that 16.0% of Primary 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

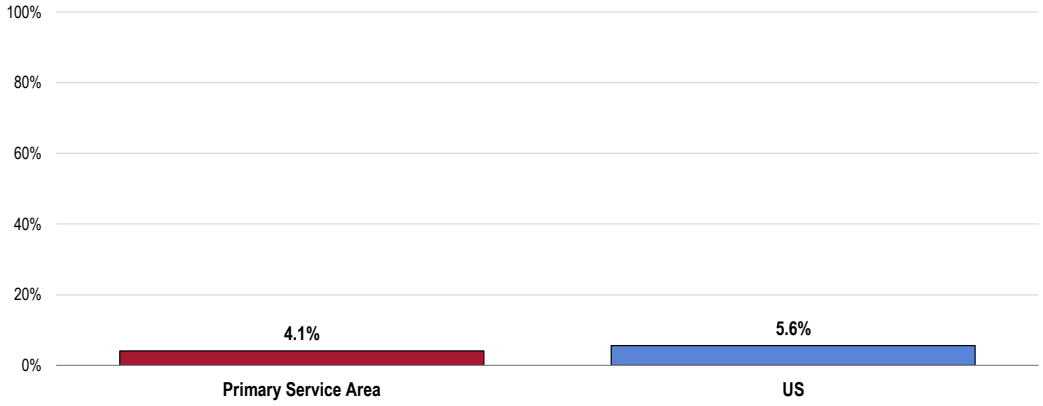
A total of 4.1% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

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.

- **BENCHMARK**: Statistically similar to the national percentage.

Had Trouble Obtaining Medical Care for Child in the Past Year

(Parents of Children 0-17)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 118]
- 2017 PRC National Health Survey, PRC, Inc.

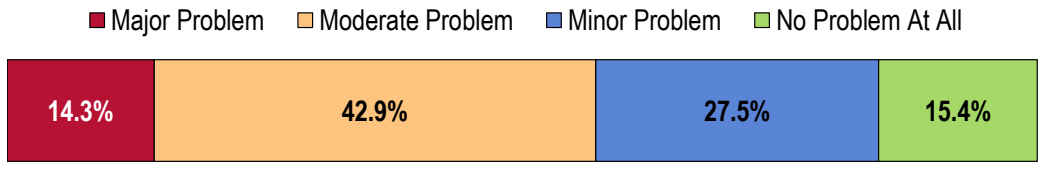
Notes:
- Asked of all respondents with children 0 to 17 in the household.

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)



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

Getting to see a physician in a timely manner. Even if you have a family doctor, it is still a month until you can get in. So you go to Urgent Care, which in turn, you are sent to the Emergency Room- like a revolving, expensive circle. — Other Health Provider

There are not enough services available, and you often need transportation to get to quality care. — Public Health Representative

The major challenge I see is not having doctors available to treat heart and sudden issues immediately at our local hospitals. Everyone is transferred to Louisville by air or by ambulance; this is difficult for families who have no ability to drive there or ability to visit. — Community Leader

Limited appointment availability, office hours. Provider or clinician shortage issues. Transportation barriers. Adequate insurance coverage not available. — Social Services Provider

Lack of qualified doctors. — Social Services Provider

Cost/Insurance Issues

Lack of coverage/inadequate coverage leads to no care. Dire situation where behavioral health, mental health/substance abuse is concerned, as there is often no inpatient beds for placement. — Other Health Provider

Finding a family physician who covers all insurances has become a severe problem. Also, finding a physician (period) has become a problem for many people. — Community Leader

People are unable to go to the doctor due to lack of insurance as well as cost. People are neglecting care because of cost. — Social Services Provider

Low cost health care and medical transportation. Many don't go to a doctor for these two reasons. — Social Services Provider

Limited services available and those in poverty have limited or no access. Health care coverage is too expensive. — Community Leader

Lack of Specialists/Specialty Care

There are not enough mental health care professionals. Also, the number of pediatric dentists who take Hoosier Healthwise is very low. — Social Services Provider

There are too few options for substance abuse treatment. — Community Leader

Homelessness

Our homeless population. Homelessness is closely connected to declines in physical and mental health; homeless persons experience high rates of health problems such as HIV infection, alcohol and drug abuse, mental illness, tuberculosis, and other conditions. Health problems among homeless persons result from various factors, such as barriers to care, lack of access to adequate food and protection, and limited resources and social services. — Social Services Provider

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified **mental health care** 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**
Mental Health Care	45.5%	27.3%	10.0%	**9**
Substance Abuse Treatment	45.5%	27.3%	0.0%	**8**
Elder Care	9.1%	9.1%	20.0%	**4**
Chronic Disease Care	0.0%	9.1%	20.0%	**3**
Primary Care	0.0%	9.1%	20.0%	**3**
Prenatal Care	0.0%	9.1%	0.0%	**1**
Urgent Care	0.0%	9.1%	0.0%	**1**
Dental Care	0.0%	0.0%	10.0%	**1**
Pain Management	0.0%	0.0%	10.0%	**1**
Palliative Care	0.0%	0.0%	10.0%	**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)

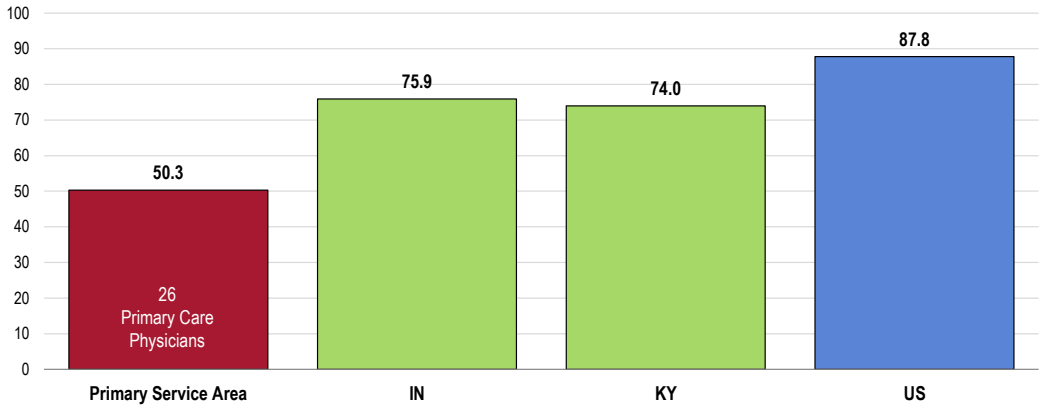
Access to Primary Care

In 2014, there were 26 primary care physicians in the Primary Service Area, translating to a rate of 50.3 primary care physicians per 100,000 population.

- **BENCHMARK**: Notably below state and (especially) national rates.

Access to Primary Care

(Number of Primary Care Physicians per 100,000 Population, 2014)



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.

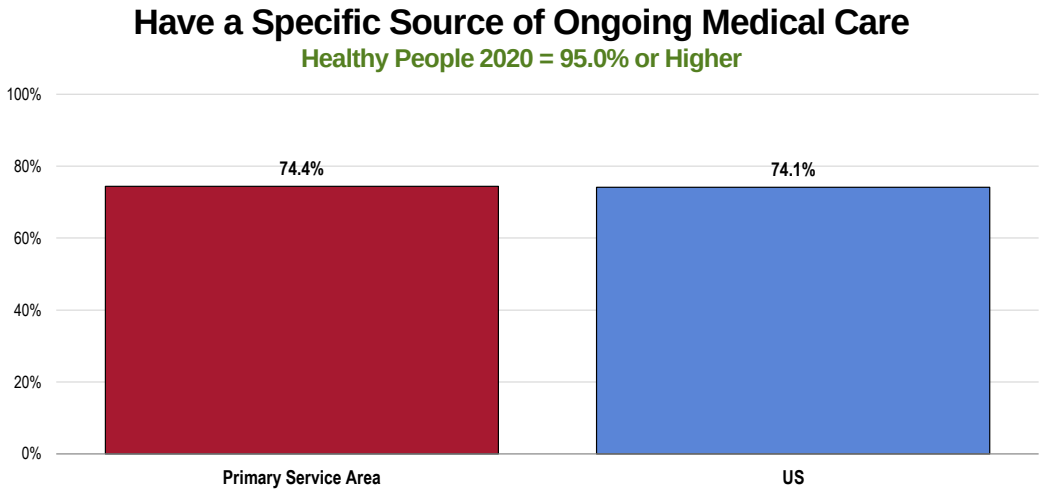
Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

More than seven in 10 Primary Service Area adults (74.4%) were determined to have a specific source of ongoing medical care.

- **BENCHMARK**: Far from satisfying the related Healthy People 2020 objective.



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.

