2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Columbus Regional Health Service Area

Sponsored by

COLUMBUS REGIONAL HEALTH

2021-1036-02

Prepared by PRC

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 1996, 2000, 2003, 2006, 2009, 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Columbus Regional 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 Columbus Regional Health by PRC, a nationally recognized health care 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 multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

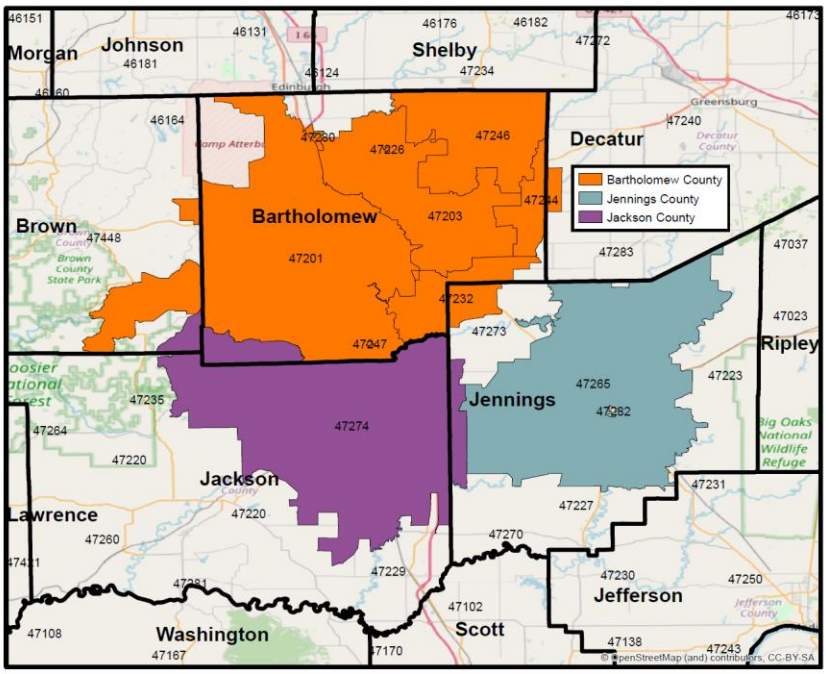
PRC Community Health Survey

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 Columbus Regional Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Columbus Regional Health Service Area” or “CRH Service Area” in this report) is defined as each of the residential ZIP Codes primarily associated with Bartholomew County, Indiana, as well as ZIP Codes 47265 in Jennings County and 47274 in Jackson County. This community definition, determined based on the ZIP Codes of residence of recent patients of Columbus Regional 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 mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (landline and cell phone) or through online questionnaires, as well as a community outreach component promoted by Columbus Regional Health through social media posting and other communications.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 400 surveys randomly throughout the region.

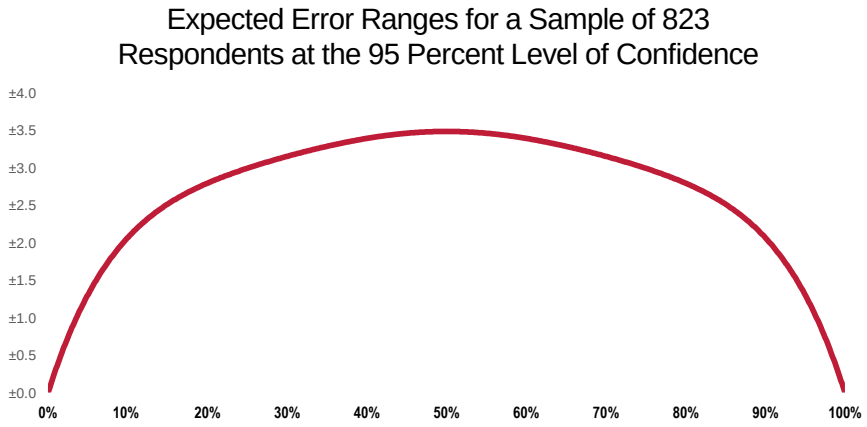
OVERSAMPLE SURVEYS (PRC) ► In addition, PRC administered 48 surveys via phone specifically among African American or Hispanic residents in the area. (These were in addition to those reached through the random sampling above; when combined, this yielded a total of 108 surveys among Hispanic residents, and 58 among Black/African American residents.)

COMMUNITY OUTREACH SURVEYS (COLUMBUS REGIONAL HEALTH) ► PRC also created a link to an online version of the survey, and Columbus Regional Health promoted this link throughout the various communities in order to drive additional participation and bolster overall samples, yielding an additional 375 surveys to the overall sample.

In all, 823 surveys were completed through these mechanisms.

Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Columbus Regional Health 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 823 respondents is ±3.5% at the 95 percent confidence level.



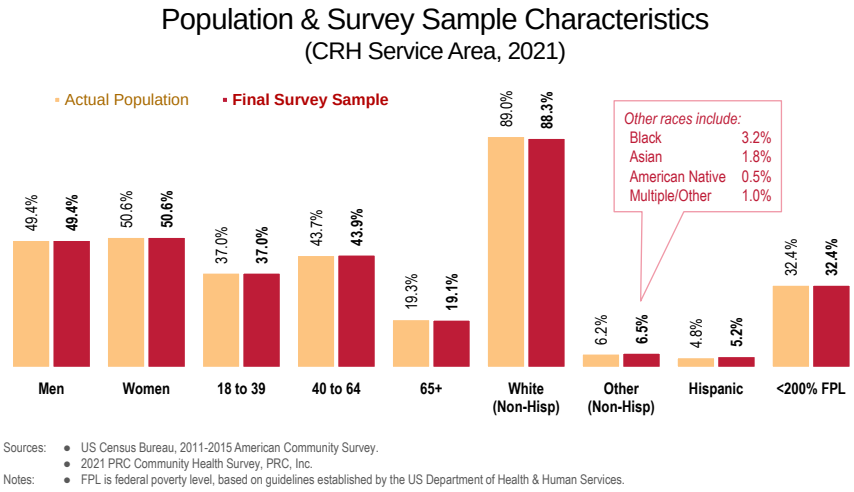
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 823 respondents answered a certain question with a "yes," it can be asserted that between 7.9% and 12.1% (10% ± 2.1%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.5% and 53.5% (50% ± 3.5%) 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 Columbus Regional Health Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]



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.

INCOME & RACE/ETHNICITY

INCOME ► 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 2020 guidelines place the poverty threshold for a family of four at $26,200 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.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

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 Columbus Regional 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, 136 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	7
Public Health Representatives	13
Other Health Providers	40
Social Services Providers	19
Other Community Leaders	56
Community Member	1

Final participation included representatives of the organizations outlined below.

- Advocates for Children
- Alliance for Substance Abuse Progress
- Asbury United Methodist Church
- Associate Director of Recreation Parks & Rec
- Bartholomew Consolidated School Corporation
- Bartholomew County Beverage
- Bartholomew County Commissioners
- Bartholomew County Council
- Bartholomew County Court - Juvenile Services
- Bartholomew County Health Department
- Bartholomew County Juvenile Court
- Bartholomew County Substance Abuse Council
- Board of Health
- Circuit Court
- City of Columbus
- Columbus East High School
- Columbus Economic Development
- Columbus Education Coalition
- Columbus Pediatrics
- Columbus Police Department
- Columbus Regional Health
- Columbus Regional Health Foundation
- Columbus Regional Hospital
- Columbus Township
- Columbus Visitors Center
- Community Center of Hope, Inc.
- Community Church of Columbus
- Community Corrections
- Community Education Coalition
- Community Medication Assistance
- Cornerstone Development
- Cummins Inc.
- Dayspring Church
- Doctors Park Family Medicine
- Family School Partners
- Family Service, Inc.
- First Financial
- First Presbyterian Church
- Flat Rock–Hawcreek School Corporation
- Flat Rock–Hawcreek Schools
- Harrison Township Trustee
- Healthy Communities
- Healthy Families
- Heritage Fund
- Hope Elementary

- Inspire Motives LLC
- Just Friends
- Lincoln Central Neighborhood
- Love Chapel
- Mark & Wendy Elwood Foundation
- Mill Race Center
- Northside Pediatrics
- OBGYN Associates
- Our Hospice
- Purdue Extension
- Reams Asset Management
- Southern Indiana OB
- Su Casa Columbus
- Taylor Brothers Construction
- Thrive Alliance
- Toyota Material Handling
- Turning Point Domestic Violence Services
- United Way
- Viewpoint Books
- VIMCare Clinic
- White River Broadcasting Co.
- Women, Infants, and Children (WIC)
- Zen Fitness

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.

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 Columbus Regional Health 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), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey

- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data for Bartholomew, Jackson, and Jennings counties.

Benchmark Data

Trending

Similar surveys were administered in the Columbus Regional Health Service Area in 1996, 2000, 2003, 2006, 2009, 2012, 2015, and 2018 by PRC on behalf of Columbus Regional Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Indiana Risk Factor Data

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

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey* or the *2020 PRC National Child & Adolescent Health Survey*; the methodological approach for these national studies 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 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.

- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

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

Columbus Regional 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, Columbus Regional 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. Columbus Regional 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 (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	35
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	179
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	15
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	16
Part V Section B Line 3h The process for consulting with persons representing the community's interests	9
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)	186

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Appointment Availability ▪ Aware of VIMCare Clinic at Columbus Regional Hospital
CANCER	▪ Leading Cause of Death ▪ Cancer Deaths – Including Lung Cancer and Colorectal Cancer Deaths ▪ Cancer Incidence – Including Lung Cancer ▪ Cancer Prevalence – Including Skin Cancer and Cancer Other Than Skin
DIABETES	▪ Diabetes Prevalence ▪ Blood Sugar Testing [Non-Diabetics] ▪ Kidney Disease Deaths
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Stroke Deaths ▪ High Blood Pressure Prevalence ▪ High Blood Cholesterol Prevalence
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Motor Vehicle Crash Deaths ▪ Bicycle Helmet Usage [Children] ▪ Firearm In or Around the Home ▪ Intimate Partner Violence ▪ Forced Sexual Activity ▪ Water Safety Instruction [Children]

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AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health [Adults & Children] ▪ Diagnosed Depression [Adults & Children] ▪ Diagnosed Anxiety [Children] ▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Children's Physical Activity ▪ Overweight & Obesity [Adults] ▪ Workplace Supportive of Healthy Lifestyles [Employed Adults]
ORAL HEALTH	▪ Regular Dental Care [Adults]
POTENTIALLY DISABLING CONDITIONS	▪ Activity Limitations
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Pneumonia/Influenza Deaths ▪ Key Informants: Coronavirus/COVID-19 ranked as a top concern.
SUBSTANCE ABUSE	▪ Excessive Drinking ▪ Unintentional Drug-Related Deaths ▪ Personally Impacted by Substance Abuse (Self or Other's) ▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

On December 2, 2021, Columbus Regional Health and the Healthy Community Council of Bartholomew County (representing a broad cross-section of community-based businesses, agencies, and organizations) convened a meeting to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

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

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

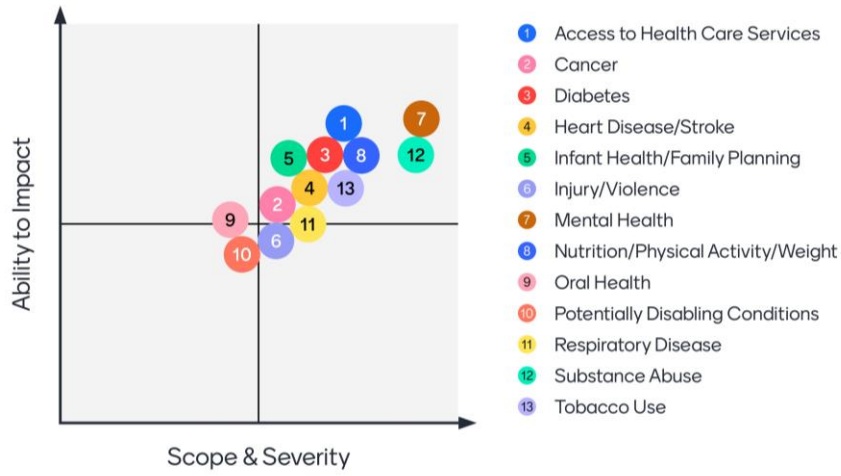
  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

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

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

1. Mental Health
2. Substance Abuse
3. Access to Health Care Services
4. Nutrition, Physical Activity & Weight
5. Diabetes
6. Tobacco Use
7. Infant Health & Family Planning
8. Heart Disease & Stroke
9. Cancer
10. Respiratory Disease
11. Injury & Violence
12. Oral Health
13. Potentially Disabling Conditions

Plotting these overall scores in a matrix illustrates the intersection of the Scope & Severity and the Ability to Impact scores. Below, those issues placing in the upper right quadrant represent health needs rated as most severe, with the greatest ability to impact.



Hospital Implementation Strategy

Columbus Regional 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

Reading the Summary Tables

In the following tables, Columbus Regional Health Service Area results are shown in the larger, gray column.

The columns to the left of the Columbus Regional Health Service Area column provide comparisons among the three county areas, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the combined opposing areas.

The columns to the right of the Columbus Regional Health Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Columbus Regional Health 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.

For Jennings and Jackson counties, survey data reflect only those ZIP Codes surveyed; for secondary data, the findings reflect the entirety of these counties.

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

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 1996 (or earliest available data). Note that survey data reflect the ZIP Code-defined Columbus Regional Health Service Area.

OTHER (SECONDARY) DATA INDICATORS:

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

Note that secondary data reflect county-level data.

SOCIAL DETERMINANTS	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	1.7	0.3	2.3	1.6	1.8	4.3		
Population in Poverty (Percent)	13.4	10.9	14.6	13.3	13.4	13.4	8.0	
Children in Poverty (Percent)	21.2	15.9	17.5	19.2	18.5	18.5	8.0	
No High School Diploma (Age 25+, Percent)	9.4	12.2	12.7	10.9	11.2	12.0		
% [Bartholomew Co] County is Generally a Friendly Community				92.2				94.6
% [Bartholomew Co] County Welcomes and Values Diversity				85.2				85.6

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	19.5	26.5	28.0	22.6	19.9	12.6		13.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	5.9	9.2	1.7	5.5	13.4	8.7	7.9	11.7
% [Insured] Went Without Coverage in the Past Year	4.2	7.4	1.7	4.1				7.5
% Cost Prevented Physician Visit in Past Year	11.5	10.0	4.0	9.6	12.6	12.9		12.7
% Cost Prevented Getting Prescription in Past Year	13.6	16.6	7.4	12.7		12.8		12.1
% Difficulty Getting Appointment in Past Year	20.2	15.1	13.6	17.9		14.5		9.1
% Transportation Hindered Dr Visit in Past Year	7.6	7.5	5.3	7.1		8.9		5.8
% Language/Culture Prevented Care in Past Year	2.5	5.0	0.4	2.4		2.8		1.8
% Difficulty Getting Child's Health Care in Past Year	9.3			5.2		8.0		10.0
% Child Has Had Checkup in Past Year	89.4			87.3		77.4		91.0
Primary Care Doctors per 100,000	102.2	57.9	86.2	89.6	88.3	100.0		
% Have a Regular Place for Medical Care	82.1	83.6	90.6	84.3	71.1	79.1		87.4

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Aware of the VIMCare Clinic at CRH	50.6	15.6	13.6	36.9				66.4

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CANCER	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)	157.9	208.3	175.0	171.8	166.4	149.3	122.7	197.0
Lung Cancer (Age-Adjusted Death Rate)				50.3	44.6	34.9	25.1	
Prostate Cancer (Age-Adjusted Death Rate)				19.0	19.4	18.6	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)				18.7	20.4	19.7	15.3	
Colorectal Cancer (Age-Adjusted Death Rate)				16.8	15.1	13.4	8.9	
Cancer Incidence Rate (All Sites)	453.8	499.4	461.1	464.3	457.9	448.6		
Female Breast Cancer Incidence Rate	125.1	113.4	113.2	119.5	124.5	126.8		
Prostate Cancer Incidence Rate	89.6	84.4	86.8	87.8	96.5	106.2		

CANCER (continued)	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Lung Cancer Incidence Rate	68.3	84.8	71.6	72.3	69.9	57.3		
Colorectal Cancer Incidence Rate	35.1	47.7	45.2	40.3	41.7	38.0		
% Cancer (Any Type)	15.7	21.5	18.7	17.3	11.9	10.0		
% Skin Cancer	9.7	8.7	9.9	9.6	6.1	6.1		6.0
% Cancer (Other Than Skin)	7.2	14.9	11.6	9.4	7.2	5.6		4.4
% [Women 50-74] Mammogram in Past 2 Years				79.5	76.6	76.1	77.1	74.3
% [Women 21-65] Cervical Cancer Screening				71.5	80.6	73.8	84.3	77.6

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DIABETES	DISPARITY AMONG COUNTIES: Bartholomew County	Jennings County	Jackson County	CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS: vs. IN	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)	8.3	23.5	25.3	16.1	25.9	21.5		19.5
% Diabetes/High Blood Sugar	13.5	9.8	14.8	13.2	12.4	13.8		7.4
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	48.2	55.2	53.3	50.5		43.3		58.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HEART DISEASE & STROKE	DISPARITY AMONG COUNTIES: Bartholomew County	Jennings County	Jackson County	CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS: vs. IN	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	157.5	188.8	178.4	169.0	180.9	163.4	127.4	188.5
Stroke (Age-Adjusted Death Rate)	41.4	55.3	48.0	45.6	40.3	37.2	33.4	52.0
% Told Have High Blood Pressure	41.0	56.3	41.2	43.5	34.8	36.9	27.7	20.4
% [HBP] Taking Action to Control High Blood Pressure				88.6		84.2		91.1
% Told Have High Cholesterol	34.4	43.8	40.7	37.3		32.7		25.3
% 1+ Cardiovascular Risk Factor	87.3	92.6	83.4	87.3		84.6		84.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Low Birthweight Births (Percent)	7.5	7.8	6.8	7.4		8.2		
Infant Death Rate	6.3		6.1	5.9	6.9	5.6	5.0	9.8
Births to Adolescents Age 15 to 19 (Rate per 1,000)	29.6	42.1	44.4	36.3	24.8	20.9	31.4	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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INJURY & VIOLENCE	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)	63.9	99.2	78.3	74.2	56.6	48.9	43.2	49.9
Motor Vehicle Crashes (Age-Adjusted Death Rate)	15.9	35.7	24.5	21.9	12.4	11.3	10.1	
% "Always" Use a Seat Belt	85.7	79.1	80.6	83.5				68.3
% [Age 5-17] Child "Always" Wear a Bike Helmet	39.9			33.4		50.1		22.5
[65+] Falls (Age-Adjusted Death Rate)				30.8	44.5	65.1	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)	10.6		17.2	13.5	14.7	11.9	10.7	

INJURY & VIOLENCE (continued)	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Homicide (Age-Adjusted Death Rate)				2.6	6.3	5.6	5.5	
% Firearm In or Around the Home	45.6	63.0	61.1	51.6				43.9
% [Households w/Firearms] Gun is Unlocked/Loaded				22.9				
% [Households w/Children] Firearm In or Around the Home	42.7			48.9				56.4
Violent Crime Rate	106.5	188.5	224.8	155.4	391.4	416.0		
% Perceive Neighborhood as “Slightly/Not At All Safe”	8.7	13.4	23.0	12.6				
% Victim of Intimate Partner Violence in the Past 3 Years	7.4	0.5	6.2	6.1				3.9
% Forced Into Sexual Activity in the Past 3 Years	1.8	0.0	7.2	2.7				1.1
% [Parents] Child Has Received Water Safety Instruction	64.6			68.5				78.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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KIDNEY DISEASE	DISPARITY AMONG COUNTIES: Bartholomew County	Jennings County	Jackson County	CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS: vs. IN	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)	18.4		21.8	19.2	17.7	12.9		20.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

MENTAL HEALTH	DISPARITY AMONG COUNTIES: Bartholomew County	Jennings County	Jackson County	CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS: vs. IN	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	25.9	24.3	20.4	24.4		13.4		15.6
% Symptoms of Depression	31.4	29.0	28.9	30.4				30.9
% Diagnosed Depression	31.8	37.8	25.6	31.4	21.0	20.6		26.9
Suicide (Age-Adjusted Death Rate)	16.9		22.8	19.0	15.5	14.0	12.8	13.9
% Considered Suicide in the Past Year	9.8	6.7	9.1	9.2				6.8
% Ease of Obtaining Mental Health Services Is "Fair/Poor"	32.8	36.6	32.6	33.4				31.2
Mental Health Providers per 100,000	88.8	86.9	40.9	74.2	87.8	115.1		
% Have Ever Sought Help for Mental Health	44.3	45.4	33.4	42.1		30.0		32.1

MENTAL HEALTH (continued)	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Unable to Get Mental Health Svcs in Past Yr	10.8	8.0	9.2	10.0		7.8		3.8
% [Age 5-17] Child Has "Fair/Poor" Mental Health	12.2			22.5		9.7		
% [Age 5-17] Child Rec'd Treatment in the Past Year	15.4			22.5		14.3		
% [Age 5-17] Child Had Symptoms of Depression	10.1			6.8		5.1		
% [Age 5-17] Child Has Been Diagnosed With Depression	9.6			15.0		9.1		
% [Age 5-17] Child Has Been Diagnosed With Anxiety	20.0			23.9		13.4		
% [Age 5-17] Bullied on School Property in the Past Year	25.8			30.1				
% [Age 5-17] Bullied in Person Outside School Property	13.4			13.1				
% [Age 5-17] Electronically Bulled in the Past Year	13.5			9.2				
% [Parents] Aware of Local Resources for Mental Health	69.0			70.3				
% [Age 5-17] Child Needed Mental Health Svcs/Past Yr	17.1			23.4		17.1		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)	36.4	25.2	33.0	33.3	28.7	22.2		
% 5+ Servings of Fruits/Vegetables Yesterday	8.7	4.3	16.7	9.7				11.3
% Eat 5+ Weekly Meals Together as a Family	44.7	48.2	37.5	43.7				36.4
% No Leisure-Time Physical Activity	21.4	28.9	27.5	24.0	30.9	31.3	21.2	28.2
% Meeting Physical Activity Guidelines	22.6	18.4	20.3	21.4	21.1	21.4	28.4	19.6
% Child [Age 2-17] Physically Active 1+ Hours per Day	41.1			42.8		33.0		61.1
% [Age 5-17] Child Spends 3+ Hours on Screen Time	40.4			51.0				43.4
Recreation/Fitness Facilities per 100,000	13.0	14.0	7.1	11.5	10.7	12.2		
% Healthy Weight (BMI 18.5-24.9)	25.4	18.0	27.3	24.6	28.8	34.5		
% Overweight (BMI 25+)	72.4	76.7	72.3	73.1	69.1	61.0		52.9
% Obese (BMI 30+)	39.4	42.3	51.8	42.7	35.3	31.3	36.0	16.8

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% [Employed] Workplace Is More Supportive of Healthy Lifestyles				72.0				82.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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ORAL HEALTH	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% [Age 18+] Dental Visit in Past Year	63.1	61.6	66.4	63.6	64.4	62.0	45.0	70.4
% Child [Age 2-17] Dental Visit in Past Year	82.0			80.0		72.1	45.0	79.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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POTENTIALLY DISABLING CONDITIONS	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Activity Limitations	30.3	28.6	33.8	30.9		24.0		19.0
Alzheimer's Disease (Age-Adjusted Death Rate)	30.2		22.3	24.8	33.4	30.4		36.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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RESPIRATORY DISEASE	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)	43.8	74.9	64.4	55.6	56.2	39.6		72.2
Pneumonia/Influenza (Age-Adjusted Death Rate)	15.5		19.5	16.0	13.1	13.8		12.7

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SEXUAL HEALTH	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
HIV Prevalence Rate	84.7	21.6	153.9	93.0	206.4	372.8		
Chlamydia Incidence Rate	342.5	275.1	467.1	366.0	523.9	539.9		
Gonorrhea Incidence Rate	85.3	68.8	141.3	98.3	182.9	179.1		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SUBSTANCE ABUSE	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	8.9		14.6	11.3	12.0	11.1	10.9	11.4
% Excessive Drinker	21.8	21.3	31.0	23.8	16.5	27.2		13.7
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)	28.8	45.9	35.3	33.5	24.4	18.8		15.3
% Personally Impacted by Substance Abuse	45.2	43.0	36.1	42.8		35.8		42.0
% Know Where to Access Substance Abuse Treatment	67.1	72.4	66.5	67.8				65.9
% Family Member Unable to Access Addiction Treatment	8.9	10.3	9.9	9.4				8.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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TOBACCO USE	DISPARITY AMONG COUNTIES			CRH Service Area	CRH SERVICE AREA vs. BENCHMARKS			
	Bartholomew County	Jennings County	Jackson County		vs. IN	vs. US	vs. HP2030	TREND
% Current Smoker	15.0	23.9	9.5	**15.2**	19.2	17.4	5.0	26.4
% Someone Smokes at Home	12.8	15.0	20.5	**14.9**		14.6		29.3
% [Household With Children] Someone Smokes in the Home	10.3			**14.7**		17.4		12.6
% [Nonsmokers] Someone Smokes in the Home	4.0	1.7	14.9	**6.3**				
% Aware of the Indiana Tobacco Quit Line	56.3	62.2	50.8	**56.0**				52.7
% Currently Use Vaping Products	9.2	11.9	10.4	**9.9**	6.0	8.9		3.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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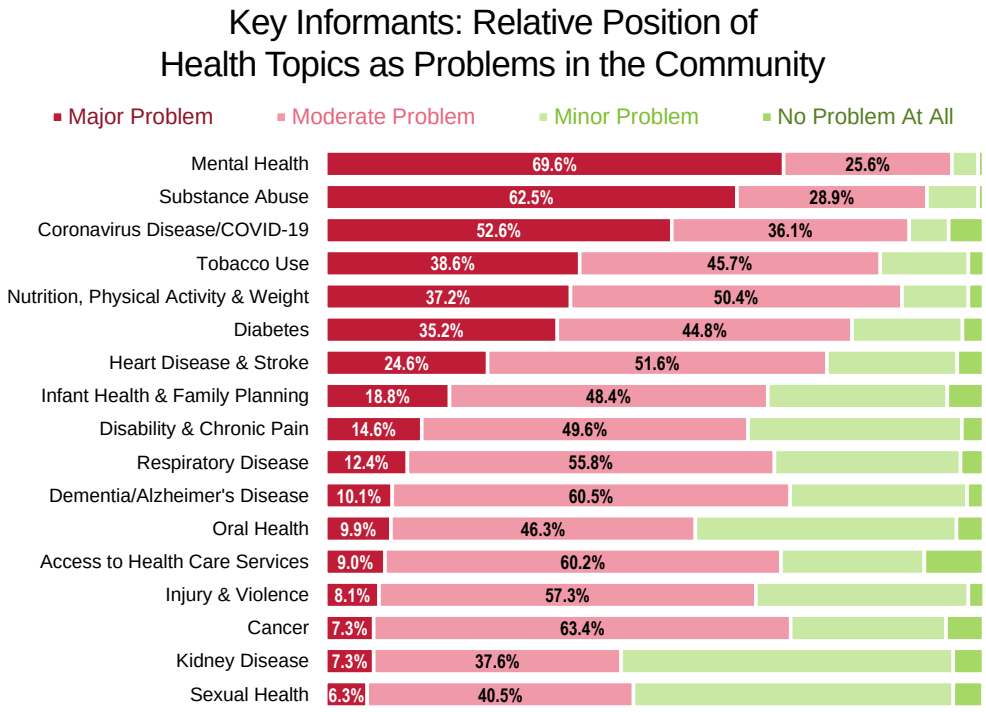
Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 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.)



COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The three-county area that encompasses the Columbus Regional Health Service Area is 1,293.48 square miles and houses a total population of 154,216 residents, according to latest census estimates.

Total Population
(Estimated Population, 2015-2019)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Bartholomew County	82,481	406.91	202.70
Jennings County	27,710	376.59	73.58
Jackson County	44,025	509.97	86.33
CRH Service Area	154,216	1,293.48	119.23
Indiana	6,665,703	35,826.63	186.05
United States	324,697,795	3,532,068.58	91.93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Population Change 2000-2010

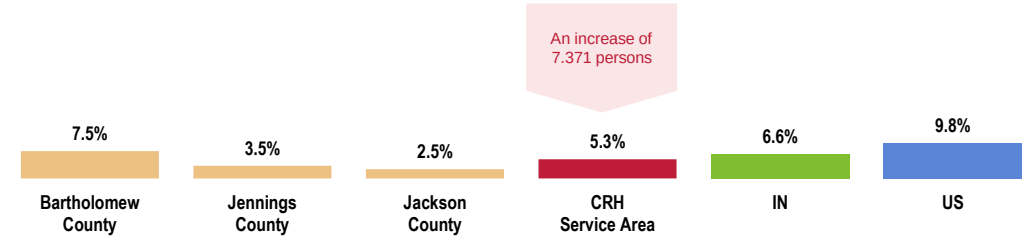
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of the Columbus Regional Health Service Area increased by 7,371 persons, or 5.3%.

BENCHMARK ► Lower population increase than was found across the state and nation.

DISPARITY ► Bartholomew County recorded the highest increase.

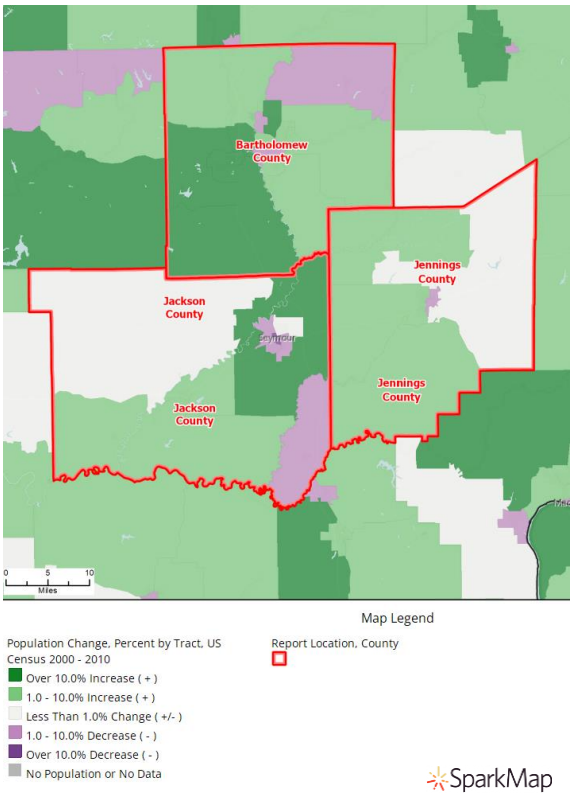
Change in Total Population
(Percentage Change Between 2000 and 2010)



Sources:
- US Census Bureau Decennial Census (2000-2010).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

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



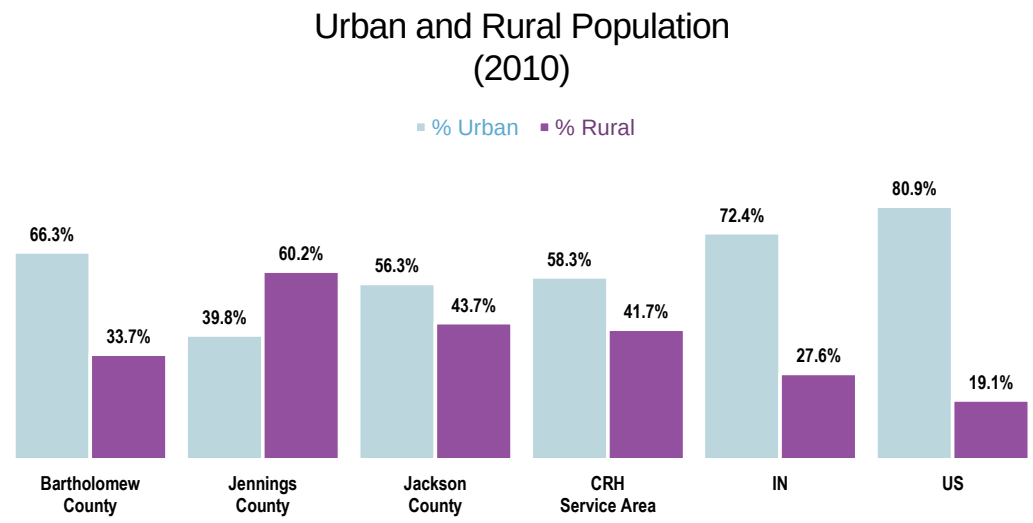
Urban/Rural Population

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 Columbus Regional Health Service Area is predominantly urban, with 58.3% of the population living in areas designated as urban.

BENCHMARK ► The service area is, however, more rural than the state and US overall.

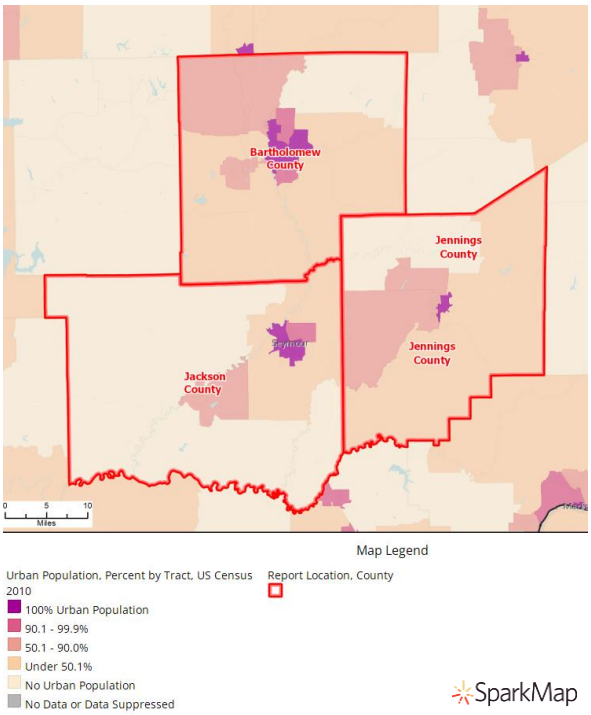
DISPARITY ► While Bartholomew County and Jackson County are mostly urban, Jennings County is predominantly rural.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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 the Columbus Regional Health Service Area.



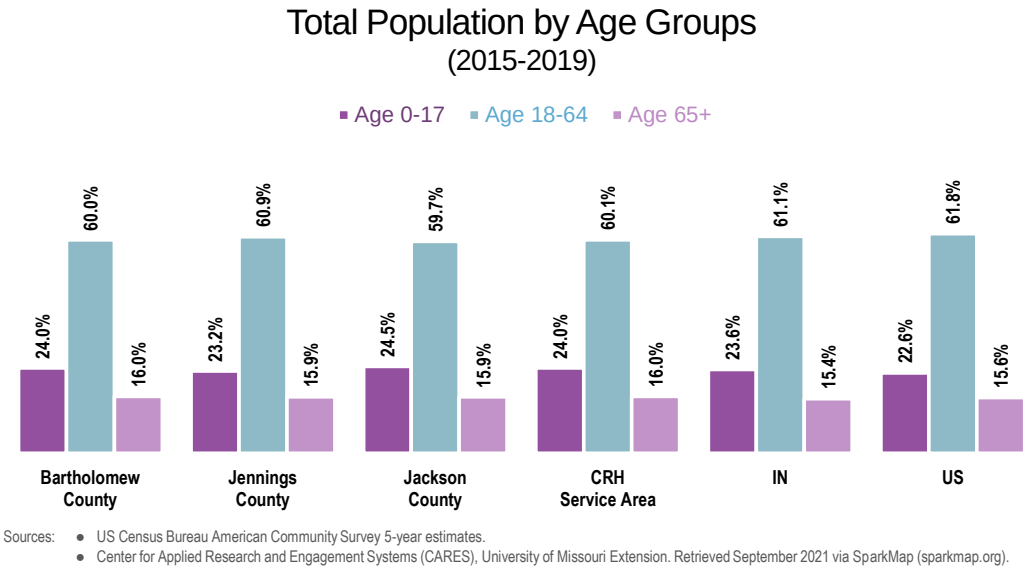
Age

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 Columbus Regional Health Service Area, 24.0% of the population are children age 0-17; another 60.1% are age 18 to 64, while 16.0% are age 65 and older.

BENCHMARK ► Similar to state and national proportions.

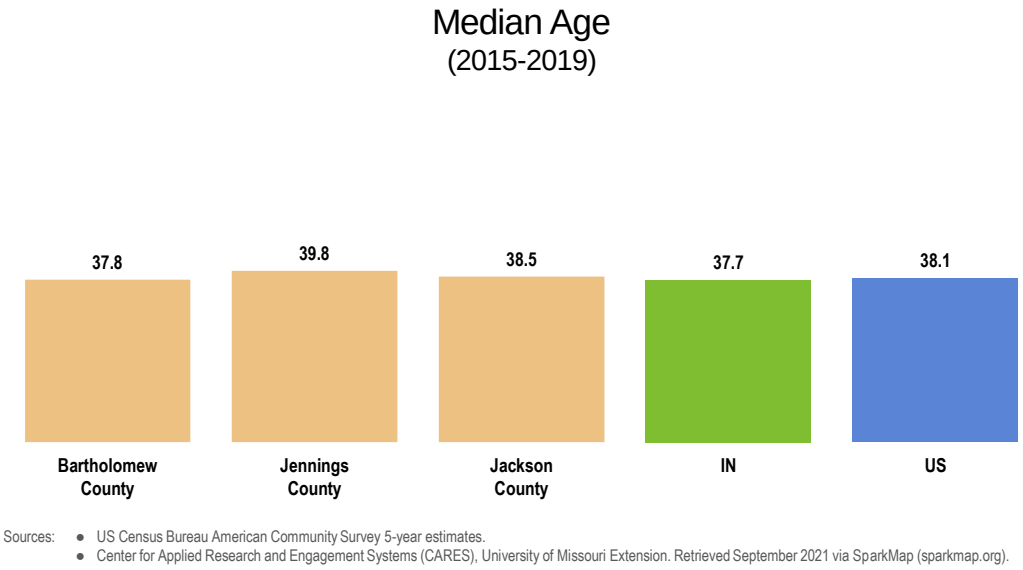
DISPARITY ► Age distribution is similar among the three county areas.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

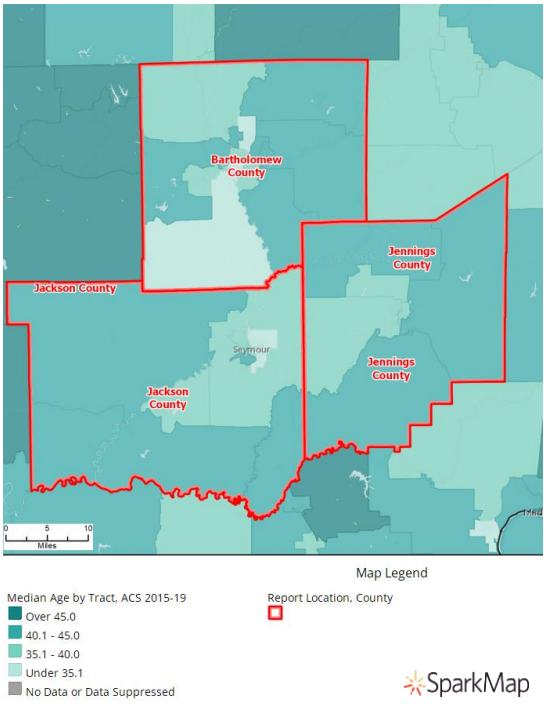
Median Age

The Columbus Regional Health Service Area is slightly "older" than the state and the nation in that the median ages are slightly higher.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age in the Columbus Regional Health Service Area.



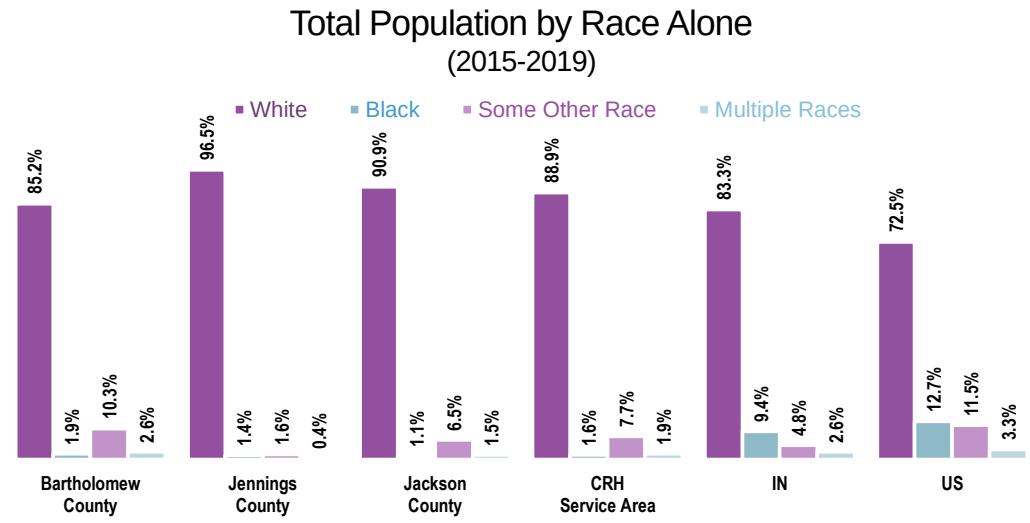
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 88.9% of residents of the Columbus Regional Health Service Area are White and 1.6% are Black.

BENCHMARK ► Less diverse than Indiana and the US.

DISPARITY ► Bartholomew County has the highest proportion of multiracial and nonwhite residents.



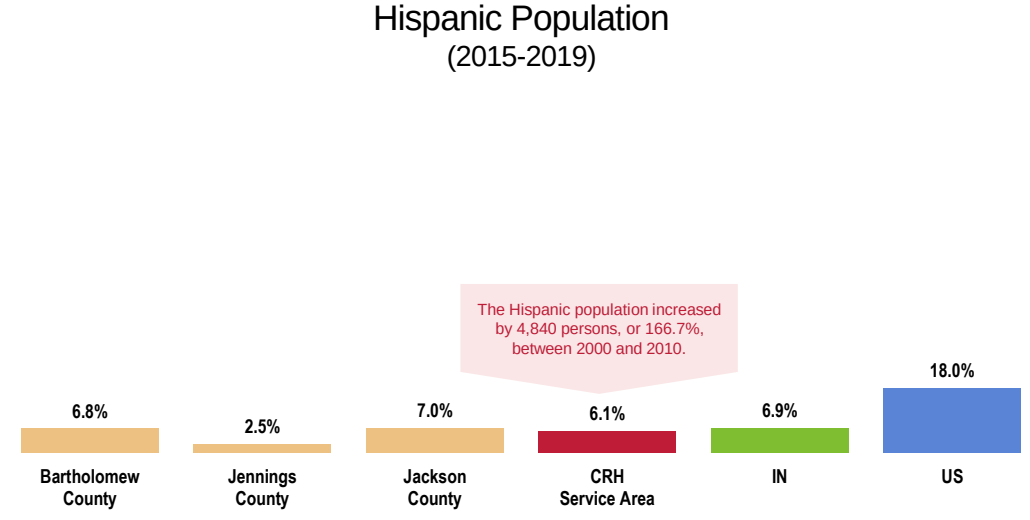
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Ethnicity

A total of 6.1% of Columbus Regional Health Service Area residents are Hispanic or Latino.

BENCHMARK ► Much lower than the national proportion.

DISPARITY ► Higher in Bartholomew and Jackson counties.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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.

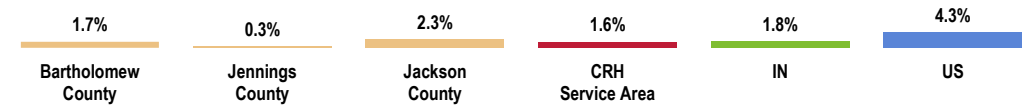
Linguistic Isolation

A total of 1.6% of the Columbus Regional Health 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 ► Well below the national percentage.

DISPARITY ► Highest in Jackson County.

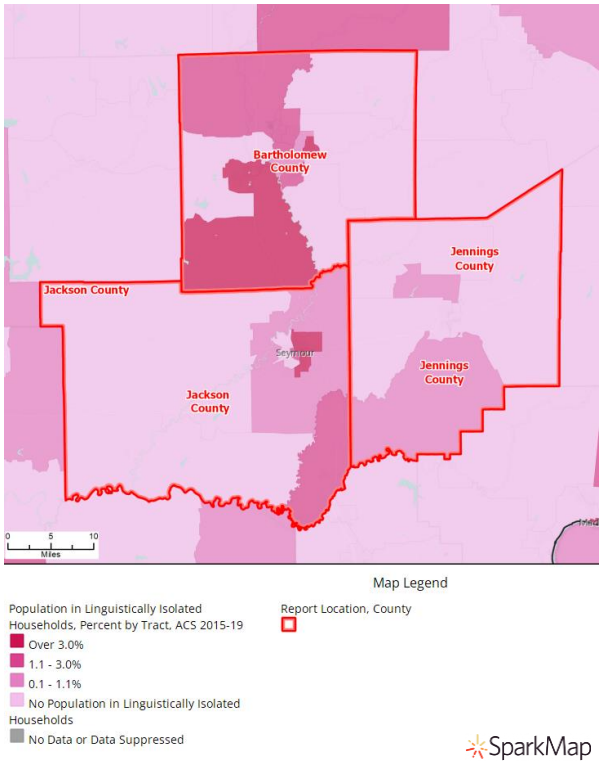
Linguistically Isolated Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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 service area.



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Poverty

The latest census estimate shows 13.3% of the Columbus Regional Health Service Area total population living below the federal poverty level.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lower in Jennings County.

Among just children (ages 0 to 17), this percentage in the Columbus Regional Health Service Area is 19.2% (representing an estimated 6,903 children).

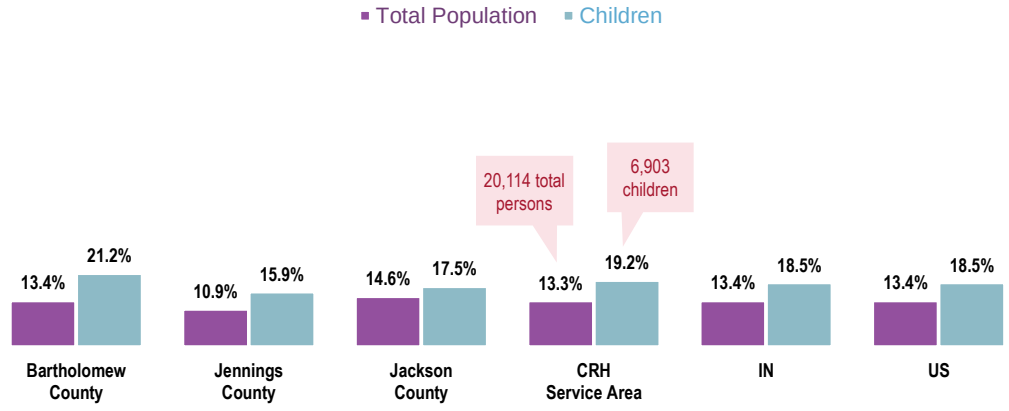
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Unfavorably high in Bartholomew County.

Population in Poverty

(Populations Living Below the Poverty Level; 2015-2019)

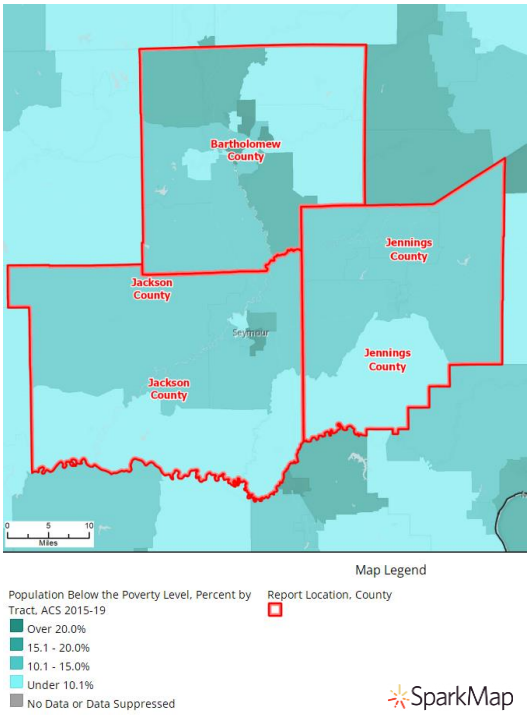
Healthy People 2030 = 8.0% or Lower

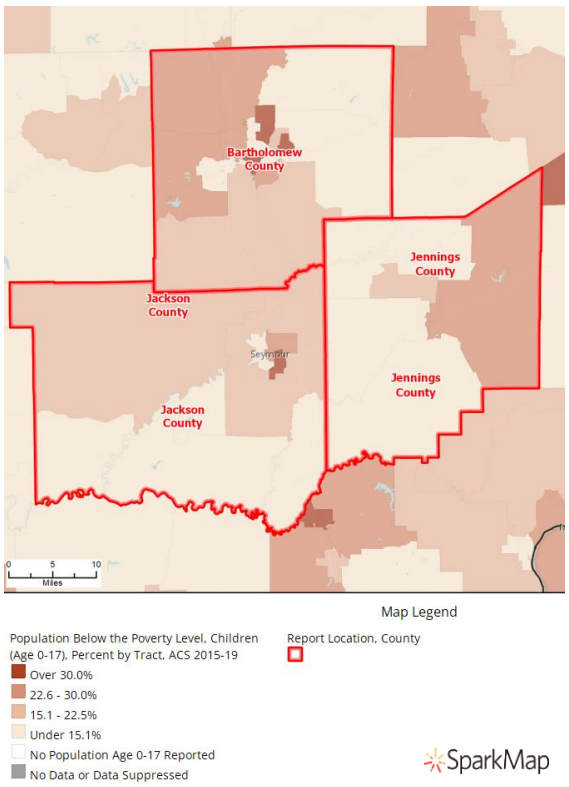


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.