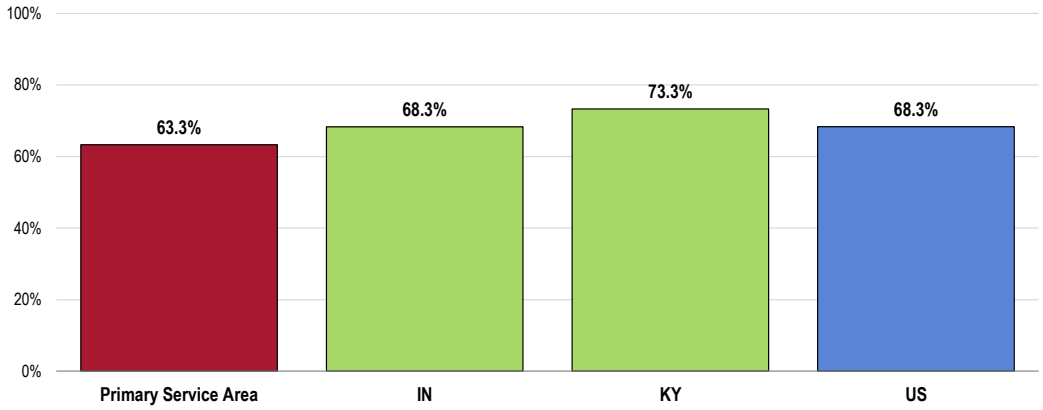
Utilization of Primary Care Services

Adults

Six in 10 area adults (63.3%) visited a physician for a routine checkup in the past year.

- **BENCHMARK**: Significantly below the Kentucky percentage.
- **DISPARITY**: Less common among adults under age 65, as well as among higher-income adults.

Have Visited a Physician for a Checkup in the Past Year

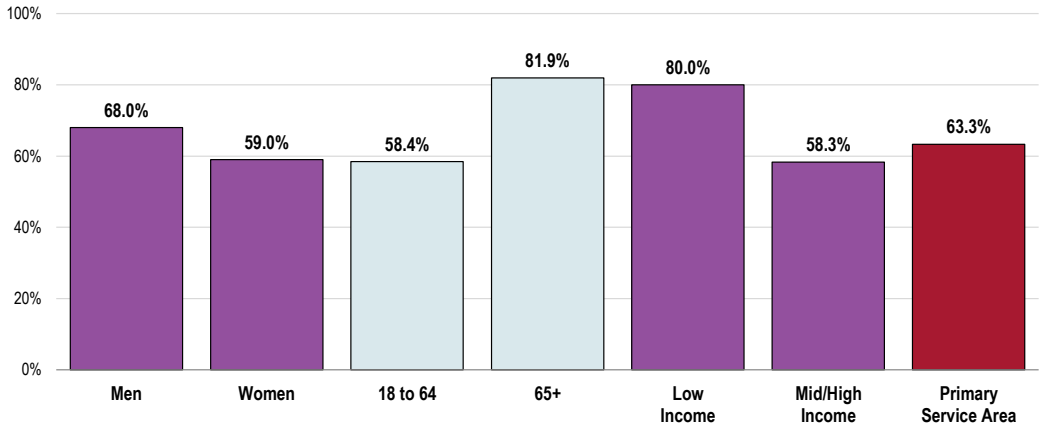


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Indiana & Kentucky data.
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year

(Primary Service Area, 2019)



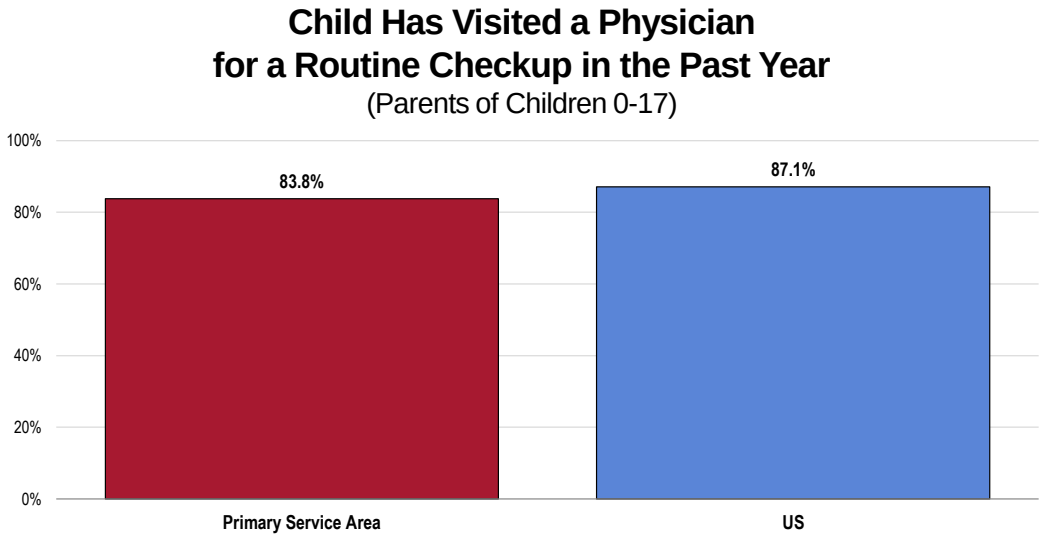
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 18]

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

Children

Among surveyed parents, 83.8% report that their child has had a routine checkup in the past year.

- **BENCHMARK**: Statistically similar to the national percentage.



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.

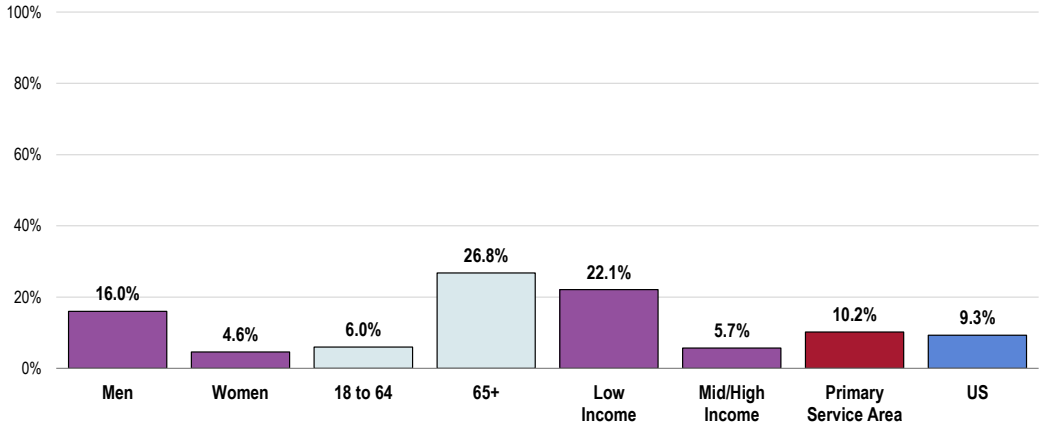
Emergency Room Utilization

A total of 10.2% of Primary Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- **DISPARITY**: Notably more common among men, older adults, and low-income residents.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(Primary Service Area, 2019)



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 22]
- 2017 PRC National Health Survey, PRC, Inc.

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.

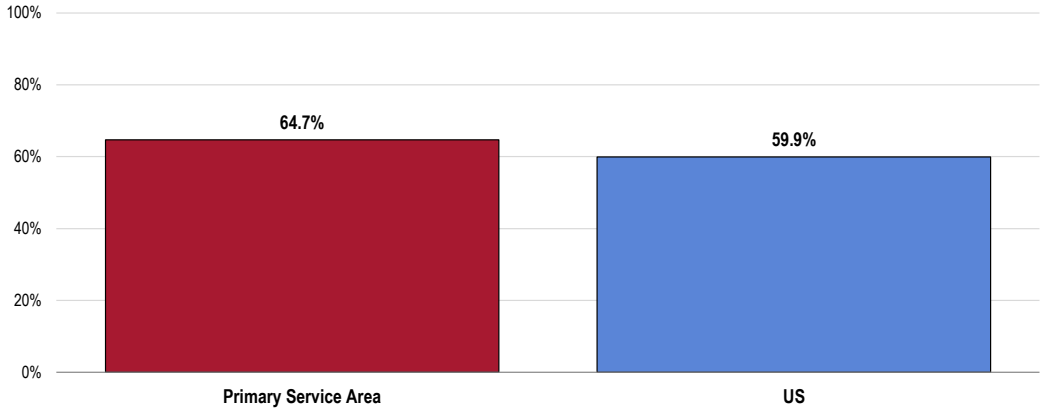
— Healthy People 2020 (www.healthypeople.gov)

Dental Insurance

More than six in 10 Primary Service Area adults (64.7%) have dental insurance that covers all or part of their dental care costs.

- **BENCHMARK**: Statistically similar to the national finding.

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

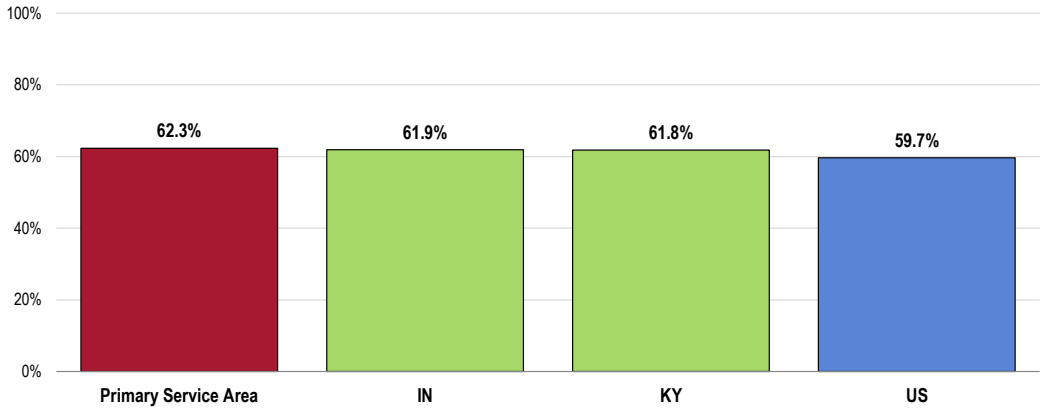
Adults

A total of 62.3% of Primary Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- **BENCHMARK**: Satisfies the related Healthy People 2020 objective.
- **DISPARITY**: Less common among men, older adults, and those without dental insurance.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 = 49.0% or Higher



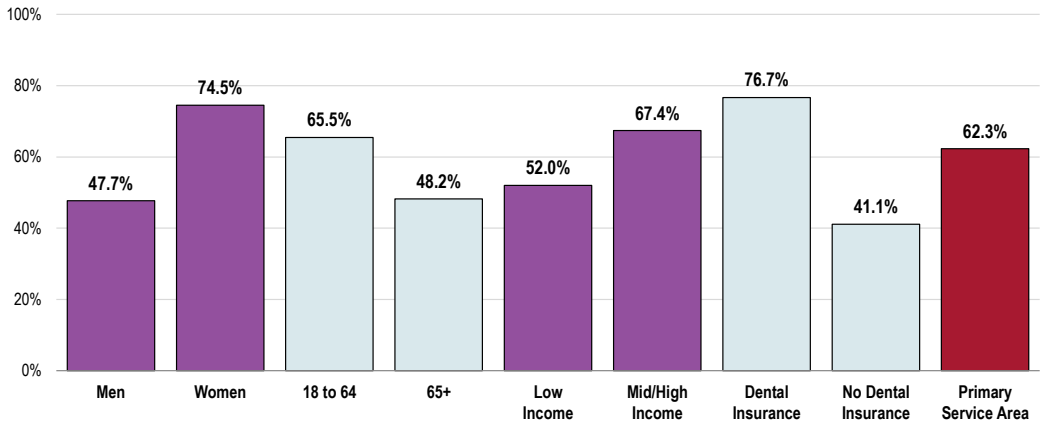
Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Indiana & Kentucky data.
- 2017 PRC National Health 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

(Primary 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

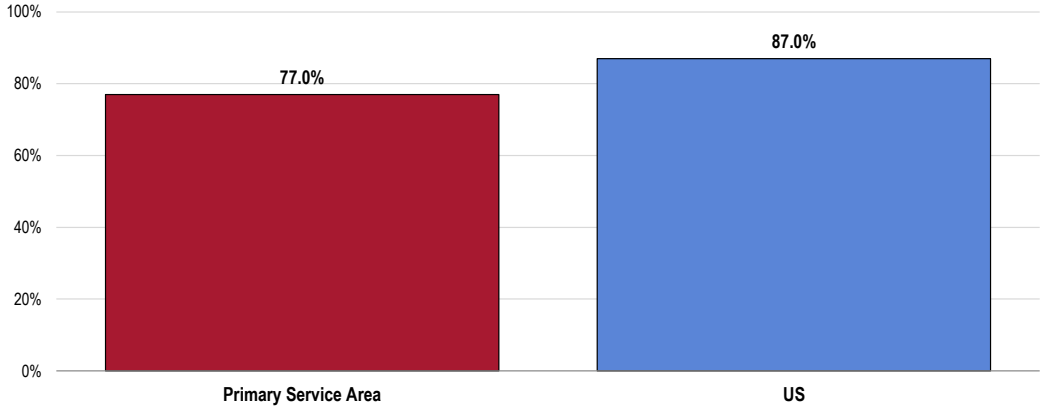
A total of 77.0% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- **BENCHMARK**: Easily satisfies the related 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

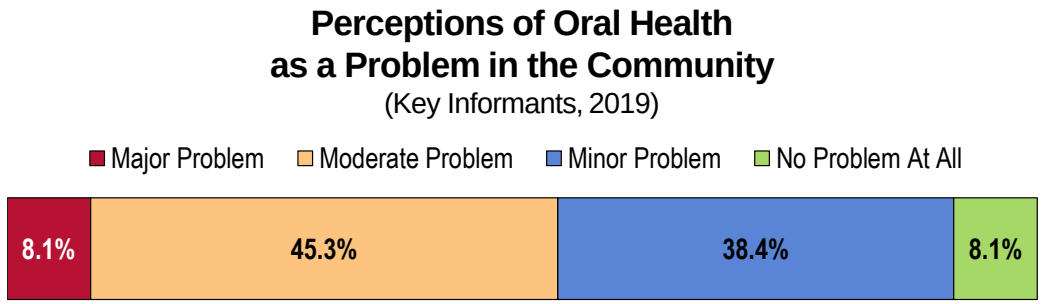


Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2017 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

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 "moderate problem" in the community.



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:

Cost/Insurance Issues

> *Many dentists want cost for services paid up front. Without (and sometimes with) insurance, families put off dental care and sometimes end up using emergency facilities for care. — Community Leader*
>
> *There are not enough pediatric dentists who take HHW. — Social Services Provider*
>
> *Lack of dentists accepting Medicaid and not wanting to see children under three years of age. Adults without dental insurance and dentist that don't accept all insurance. — Public Health Representative*
>
> *Many dentists do not take Medicaid or Medicare. — Community Leader*

Poverty

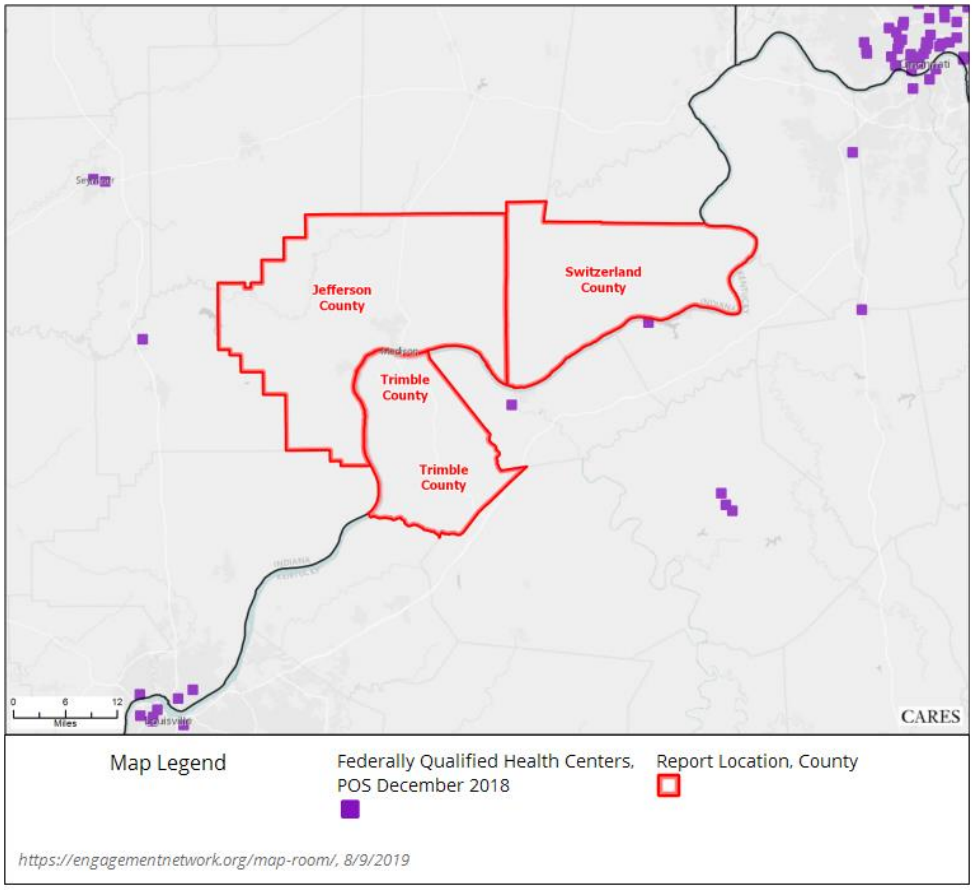
> *The amount of families we have living in poverty that do not attend to dental care for themselves or their children is significant. Severe dental decay is something that many of our local children suffer from. There was a free dental clinic at the clearinghouse in previous years, but it had a significant waiting list. I am unaware if it still exists. A local dentist travels to a neighboring county to provide free dental care to children in need at schools; however, that is not a service we offer in Jefferson County. — Social Services Provider*