Bartholomew County
Jennings County
Jackson County
Seymour
Jennings County
Jackson County
0
5
10
Miles
Map Legend
Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2015-19
Over 30.0%
22.6 - 30.0%
15.1 - 22.5%
Under 15.1%
No Population Age 0-17 Reported
No Data or Data Suppressed
Report Location, County
SparkMap

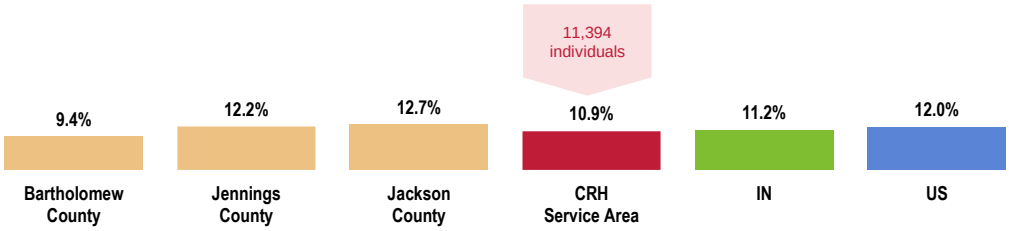
Education

Among the Columbus Regional Health Service Area population age 25 and older, an estimated 10.9% (over 11,000 people) do not have a high school education.

DISPARITY ► Lowest in Bartholomew County.

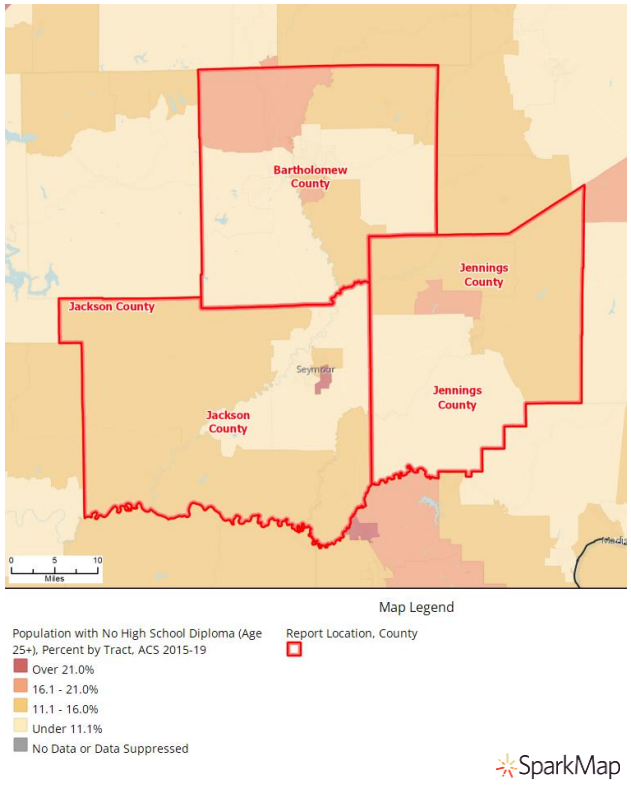
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

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



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.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* in the **Modifiable Health Risks** section of this report.

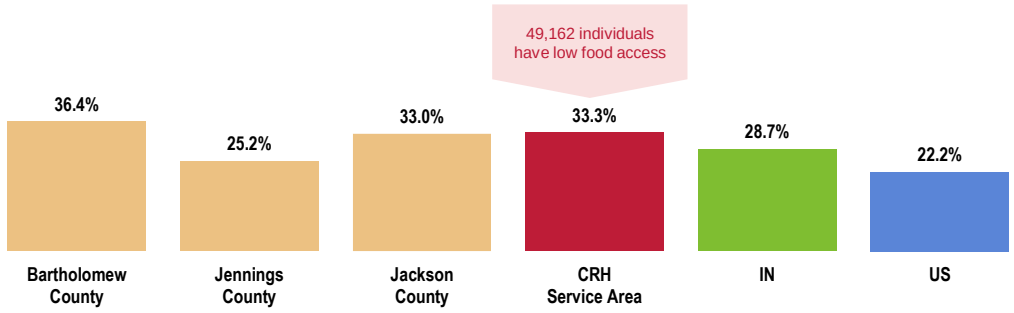
US Department of Agriculture data show that 33.3% of the Columbus Regional Health Service Area population (representing over 49,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

BENCHMARK ► Higher than the US percentage.

DISPARITY ► Lowest in Jennings County.

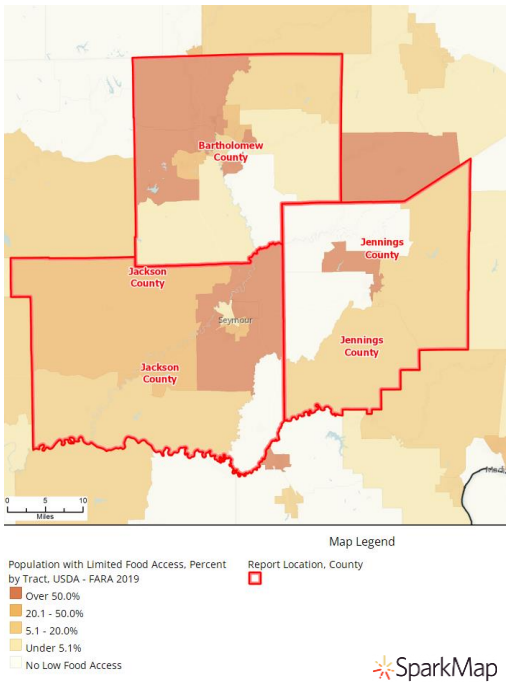
Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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.



Diversity in Bartholomew County

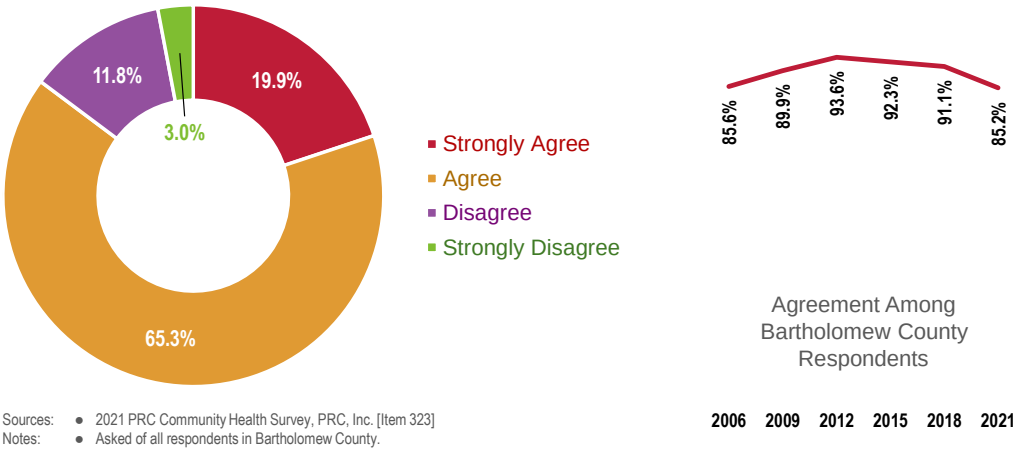
Over 8 in 10 Bartholomew County respondents believe that the county welcomes and values diversity (65.3% "agree" and 19.9% "strongly agree").

TREND ► Agreement that the county welcomes and values diversity has declined in recent years, but is similar to baseline 2006 findings.

In contrast, 14.8% of adults disagree with the statement.

DISPARITY ► Among communities of color, 19.9% disagree (versus 14.1% among non-Hispanic White respondents).

Agreement With the Statement: *"In Bartholomew County, diversity is generally welcomed and valued."*
(Bartholomew County Residents, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 323]
Notes: ● Asked of all respondents in Bartholomew County.

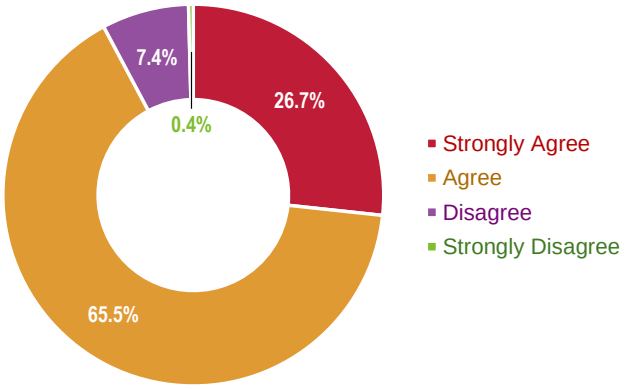
COMMUNITY FRIENDLINESS

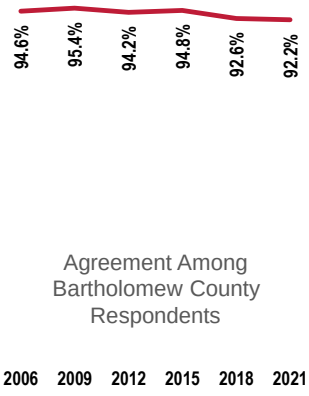
Most Bartholomew County residents agree with the statement "*Bartholomew County is generally a friendly community*."

TREND ► Agreement that the county is a friendly community has not changed significantly over time.

In contrast, 7.8% disagree with the statement.

Agreement With the Statement:
"Bartholomew County is generally a friendly community."
(Bartholomew County Residents, 2021)





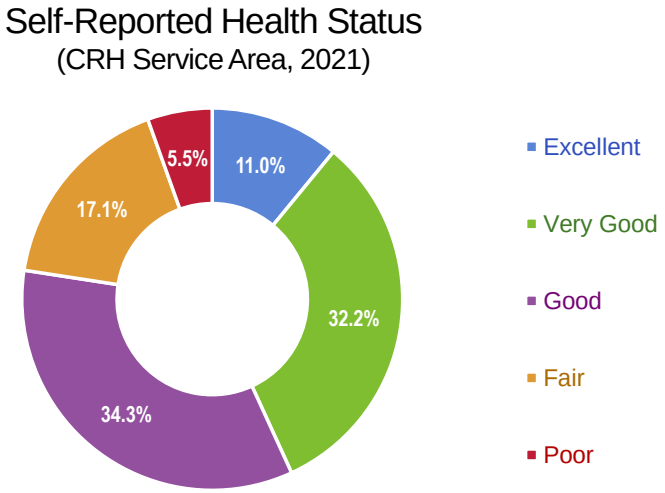
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 322]
Notes: • Asked of all respondents in Bartholomew County.

HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"

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



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

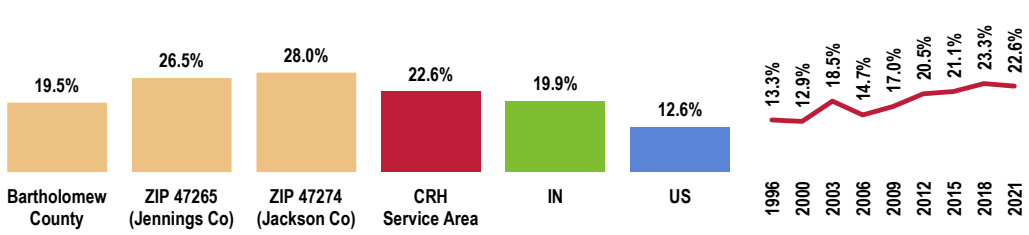
However, 22.6% of Columbus Regional Health Service Area adults believe that their overall health is "fair" or "poor."

BENCHMARK ► Worse than the national finding.

TREND ► Increasing significantly over time.

DISPARITY ► Lowest in Bartholomew County. "Fair" or "poor" health is more often reported among male respondents, low-income adults, and Black residents.

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.



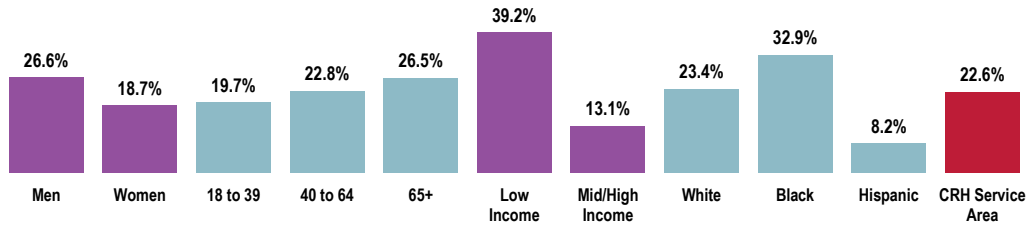
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

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.

Here, "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.

In addition, all Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

Experience "Fair" or "Poor" Overall Health
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

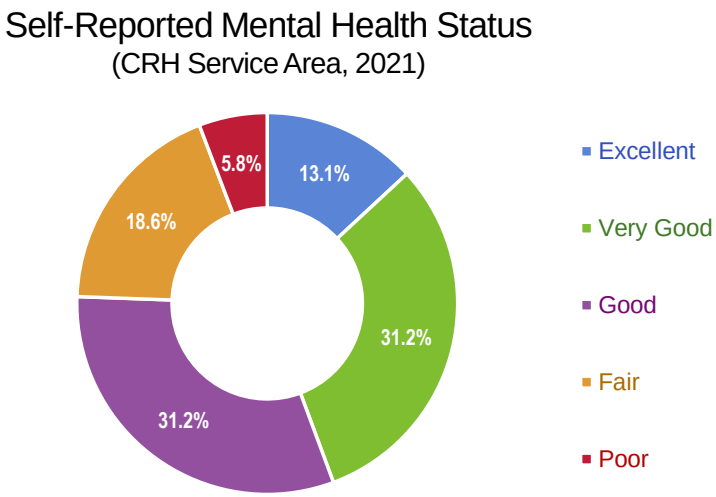
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

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 Columbus Regional Health Service Area adults rate their overall mental health favorably ("excellent," "very good," or "good").



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 99]
Notes: ● Asked of all respondents.

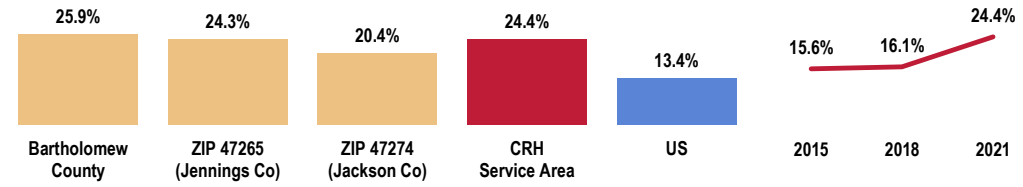
However, 24.4% believe that their overall mental health is "fair" or "poor."

BENCHMARK ► Much higher than the US percentage.

TREND ► Trending significantly higher in the service area.

Experience "Fair" or "Poor" Mental Health

CRH Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 99]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression

Diagnosed Depression

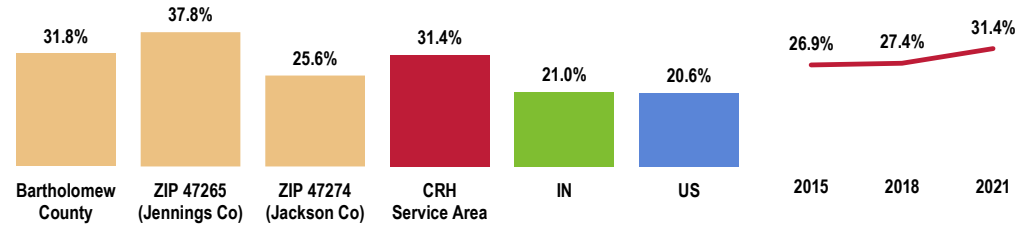
A total of 31.4% of Columbus Regional Health Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

See also *Child Depression & Anxiety* in the Children's Mental Health section of this report.

BENCHMARK ► Significantly higher than both state and national findings.

Have Been Diagnosed With a Depressive Disorder

CRH Service Area



Sources:
- 2021 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): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.

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

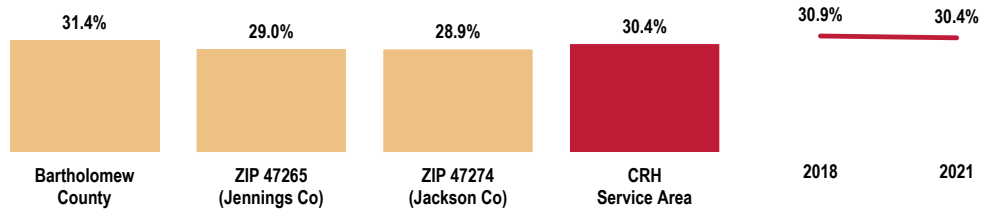
Symptoms of Depression

A total of 30.4% of survey respondents have had at least one two-week period of sadness or depression over the course of the past year (symptoms of depression).

DISPARITY ► More often reported among women, young adults, and lower-income respondents.

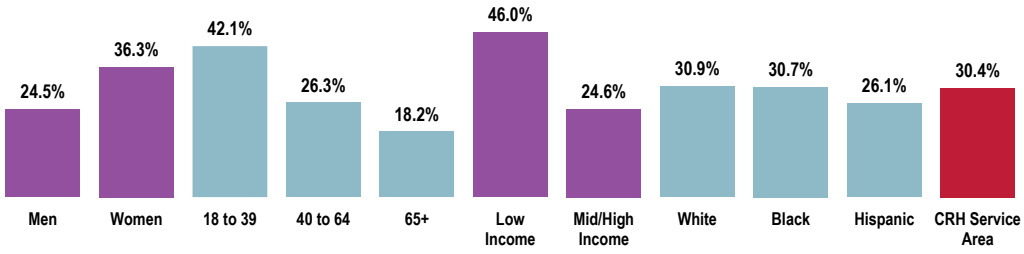
Had Symptoms of Depression in the Past Year

CRH Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 341]
Notes: ● Asked of all respondents.
● Reflects respondents reporting any period of 2 or more weeks in the past year when they felt sad or depressed most days.

Had Symptoms of Depression in the Past Year
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 341]
Notes: ● Asked of all respondents.
● Reflects respondents reporting any period of 2 or more weeks in the past year when they felt sad or depressed most days.

Suicide

Suicide Deaths

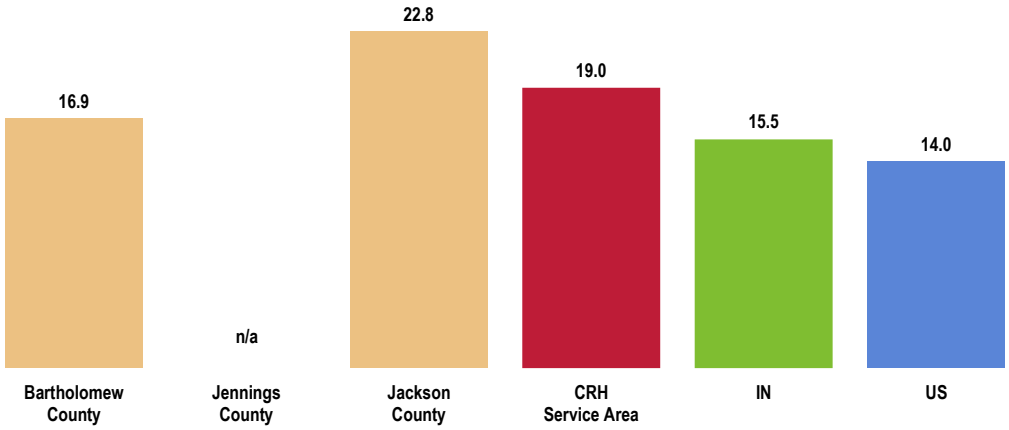
In the Columbus Regional Health Service Area, there were 19.0 suicides per 100,000 population (2017-2019 annual average age-adjusted rate).

BENCHMARK ► Worse than found across Indiana and the US. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Highest in Jackson County.

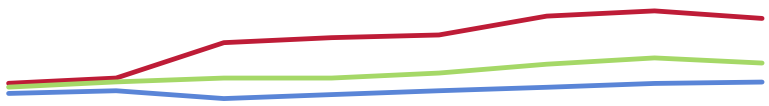
TREND ► Increasing significantly over time.

Suicide: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	13.9	14.3	17.1	17.5	17.7	19.2	19.6	19.0
IN	13.6	14.0	14.3	14.3	14.7	15.4	15.9	15.5
US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

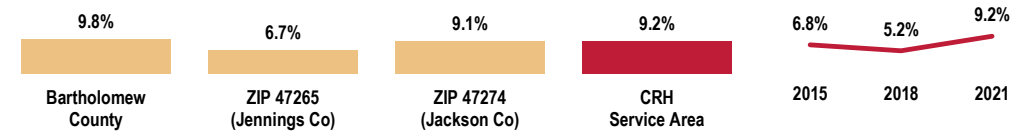
Suicide Ideation

A total of 9.2% of CRH Service Area adults have had a time in the past year when they thought about taking their own lives.

DISPARITY ► More often reported among young adults and low-income respondents.

Considered Suicide in the Past Year

CRH Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 342]
Notes: ● Asked of all respondents.

Considered Suicide in the Past Year
(CRH Service Area, 2021)

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 342]
Notes: ● Asked of all respondents.

Mental Health Treatment

Mental Health Providers

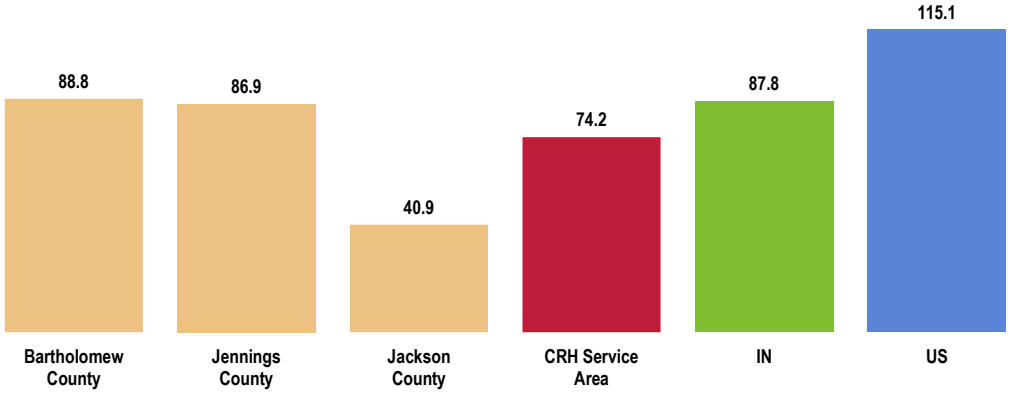
Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the Columbus Regional Health Service Area and residents in the Columbus Regional Health Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

In the Columbus Regional Health Service Area in 2021, there were 74.2 mental health providers for every 100,000 population.

BENCHMARK ► Less favorable than state the national ratios.

DISPARITY ► Particularly low in Jackson County.

Access to Mental Health Providers
(Number of Mental Health Providers per 100,000 Population, 2021)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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.

Seeking Professional Help

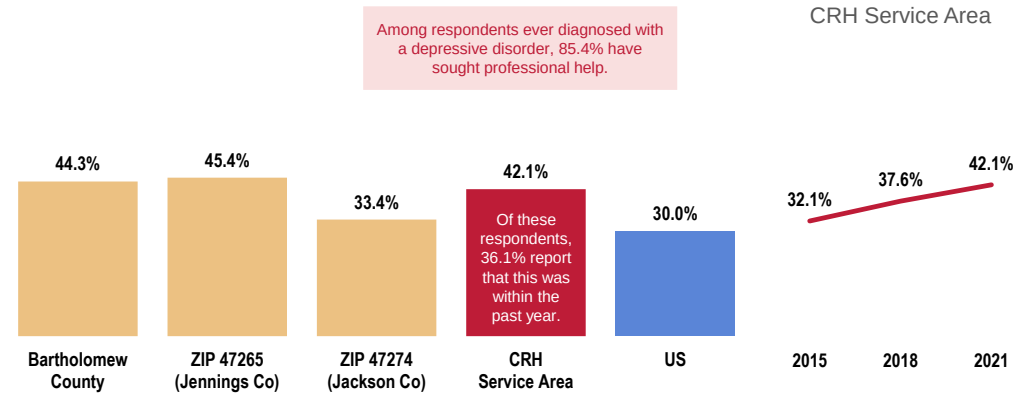
A total of 42.1% of service area adults have ever sought professional help for a mental or emotional problem.

BENCHMARK ► Higher than the national finding.

TREND ► Has increased significantly over time within the service area.

DISPARITY ► Lowest in Jackson County ZIP Code 47274.

Have Ever Sought Professional Help for a Mental or Emotional Problem



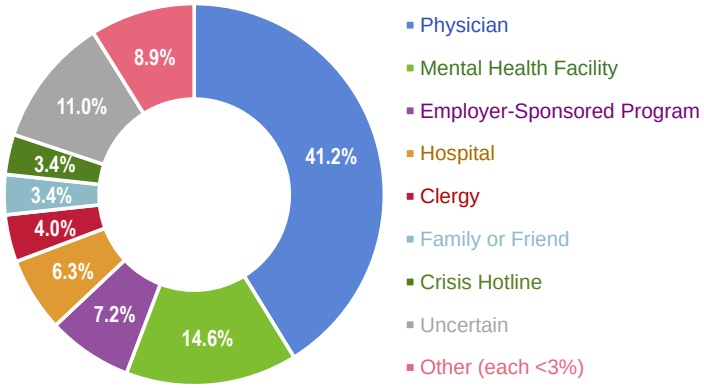
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 104, 127, 343]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Site for Services

Asked where they would seek services for mental or behavioral health if needed, the largest share of respondents (41.2%) mentioned a physician, while 14.6% would go to a mental health facility for help.