Local Resources

Healthcare Resources & Facilities

Federally Qualified Health Centers (FQHCs)

The following map shows that there were no Federally Qualified Health Centers (FQHCs) within the Primary 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 to Healthcare Services

- *Dentist's Offices*
- *Doctor's Offices*
- *Healthcare Navigators*
- *Hospitals*
- *Jefferson, Trimble and Switzerland County Health Departments*
- *King's Daughters' Health*
- *LifeSpring*
- *LifeTime Resources*
- *Madison State Hospital*
- *Medication-Assisted Treatment (MAT) Treatment*
- *Nurse Managed Health Care*
- *Nursing Homes*
- *Ohio Valley Opportunities SIEOC (Southeastern Indiana Economic Opportunity Corporation)*
- *Social Services*
- *TeleHealth*
- *The Clearing House Project*
- *Trimble County CARES Coalition*
- *Trimble County Health Department*
- *Urgent Care*

Arthritis, Osteoporosis & Chronic Back Conditions

- *Convenient Care Facilities*
- *Doctor's Offices*
- *Fit For The King*
- *King's Daughters' Health*
- *King's Daughters' Home Care and Hospice*
- *Physical Therapy*
- *Planet Fitness*
- *YMCA*

Cancer

- *American Cancer Society*
- *Breast Cancer Support Group*
- *Dentist's Offices*
- *Doctor's Offices*
- *EPA Office*
- *Hospice*
- *Hospitals*
- *King's Daughters' Health*
- *King's Daughters' Home Care and Hospice*
- *PMC Urgent Care*
- *Relay for Life*
- *Retired Senior Volunteers Transport Program*
- *River Valley Resources (RVR)*
- *Support Groups*
- *Support Programs*
- *Swiss County Medical Clinic*
- *Trimble County Health Department (TCHD)*
- *Treatment Center*
- *Urgent Care*

Dementias, Including Alzheimer's Disease

- *Assisted Living Facilities*
- *Doctor's Offices*
- *Hickory Creek at Madison*
- *Home Health Services*
- *Hospitals*
- *Jewell House*
- *King's Daughters' Health*
- *LifeTime Resources*
- *Mental Health Services*
- *Nursing Homes*
- *The Waters of Clifty Falls*

Diabetes

- *Doctor's Offices*
- *Fitness Centers/Gyms*
- *Healthy Communities Initiative*
- *Hospitals*
- *King's Daughters' Health*
- *Purdue Extension Office*

School System
Weight Watchers

Family Planning

Doctor's Offices
King's Daughters' Health

Heart Disease & Stroke

American Heart Association
Anytime Fitness
Baptist Health
Cardiac Services
Doctor's Offices
Employers
Fit For The King
Fitness Centers/Gyms
Food Pantries
Health Department
Healthy Communities Initiative
Hospitals
King's Daughters' Health
Nursing Homes
Purdue Extension Office
Salvation Army
Urgent Care
Weight Watchers
YMCA

HIV/AIDS

Health Department

Immunization & Infectious Diseases

Health Department

Infant & Child Health

Department of Child Services
Education Services
First Steps
Head Start
Health Department
Healthy Communities Initiative
Healthy Families
King's Daughters' Health
Life Choices Clinic
Madison County CERT (Community Emergency Response Team) Association
Nurse-Family Partnership
Ohio Valley Opportunities (OVO)
Ohio Valley Resources
School System
Second Stories
Smoking Cessation Program
WIC

Injury & Violence

AA/NA
Boys and Girls Club
Centerstone
Jefferson County Community Corrections
Jefferson County Courts
King's Daughters' Health
Law Enforcement
LifeSpring
Prosecutor's Office
Safe Passage
Safe Place
Salvation Army
School System

Kidney Disease

American Dialysis Center
American Kidney Center (AKC)
Bluegrass Kidney Specialist
"Catch-a-Ride" Madison
Dialysis Centers
Doctor's Offices
Fresenius Kidney Care
Hospitals
King's Daughters' Health
Nephrology Associates

Mental Health

Behavioral Health Services
Bloomington Meadows
Centerstone
Churches
Community Mental Health
Cornerstone
Counseling Services
Dockside
Doctor's Offices
Healthy Communities Initiative
Hospitals
Intensive Wrap Around Services
Jefferson County Veterans Administration
King's Daughters' Health
LifeSpring
LifeTime Resources
Madison State Hospital
Mental Health Services
National Alliance on Mental Illness

Robert Pimlott LMFT
Salvation Army
School System
Substance Abuse Initiative
Suicide Prevention Hotline
The Clearing House Project
Town of Ireland
Wellstone
Youth Villages
Zero Suicide Initiative

Nutrition, Physical Activity & Weight

Anytime Fitness
Bike and Running Clubs
Businesses/Restaurants
City of Madison
Clifty Falls State Park
Community Weight Loss Challenges
Crystal Beach Water Fitness
Doctor's Offices
Farmer's Markets
Fit For The King
Fitness Centers/Gyms
Food Banks
Hanover College Fitness Center
Hatcher Hill Path
Health Department
Healthy Communities Initiative (HCI)
Healthy Lifestyles Initiative
Heritage Trail
Hospitals
House of Hope
Jefferson County Extension Office
King's Daughters' Health
Molly Dattilo Run
Parks and Recreation
Planet Fitness
Purdue Extension Office
Salvation Army
School System
Senior Citizen Center
Sports Programs
The Clearing House Project
Weight Watchers
WIC
YWCA

Oral Health

Canida Dentistry
Dentist's Offices
Salvation Army
The Clearing House Project

Respiratory Diseases

COPD Program
Doctor's Offices
Fitness Centers/Gyms
Health Department
Home Health Services
Indiana Stop Smoking Program
King's Daughters' Health
LifeTime Resources
Oxygen Companies
Pharmacies

Sexually Transmitted Diseases

Health Department
King's Daughters' Health
Life Choices Clinic

Substance Abuse

211
AA/NA
Celebrate Recovery
Centerstone
Churches
Clark Memorial
Clubs and Organizations for Kids
Community Corrections
Counseling Services
Court System
Doctor's Offices
Education Services
Fairbanks Alcohol & Drug Addiction Treatment Center
Halfway Houses
Health Department
Healthy Communities Initiative (HCI)
Hospitals
IOP (Intensive Outpatient Program)
Jefferson Men's House
King's Daughters' Health
LCC (Latino Chamber of Commerce), JC-JTaP (Jefferson County Justice Treatment and Prevention)
LifeSpring
Madison State Hospital

Mental Health Services
National Alliance on Mental Illness
New Life Fellowship Church
Outpatient Services
Police Department
Ruth Haven House
Salvation Army
School System
Substance Abuse Services
Support Groups
Wellstone

Tobacco Use

1-800-QUIT-NOW
Baby & Me Tobacco Free Program
Counseling Services
Doctor's Offices
Education Services
Health Department
Hospitals
Indiana Quitline
ITPC (Indiana Tobacco Prevention & Cessation) Commission
Jefferson County Tobacco Educator
King's Daughters' Health
School System
Smoking Cessation Program
Tobacco Coalition
Truth- A Tobacco Campaign

Vision & Hearing

Doctor's Offices

Appendix:
Evaluation of Past Activities

King’s Daughters’ Health

2017 – 2019 Implementation Strategy
Responding to the 2016 Community Health Needs Assessment

1373 E. SR 62 Madison, IN 47250 – Facility License # 16-005063-1
www.kdhmadison.org

Table of Contents

Introduction

The implementation strategy describes how King's Daughters' Health plans to address significant health needs identified in the 2016 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2017 through 2019.

The 2016 CHNA and the 2017 - 2019 implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The implementation strategy addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

King's Daughters' Health welcomes comments from the public on the 2016 Community Health Needs Assessment and 2017 – 2019 implementation strategy. Written comments can be submitted:

- By emailing the King's Daughters' Health Wellness department at foyh@kdhmadison.org;
- Through the mail to 1373 E. SR 62, P.O. Box 447 Madison, IN 47250;
- In-person at the KDH Community Relations Department, 600 West St. Madison, IN 47250.

About King's Daughters' Health

King's Daughters' Health (KDH) is a not-for-profit health network providing inpatient care in Madison, IN and offering physician offices in Jefferson, Ripley, and Switzerland Counties in Indiana and Trimble and Carroll Counties in Kentucky.

The mission of King's Daughters' Health is to improve the health of our patients through care, service, and education.

- In 2016, King's Daughters' Health invested over $9.4 million in Medicaid Unreimbursed Costs. In addition in 2016, KDH offered over $546,000 in Charity Care Costs to patients who could not afford to pay. King's Daughters' is the only inpatient health care facility available in Jefferson and Switzerland Counties in Indiana and Trimble County in Kentucky, providing services to insured and under/uninsured patients 365 days a year.