Other resources mentioned included an **employer-sponsored program** (mentioned by 7.2%), **hospital** (6.3%), **clergy** (4.0%), **family or friend** (3.4%), and a **crisis hotline** (3.4%). A total of 8.9% mentioned various other resources, and 11.0% expressed uncertainty.

Anticipated Site for Mental Health Services If Needed
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 344]
Notes: ● Asked of all respondents.

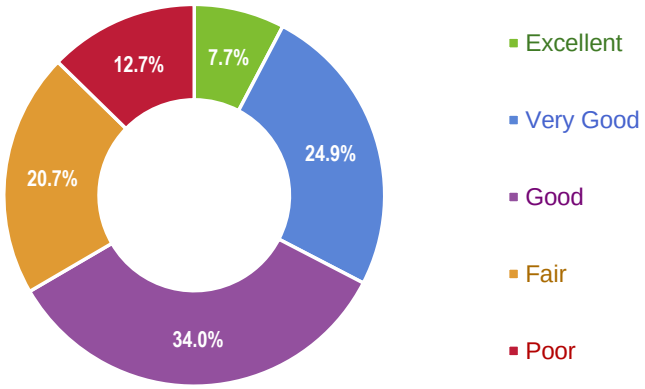
Access to Mental Health Services

Perceptions of Accessibility

When asked to rate the level of difficulty they face when accessing local services for mental health, 33.4% of service area adults gave "fair" or "poor" responses.

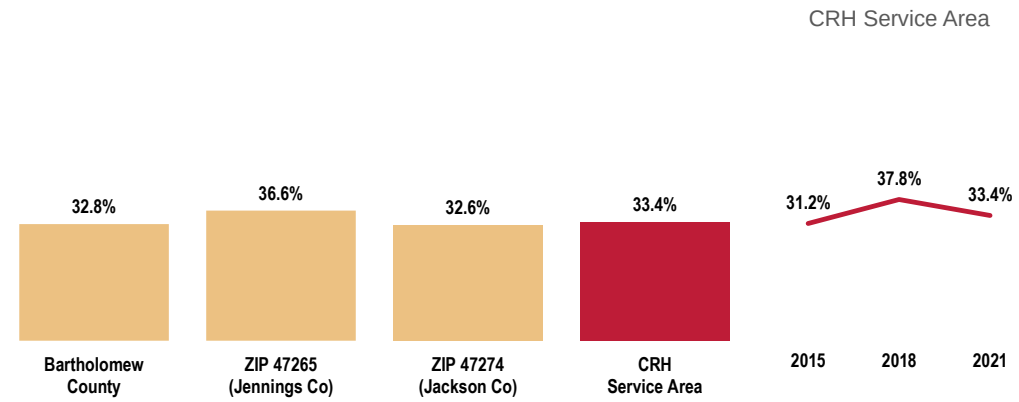
DISPARITY ► More often reported among adults under age 65, White residents, and Black residents.

Perceived Ease of Obtaining Local Mental Health Services
(CRH Service Area, 2021)



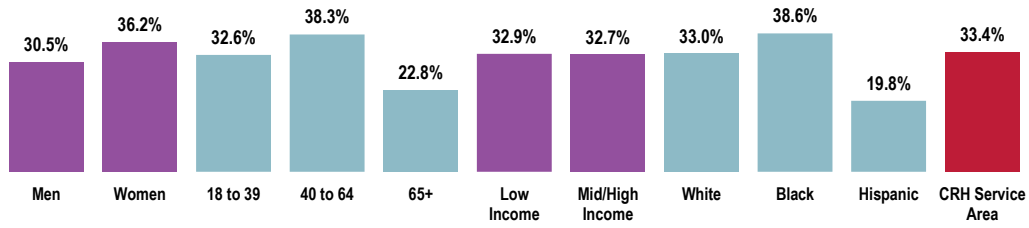
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 340]
Notes: ● Asked of all respondents.

Ease of Obtaining Local Mental Health Services Is "Fair" or "Poor"



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 340]
Notes: ● Asked of all respondents.

Ease of Obtaining Local Mental Health Services Is “Fair” or “Poor”
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 340]
Notes: ● Asked of all respondents.

Difficulty Accessing Services

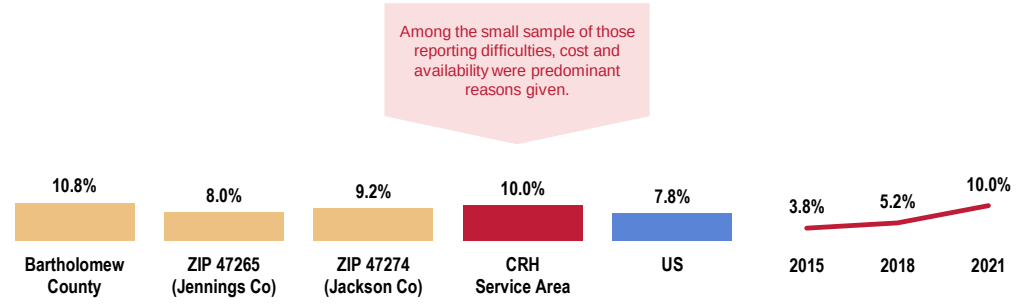
A total of 10.0% of Columbus Regional Health Service Area adults report a time in the past year when they needed mental health services but were not able to get them.

TREND ► Rising significantly higher over time.

DISPARITY ► Reported more often among young adults and lower-income residents.

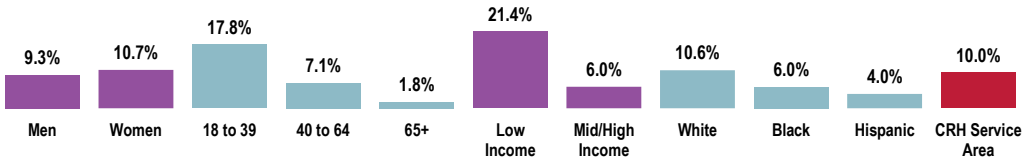
Unable to Get Mental Health Services When Needed in the Past Year

CRH Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 105-106]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 105]
Notes: ● Asked of all respondents.

Children's Mental Health

Children's Mental Health Status

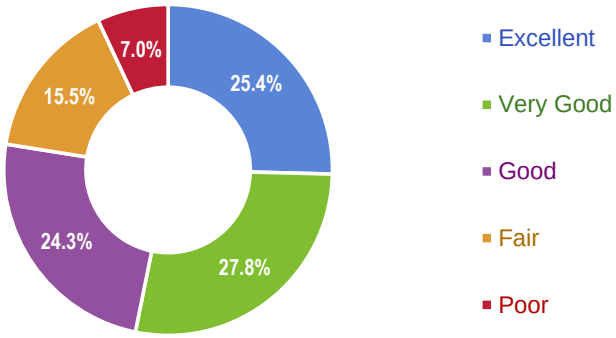
More than one-half of parents of a child age 5-17 (53.2%) consider their child's mental health to be "excellent" or "very good."

In contrast, 22.5% of Columbus Regional Health Service Area parents feel their school-age child has "fair" or "poor" mental health.

BENCHMARK ► Higher than found nationally (9.7%).

Child's Mental Health Status
(CRH Service Area Parents of Children Age 5-17, 2021)

In all, 22.5% of children are reported to have "fair" or "poor" mental health (compared to 9.7% nationally).



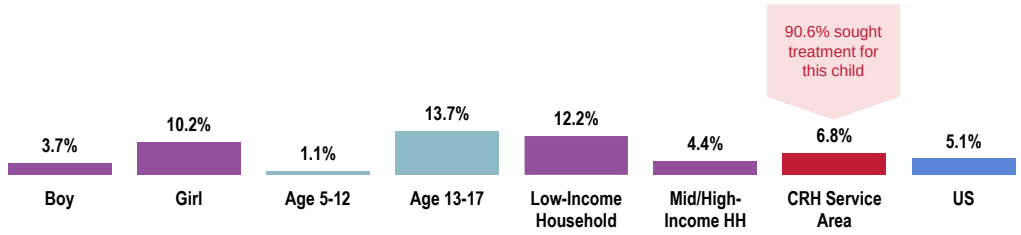
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 357-358]
Notes: ● Asked of all respondents with a child age 5-17 at home.

Child Depression & Anxiety

In the past year, 6.8% of parents indicate that their child (age 5-17) felt so sad or hopeless almost daily for two or more weeks that he/she stopped doing some usual activities (symptoms of depression).

DISPARITY ► Highest in Bartholomew County (not shown). Higher among children age 13-17.

Child Experienced Symptoms of Depression in the Past Year
(Children Age 5-17; CRH Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 360-361]
- 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with a child age 5-17 at home.
- In this case, the child felt so sad or hopeless almost every day for two weeks or more in a row that s/he stopped doing some usual activities.

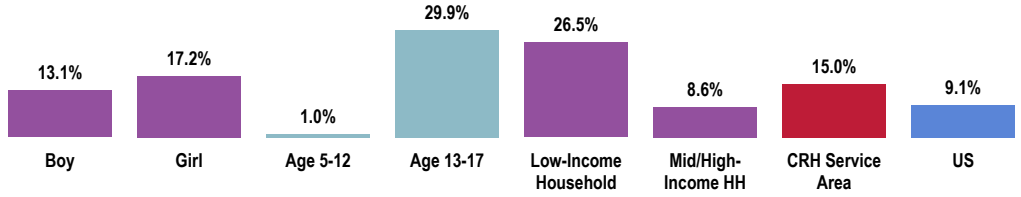
Diagnoses

A total of 15.0% of parents indicate that their child (age 5-17) has been diagnosed with depression.

BENCHMARK ► Higher than found nationally.

DISPARITY ► Higher among children age 13-17 and those living in lower-income households.

Child Has Been Diagnosed With Depression
(Children Age 5-17; CRH Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 362]
- 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.

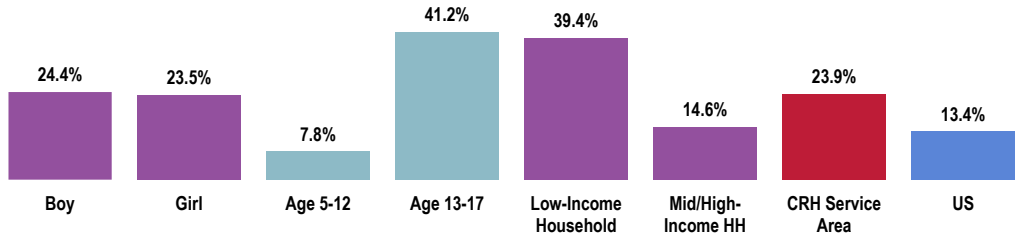
Notes:
- Asked of all respondents with a child age 5-17 at home.

Separately, 23.9% report that their school-age child has been diagnosed with anxiety.

BENCHMARK ► Much higher than found nationally.

DISPARITY ► Higher among children age 13-17 and those living in lower-income households.

Child Has Been Diagnosed With Anxiety
(Children Age 5-17; CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 363]
● 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with a child age 5-17 at home.

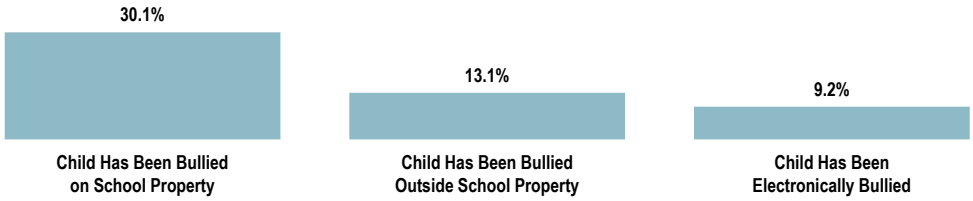
Bullying

Bullying is when one or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when two students of about the same strength or power argue, fight, or tease each other in a friendly way.

In the past year, 30.1% of parents with school-age children report that their child was bullied on school property, while 13.1% were bullied outside school property, and 9.2% were electronically bullied (through email, chat rooms, instant messaging, websites, or texting).

DISPARITY ► Electronic bullying is unfavorably higher in Bartholomew County (not shown).

Incidence of Bullying in the Past Year
(Children Age 5-17; 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 364-366]
Notes: ● Asked of all respondents with a child age 5-17 at home.
● In this case, electronic bullying includes bullying through email, chat rooms, instant messaging, websites, or texting.

Treatment for Children's Mental Health

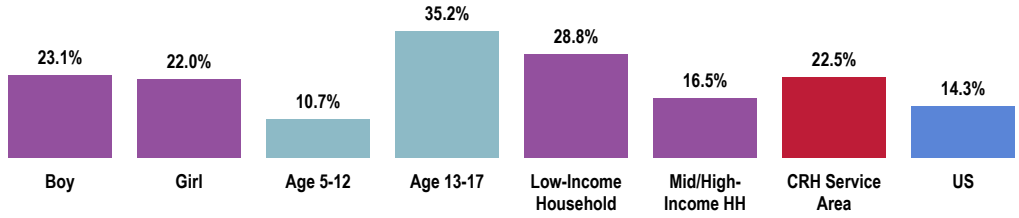
In all, 22.5% of service area children age 5 to 17 received some kind of treatment or counseling for mental health in the past year (a similar 23.4% were reported by parents to have had a need).

BENCHMARK ► Treatment level is well above that found for school-age children nationally.

DISPARITY ► Treatment level is lowest in Bartholomew County (not shown). Overall, treatment levels are notably higher among children age 13-17 and those living in lower-income households.

Child Received Professional Treatment/Counseling in the Past Year
(Children Age 5-17; CRH Service Area, 2021)

Note that 23.4% of service area children age 5-17 have needed mental health services in the past year.



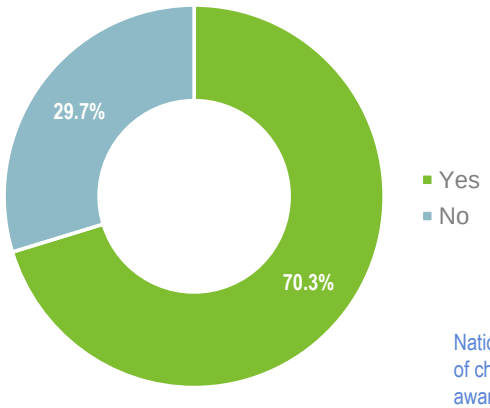
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 359]
- 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.

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

Awareness of Resources

Among Columbus Regional Hospital Service Area respondents with children under the age of 18 in the household, 70.3% are aware of local resources for children's mental health.

Awareness of Local Resources for Children's Mental Health
(CRH Service Area Parents of Children Age 0-17, 2021)



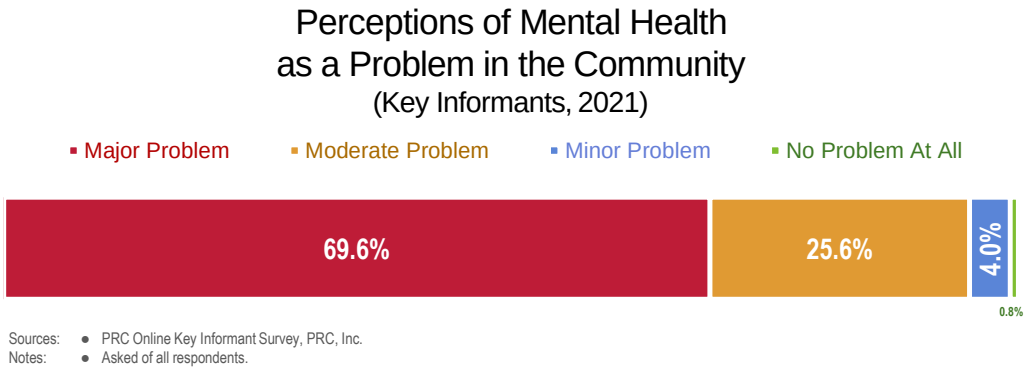
Nationally, 70.2% of parents of children age 5-17 are aware of local resources.

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 367]
- 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with a child age 0-17 at home.

Key Informant Input: Mental Health

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



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

Access to Care/Services

Our community's access to mental health care is severely lacking. Centerstone is the largest provider of mental health care in our community, however it takes months for an intake assessment to be completed and months further from that they have a first appointment scheduled. And turnover of mental health care providers creates for lack of continuity in providing care. – Other Health Provider

Access, quality mental health services, people of color having therapist of their own color to talk to. Also, people of different languages having a therapist to talk to in their own language. Mental Health covers all ages. Suicide support. – Social Services Provider

Access to care. – Public Health Representative

There is a considerable lack of access. Mental health care has been a real struggle for many, and during the pandemic it has been hard on folks. A lot of people refuse to seek care. Or they think that seeing a mental health professional is only for "when things get bad" and that vague definition keeps them away. For seeking care, it seems like there is a two-tier system: those who have connected with various agencies/services before (WIC, Medicare/Medicaid, San Souci, etc), and those who haven't. That disconnect can be a barrier. An additional dimension to the lack of access involves the services matching cultural needs. Someone who is not a white American born resident may have trouble finding a provider who can parse cultural expectations and occurrences. Language barriers are an issue for our immigrant community. Knowing you have extremely limited amount of time can frustrate the communication process if English is not your first language. – Community Member

Finding the right type of help and being able to maintain that help. Currently many patients have to depend on Centerstone for their help, however Center Stone is not an immediate assistance for things. Their new appointments are booked out for a few months at times. Patients have to utilize the ER for assessment, but if they are out of medications then ER does not prescribe them. Patients who don't have a primary care physician are often frequent visitors to the ER for treatment only to be discharged with no plan of action. – Other Health Provider

Access to mental health care providers in a timely and ongoing manner. – Other Health Provider

Not enough access to outpatient care or inpatient facilities. – Other Health Provider

Access to care. – Other Health Provider

Access to inpatient treatment when needed. Lack of staffing at outpatient treatment facilities. – Community/Business Leader

Access to quality care. – Public Health Representative

Although our community has made great strides with the ASAP program, mental health is still not easily accessible. We should have three times the number of dedicated professionals to serve this population in a timely manner. There are not enough support groups to meet the needs of specific mental health issues like eating disorders, alcohol and drug additions. These individuals need support in the moment of their crisis not next week when they can get an appointment. Support for Eating disorders are not even available in our community. Virtual support is helpful but still not enough. – Other Health Provider

Lack of access to behavioral therapies. Lack of access to prescribing physician when common medication is not effective. Wrap around services for school age children. – Physician

Centerstone is the only resource, and they are full and don't have capacity and when they could have opened up, they stayed virtual, that is not helping. – Other Health Provider

Access to treatment. I feel that in person treatment is vital and not currently accessible because of COVID. Meetings are Zoom and we are seeing an increase in mental health issues and suicide attempts. – Other Health Provider

Not enough access to help. Long waits, insurance problems, not enough providers for counseling and medication management, especially for kids. – Other Health Provider

Not being able to get in to see a psychiatrist. They must jump through hoops before being given the opportunity to see a psychiatrist and there are not very many in our community. – Other Health Provider

Reliable access to outpatient services. – Other Health Provider

Inpatient resources are at a minimum or on a waiting list. There is still a stigma for getting care. – Other Health Provider

Access to psychiatry and mental health care professionals for therapy, medication management. – Other Health Provider

Weak community mental health support network for those who have chronic severe MH needs and cost for those who have depression/anxiety/stress/other issues. – Other Health Provider

Lack of access to mental health providers. Almost no mental health resources for children locally. This is a huge gap. – Other Health Provider

Lack of access for outpatient psychiatric services. – Physician

Lack of appropriate mental health services and providers. – Community/Business Leader

No institutions to give them medications, food, shelter, some people need to be in a structured environment for the health of the individual and the community. – Community/Business Leader

Lack of resources for those seeking diagnosis and treatment. Many local providers not qualified to actually diagnose mental illness (LCSW as example). Higher level psychiatrists needed in our county. – Other Health Provider

Our mental health resources are severely lacking in Columbus, Indiana. I know from a personal, family experience with a close family member that it was impossible to get appropriate mental health support until the family member became suicidal. Our in-patient mental health support at CRH for my family member was sub-par. I was able to witness the in-patient mental health support at IU Health in Bloomington, Indiana, and their programs and support were a thousand times better than CRH. – Other Health Provider

Timely access to services. – Social Services Provider

Access to counselors, affordable mental healthcare, lack of counselors for kids. – Community/Business Leader

Access, support, long term care. – Community/Business Leader

Access to services. – Other Health Provider

Access to mental health professionals. – Community/Business Leader

Individuals need qualified case managers/caregivers to help monitor taking medications and have some education about mental health issues. – Social Services Provider

Having accessible counseling. There are no options for families. – Community/Business Leader

Access to care for proper diagnosis, lack of services, and lack of ability to maintain services and compliance once properly diagnosed and treated. – Community/Business Leader

We don't really have well define programs and coordination in Columbus. Centerstone is not the answer. – Community/Business Leader

Contributing Factors

So many times, lack of resources and care for mental health are leading to substance abuse. – Other Health Provider

Access to quality services. There are not enough providers, or they cannot afford services, such as they have too high of a deductible for their insurance and can't afford services, or they don't have insurance. Many individuals need medication and have chronic mental health challenges and need the Community Mental Health provider in our community, but there is not enough therapist to provide. 1) access to services 2) don't have the financial means 3) need medication and can't find a provider for mental health. The Spanish speaking population also suffers in this regarding not having financial means to pay for services. – Social Services Provider

Not enough resources, not enough financial support. – Other Health Provider

Timely access to quality care and affordable medication combined with social stigma. – Community/Business Leader

Unless someone is admitted to the hospital it is almost impossible to see a provider who prescribed medication. Three months wait and lots of hoops to jump through at Center Stone. – Other Health Provider

It is near impossible for those seeking help to get into services to be evaluated for mental health services. Either they cannot due to insurance barriers, or they can, but it is over a month before they can be seen. If a medication need is present, it is not able to be addressed in anywhere close to in a timely manner. – Other Health Provider

I think Bartholomew County, like many places around the country, suffers from a lack of mental health resources. People facing a mental health crisis often struggle with getting help due to the stigma around mental health, but even if that can be overcome, they frequently don't know where to turn. I think there needs to be public outreach to educate people regarding whether they can get help. I also think we as a community need to look at adding resources in this area. – Community/Business Leader

Limited number of providers and perception that help is not available. Also, many are reluctant to seek help for mental health. – Social Services Provider

Lack of access to care due to shortage of mental health counselors. Lack of insurance coverage to pay for mental health counseling. – Community/Business Leader

No available providers, no available comprehensive mental health "system" unless in crisis, then limited. No mental health transitional or supportive living services, too many churches. – Community/Business Leader

Not enough providers, especially for youth, cost or lack of insurance. – Public Health Representative

Many people are getting effective help with mental health issues, and that it good. It seems for those without financial means and family support, effective mental health services are out of reach. These individuals – who often have co-existing drug addiction issues – brush up against services, but never seem to access true help that actually gets them healthy. They go in and out of the ER, occasionally admitted to inpatient, but generally regurgitated back into the community without long-term solutions or follow-up. This small number of people represent a constant ongoing drain to the police (that's who people call) and the ER (that's the only thing police can do with the mentally ill). Because of this inefficiency, these individuals are often directed to the criminal justice system (jail). There has been a local movement led by police to create a Crisis Intervention Team (CIT), which has proven very successful in other communities. – Community/Business Leader

Access to mental health services for low-income members of the community should be improved/increased. In addition, it is an ongoing challenge to de-stigmatize mental health care. – Social Services Provider

Affordable counseling for those who make too much to be on Medicaid and don't have good insurance. Most therapists have wait lists too. – Community/Business Leader

Limited affordable or any counseling services available. Many are booked well in advance. Few psychiatrists, group therapy or other therapy options. No inpatient support for adolescents and very few options for young adults and older. No community wide education and/or life skills taught broadly through school system or other community resources. – Other Health Provider

Stigma related to receiving help, ability to easily get to a facility that could help, education about what options are available for free to those that need it and can't afford it. – Community/Business Leader

We haven't made the clear link of diet and exercise to mental health. – Community/Business Leader

So many people are going untreated... I believe this is two-fold – not enough resources (psychiatrists, therapists, facilities, etc.) and no mandates forcing people to take medications they NEED to maintain mental illness. Organizations who work with those in the mental health field are stretched very thin and can't get enough staff. There are not many laws forcing people to take medicine or be kept in a facility to help them. – Social Services Provider

Culturally, many of our families do not recognize mental health. Helping them understand what it is and ways to get help has been an ongoing challenge. Due to situational stress, trauma, barriers, lack of food, community racism, language barriers, and economical struggles has lent to an increase in our family’s poor mental health. – Social Services Provider

I think in our community, mental health is a very prominent issue. I don't know if it is lack of support from family or lack of resources that has caused the many challenges. I feel like families do not have support in dealing with mental health issues. I also feel like patients’ resources are limited to availability. Other offices are full or not taking new patients. Centerstone does not have appointments available and often times patients are not properly taking their medications, etc. I don't have a good answer for this, but I know that resources would be a huge step in the right direction. – Other Health Provider

Social media facilitates a culture of comparing (the grass is always greener), highlighting the good AND the bad, misinformation, and giving a voice to people who really should not have one. There is also a significant lack of therapists in the community ESPECIALLY Spanish speakers. – Social Services Provider