- In 2015 King's Daughters' Health opened a state-of-the-art Cancer Treatment Center at our main hospital campus. This center provides vital cancer services to patients in a five-county area, where access to local cancer care is limited.

- King's Daughters' Health continues to provide Emergency Medical Services for Jefferson County, Indiana. This valuable service is essential for local residents and has saved county tax payers more than 1.5 million dollars since 1998, when KDH offered to provide this service without financial support from local city and county government. In addition, KDH EMS routinely provides coverage for local sporting events and youth safety education programs in schools.

- King's Daughters' Health continues to support a full time Wellness Coordinator on staff. This individual is instrumental in offering additional programming, not featured in this document, to improve the health of the community. Programming such as a large women's health event, men's health event, weekly speaking engagements for schools, civic groups, and businesses, safety and self-defense workshops, special events like 5Ks that are hosted by KDH, and employee

Wellness efforts are part of the Wellness Coordinator's duties. In addition, this position coordinates a Girls on the Run council, which is national 12-week program that uses the power of running to teach health lessons and build confidence and self-esteem for girls in grades 3-5.

- The timing of this 2017-2019 Implementation Strategy is ideal for a brand new initiative led by King's Daughters' Health. Based on results from the CHNA, KDH is taking a lead role and pledged a commitment to create a Healthy Communities Initiative for Jefferson County. The idea to form a Healthy Communities Coalition was created from a county-wide vision plan titled Envision Jefferson County. KDH invested funding to pay for a part-time coordinator to lead the efforts in developing and supervising the Healthy Community Initiative. Key hospital leaders and community support staff created three HCI teams to set goals and implement programs, many that are found in this working document. Formal HCI efforts did not start until February 2017, so many program ideas and initiatives are currently in an infancy stage.

Every three years, King's Daughters' Health coordinates a Community Health Needs Assessment, which identifies local health care priorities and guides our community health programs. The assessments help ensure that we invest our community benefit dollars in a way that targets and address real community needs.

For more facts and information about King's Daughter's Health, visit www.kdhmadison.org

2016 Community Health Needs Assessment Summary

The full 2016 Community Health Needs Assessment (CHNA) and a Summary conducted by King's Daughters' Health is available at www.kdhmadison.org. King's Daughters' Health contracted with an independent marking consultant to complete the CHNA. The study included the following components:

- Analysis of secondary data to develop county profiles compared to state and national data.
- In-person interviews with lead KDH staff.
- In-depth telephone interviews with community leaders.
- Comments from community leaders in attendance at a Healthy Communities Initiative meeting.
- In-person written surveys with low income individuals.
- In-person written surveys with senior citizens.
- Web-based survey open to the general public.

Definition of the Community Served by the Hospital

King's Daughter's Health provides health care services to five counties in southern Indiana and northern Kentucky. The 2016 KDH CHNA included its primary service areas of Jefferson and Switzerland Counties in Indiana and Trimble County in Kentucky. The additional two counties (Ripley in Indiana and Carroll in Kentucky) have multiple health care facilities that currently conduct a CHNA. To avoid duplication, the three primary counties described were included in the 2016 KDH CHNA. A few descriptive demographic highlights for these three counties include:

Jefferson County, Indiana

Total population – 32,428, median age 40.9 (above state average of 37.0)
Racial/ethnic composition – 95.4% Caucasian
Percent poverty – 16.2% (above the state average of 15.2%)
Percent uninsured – 14% adults under 65 have no insurance (13.8% state average)
Unemployment rate – 6.0% (same as state average)
Education level – 15% of adults 25+ have less than a high school diploma (state average 12%)

Switzerland County, Indiana

Total population – 10,613
Racial/ethnic composition – 97.7% Caucasian
Percent poverty – 28%
Percent uninsured – 15.7% adults under 65 have no insurance
Unemployment rate – 4.9%
Education level – 18% of adults 25+ have less than a high school diploma

Trimble County, Kentucky

Total population – 8,769
Racial/ethnic composition – 94% Caucasian
Percent poverty – 17.4% (below state average of 18.9%)
Percent uninsured – 9.6% adults under 65 have no insurance (9.8% state average)
Unemployment rate – 7.2% (above the state average of 6.5%)
Education level – 15.8% of adults 25+ have less than a high school diploma (same state average)

Significant Health Needs Identified in the 2016 CHNA

The following significant health needs were identified in the 2016 CHNA:

1. SUBSTANCE ABUSE / ADDICTIONS
2. OVERWEIGHT AND OBESITY
3. TOBACCO USE
4. LACK OF PHYSICAL ACTIVITY
5. CHRONIC DISEASE
6. MENTAL HEALTH / SUICIDE

2017 – 2019 Implementation Strategy

The implementation strategy describes how King's Daughters' Health plans to address significant health needs identified in the 2016 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impact of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2016 CHNA.

The prioritized significant health needs the hospital will address are:

1. SUBSTANCE ABUSE / ADDICTIONS
2. OVERWEIGHT AND OBESITY AND LACK OF PHYSICAL ACTIVITY (COMBINED)
3. TOBACCO USE
4. CHRONIC DISEASE
5. MENTAL HEALTH / SUICIDE

SUBSTANCE ABUSE / ADDICTIONS

Name of program/activity/initiative	**Safe Drug Drop Off Program**
Description	King's Daughters' Health will support the Jefferson County Health Department with multiple drug drop off events each year. Many of these events will be hosted on the KDH campus. KDH will advertise all drop off events to medical providers, internally to staff, and through social media efforts.
Goals	To provide a safe alternative to disposing of unwanted prescription medications. Medications are incinerated by law enforcement after collection.
Anticipated Outcomes	To reduce the number of available prescription narcotics that are in the community. The stockpiles of medications that are in homes are known to be the first place where many children start their addictive behavior. Elderly individuals are also targeted by theft of narcotics in their own homes. Any medications disposed of improperly in toilets or trash cans eventually end up in water ways. Thus, safe collection and disposal of medications can lead to a cleaner environment.
Plan to Evaluate	Health Department and law enforcement tracking. KDH marketing department will also support by advertising these events and tracking methods of promotion.
Metrics Used to Evaluate the program/activity/initiative	The Health Department will evaluate the number of special drop off events each calendar year. The number of individuals dropping off drugs/medicine will be tracked as well as the total pounds of drugs collected. KDH will promote the drug drop off program by offering a minimum of three different promotional methods for each special event.

YEAR 1 – 2017 UPDATE:

- Number of drug drop off events in 2017: 5 (4 held on the KDH campus and 1 held at a community women's health event, sponsored by KDH).
The following numbers were measured for 3 of the 5 events.
- Number of individuals dropping off drugs/medicine: 142
- Total pounds of drugs collected: 327 lbs.
- Total pounds of syringes collected: 69 lbs.
- Methods of promoting drug drop off events: KDH Website, KDH social media (Facebook/Twitter), fliers posted in physician office areas, all staff KDH email reminders sent prior to each event.
A total of 9 different documented methods of promotion were recorded from participants who were asked how they heard about the drug drop off events.

*** To tackle the number one prioritized significant health need, KDH has taken a lead role with the newly formed Healthy Communities Substance Abuse team. Additional programs with KDH involvement that are not listed as indicators on the Implementation Strategy include:
- Host Substance Abuse team meetings at KDH. KDH employees serve as team members and team leaders.
- KDH collaborates with Second Stories Inc., an organization that provides parents with tools and resources to build successful families. The KDH OB department now makes direct referrals to the Mentors for Moms program which partners a positive role model with an at-risk mother who will provide support and education.
- Working with the Salvation Army and a local pastor, the Substance Abuse team created the Road to Recovery program. This program provides reliable transportation to treatment options for local individuals dealing with addiction.
- KDH physician offices and departments such as the Emergency Department now provide a referral list of local addiction support meetings to patients and patient families who need such resources.

YEAR 2 – 2018 UPDATE:

- Number of drug drop off events in 2018: 4 (all events were held at the KDH campus)
- Number of individuals dropping off drugs/medicine: 93
- Total pounds of drugs collected: 211 lbs.
- Total pounds of syringes collected: 59.5 lbs.
- Similar promotion methods for all drug drop off events occurred in 2018. In addition, fliers were distributed by the local health department. In 2018 a total of 10 different documented methods of promotion were recorded from participants who were asked how they heard about the drug drop off events.

*** KDH continues to take a lead role in the Substance Abuse team (part of the Healthy Communities Initiative). In 2018, KDH supported by:
- Hosting Substance Abuse team meetings at KDH. KDH employees serve as team members and team leaders. KDH also provides leadership on the executive team for the Local Coordinating Council (JCJTaP) which provides funding locally for substance abuse justice, treatment, and prevention.
- Supporting Second Stories Inc. with referrals. In addition, support has been given to the developments of support groups for addicts.
- Additional trainings for volunteer drivers for the Road to Recovery program were held in 2018.
- A community presentation was held in July 2018 on the impact of trauma/substance abuse.
- KDH Emergency Department and Social Services now provide CERT referrals for patients. CERT offers 24-hour assessments and provides support for patients and families in a substance abuse or mental health crisis. Treatment placement is also provided for those wanting substance abuse help.