Lack of Providers

There are not enough providers. – Community/Business Leader

Lack of providers – Therapists, Psychologists, Psychiatrists, Psychiatric Nurse Practitioners. It is very difficult to get mental health care specifically for ADHD. Centerstone has poor customer service and treats patients like things and not people. It takes months to get set up with a therapist before seeing a med prescribing professional. By this time, people are off their meds. For people with severe mental illness, there is no supportive housing. Research is clear on this. Supportive housing works for people with SMI. People with SMI often end up in jail, which is not a rehab. there is one part time therapist for the entire jail. It is not enough. There is no place to go when one is having a mental health emergency except the ER, which is not set up to handle such things. – Community/Business Leader

> THERE ARE NOT ENOUGH PROVIDERS OF MENTAL HEALTH CARE. Especially for those that go beyond mild depression. THERE ARE NOT ENOUGH SOURCES OF ONGOING COMPREHENSIVE TREATMENT FOR SERIOUS MENTAL HEALTH PROBLEMS. Mental health unit at CRH is inadequately small and limited in scope, highly regulated to avoid adequate stays to accomplish comprehensive diagnosis. THE OUTPATIENT SERVICES ARE PAINFULLY LIMITED, the only choice is Centerstone and that is also limited and controlled by the availability or lack of reimbursement. THERE IS NO OPTION FOR LONG TERM RESIDENTIAL CARE, very sick, inadequately followed individuals are homeless and without resources to help themselves enough to seek or stay in treatment. OUR COMMUNITY OSTRACIZES THOSE WITH MENTAL HEALTH, family and friends disappear and the community responses are inadequate for the magnitude of the problem. This is an urgent issue as we try to remain the "Athens of the Prairie" that attracts young professionals. – Other Health Provider
>
> More mental health providers are needed in the community. Individuals with mental health concerns often have to wait to be seen. Furthermore, there is a lack of psychiatrists locally, especially psychiatrists specializing in pediatric and adolescent care. We also have a need for mental health providers who specialize in working with the LGBTQIA+ population and immigrant populations. – Social Services Provider
>
> There is a severe shortage of mental health care providers in Bartholomew County. There are no outpatient psychiatrists (just two nurse practitioners). It is impossible to find an outpatient psychiatrist for a patient with Medicaid. There aren't enough counselors/therapists. – Other Health Provider
>
> Not enough providers! Long wait time. – Social Services Provider
>
> Our community has no full-time outpatient psychiatrist. The only psychiatrists work in the inpatient setting or work very part-time. There's only one outpatient psychiatrist in Seymour, and she is overwhelmed. There are no psychiatrists in our other surrounding counties, although Johnson County may be an exception. Because they are largely untreated, serious mental health conditions, such as schizophrenia, bipolar disorder, and others, are incredibly costly to our local health system and public payers. Primary care providers are generally not trained to manage these relatively common serious mental health problems, and even if they were, they're already stretched thin with managing the other conditions on this survey (e.g., diabetes, heart conditions, obesity). The addition of a full-service, accessible inpatient and outpatient mental health program within our community would be a worthy and welcome investment. – Physician

Denial/Stigma

> Stigma preventing one reaching out for care, not knowledgeable of the signs of there being mental health issues at hand. – Public Health Representative
>
> Stigma, lack of understanding of recognition and treatment, especially in youth. – Public Health Representative
>
> The stigma surrounding mental health. Individuals not knowing the resources available to them through their employment, along with not knowing in general. Not understanding that mental health is real, and not just in your mind. What protections individuals with mental health have in relation to taking time off work. – Community/Business Leader

Social Isolation

> Social isolation. Older adults who are socially isolated die faster and have poorer health and those with chronic illness are at even higher risk (Goll et al., 2015; Holley, 2007; Merz and de Jong Gierveld, 2016). Social isolation has been studied for nearly 40 years. A 2020 meta-analysis stated that social isolation has that the magnitude of mortality risk may be comparable to or greater than other well-established risk factors such as smoking, obesity, and physical inactivity. The same analysis examined studies with data from 300,000 people and found that having a stronger social connection was associated with 50 percent greater odds of survival. – Community/Business Leader

Co-Occurrences

> Many of those placed on probation following arrest and conviction for criminal charges, are dealing with chronic mental health issues and in many cases, they are in need of some type of residential treatment and housing. Many are homeless. Juveniles and their families have indicated that their best option is to have the child in the 'system' for juvenile delinquency in order to receive timely services. – Community/Business Leader

Law Enforcement

> Our law enforcement professionals increasingly seem to be trying to manage situations involving individuals with mental health issues, and they are ill-prepared to do so. Some situations have resulted in death and/or injury to those suffering from mental health issues and/or their family members, caregivers, or law enforcement. Our county seems to lack the resources needed to truly help people. – Community/Business Leader

COVID-19

> Overall rise in stress from the ongoing COVID pandemic; burn-out in health care professionals; social isolation and depression in seniors and people with disabilities. Poor mental health stresses all areas of life, including leading to higher rates of domestic and other violence, depression, suicide. – Social Services Provider

Awareness/Education

> Awareness. Lack of community understanding. Data not being public, percentage of population with. – Community/Business Leader

Incidence/Prevalence

> I meet with people who speak openly about their issues with mental health. – Community/Business Leader

Diagnosis/Treatment

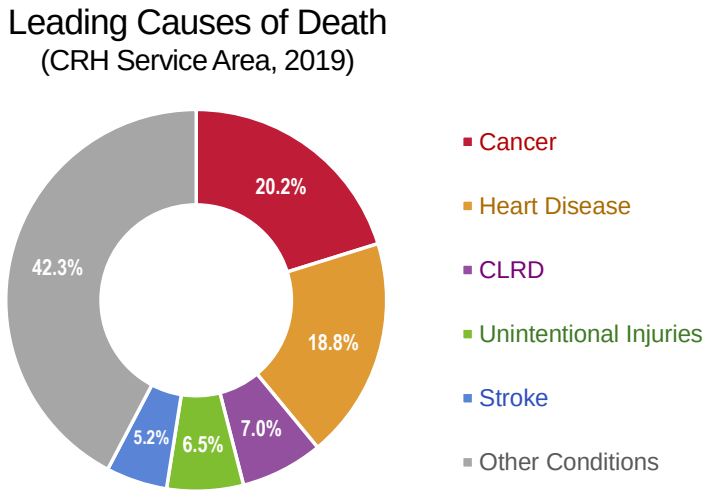
> Centerstone seems inadequate. – Community/Business Leader

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, cancers and heart disease accounted for well over one-third of all deaths in the Columbus Regional Health Service Area in 2019.



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 2021.
Notes: ● Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

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

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that 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 following chart outlines 2017-2019 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Columbus Regional Health Service Area.

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

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

Age-Adjusted Death Rates for Selected Causes
(2017-2019 Deaths per 100,000 Population)

	CRH Service Area	Indiana	US	HP2030
Malignant Neoplasms (Cancers)	171.8	166.4	149.3	122.7
Diseases of the Heart	169.0	180.9	163.4	127.4*
Unintentional Injuries	74.2	56.6	48.9	43.2
Chronic Lower Respiratory Disease (CLRD)	55.6	56.2	39.6	n/a
Cerebrovascular Disease (Stroke)	45.6	40.3	37.2	33.4
Drug-Induced	33.5	24.4	18.8	n/a
Fall-Related Deaths (65+)	30.8	44.5	65.1	63.4
Alzheimer's Disease	24.8	33.4	30.4	n/a
Motor Vehicle Deaths	21.9	12.4	11.3	10.1
Kidney Diseases	19.2	17.7	12.9	n/a
Intentional Self-Harm (Suicide)	19.0	15.5	14.0	12.8
Diabetes Mellitus	16.1	25.9	21.5	n/a
Pneumonia/Influenza	16.0	13.1	13.8	n/a
Firearm-Related	13.5	14.7	11.9	10.7
Cirrhosis/Liver Disease	11.3	12.0	11.1	10.9
Homicide	2.6	6.3	5.6	5.5

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

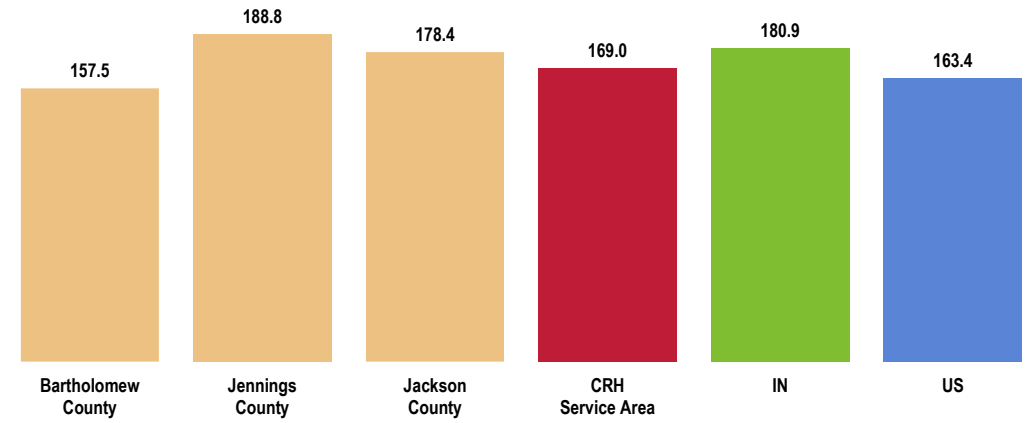
Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

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

Between 2017 and 2019, there was an annual average age-adjusted heart disease mortality rate of 169.0 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	188.5	178.6	183.1	184.3	188.6	186.0	176.4	169.0
IN	189.1	187.3	185.8	183.7	181.9	182.0	181.5	180.9
US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

Between 2017 and 2019, there was an annual average age-adjusted stroke mortality rate of 45.6 deaths per 100,000 population in the Columbus Regional Health Service Area.

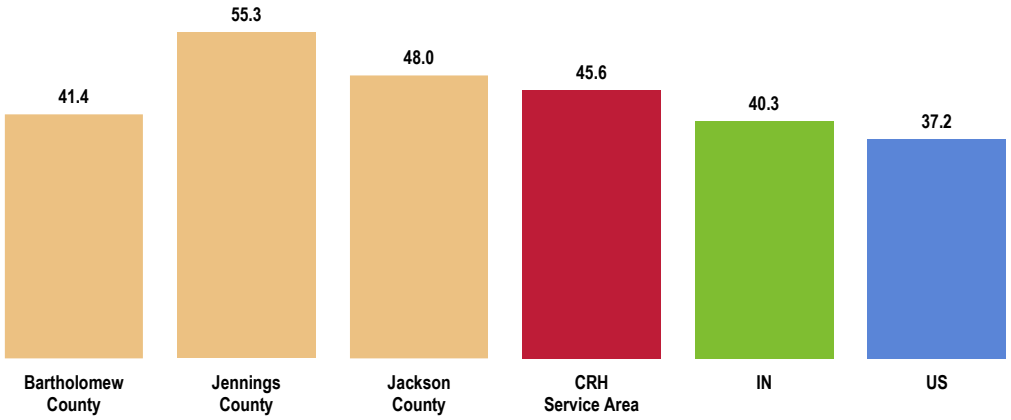
BENCHMARK ► Higher than the US rate. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lowest in Bartholomew County.

Stroke: Age-Adjusted Mortality

(2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

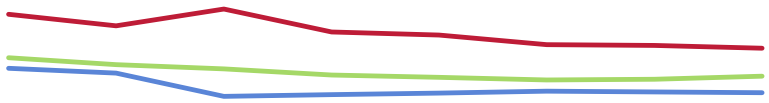


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	52.0	49.8	53.0	48.7	48.1	46.3	46.1	45.6
IN	43.8	42.5	41.7	40.5	40.1	39.6	39.7	40.3
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

A total of 43.5% of Columbus Regional Health Service Area adults have been told by a health professional at some point that their blood pressure was high.

BENCHMARK ► Higher than state and national percentages. Fails to satisfy the Healthy People 2030 objective.

TREND ► Rising significantly higher over time within the service area.

DISPARITY ► Highest in Jackson County ZIP Code 47274 (not shown).

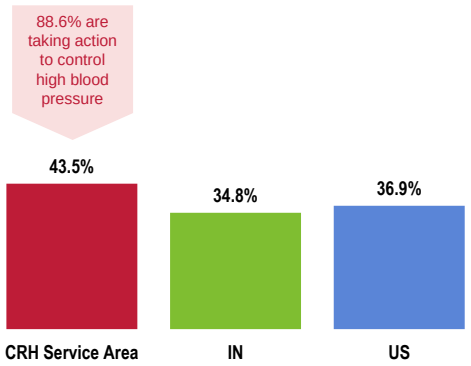
A total of 37.3% of adults have been told by a health professional that their cholesterol level was high.

BENCHMARK ► Higher than the national percentage.

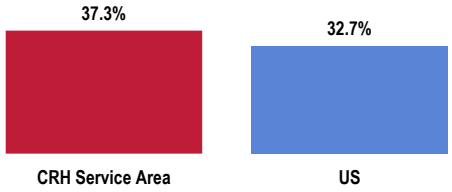
TREND ► Trending significantly higher over time.

Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower



Prevalence of High Blood Cholesterol

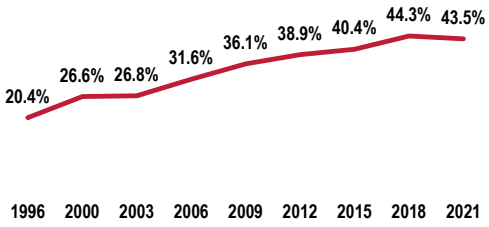


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 39, 41, 43]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

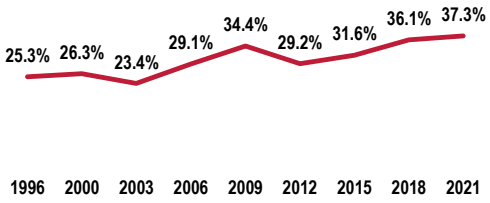
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure (CRH Service Area)

Healthy People 2030 = 27.7% or Lower



Prevalence of High Blood Cholesterol (CRH Service Area)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 39, 43]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

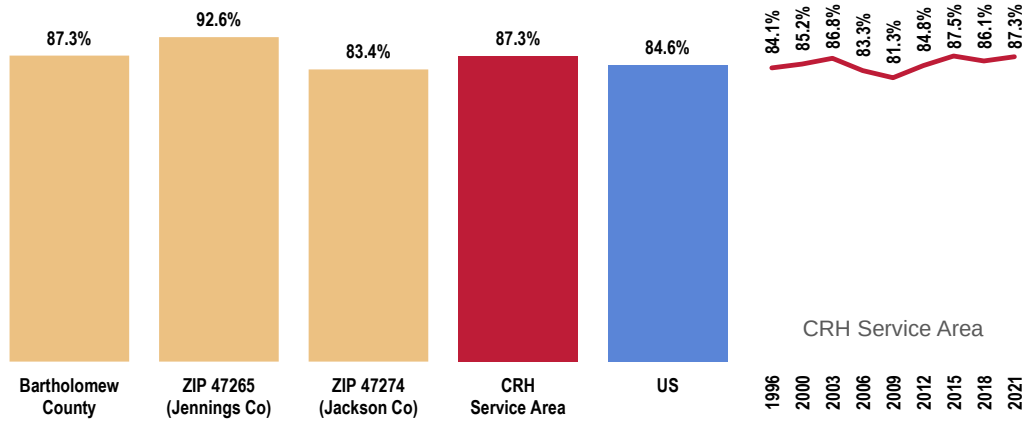
Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

A total of 87.3% of Columbus Regional Health 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.

DISPARITY ► Unfavorably higher in Jennings County ZIP Code 47265. More often reported among men, adults age 40+, lower-income adults, White residents, and Black residents.

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

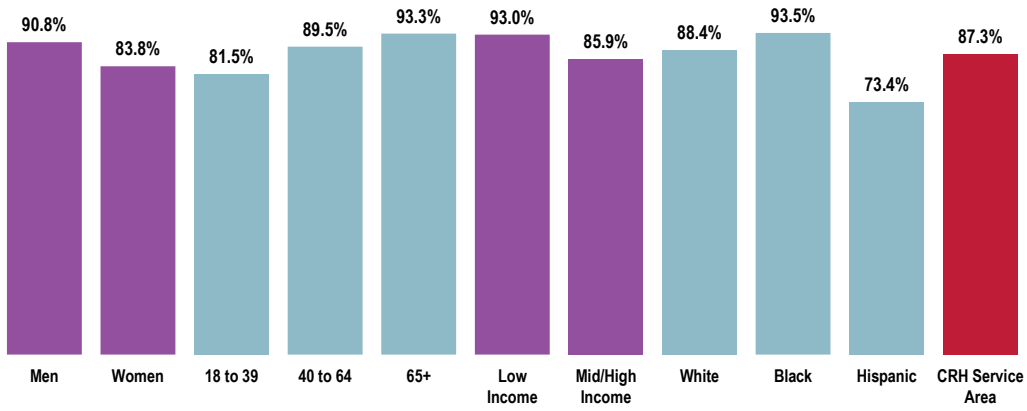
Present One or More Cardiovascular Risks or Behaviors



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 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.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Present One or More Cardiovascular Risks or Behaviors
(CRH Service Area, 2021)

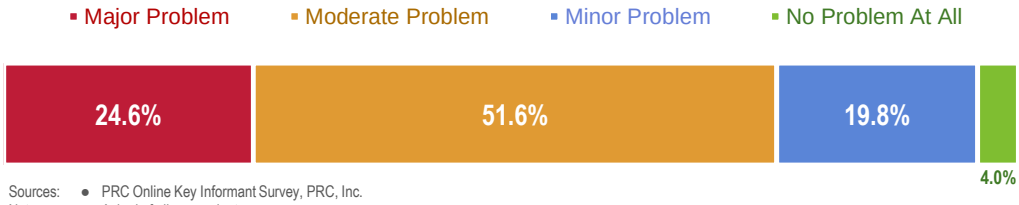


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
Notes: • Reflects all respondents.
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

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, 2021)



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

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

Contributing Factors

> Incidence of disease, obesity, smoking, lack of preventive care. – Physician
>
> High risk community, smoking, obesity, high blood pressure. – Other Health Provider
>
> People smoking too much, too much obesity, not enough attention to their health. – Other Health Provider
>
> Smoking. High consumption of fat and sugar. – Community/Business Leader
>
> High rate of tobacco use and obesity. – Physician
>
> The percentage of local residents who smoke and who are morbidly obese, plus an aging population, results in heart disease and stroke. – Community/Business Leader
>
> Obesity and smoking are now viewed as culturally acceptable lifestyles in certain demographics. – Community/Business Leader

I believe this is also due to high stress and lack of self-care due to mitigating circumstances that are sometime beyond our family's control. Proper nutrition, preventative care and an active lifestyle can lend to lowering some of these problems. Sometimes we see culturally that our families work a lot and then take care of their children, plus other family members which aids in the lack of self-care. Many do not have health insurance so do not do preventative care. Many are stressed and tired at the end of the day so lack the physical activity they need to keep their heart strong and healthy. – Social Services Provider

Genetic conditions, unhealthy lifestyle, including diet and exercise, tobacco use. – Community/Business Leader

I am seeing younger people who are not physically active, and do not eat healthy foods. There is a serious deficiency in the knowledge link between healthy lifestyle, weight, and heart disease. The number of people who are obese is alarming. The number of people who are over the age of 55 who do not reach average life expectancy increases each year. (Over 500 people in 2020.) Cardio-vascular issues are the number one reason for this. – Social Services Provider

Mostly from my perspective, the problem resides in the lifestyle of the Midwest, and the choices of individuals: Diet and Exercise are inadequate for most individuals in our communities, some due to isolation, some to food deserts, some to education level. Again... social determinants of health, transmitted from one generation to another: and present in the marginalized communities (by social status, language differences, poverty, and low education) – Other Health Provider

Poor meat-based diet, stress of an unequal, unfair society where the most draining jobs are the least paid, lack of mental health resources, too many churches vs. available resources, like childcare. – Community/Business Leader

Incidence/Prevalence

High rates of heart disease and stroke. – Community/Business Leader

Heart disease is the leading cause of death in the country and in Bartholomew County and accounted for over four out of 10 deaths in 2016. – Community/Business Leader

Of the population I serve, 8 of 10 will die from cardiovascular complication. Prevention and disease management to reduce risks are primary focus. – Other Health Provider

Again, my personal experience, family, friends and coworkers. – Social Services Provider

It seems that we have a lot of patients with CHF and decreased cardiac ability. – Social Services Provider

Heart disease is the number one cause of death in women. – Other Health Provider

The number one cause of death in Indiana. – Public Health Representative

Appears to be too many premature deaths from heart and stroke issues. – Community/Business Leader

Obesity

Obesity. – Community/Business Leader

CANCER

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

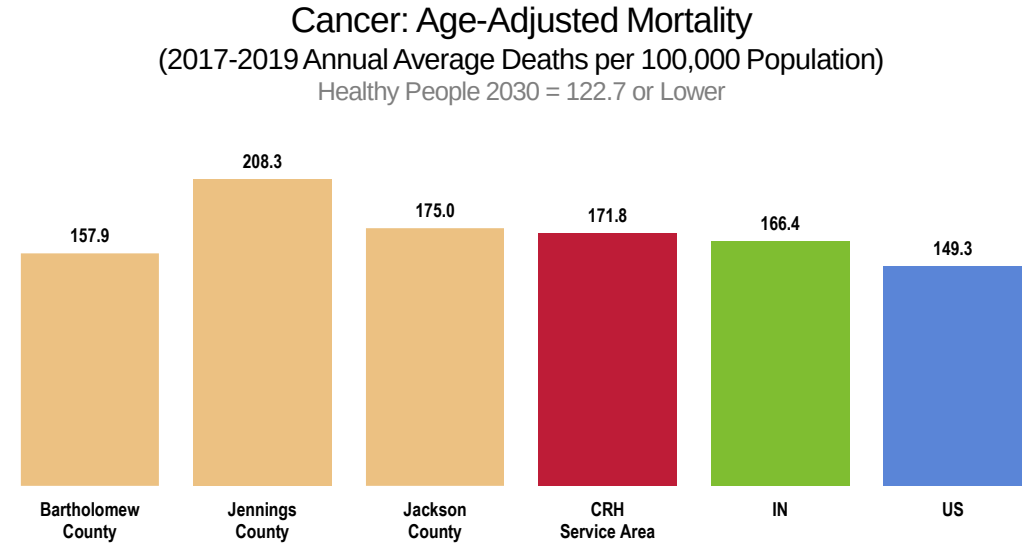
Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2017 and 2019, there was an annual average age-adjusted cancer mortality rate of 171.8 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Notably higher in Jennings County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	197.0	196.7	197.0	192.7	181.8	174.9	171.2	171.8
IN	186.1	183.1	181.2	178.5	176.2	172.9	169.4	166.4
US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the Columbus Regional Health Service Area.

Other leading sites include prostate cancer (men), female breast cancer, and colorectal cancer (both sexes).

BENCHMARK

Lung Cancer ► Higher than the national rate. Fails to satisfy the Healthy People 2030 objective.

Female Breast Cancer ► Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Higher than the national rate. Fails to satisfy the Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site

(2017-2019 Annual Average Deaths per 100,000 Population)

	CRH Service Area	Indiana	US	HP2030
ALL CANCERS	**171.8**	**166.4**	**149.3**	**122.7**
Lung Cancer	**50.3**	**44.6**	**34.9**	**25.1**
Prostate Cancer	**19.0**	**19.4**	**18.6**	**16.9**
Female Breast Cancer	**18.7**	**20.4**	**19.7**	**15.3**
Colorectal Cancer	**16.8**	**15.1**	**13.4**	**8.9**

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Incidence

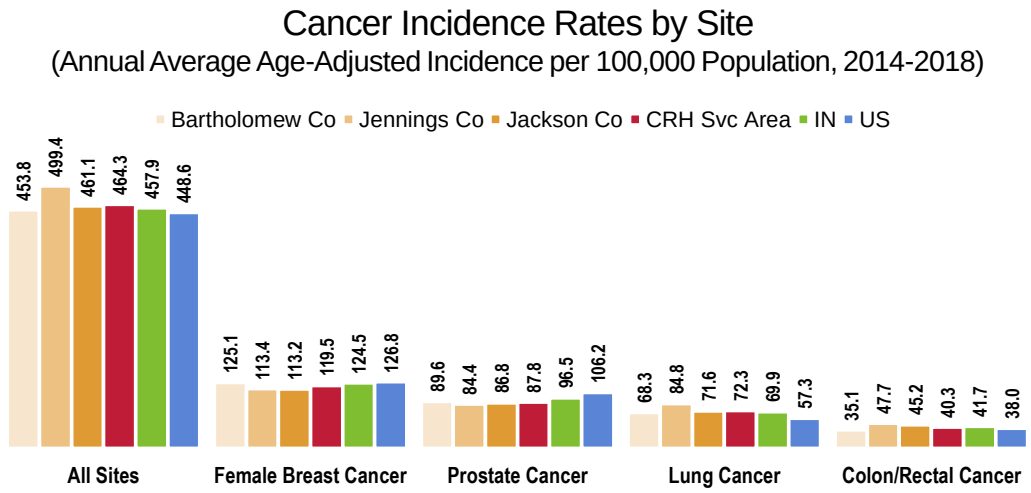
"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

The highest cancer incidence rates in the area are for female breast cancer and prostate cancer.