OVERWEIGHT AND OBESITY AND LACK OF PHYSICAL ACTIVITY

Name of program/activity/initiative	**Fit Kids**
Description	Fit Kids is a curriculum-based health education program offered in the school classroom setting. KDH staff visit 5th grade school classrooms for 7 weeks offering lessons targeting the subject of childhood obesity. Age-appropriate education and weekly take-home challenges to involve families are offered each lesson. All health lessons focus on a specific area of nutrition and physical activity.
Goals	To extend the Fit Kids program to both Switzerland County, IN and Trimble County, KY elementary schools. In addition, the program will continue to be offered to all Jefferson County elementary schools.
Anticipated Outcomes	Improved heart health knowledge, increase physical activity for children, and improved nutrition choices such as; increase water intake, decrease high sugary beverages, increase in fruit and vegetable consumption, controlled portion sizes, and increase percentage of children who consume breakfast each day.
Plan to Evaluate	Pre/post surveys, weekly take home challenge participation.
Metrics Used to Evaluate the program/activity/initiative	A new pre/post survey will be developed and implemented for all participating students. Instructors will track percent of students who complete weekly take-home challenges.

YEAR 1 – 2017 UPDATE:

- The program was offered at four school systems in Jefferson County.
- The goal to expand the program to Switzerland County will be achieved in early 2018 (all prep work completed in 2017).
- A total of 18 classrooms were reached. This included 331 students and 18 teachers.
- New education handouts for students to take home were implemented in 2017.
- After discussion with school staff, a pre/post survey not implemented. The program is offered in a limited 30-minute teaching window, and with the high volume of required academic testing needed in the classrooms, it was decided not to add an additional pre-post test/survey. Students are still given a chance to share on a paper format what they learned in the program and a healthy change they have made in their life.
- Take home weekly challenges were updates for both exercise and nutrition. Number of students who completed these challenges was shown by a quick raising of hands, but formal numbers were not tracked. This will be considered for 2018.

YEAR 2 – 2018 UPDATE:

- The program was offered at three school systems in Jefferson County.
- One of the two elementary schools in Switzerland County were added. This included three new 5th grade classrooms.
- A total of 18 classrooms were reached. This included 382 students and 18 teachers.
- New visual aids were added in 2018.
- A new hospital Foundation fundraiser was added in 2018. Proceeds from this event were designated to the Fit Kids program. This funding will help cover stipend pay for additional Fit Kids instructors to assist the Wellness Coordinator and a healthy snack and gift for all 5th grade students. These items are given in the final week's review lesson.

Name of program/activity/initiative	**Healthy Communities Initiative (HCI) – Healthy Lifestyles Team, Community-Wide Wellness Challenges**
Description	The newly formed Healthy Lifestyles team will create and implement a minimum of one community-wide Wellness challenge each calendar year. These challenges will be incentive-based and open to all county residents.
Goals	Create creative challenges that will motivate participants to improve their health. The team will work to get as many local residents involved by targeting promotion and signups to industries/businesses, schools, churches, and civic groups.
Anticipated Outcomes	Increase physical activity, improve nutritional habits, and improve misc. healthy lifestyle choices like stress management and quality/quantity of sleep. The ultimate outcome is to lower the rate of overweight and obese residents in the community.
Plan to Evaluate	The Healthy Lifestyles team, under the leadership of the HCI Coordinator and Wellness Coordinator will evaluate participation levels and any biometric measurements that can be captured. Participation surveys will be offered when possible.
Metrics Used to Evaluate the program/activity/initiative	Number of challenges each calendar year will be documented along with number of individuals participating and percent of people who complete/finish the challenge. Challenge tracking tools will be measured, depending on the theme/focus of the challenge; example- calculating total steps, exercise minutes, change in BMI, servings of fruits/vegetables, etc.

YEAR 1 – 2017 UPDATE:

- Healthy Lifestyles team met 9 times in 2017. The team has 44 members.
- A June Healthy Lifestyles Challenge was held with over 200 participants. A large kick off event was held with 30 incentive prizes offered. Participants were challenged to complete tasks in the following categories: *Physical Activity, Nutrition, Community, and Mindfulness.*
- A survey was conducted to gather feedback to improve future challenges.
- In addition, the Healthy Lifestyles team held a Healthy Youth Tailgate event, focusing on physical activity and healthy eating for area youth. Over 400 people were in attendance.

YEAR 2 – 2018 UPDATE:

- Healthy Lifestyles team met 12 times in 2018. The team has 59 members.
- Frequent updates are made for the Healthy Lifestyles resource guide. This Jefferson County guide is available on-line and in print.
- A 2018 Lighten Up Jefferson County community weight loss challenge was held. 126 adults participated with a recorded 391 lb. total weight loss.
- A summer Healthy Lifestyles Challenge was held again in 2018.
- Summer community Pep Walk was held.
- A fall 2018 Healthy Youth Tailgate event was held with 400 in attendance, 20 health education booths, and 50 volunteers.

Name of program/activity/initiative	**Strive for 5 Weight Loss Education Class**
Description	This 5-week class series teaches basic weight loss concepts and focuses on different aspects of healthy nutrition and exercise each week. Class participants weigh during the first and last class. The one-time class fee of $5 is refunded to anyone who loses at least 5 pounds of their body weight.
Goals	Offer a minimum of three 5-week class series each calendar year, with a minimum of 30 participants. Achieve a 50% rate each class series for participants who lose the minimum of 5 pounds of body weight during the 5 week class series.
Anticipated Outcomes	Improve nutritional habits and increase physical activity for all class participants. Motivate, educate, and assist class participants to reduce BMI.
Plan to Evaluate	Strive for 5 instructor calculations.
Metrics Used to Evaluate the program/activity/initiative	Track number of class series offered, number of participants, and attendance. Offer pre and post body weight checks and measure any weight change.

YEAR 1 – 2017 UPDATE:

- One 5-week class series was held in 2017 with 9 total participants.
- 9 total participants. 78% of participants completed the 5 week program.
- Class lost a total of 30 lbs. and 86% of participants lost weight. 43% of participants who completed the class lost the suggested 5+ lbs. during the class.

YEAR 2 – 2018 UPDATE:

- Two 5-week class series was held in 2018 with 19 total participants.
- 9 total participants. 75% of participants completed the 5 week program.
- These classes lost a total of 56.6 lbs. and 85% of participants lost weight. 35% of participants who completed the class lost the suggested 5+ lbs. during the class.

TOBACCO USE

Name of program/activity/initiative	**Outreach through WIC and OB/GYN providers**
Description	Tobacco Prevention and Cessation Coordinator, employed full time at KDH, will provide educational literature and resources regarding the health and financial effects of smoking during pregnancy through WIC and KDH OB/GYN providers. The coordinator will meet with women face to face as necessary to provide counseling and additional resources.
Goals	Decrease smoking rate among pregnant women.
Anticipated Outcomes	The main anticipated outcome is a decreased smoking rate among pregnant women, which would also lead to decreased pre-term births, low birth weight and birth defects due to smoking.
Plan to Evaluate	WIC and OB/GYN provider tracking, Indiana State Department of Health/CDC statistics and reports.
Metrics Used to Evaluate the program/activity/initiative	Number of pregnant women who receive educational materials, resources, counseling, etc.

YEAR 1 – 2017 UPDATE:

- Number of OB/GYN patients referred to the tobacco Quitline – 9.
- All new OB patients received written tobacco literature in new patient bags.
- Additional training provided to WIC clinic and OB/GYN providers on cessation resources.
- 2017 Jefferson County smoking while pregnant rate decreased to 30.4% (was 31.3% in 2016).

YEAR 2 – 2018 UPDATE:

- Number of OB/GYN patients referred to the tobacco Quitline – 32.
- Education/cessation literature continues to be provided to each OB patient.
- 2018 Jefferson County smoking while pregnant rate decreased to 28.2% (was 31.3% in 2016 and 30.4% in 2017).

Name of program/activity/initiative	**Indiana Tobacco Quitline**
Description	KDH Tobacco Prevention and Cessation Coordinator will promote the Indiana Tobacco Quitline in order to increase the number of people who utilize or are referred to the Quitline via their medical provider or employer. The Quitline is a free resource for all IN residents that connects them with a cessation counselor and provides free Nicotine replacement products for those enrolled in Medicare, Medicaid, or are uninsured.
Goals	Decrease smoking rate among adults.
Anticipated Outcomes	The main anticipated outcome is a decreased smoking rate among adults, which would also lead to a decreased incidence of chronic disease and illness due to smoking.
Plan to Evaluate	Tobacco Prevention and Cessation tracking and reports.
Metrics Used to Evaluate the program/activity/initiative	Number of Quitline calls, number of Quitline referrals, number of patients who accept Quitline services, data regarding how patients are hearing about the Quitline.