BENCHMARK

Prostate Cancer ▶ Lower than the national rate.

Lung Cancer ▶ Higher than the national rate.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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

Overall, 17.3% of surveyed Columbus Regional Health Service Area adults report having ever been diagnosed with any type of cancer (not shown).

BENCHMARK ▶ Much higher than found statewide (11.9%) or nationally (10.0%).

Specific types of cancers reported among survey respondents are discussed in the following sections.

Skin Cancer

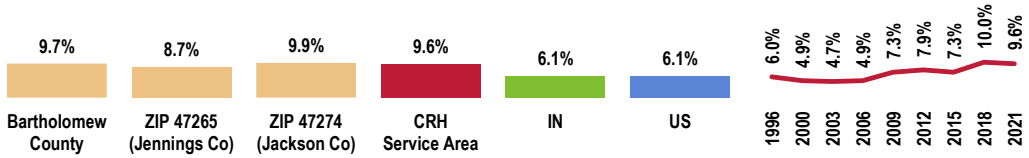
A total of 9.6% of surveyed Columbus Regional Health Service Area adults report having ever been diagnosed with skin cancer.

BENCHMARK ► Worse than state and US percentages.

TREND ► Increasing since the mid-2000s.

Prevalence of Skin Cancer

CRH Service Area



Sources:
- 2021 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): 2019 Indiana data.

Notes:
- Reflects all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Other Cancers

A total of 9.4% of survey respondents have been diagnosed with some type of (non-skin) cancer.

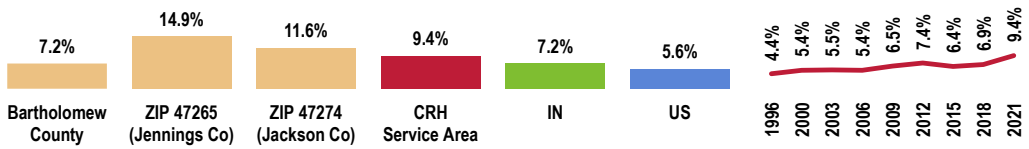
BENCHMARK ► Worse than state and national findings.

TREND ► Trending significantly higher over time.

DISPARITY ► Lowest in Bartholomew County.

Prevalence of Cancer (Other Than Skin Cancer)

CRH Service Area



Sources:
- 2021 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): 2019 Indiana data.

Notes:
- Reflects all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* 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

Women's 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 two cancer sites: female breast cancer (mammography); and cervical cancer (Pap smear 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) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

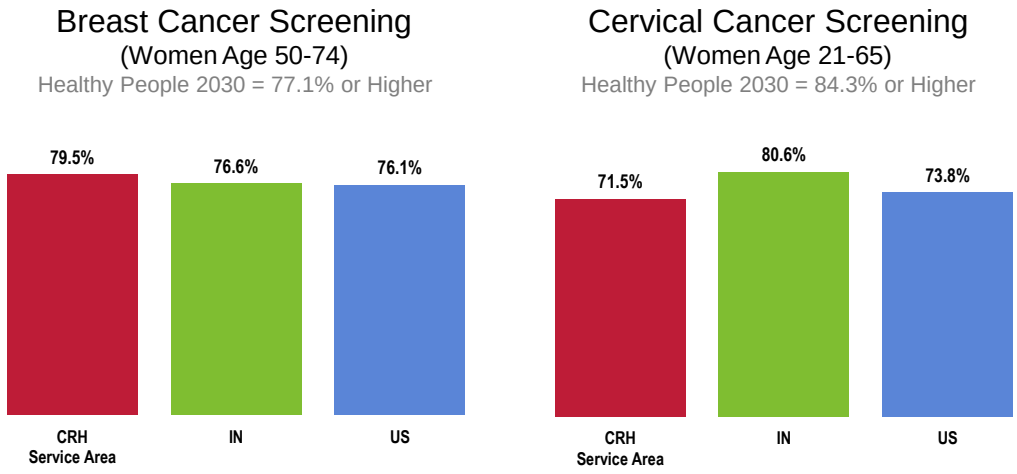
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Among service area women age 50-74, 79.5% have had a mammogram within the past 2 years.

BENCHMARK ► Similar to the Healthy People 2030 objective.

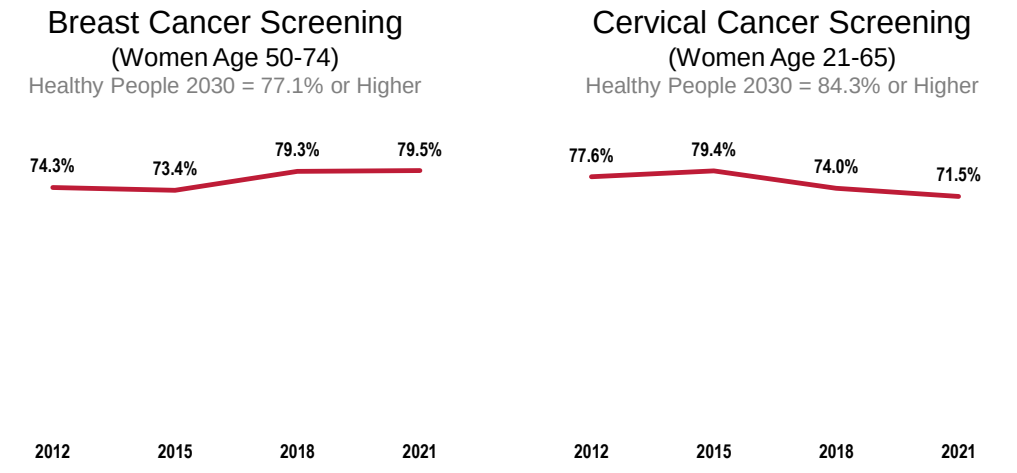
Among service area women age 21 to 65, 71.5% have had cervical cancer screening.

BENCHMARK ► Lower than the statewide percentage. Fails to satisfy the Healthy People 2030 objective.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 133, 134]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

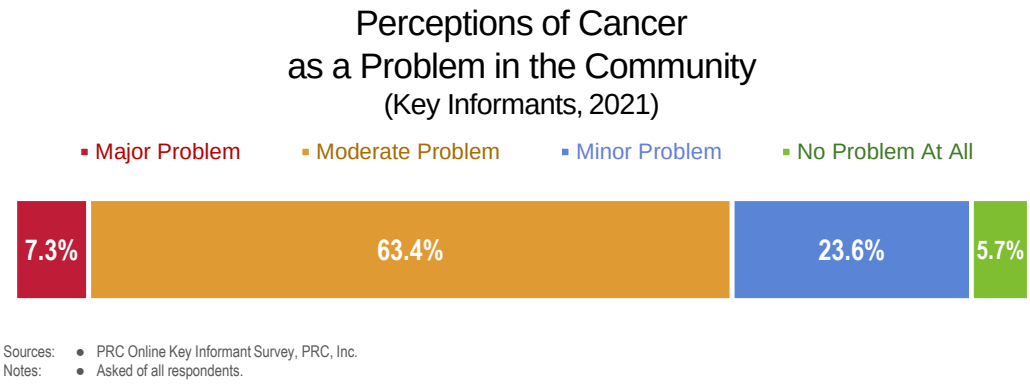


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 133, 134]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.



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

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

Incidence/Prevalence

> I am currently working, involved in cancer care, and know the stressors in the system. – Public Health Representative
>
> I know of people through my family, church, coworkers, and acquaintances who have had or have cancer. – Social Services Provider
>
> I answered this way based on the number of people diagnosed, but I think our local medical providers and hospital provide outstanding cancer treatment services. I think they do a great job! – Social Services Provider
>
> If someone is diagnosed with cancer, it's typically a "major" concern, so I listed it as a "major problem." – Community/Business Leader

Access to Care/Services

> Cancer is what I consider a "high stress" diagnosis. We don't have a go-to cancer center or group of doctors. This lack of visibility means that people feel especially alone in their illness. Also, many have to travel for specialty medical care and so they don't even consider if anything may be available closer to home. – Community Member
>
> Recent experience with cancer patient. Spent 1.5 going to IU Health for chemo, surgery by special orthopedic surgeon and more follow up. – Other Health Provider

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

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.

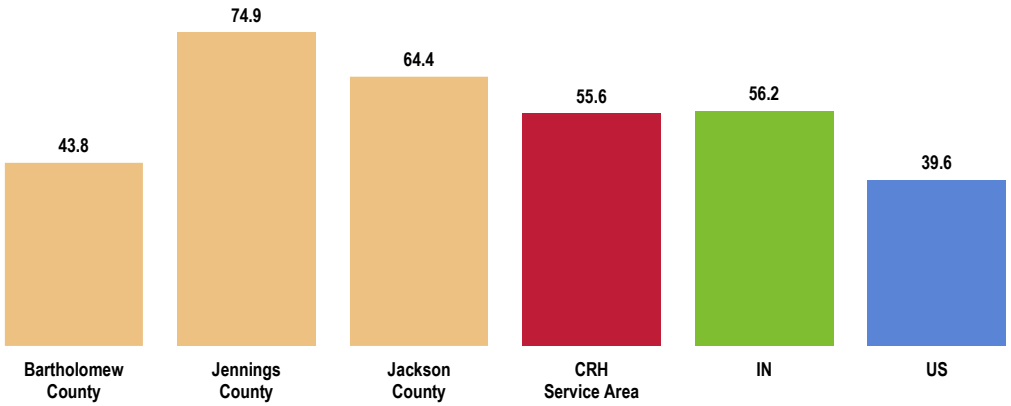
Between 2017 and 2019, there was an annual average age-adjusted CLRD mortality rate of 55.6 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Worse than the national rate.

TREND ► Trending favorably lower over time.

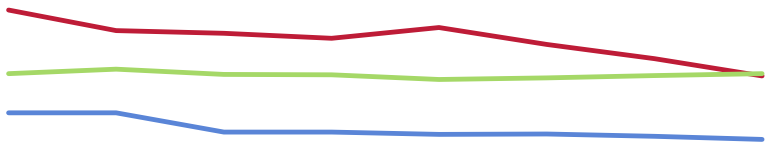
DISPARITY ► Lowest in Bartholomew County.

CLRD: Age-Adjusted Mortality
(2017-2019 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 2021.
Notes: • CLRD is chronic lower respiratory disease.

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	72.2	67.0	66.3	65.1	67.8	63.5	59.9	55.6
IN	56.2	57.3	56.0	55.9	54.7	55.1	55.7	56.2
US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Notes:
- CLRD is chronic lower respiratory disease.

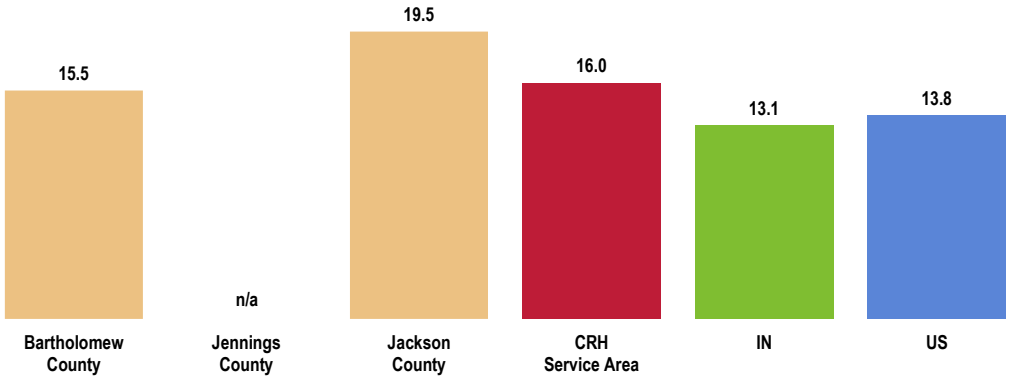
Pneumonia/Influenza Deaths

Between 2017 and 2019, the Columbus Regional Health Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 16.0 deaths per 100,000 population.

BENCHMARK ► Worse than the Indiana mortality rate.

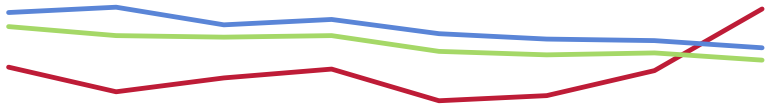
TREND ► Has increased significantly within the service area.

Pneumonia/Influenza: Age-Adjusted Mortality
(2017-2019 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 2021.
- 2021 PRC Community Health Survey, PRC, Inc. [Item 144]

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



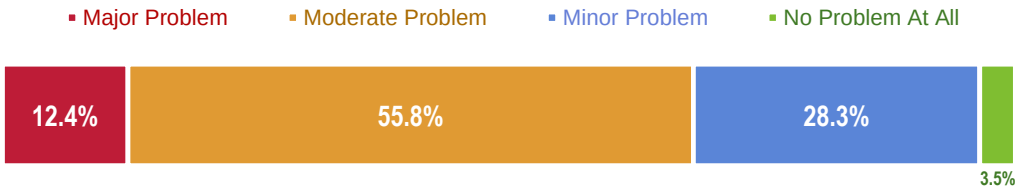
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	12.7	11.3	12.1	12.6	10.8	11.1	12.5	16.0
IN	15.0	14.5	14.4	14.5	13.6	13.4	13.5	13.1
US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

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 2021.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases as a Problem in the Community
(Key Informants, 2021)



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

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

Incidence/Prevalence

> Those with breathing problems. – Community/Business Leader
>
> Many people who attend our facility have respiratory problems and asthma. – Community/Business Leader
>
> High rates of lung cancer, COPD and smoking. – Physician
>
> COPD rate. – Community/Business Leader

Tobacco Use

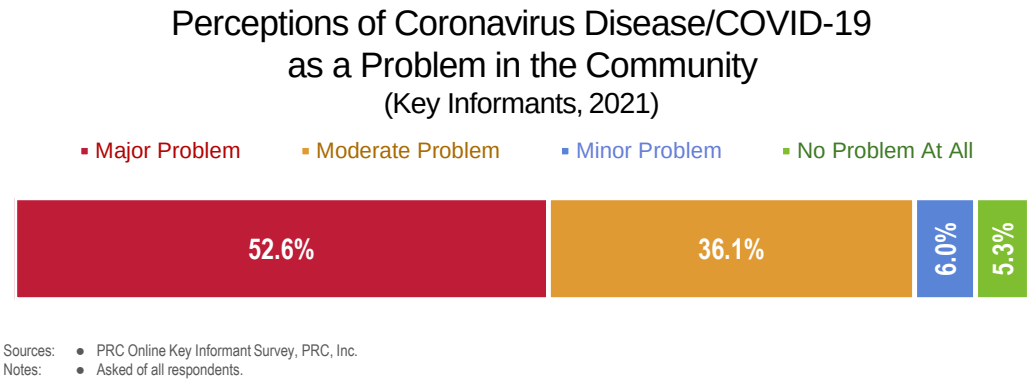
> Smoking. – Community/Business Leader
>
> Daily interaction and communication with individuals who smoke, who have breathing and respiratory problems. – Social Services Provider
>
> History of smokers, COVID. – Other Health Provider
>
> A lot of people in our community smoke and then get respiratory disease. – Social Services Provider

Contributing Factors

> High risk population, obesity, smoking. – Other Health Provider

Key Informant Input: Coronavirus Disease/COVID-19

The greatest share of key informants taking part in an online survey characterized *Coronavirus Disease/COVID-19* as a "major problem" in the community.



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

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

Lack of Adherence to Public Health Measures

The county is only 52% fully vaccinated. Granted, children under 12 are not eligible, but not having masks be mandatory again along with not the majority vaccinated poses concerns. – Community/Business Leader

The vaccination rate in Bartholomew and surrounding counties is far too low. The hospital is at capacity. Too few people are wearing masks indoors. – Social Services Provider

Low percentage of individuals who are vaccinated and total disregard for public health recommendations regarding mask wearing. – Public Health Representative

Not enough people getting vaccinated, not enough people wearing masks, local government is not taking any action. – Other Health Provider

COVID is a major problem for much of the US. Over 50% of residents in Indiana have not taken the vaccine and masks are no longer mandated in Indiana. Schools are in session and there are several instances of exposures. – Other Health Provider

Resistance to vaccines and mask-wearing, which is perpetuating spread, allowing the virus to mutate into a more deadly version, and severely affecting our children and our community members' mental and economic health. – Other Health Provider

Only roughly half of the population has been vaccinated. – Other Health Provider

Not enough people vaccinated. Very few wear masks in public and our virus spread is still large. – Other Health Provider

We have a very high infection rate currently and our vaccination status is near 50%, not good. – Community/Business Leader

Significant hesitancy to receive COVID vaccination with rising hospitalizations and number of cases. – Physician

Lack of vaccine uptake has created a recent surge from the Delta variant. The hospital is strained and workers are burned out. We need to reinstate the state mask mandate. – Physician

Significant proportion of residents not vaccinated or taking other proven control actions, for example wearing face mask, social distancing, as shown by our spikes in cases. – Social Services Provider

Only 50% of our eligible population is vaccinated and many are not wearing masks in public. The local hospital has an extremely high census due to COVID admissions. – Community/Business Leader

Too many people are not getting vaccinated and not wearing masks. – Community/Business Leader

Vaccination numbers are too low. Hospital is reaching capacity to treat patients due to severity of cases. Access to testing is slow. Hard to schedule a test quickly! – Other Health Provider

The numbers of local residents infected with the virus is causing a strain on our local health system. In addition, the vaccination rate is not high enough to help the community get close to herd immunity. – Social Services Provider

Coronavirus has consumed our lives for 1.5 years and when things loosened up a bit, people disregarded all precautions, and we are now seeing cases rising again. We need to get more people vaccinated so we can get a handle on this. – Public Health Representative

Continuing large number of cases, due in no small part to large number of unvaccinated residents, leads to stress and adverse impact on the health care system, education system and the local economy. – Community/Business Leader

Not enough people are choosing to vaccinate. The availability of the booster dose is not coming fast enough for those who vaccinated early, therefore we have both a 'false' sense of security and positive cases on people who are fully vaccinated. – Other Health Provider

Unacceptably high positivity rate. No local, regional, or state-wide mask mandate. Unacceptably low vaccination rate. – Other Health Provider

Fairly widespread at this time. No mask mandate currently and lower than desired vaccination rates. – Other Health Provider

Incidence/Prevalence

Number of cases are increasing. – Public Health Representative

The recent surge in cases is very troubling. – Public Health Representative

Deaths continue to rise. Family and friends getting infected after vaccination. One passed. – Other Health Provider

I view my community not as Bartholomew County as a whole (because I simply do not know the answers to the questions for the entire community), but rather the people who I encounter on a daily basis through my work as an early childhood care provider. COVID is consuming the physical and mental health of our families, the kids and the parents alike. – Community/Business Leader

People are infected and dying at an alarming rate. – Other Health Provider

Current numbers are very high and seem to be getting higher. – Community/Business Leader

Based on number of individuals who are hospitalized at CRH. – Social Services Provider

Well, cases are on the rise again. BUT – our local systems (CRH, affiliates and Barth. Co. Health Department) have done an outstanding job providing testing, treatment, and vaccines. They provided fast service at all hours to ensure folks in need were being served as quickly as possible. I think it remains a major problem because not enough people are vaccinated, and Delta is spreading like crazy. – Social Services Provider

Numbers are increasing. – Community/Business Leader

Our COVID numbers are increasing dramatically and placing our hospital under extreme stress. – Community/Business Leader

Cases are rising with the Delta variant. People have died, gotten very sick. CRH and staff are tired and overwhelmed. People refuse to listen to medical experts about masking and getting the vaccine. – Social Services Provider

Awareness/Education

COVID-19 is a major problem nation-wide. Bartholomew County has done a great job of making the vaccine available to its citizens; however, I think more public outreach ensuring that the vaccine is safe as well as educating on the new delta variant would be helpful. The last data I saw indicated that over half of Bartholomew County was not vaccinated and this makes me fearful for what the coming months may bring. – Community/Business Leader

Misinformation about how vaccines protect against COVID-19 and other information that is being shared about COVID-19 that does not come from local, reputable resources. – Public Health Representative

Parts of our community are failing to comprehend the severity of this disease and are not following mitigating protocol (masking, social distancing) and are relying on false information surrounding the vaccine. – Other Health Provider

We are currently seeing a record number of hospitalizations. Quite frankly, too many get their health advice from TV personalities not supportive of public health measures. This complicates, with serious ramifications, the community response. – Other Health Provider

We have too many citizens ill-informed and refusing safety measures. Our hospital is overrun with sick people. – Other Health Provider

COVID vaccinations. Unfortunately, like the other biggest challenges, this appears to be national media/politically guided, directed at the gullible and those lacking in critical thinking skills. I am not sure what could be done locally to overcome those loud national voices of unreason. – Other Health Provider

Contributing Factors

Low vaccination rates and lack of mask mandate increase chance of spread significantly. When a COVID case appeared in the small nonprofit I run, we were given 2 completely different recommendations by the local health department. Unsure what to do, we ended up calling the ISDH hat gave us a better course of action. – Community/Business Leader

Lack of hospital bed. Lack of vaccinated people. Children vaccinations. People still dying. – Community/Business Leader

> Not enough people in our community have chosen to be vaccinated. Too many people are sick and currently hospitalized, most of whom are not vaccinated. The surge in COVID hospitalizations has severely impacted our local healthcare system, such that elective surgeries have been suspended and ICU beds are full or in short supply. The number of COVID cases requiring hospitalization is impacting all of the rest of us who may need access to hospital care. COVID is a single disease that is causing much harm to those who have the disease and much harm to those who do not have the disease but need care for other health reasons. A single disease causing so much widespread harm and risk across our entire community (not to mention state and nation) – this is what I would describe as a major, catastrophic problem. – Community/Business Leader
>
> I think the numbers in our hospital and the rapid increase of positive cases speaks for itself.... but I also think that the fact that there has been so much politics tied to the pandemic, it has made people have a hard time believing the facts about the virus from doctors. I also think people are genuinely "over it" so they do not want to comply with the masking and social distancing anymore because they want to get back to their normal "pre-COVID" lives. – Other Health Provider

Vaccination Levels

> People who could be avoiding illness, hospitalization, and death due to being vaccine eligible aren't getting vaccinated. Not enough community measures being taken to protect our kids who aren't vaccine eligible. – Other Health Provider
>
> Many of the families we serve are Hispanic and have yet to be vaccinated. It continues to spread among the families we serve. Communication to each family is important around prevention and vaccination, but fear and other beliefs seem to take precedence. – Social Services Provider
>
> Too many residents are ignoring health experts and choosing to be unvaccinated. – Community/Business Leader
>
> Too many unvaccinated people. – Community/Business Leader
>
> Due to high number of unvaccinated individuals still. – Community/Business Leader

Impact on Quality of Life

> It is affecting our education of students and the family impact of eLearning, quarantine, etc. – Community/Business Leader
>
> It is not only a concern that we have not dealt with before, but it has also caused other problems due in the areas of mental health. – Public Health Representative
>
> Negative effects on the health and wellbeing of the population. Taxing the capacity of the medical facilities. Economic impact of the mitigation efforts. – Community/Business Leader
>
> The COVID-19 pandemic has put a significant strain on our health system during several surges. The pandemic has also led to social and economic strife, while also causing a relative divide between the beliefs of the vaccinated and most unvaccinated individuals. – Public Health Representative

Government/Policy

> This is a worldwide issue, not just for our community. It feels like our leaders are doing the best they can to deal with this major problem in our community. It seems senseless that it has become so political and disappointing that health leaders are being questioned. – Other Health Provider
>
> The situation is pressing, but the community is greatly divided on management of the virus and its spread. The inconsistency and frequent changing of the recommendations, especially in the school system, has led to greater division. – Social Services Provider

Housing

> Large populations living in with several families in one household. – Other Health Provider

Language Barriers

> There is not enough information in Spanish about COVID-19. There is a lot of wrong information. – Community/Business Leader

Prevention/Screenings

> It's a preventable problem that is driving a wedge into the community and eating hospital space. – Social Services Provider

Children

> I have children and I want them to be safe. – Social Services Provider

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2017 and 2019, there was an annual average age-adjusted unintentional injury mortality rate of 74.2 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Higher than statewide and national rates. Fails to satisfy the Healthy People 2030 objective.

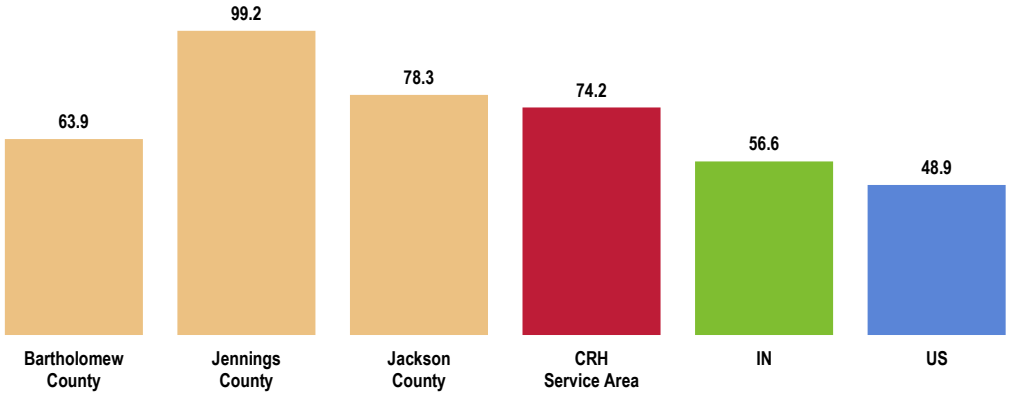
TREND ► Trending significantly higher.