YEAR 1 – 2017 UPDATE:

- Number of 2017 Quitline referrals – 194.
- Number of accepted services – 18.
- Number of declined services – 44.

YEAR 2 – 2018 UPDATE:

- Number of 2018 Quitline referrals – 181.
- Number of accepted services – 32. (does not include Nov/Dec due to error in report)
- Number of declined services – 51. (does not include Nov/Dec due to error in report)

Name of program/activity/initiative	**Youth outreach through schools and youth organizations**
Description	KDH Tobacco Prevention and Cessation Coordinator will hold presentations and organize activities at schools and youth organizations regarding health effects of tobacco use, and the marketing tactics of big tobacco and e-cigarettes.
Goals	Decrease current youth smoking rates and discourage youth from smoking. Educate youth about marketing tactics of big tobacco used to target young people.
Anticipated Outcomes	The main anticipated outcome is a decreased smoking rate among youth, as well as a more educated group of youth who do not desire to start smoking and can also recognize the tactics big tobacco uses to target young people.
Plan to Evaluate	Surveys, pre and post tests, IN State Department of Health and CDC statistics and reports.
Metrics Used to Evaluate the program/activity/initiative	Number of presentations, number of students reached, survey and test results.

YEAR 1 – 2017 UPDATE:

- Four tobacco presentations were held at area elementary schools and the local Boys & Girls Club. An estimated total of 400 youth in attendance. No survey or test results were used in 2017.

YEAR 2 – 2018 UPDATE:

- Eight youth-based tobacco presentations were held in 2018.
- One youth-based cigarette butt clean up event was held with support of the Boys & Girls Club staff and youth members.
- KDH participated in the youth tobacco survey at Switzerland County High School.
- KDH participated in the STARS tobacco retail survey in Jefferson County.

Name of program/activity/initiative	**Outreach through Respiratory Therapy department**
Description	KDH Tobacco Prevention and Cessation Coordinator will provide free nicotine patches for respiratory therapy patients at KDH. Patients who smoke and suffer from COPD will be offered nicotine replacement products and educational information regarding the health effects of smoking, as well as information about the IN tobacco Quitline. Patches will be purchased through a grant, funded from the Jefferson County Justice, Treatment, and Prevention coalition.
Goals	Assist respiratory patients with smoking cessation.

Anticipated Outcomes	The main anticipated outcome is a decreased number of respiratory patients that smoke, which would also lead to improved respiratory function, and possibly a decreased chance of hospital admissions.
Plan to Evaluate	Respiratory department tracking.
Metrics Used to Evaluate the program/activity/initiative	Number of patches distributed, number of patients seen in respiratory department, number of COPD patients who smoke.

YEAR 1 – 2017 UPDATE:

- Number of patches given by Respiratory department to patients in 2017: 15
Supply of these patches ran out. Additional grant to purchase more patches is secured for the following calendar year.
- Number of patients in Respiratory department to receive smoking cessation information in 2017: 50
Note – The exact number of COPD patients who smoke was not found.

YEAR 2 – 2018 UPDATE:

- Number of patches given by Respiratory department to patients in 2018: 5
- The number of inpatients to receiving smoking cessation information from the Respiratory Department staff in 2018 was not recorded. All inpatient who are labeled as tobacco users are offered cessation counseling. Quitline referrals are offered and cessation information (brochures, literature, items such as stress balls) are given when the patient is willing to accept.
A better tracking system will be put into place for 2019 to improve tobacco cessation for inpatients.

CHRONIC DISEASE

Name of program/activity/initiative	**House of Health**
Description	The KDH Wellness Department will offer a monthly education program targeting chronic disease prevention and early detection at the House of Health food pantry. The House of Health program is the largest community food pantry in the county. The program serves an average of 400 low-income families per month.
Goals	Lower chronic disease risk by offering valuable health information and free screens to a low-income population.
Anticipated Outcomes	Improve knowledge and health awareness by offering information on such topics as; Heart disease, skin and breast cancer prevention and detection, STD/HIV prevention and detection, basic first aid, etc.
Plan to Evaluate	Personal success stories shared from participants will be documented.
Metrics Used to Evaluate the program/activity/initiative	Number of House of Health sessions held. The number of people in attendance will be measured. The number of people participating in free screening services will be measured (example – blood pressure, skin cancer screen).

YEAR 1 – 2017 UPDATE:

- Twelve programs were held in 2017.
- Attendance ranged from 30-70 people each month.
- Topics included: *Healthy goal setting, heart health, nutrition, STD/HIV/Hep C, first aid, mosquitos, skin cancer, immunizations, tobacco, breast cancer, food safety, weight loss.*
- The only biometric screen offered in 2017 was blood pressure. A total of 21 individuals were screened.

YEAR 2 – 2018 UPDATE:

- Eleven programs were held in 2018.
- Attendance ranged from 30-75 people each month.
- Topics included: *Heart health, nutrition, STD/HIV/Hep C, tobacco, mosquitos, skin cancer, immunizations, Healthy Communities, breast cancer, food safety, weight loss.*
- The only biometric screen offered in 2018 was blood pressure. A total of 25 people were screened.

Name of program/activity/initiative	**Chronic Obstructive Pulmonary Disease (COPD) Readmission Prevention Program**
Description	A multi-disciplinary team of staff at KDH will target COPD patients and the problem of readmission. Readmission is costly to the patient, the health care organization, the insurance company, and readmissions increase health concerns for the patient. Emergency medication kits will be provided to COPD patients with details instructions for use and self-home care. Take-home binders with health education are also given to all COPD patients.
Goals	To decrease readmission for COPD patients.
Anticipated Outcomes	Improve chronic disease management skills so the patient can manage problems safely and effectively at home, to avoid a return to the hospital for readmission.
Plan to Evaluate	Readmission rates are measured by a program titled Medisolve. Follow up patient phone calls are also documented.
Metrics Used to Evaluate the program/activity/initiative	The number of COPD patients will be measured. The number of COPD emergency med kits and the number of health education binders distributed will be documented.

YEAR 1 – 2017 UPDATE:

- # of emergency med kids distributed to COPD patients: 197
- # of health education binders distributed to COPD patients: 226
- All patients received a minimum of two follow up phone calls.

Note- Readmission COPD rate for 2017 was 12.6%.

YEAR 2 – 2018 UPDATE:

- # of emergency med kids distributed to COPD patients: 146
- # of health education binders distributed to COPD patients: 74
- A total of 178 documented follow-up phone calls were made in 2018 to COPD patients.

Note- Readmission COPD rate for 2018 was 13.3%.

Name of program/activity/initiative	**Congestive Heart Failure (CHF) Readmission Prevention Program**
Description	Home scales to track body weight will be given to CHF patients in need. CHF education binders with health instructions for home care will also be given to all CHF diagnosed patients. Multi-disciplinary In addition, the ACO Coordinator will provide follow-up with individuals on an out-patient level, providing reminders of appointments, attending physician office visits if needed, and will serve as a resource to help patients meet needs.
Goals	To decrease readmission for CHF patients.

Anticipated Outcomes	Improve chronic disease management skills so the patient can recognize problems safely and effectively at home, to reduce risk of returning to the hospital for a readmission.
Plan to Evaluate	Readmission rates are measured by a program titled Medisolve. Follow up patient phone calls are documents one week after discharge.
Metrics Used to Evaluate the program/activity/initiative	The number of CHF patients will be measured. The number of scales given for home use and the number of health education binders distributed will be documented. The number of home phone calls will be tracked and statistics will be gathered from the ACO coordinator.

YEAR 1 – 2017 UPDATE:

- # of scales distributed to CHF patients: 18
- # of health education binders distributed to COPD patients: 72
- All patients received a minimum of two follow up phone calls.

Note- Readmission CHF rate for 2017 was 12.7%.

YEAR 2 – 2018 UPDATE:

- # of scales distributed to CHF patients: 19
- # of health education binders distributed to COPD patients: 85
- All patients received a follow up phone call.

Note- Readmission CHF rate for 2018 was 15.6%.

MENTAL HEALTH / SUICIDE

Name of program/activity/initiative	**Healthy Communities Initiative (HCI) – Mental Health/Suicide Team, Resource Guide**
Description	The newly formed Mental Health/Suicide Team will promote available trainings designed to teach people how to recognize individuals who are at risk for suicide and offer early intervention to resources.
Goals	Increase the number of individuals who are trained in a structured program such as, but not limited to; Question Persuade and Refer (QPR) or Applied Suicide Intervention Skills Training (ASIST). Create a resource guide that highlights all suicide prevention personal and any/all local mental health/suicide resources in the community. Promote and advertise this resource guide county-wide. In addition, KDH will increase the number of KDH staff members who are trained in QPR or Asist.
Anticipated Outcomes	By increasing the number of people trained in suicide support, the ultimate outcome is to reduce the number of suicide attempts and deaths.
Plan to Evaluate	Mental Health/Suicide Team tracking.
Metrics Used to Evaluate the program/activity/initiative	Number of trained suicide prevention personal. Work with KDH IT and ER staff and the county Coroner's office to obtain number of suicide attempts and number of suicide deaths each calendar year. Number of promotional methods for the resource guide will be tabulated.