DISPARITY ► Particularly high in Jennings County.

Unintentional Injuries: Age-Adjusted Mortality

(2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower

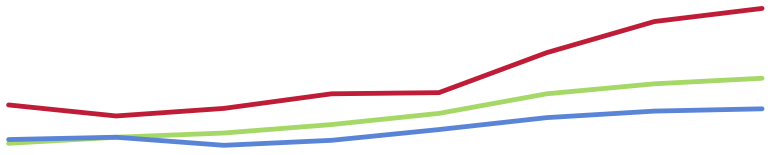


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



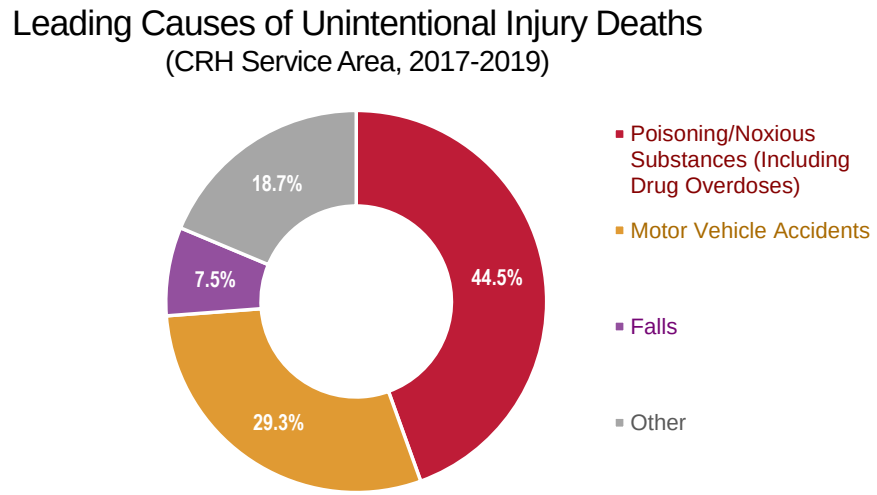
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	49.9	47.1	49.0	52.7	53.0	63.0	70.9	74.2
IN	40.2	41.7	42.8	44.9	47.7	52.7	55.2	56.6
US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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 Columbus Regional Health Service Area between 2017 and 2019.



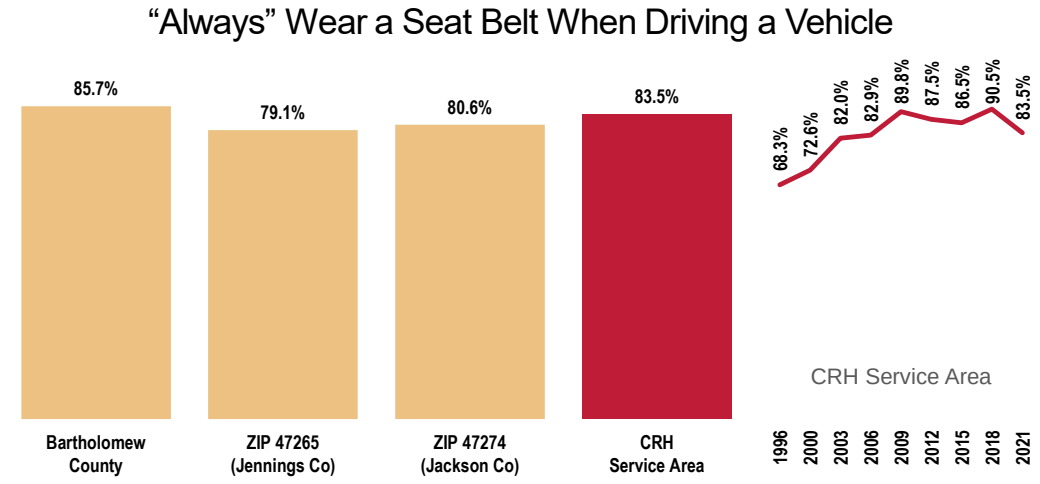
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Seat Belt Use

Most survey respondents (83.5%) report "always" using a seat belt when driving or riding in a vehicle.

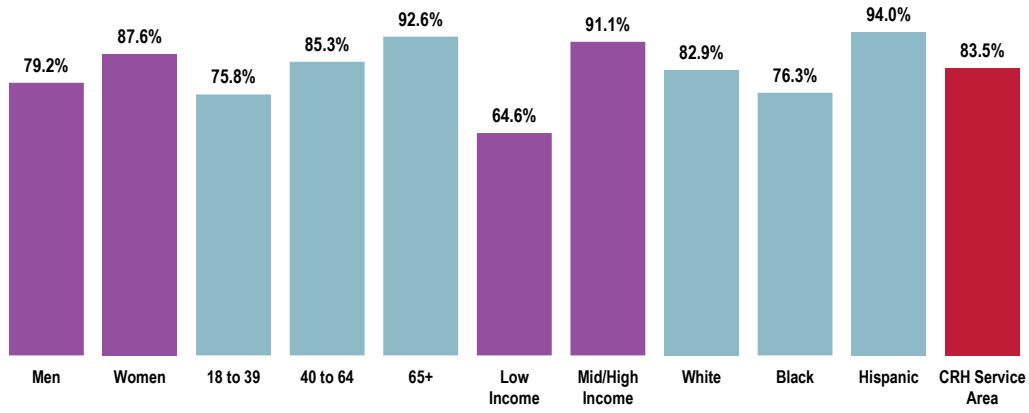
TREND ► Higher than the 1996 baseline.

DISPARITY ► Those less likely to report wearing a seat belt include men, adults younger than 65, lower-income adults, White residents, and Black residents.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

“Always” Wear a Seat Belt When Driving a Vehicle
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.

Bicycle Helmets

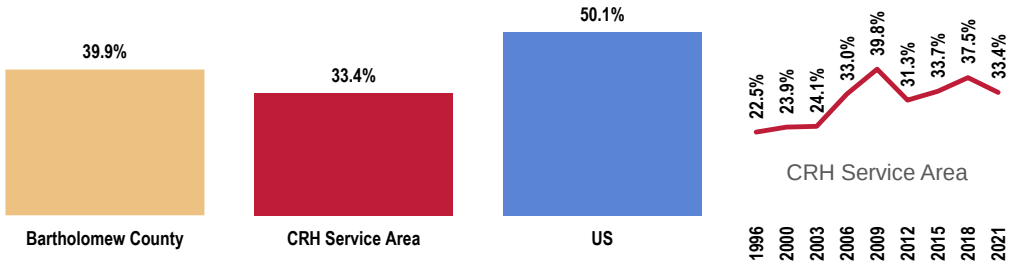
Among service area residents with children age 5 to 17, 33.4% report that their child “always” wears a helmet when riding a bike.

BENCHMARK ► Less favorable than found nationally.

TREND ► Better than the 1996 baseline.

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

For this question, sample sizes in Jennings and Jackson counties were too small to provide independent results.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 349]
● 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 5 to 17 at home.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

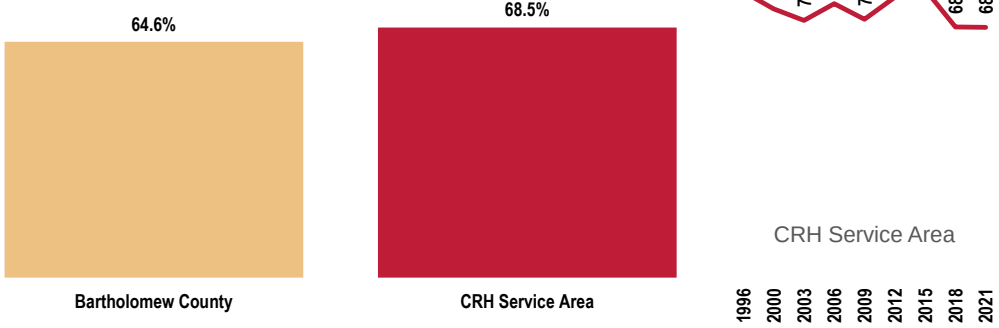
Water Safety

Among service area residents with children age 5 to 17, 68.5% report that their child has ever received instruction in swimming or water safety.

TREND ► Lower than the 1996 baseline.

Child Has Received Instruction in Swimming or Water Safety
(CRH Service Area Children <18)

For this question, sample sizes in Jennings and Jackson counties were too small to provide independent results.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 347]

Notes:
- Asked of all respondents with children under 18 at home.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Firearms

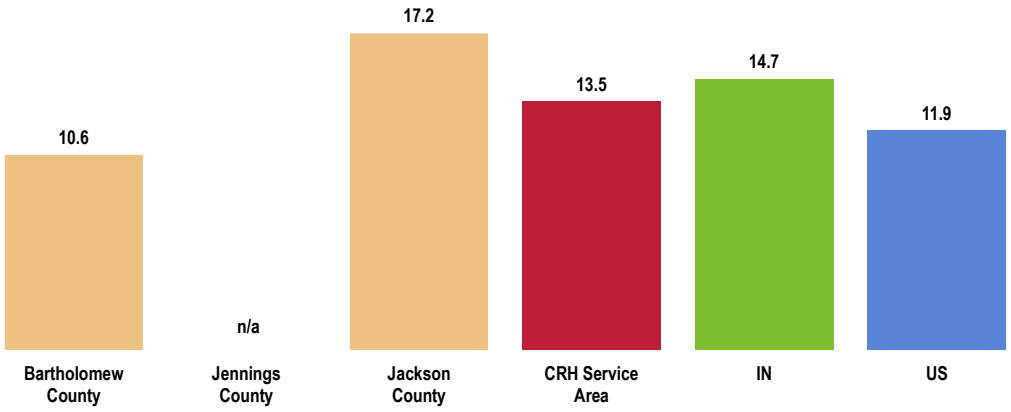
Age-Adjusted Firearms-Related Deaths

The Columbus Regional Health Service Area reported a firearms-related death rate of 13.5 per 100,000 population (2017-2019 annual average age-adjusted rate).

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Highest in Jackson County.

Firearms-Related Deaths: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 10.7 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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

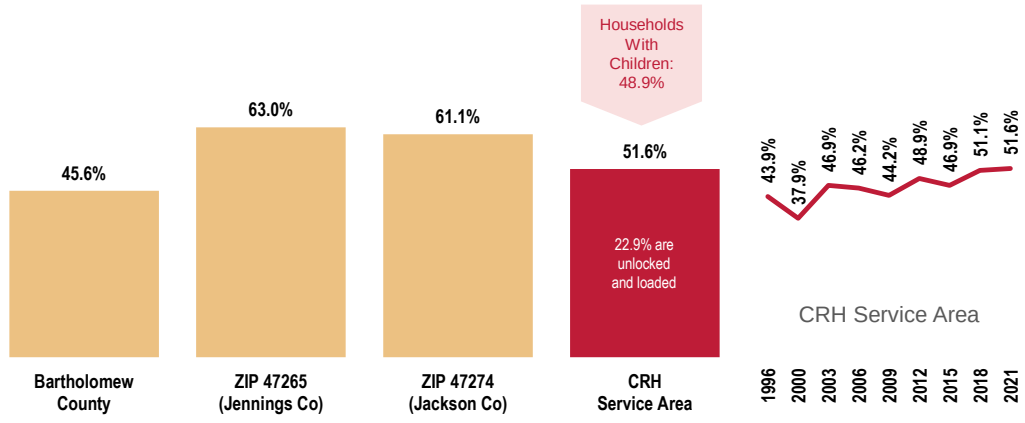
Firearms

A total of 51.6% of CRH Service Area adults have a firearm kept in or around the home (including 48.9% among households with children); of these residents, 22.9% report that the gun is kept loaded and unlocked.

TREND ► Higher than found previously.

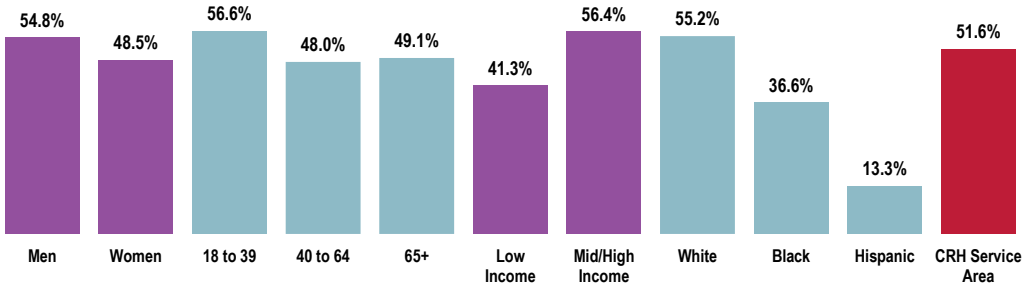
DISPARITY ► Favorably lower in Bartholomew County. More often reported among young adults, mid- to high-income respondents, and White residents.

Have a Firearm Kept In or Around the Home



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 310, 351-352]
Notes: ● Asked of all respondents.
● In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Have a Firearm Kept In or Around the Home
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: ● Asked of all respondents.
● In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

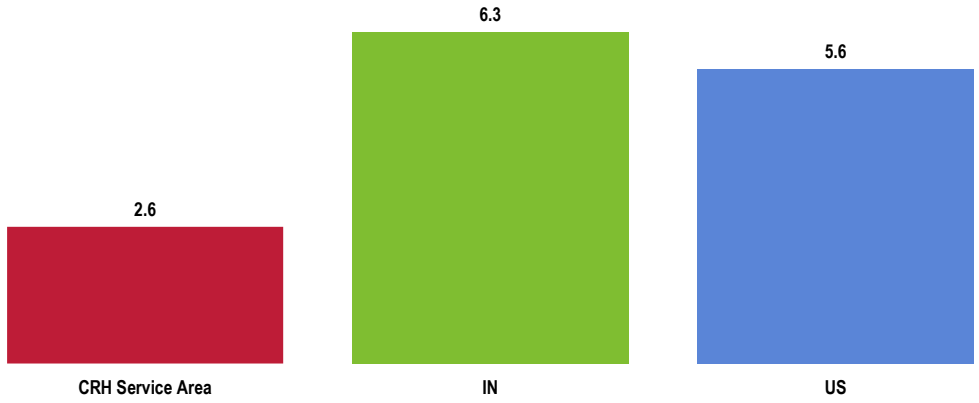
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

In the Columbus Regional Health Service Area, there were 2.6 homicides per 100,000 population (2017-2019 annual average age-adjusted rate).

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

BENCHMARK ► Better than state and national rates. Satisfies the Healthy People 2030 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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Violent Crime

Violent Crime Rates

In 2016, there were a reported 155.4 violent crimes per 100,000 population in the Columbus Regional Health Service Area.

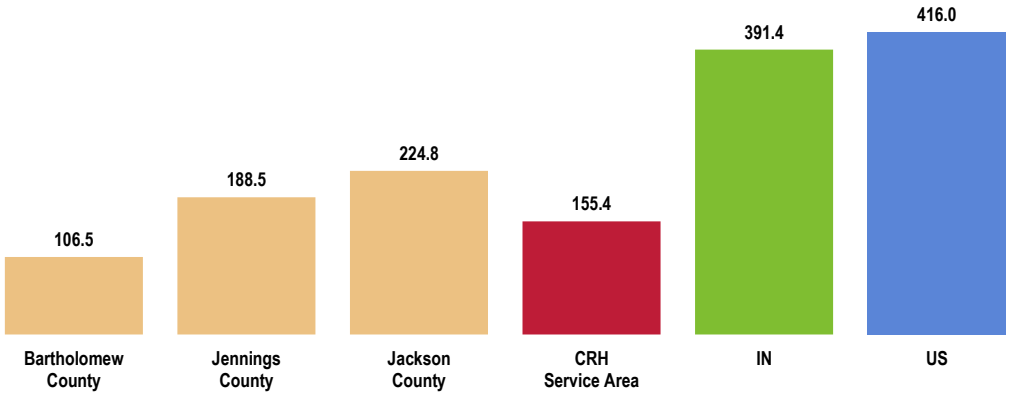
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

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.

BENCHMARK ► Considerably lower than was found across the state and nation.

DISPARITY ► Highest in Jackson County.

Violent Crime
(Rate per 100,000 Population, 2016)



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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.

Family Violence

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."

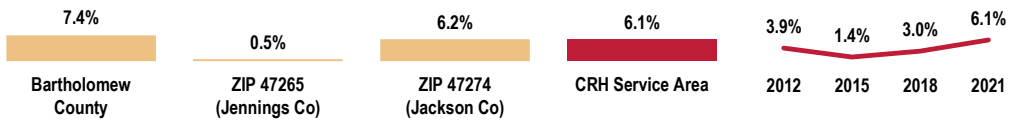
A total of 6.1% of Columbus Regional Health Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner in the past three years.

TREND ► Worse than the 2012 benchmark.

DISPARITY ► Favorably low in Jennings County ZIP Code 47265. More often reported among young adults and lower-income adults.

Have Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner in the Past 3 Years

CRH Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 47]

Notes:
- Asked of all respondents.

Have Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner in the Past 3 Years
(CRH Service Area, 2021)

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 47]
Notes: ● Asked of all respondents.

Sexual Violence

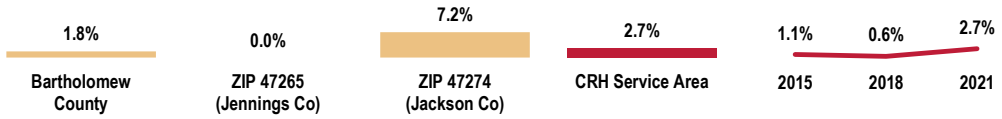
A total of 2.7% of service area respondents report that someone has forced them to engage in sexual activity that they did not want at some point in the past three years.

TREND ► Worse than the 2015 benchmark.

DISPARITY ► Unfavorably higher in Jackson County ZIP Code 47274.

Have Been Forced Into Sexual Activity in the Past 3 Years

CRH Service Area

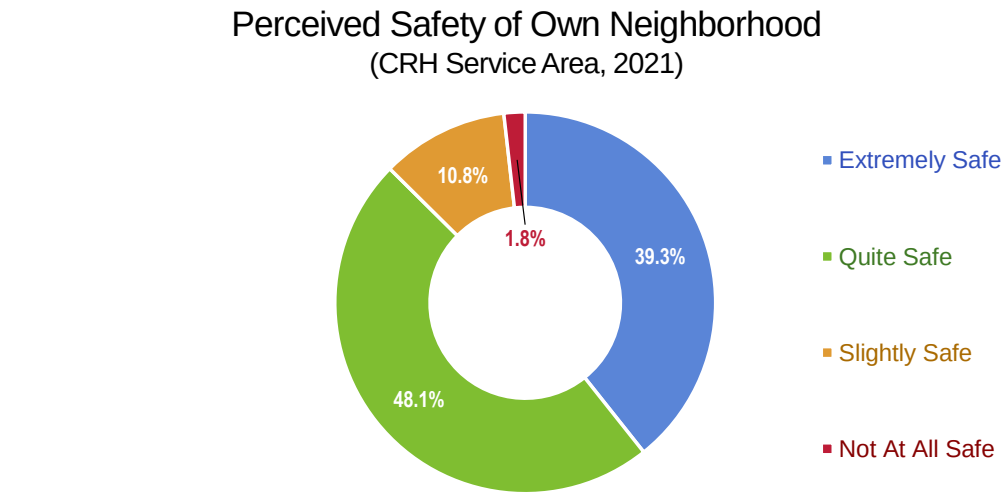


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 309]
Notes: ● Asked of all respondents.

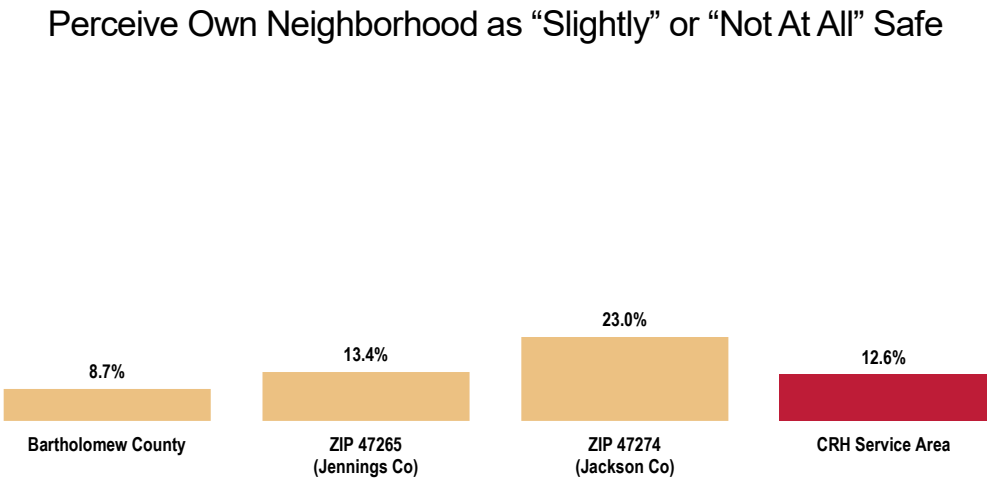
Perceived Neighborhood Safety

While most Columbus Regional Health Service Area adults consider their own neighborhoods to be "extremely safe" or "quite safe," 12.6% consider it only "slightly safe" or "not at all safe."

DISPARITY ► Unfavorably higher in Jackson County ZIP Code 47274. Those more likely to rate their neighborhood as "slightly" or "not at all" safe include young adults, low-income respondents, and Hispanic residents.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 355]
Notes: ● Asked of all respondents.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 355]
Notes: ● Asked of all respondents.

Perceive Own Neighborhood as “Slightly” or “Not At All” Safe
(CRH Service Area, 2021)

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 355]
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a “moderate problem” in the community.

Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2021)

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

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

Incidence/Prevalence

> Too often it seems like violence is the primary means of problem resolutions. – Community/Business Leader
>
> Unfortunately, despite interventions by community resources, violence is on the rise, domestic and random. Just recently we've seen an increase in traffic accidents. I fear this is due to distracted and impaired driving. – Social Services Provider
>
> I think it is growing. It seems there are more instances for violence because this is how people are handling their problems with each other. – Social Services Provider
>
> Rape, molestation, and domestic violence rates are the second highest in the country. In Indiana, 42 percent of women have experienced some form of violence from an intimate partner in their lifetime. – Community/Business Leader

Income/Poverty

> Many of our families live in low-income neighborhoods or trailer parks, which is high risk for violence since they do not see assistance. Many of our families do not have health insurance so when injured will utilized emergency care instead of a family physician. Most families are very cautious and do not do many extra activities because of this fear and whether they can afford the care. – Social Services Provider

Access to Care/Services

> We need sexual assault nurse examiners (SANEs) that are accessible for sexual assault exams all the time. I understand that nurses often take SANE duties on in addition to their regular workload. However, SANEs need to be accessible when services are needed. I know of an instance where sexual assault survivors have had to go out of the community to obtain sexual assault exams due to a SANE not being on duty. This creates barriers for survivors. – Social Services Provider

Awareness/Education

> The numbers are underreported for domestic violence and the lack of resources for domestic violence in Columbus. – Other Health Provider

Co-Occurrences

> Crime and violence are increasing as problems with mental health and substance abuse have risen. – Other Health Provider

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

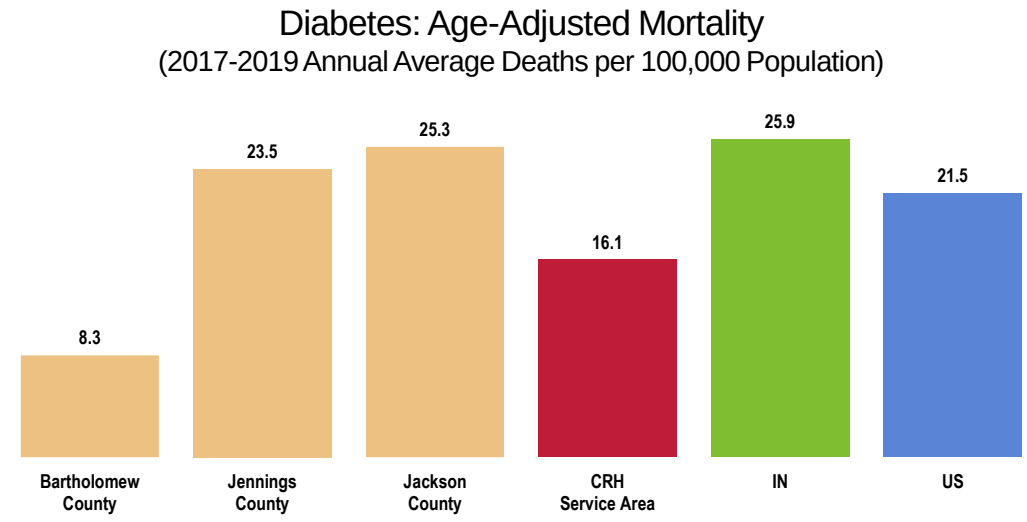
Age-Adjusted Diabetes Deaths

Between 2017 and 2019, there was an annual average age-adjusted diabetes mortality rate of 16.1 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Lower than Indiana and US rates.