YEAR 1 – 2017 UPDATE:

- Three ASIST/QPR trainings were held in Jefferson County in 2017. A KDH Emergency Department was in attendance at a training.
- In addition, KDH hosted a speaker in 2017 who facilitated a community meetings on what a Zero Suicide Initiative would mean for Jefferson County. Following this meeting, a formal group was put in place to begin working on this Initiative and funding opportunities. (Successfully secured, see next indicator). KDH staff members were in attendance at this event.
- KDH hosted a state Suicide Prevention Coordinator to discuss suicide prevention needs in the county. KDH staff members were in attendance at this event.
- A formal mental health resource guide was not formally created in 2017, but work was conducted to include Jefferson County in the Look Up Indiana website, which is a state-wide resource guide.
- Jefferson County is now fully participating in the Indiana Violent Death Registry System, which will enable KDH to work with the Coroner's office to obtain the number of suicide deaths per year.

YEAR 2 – 2018 UPDATE:

- Multiple suicide-focused trainings were held in 2018:
  - AMSR (Accessing and Managing Suicide Risk) training held at KDH – 25 people trained.
  - Three Mental Health First Aid training classes held – 78 people trained.
  - Six Jefferson County professionals attended the Indiana State Suicide Prevention Conference.
  - QPR/Question, Persuade, Refer Train the Trainer held – 19 people trained.
  - safeTALK Suicide Prevention Train the Trainer held.
  - ASIST Train the Trainer held – 15 people trained.

Name of program/activity/initiative	**Healthy Communities Initiative (HCI) – Mental Health/Suicide Team, School Based Mental Health Grant**
Description	A large grant, which will support a comprehensive Mental Health/Suicide prevention program in the county's largest school system, will be researched, written, and submitted. If grant funding is obtained, this program will be based out of the Madison Consolidated School system's special services and counseling departments. The HCI Mental Health/Suicide team will support the school system with all programming implemented from grant funding.
Goals	Obtain grant to bring a comprehensive Mental Health / Suicide program to the Madison Consolidated School system.
Anticipated Outcomes	Awarding of grant funding. The ultimate outcome is to reduce the number of suicide attempts and deaths from suicide. Secondary outcomes include; reduce bullying concerns, improve self-worth in students, increase supportive resources for students, school staff, and families, and improve counseling services.
Plan to Evaluate	* See below, metrics used to evaluate.
Metrics Used to Evaluate the program/activity/initiative	* Since grant funding is not confirmed at the time of Implementation Strategy submission, metrics will currently not be determined. If/when funding is established, the Special Services and Counseling departments of MCS will work with the Mental Health/Suicide team to determine evaluation methods and metrics.

YEAR 1 – 2017 UPDATE:

- Two large grants were received in 2017 targeting mental health/suicide.
    * KDH supported MCS and the HCI mental health team to apply for a Lilly Grant. This 3-year grant was successfully received and work is in place to bring a comprehensive mental health/suicide program to the school system beginning in 2018.
    * A $40,000 grant from the Community Foundation of Jefferson County was awarded to the HCI mental health/suicide team. This money will be used to establish a Zero Suicide Initiative Plan for the Jefferson County. A core team of twelve individuals, including a KDH representative, will work to implement the plan beginning in 2018.

YEAR 2 – 2018 UPDATE:

Zero-Suicide plan began in 2018 with $40,000 grant. Accomplished activities supported by the grant include:

- County-wide 40-day Kindness Challenge held.
- Community and school-based presentations held with author of A Case for Kindness.
- Community wide presentation held with Kevin Hines, suicide survivor.
- Suicide hotline posters (and frames) printed and placed around the county.
- PATHA Curriculum funded and implemented in the fall of 2018 at area elementary school.
- Multiple suicide-focused trainers were held (see previous indicator).

MCS-based Lilly Grant work continues independently.

Name of program/activity/initiative	**Support local suicide support group(s) and area awareness activities**
Description	KDH will support the local suicide support group and any suicide prevention community activities.
Goals	Promote suicide support group to all internal KDH staff and patients. Support the group by offering meeting space if needed. Support local Out of the Darkness Suicide Awareness community event. Promote the event to staff, form a team of KDH employees, encourage financial donations, and secure that donations are being used on a local level.
Anticipated Outcomes	Increase number of attendees at monthly suicide support group. Increase number of participants and funds raised for local suicide awareness walk event.
Plan to Evaluate	Social Services staff at KDH will work with suicide support group facilitator.
Metrics Used to Evaluate the program/activity/initiative	Track number of participants at monthly suicide support group meetings. Report number of participants at community Out of the Darkness awareness event, dollars raised at the event, and % of dollars that will stay local in Jefferson County.

YEAR 1 – 2017 UPDATE:

- Due to staffing changes, a KDH-led team did not participate in the Out of the Darkness walk. KDH did help to promote the event and served as a financial sponsor. Jefferson County hosted 1 of 18 walks in Indiana. $21,101 was raised at the 2017 Jefferson County walk. Funds were distributed for programs throughout Indiana by the American Foundation for Suicide Prevention (AFSP). A KDH employee serves as one of the coordinators for the Jefferson County Out of the Darkness walk.
- A formal suicide support group did not meet consistently in 2017. When meetings resume, KDH will help to promote this support group with advertising and patient referrals.
- Additional community activities include a Suicide Survivor Candlelight Service that was held in 2017 through joint efforts of the Greater Ministerial Association and HCI/KDH.

YEAR 2 – 2018 UPDATE:

- Almost $25,000 was raised at the 2018 Out of the Darkness walk in Jefferson County. Some of this money raised remained in the county to purchase books/teaching materials for the suicide prevention trainings mentioned above. KDH promoted this event to all employees for participation and served as a financial sponsor for the event.
- Candlelight service held in conjunction with World Suicide Prevention Day again in 2018.

Plans not to address the following needs:
No hospital can address all of the health needs present in its community. King's Daughters' Health is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2016 Community Health Needs Assessment:

1. KDH will focus strategies targeting **Substance Abuse / Addictions** primarily to residents of Jefferson County, Indiana. KDH will continue to be involved in the local coordinating council in Switzerland County, the Switzerland County Awareness Team (SCAT) to support programs funded through SCAT dollars. These programs target substance abuse prevention, treatment, and justice efforts. KDH will encourage staff from the Switzerland County physicians practice office to stay informed with SCAT efforts and any county programming targeting substance abuse. KDH will not have an active presence in Trimble County Kentucky regarding substance abuse concerns due to lack of staffing and resources. Residents of both Switzerland and Trimble Counties have the potential to indirectly benefit from strategies in Jefferson County, as many residents in these neighboring counties work, shop, dine, or even go to school in Jefferson County.

2. Two of the three strategies targeting **Overweight / Obesity and Lack of Physical Activity** have the potential to benefit residents in all three counties surveyed in the 2016 CHNA. Residents in Switzerland and Trimble counties will have the ability to participate in the Strive for 5 classes, just like Jefferson County residents. The Fit Kids program will expand to elementary schools in Switzerland County and potentially Trimble County at a later date. The HCI Healthy Lifestyles Wellness challenge will be exclusive to Jefferson County residents. This is due to HCI currently focusing efforts in Jefferson County. Lack of staffing and a non-existing community health initiative in Switzerland and Trimble counties at the present time limit a similar program to HCI.

3. **Tobacco Use** efforts will primarily be focused in Jefferson County. Current state funding, supported in-kind by KDH, limits programming to Jefferson County residents. Some flexibility applies to positively impact residents of Switzerland County Indiana. These individuals can still benefit from the IN state Quitline services and the Tobacco Coordinator can provide resources when requested to the physician office in Switzerland County. Residents of Trimble County Kentucky who work, shop, and dine in Jefferson County will benefit from smoke-free air efforts.

4. Two of the three strategies targeting **Chronic Disease** are inclusive to residents in both Switzerland and Trimble Counties. Individuals who are patients at King's Daughters' Health, regardless of residence, have the potential to participate in both the CHF and COPD Readmission Programs. Residents in these counties cannot participate in the House of Health program, as the House of Hope food pantry is exclusive for residents of Jefferson County.

5. The majority of strategies targeting **Mental Health / Suicide** will be exclusive to Jefferson County, due to the MCS and HCI efforts and partnership. Residents of neighboring counties are welcome to attend the suicide support group and additional suicide awareness activities like the Walk to Remember.