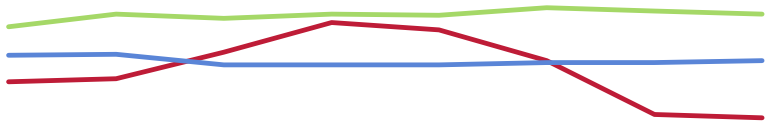
TREND ► Declining to an all-time low in the service area.

DISPARITY ► Relatively low in Bartholomew County.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	19.5	19.8	22.3	25.1	24.4	21.5	16.4	16.1
IN	24.7	25.9	25.5	25.9	25.8	26.5	26.2	25.9
US	22	22.1	21.1	21.1	21.1	21.3	21.3	21.5

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 2021.

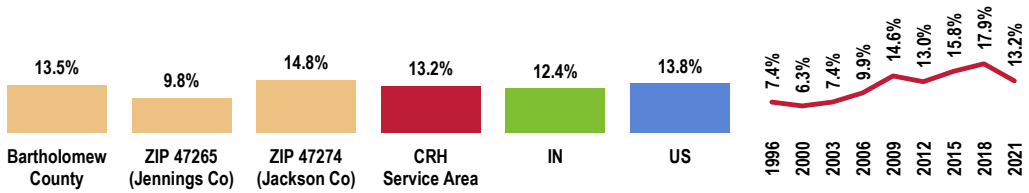
Prevalence of Diabetes

A total of 13.2% of Columbus Regional Health Service Area adults report having been diagnosed with diabetes.

TREND ► Marks a significant increase from the 1996 baseline survey, but a significant decrease from the 2018 survey.

DISPARITY ► More often reported among adults age 65+, lower-income residents, and Black respondents.

Prevalence of Diabetes

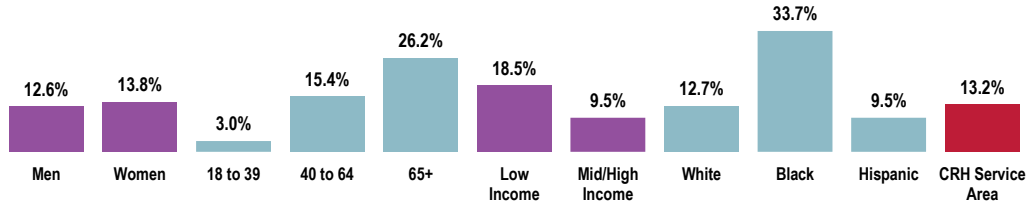


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Prevalence of Diabetes
(CRH Service Area, 2021)

Note that among adults who have not been diagnosed with diabetes, 50.5% report having had their blood sugar level tested within the past three years.

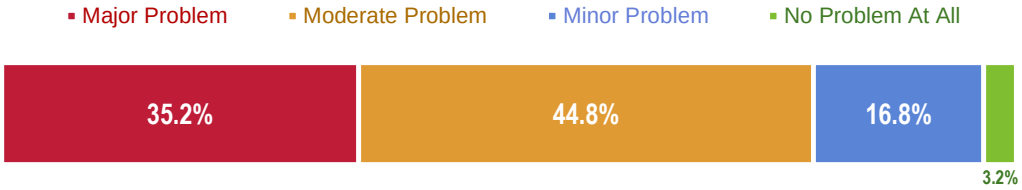


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 36, 37]
Notes: ● Asked of all respondents.
● Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

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

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2021)



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

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

Contributing Factors

> Education and motivation/willingness to change behaviors. COVID is making access to care more difficult. – Other Health Provider
>
> Ease of access to giant sugary drinks and unhealthy snacks in combination with sentient lifestyles. There is, I am sure, an education component here, as well as access to a more nutritious diet and economic considerations relating to the cost of cheap filling – tasty – foods relative to more expensive healthy alternatives. – Other Health Provider
>
> Access to physicians, including primary care physicians and endocrinology. Knowledge about their disease and appropriate management. Obesity. – Other Health Provider
>
> Affordability of health food choices. Affordability of health insurance and access to insulins and medications that treat diabetes. – Other Health Provider
>
> Access to affordable healthy food, excessive availability of horrible fast food, the difficulty and expense involved in going and doing recreational activities. – Community/Business Leader

Lack of access to preventive and medical care for fragile populations. Following are all impediments to access: low income, low educational level, outright poverty, food desert neighborhoods, language and cultural differences, and other social conditions (isolation, mental health disease, drug use.). Columbus is a divided community between access and no-access to health education and health services provided according to the need (see list of the impediments to access). the services may exist, but they are not easily accessible to those that are at risk in the 'underserved' populations. Cost. – Other Health Provider

Cost of wrap-around care, i.e., educators, dieticians, endocrinology, etc. Also, general culture of obesity. – Other Health Provider

Eroding health due to compounding health impacts, and therefore ability to remain active in the community. Low-income families are particularly vulnerable, since they often cannot afford a high-quality diet and have other social determinants of health (e.g., where they live) working against them. – Social Services Provider

Disease prevalence is high, a system wide proactive effort to engage people with diabetes (PWD) with self mgt support options early would offer high ROI. 1. Focus on Implementation of low cost technology tools; 2. Develop remote monitoring options services for people who need additional support till back on track (Reimbursement available for these remote services that utilize support staff); 3. Consider intro to Medicare services for PWD -to assist with insurance- med costs – MAP options and navigation-good Reimbursement available for 14 hours of training, education, support for PWD new to Medicare. – Other Health Provider

Obesity, smoking. These are now culturally acceptable lifestyle choices as much as they are addiction. – Community/Business Leader

Awareness/Education

More willingness to publicly talk about it. – Community/Business Leader

May not be getting the education that they need. – Public Health Representative

Understanding of care for their chronic illness, lack of awareness about prevention for those at risk. – Public Health Representative

Understanding and implementing lifestyle modifications to prevent and/or slow the progression of their disease. Many people that I work with report being diagnosed by their PCP and having no referral or further education on the disease; this especially applies to people that are on medication management. Those who need insulin are referred for education, those on medication management receive no further education about their disease. – Social Services Provider

Education, there is not any great education in our community. – Other Health Provider

Not enough information. More health education. – Community/Business Leader

Knowledge with how to live with disease. – Other Health Provider

Nutrition

Proper diets and money to manage diets and meds. – Other Health Provider

Excessive fast-food availability and lack of knowledge about cooking healthier options. – Physician

Diet. Willingness to change. – Community/Business Leader

Poor nutrition habits. – Other Health Provider

Poor diets. – Community/Business Leader

Fast food. – Community/Business Leader

Affordable Medications/Supplies

Access to medication, supplies, for people with diabetes living in poverty. – Community/Business Leader

Being able to afford their insulin and other medications. Also, for those without insurance, being able to afford their diabetes supplies. – Other Health Provider

I understand that diabetes medication prices have increased dramatically and people with fewer financial resources must choose between medication and other important basic needs (housing, food, etc.). – Community/Business Leader

Access to affordable medicine and knowing the resources available. – Community/Business Leader

Access to Care/Services

Access to insulin, testing equipment, and the ability to get transport to the doctor and pharmacy. – Community/Business Leader

Resources for medications and knowledge to treat. – Other Health Provider

Timely appointments, access to supplies needed and meds. – Social Services Provider

Access to healthcare, availability of appointments, transportation to appointments, high cost of insulin. – Other Health Provider

Having medical professionals in this field. – Community/Business Leader

> Access to care, nutritional counseling, counseling for lifestyle changes. – Physician

Prevention/Screenings

> Clearly, they need to be doing more work to prevent Type 2 diabetes from forming, but they are not. It could be cost – cheap food is unhealthy generally. It could also be lack of exercise – this is a culture based on driving. We need more people walking and biking to school, work, and for pleasure. – Social Services Provider

Access to Affordable Healthy Food

> Affordable proper nutrition, information, and cultural differences. Many of the families we serve culturally eat a high-carb diet for cost, affordability, and customs. – Social Services Provider
>
> Access to healthy, affordable food. – Community/Business Leader

Disease Management

> Managing their diabetes without medication, if possible. – Social Services Provider

Lifestyle

> Finding ways to make behavior changes. – Public Health Representative

KIDNEY DISEASE

ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

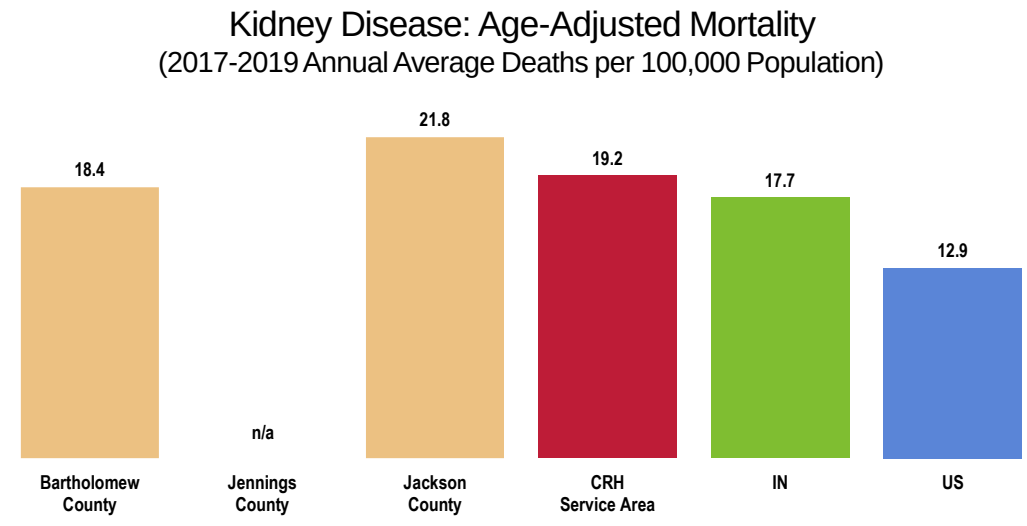
Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

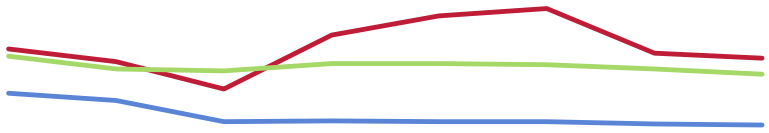
Between 2017 and 2019, there was an annual average age-adjusted kidney disease mortality rate of 19.2 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Worse than the national finding.



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 2021.

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



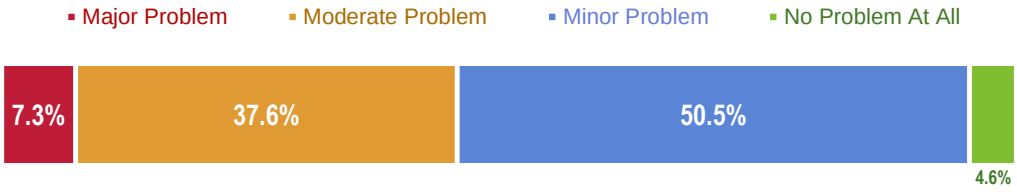
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	20.1	18.9	16.3	21.4	23.2	23.9	19.7	19.2
IN	19.4	18.2	18.0	18.7	18.7	18.6	18.2	17.7
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

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 2021.

Key Informant Input: Kidney Disease

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

Perceptions of Kidney Disease as a Problem in the Community
(Key Informants, 2021)



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

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

Incidence/Prevalence

> Based on individuals who attend their place of worship and employment location. – Social Services Provider
> The number of people on dialysis. – Community/Business Leader

Access to Care/Services

> New, larger Dialysis Center has been built. – Community/Business Leader

POTENTIALLY DISABLING CONDITIONS

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

A total of 30.9% of Columbus Regional Health Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

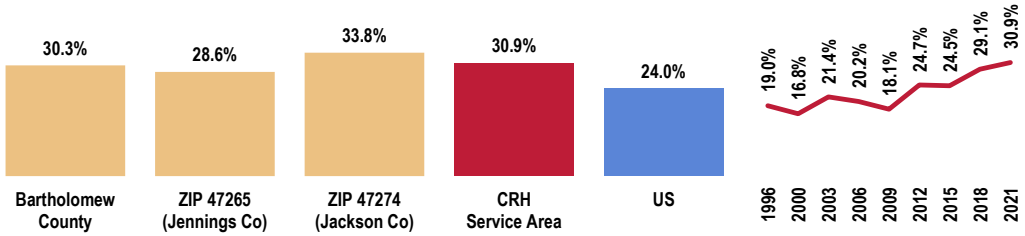
BENCHMARK ► Worse than the national finding.

TREND ► Increasing significantly over time.

DISPARITY ► More often reported among low-income adults and White respondents.

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

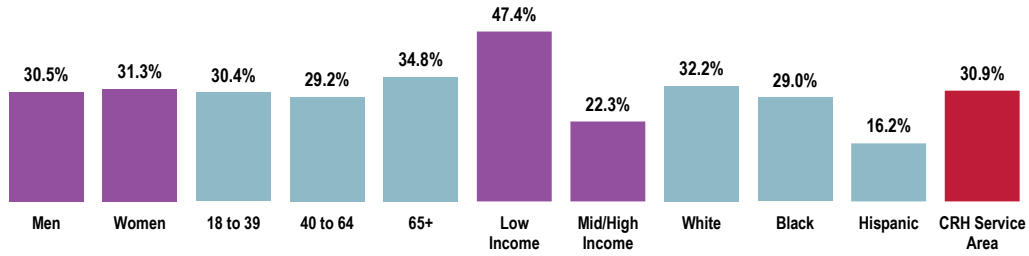
CRH Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

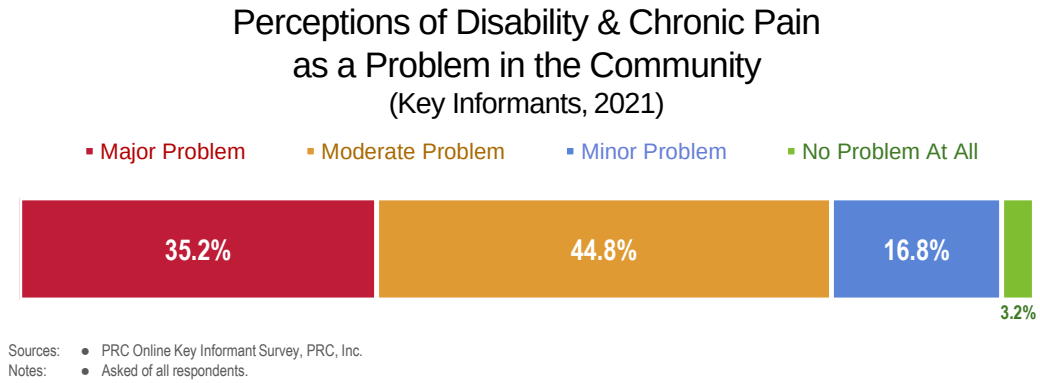
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(CRH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 109]
Notes: • Asked of all respondents.

Key Informant Input: Disability & Chronic Pain

Key informants taking part in an online survey most often characterized *Disability & Chronic Pain* as a "moderate problem" in the community.



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

Contributing Factors

> It seems that disability and chronic pain are major contributors to substance abuse. This group also seems to have a major lack or resources. – Other Health Provider
>
> Lack of mental health resources and low income/no income. – Other Health Provider
>
> Various reasons lend to this problem. High stress, lack of self-care, generational understanding, and mental health. Barriers such as lack of transportation, and no health insurance deters prevention which lends to chronic problems, which then need immediate or emergency care. – Social Services Provider
>
> I am a provider in ambulatory care and pain and mental health are two biggest challenges with chronic care management in the population. – Other Health Provider
>
> I hear of people having issues managing their pain. There is a pain clinic in Columbus. – Community/Business Leader
>
> Factory work, poor diet and nutrition, intellectual and developmental delays, impulsive behavior (impaired driving, reckless driving, fighting, etc.), unscientific beliefs. – Community/Business Leader

Incidence/Prevalence

> According to the current public transit human services transportation plan, there were approximately 12,000 disabled adults and 13,000 older adults living within Bartholomew County alone in 2006. The number of older adults and disabled people increased by 10% from 2006-2020. The silver tsunami expected over the next 2 decades (Boomers entering older adult and disability categories) will only exacerbate this. In the next 20 years, there will be more older adults that people under age 18. This will put a large strain on our healthcare, transportation, and other systems of care. Nearly 25% of people in Bartholomew County have a disability. There are minimal places in Columbus that accept Medicaid for chronic pain. All the people who have Medicaid and chronic pain at our facility go to Seymour for their pain management. – Community/Business Leader
>
> Arthritis, I go to Greenwood for care. – Community/Business Leader
>
> Because of family members' and friends' personal experiences. – Social Services Provider
>
> Parkinson's seems to be diagnosed more and more. – Community/Business Leader

Alcohol/Drug Use

> High use of opioids. – Community/Business Leader
>
> Seems to be too much dependence on addictive drugs for treatment. – Community/Business Leader

Access to Care/Services

> Only have one office that provides this service, Wellspring, and they provide drugs to address issues. Saint Vincent had at one time a whole division dedicated to pain management. – Community/Business Leader

Diagnosis/Treatment

> Several people suffer from chronic pain that see pain clinics but are prescribed narcotics. Several patients are attempting to get disability and more commonly being evaluated for this. – Other Health Provider

Access for Medicare/Medicaid Patients

> There are no local resources for those with Medicaid for chronic pain management. These individuals have limited access to transportation and cannot seek care outside of the county due to this restriction. – Other Health Provider

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

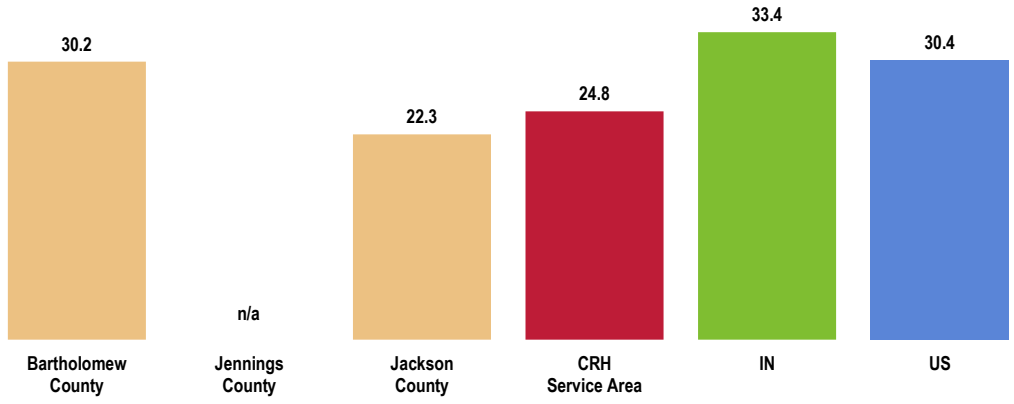
Between 2017 and 2019, there was an annual average age-adjusted Alzheimer's disease mortality rate of 24.8 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Lower than state and national rates.

TREND ► Continuing a significant decline within the service area to an all-time low.

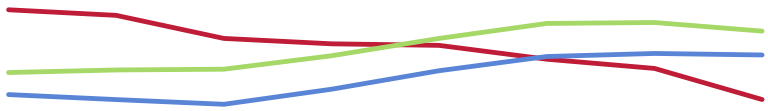
DISPARITY ► Favorably lower in Jackson County.

Alzheimer's Disease: Age-Adjusted Mortality
(2017-2019 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 2021.

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



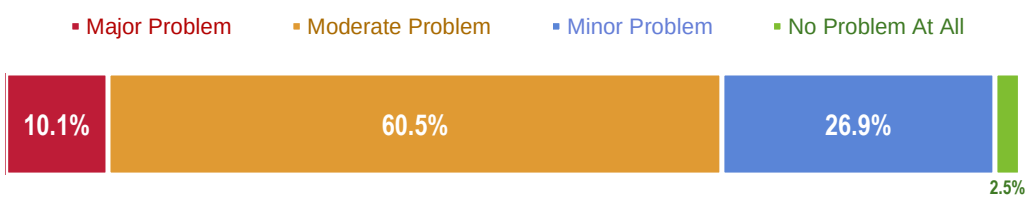
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	36.1	35.4	32.5	31.8	31.6	29.9	28.7	24.8
IN	28.2	28.5	28.6	30.3	32.5	34.4	34.5	33.4
US	25.4	24.8	24.2	26.1	28.4	30.2	30.6	30.4

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 2021.

Key Informant Input: Dementia/Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementia/ Alzheimer's Disease* as a "moderate problem" in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, 2021)



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

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

Contributing Factors

> Increasing numbers of people with Alzheimer's and related dementias is being driven by our aging population, accelerated by social isolation through the pandemic. Unless our community can become dementia friendly so people with dementia can continue to live at home and participate in community life, we will quickly overwhelm any "institutional" resources to care for them. – Social Services Provider
>
> A great majority of the older patient population suffer from Dementia/Alzheimer's disease, which is somewhat the normal expectation, but lifestyle and food intake of modern times is not conducive to forestalling degeneration of the brain. Additionally, an increasing number of these patients reside in residential or nursing facilities because the increasing lack of family available to care for older family members in the home/family setting. In facilities interaction and social activity are limited, and during the almost two years of the COVID pandemic there has been even more limited interaction. The brain that is already fragile requires constant stimulation that the current U.S culture does not support. – Other Health Provider
>
> Indiana is ranked the last state in the nation for Long Term Supportive Services (LTSS) and 49th for public health spending. Only 5% of Hoosiers have Long Term Care Insurance, and at least half will need it in their lifetime. 90% of Hoosiers want to stay in their homes. One in five Hoosiers is 65+. The age group is expected to grow 20% in the next 10 years. 10% of them need dementia-specific care. The Community Assessment Survey for Older Adults states that 25% of caregivers are overwhelmed, leading more people to live in institutions that don’t need to. to the AARP Public Policy Institute survey states that â€œ18% of caregivers report high financial strain as a result of caregiving and 45% have experienced at least one financial impact as a result of their caregiving, individuals who have high social isolation and loneliness have a 68 percent increased risk of hospitalization and a 57 percent increased risk of emergency department visits. – Community/Business Leader

Aging Population

> It seems to be an epidemic that those that retire get it in their early 70's now. – Social Services Provider
>
> Seems to be more aging adults that are suffering. – Community/Business Leader
>
> As population ages, greater occurrence. – Public Health Representative

Affordable Care/Services

> Many people experiencing dementia/Alzheimer's disease can't afford the support they (and their families) need. Quality of life for everyone is affected. – Community/Business Leader

Impact on Caregivers/Families

> Most need around the clock care and it is so hard on families trying to work and take care of loved ones. We need more facilities to take on these patients or home health care for them. – Community/Business Leader

Incidence/Prevalence

> There are multiple patients in our community that suffer from dementia of some sort. – Other Health Provider

Awareness/Education

> I have no idea where to go for this type of support. – Other Health Provider

BIRTHS

BIRTH OUTCOMES & RISKS

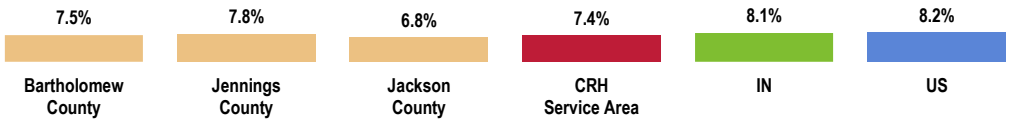
Low-Weight Births

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 7.4% of 2013-2019 Columbus Regional Health Service Area births were low-weight.

Low-Weight Births
(Percent of Live Births, 2013-2019)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2021.

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

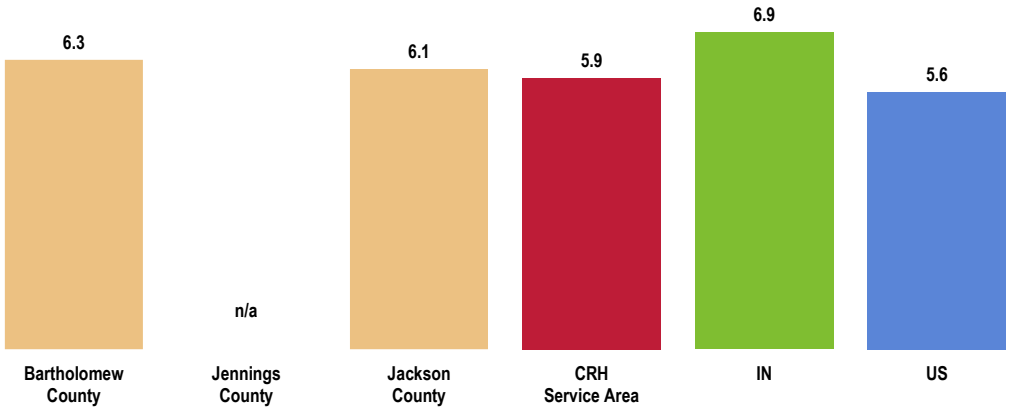
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2017 and 2019, there was an annual average of 5.9 infant deaths per 1,000 live births.

BENCHMARK ► Better than the statewide rate. Fails to satisfy the Healthy People 2030 objective.

TREND ► Denotes a significant decline over time.

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2017-2019)
Healthy People 2030 = 5.0 or Lower



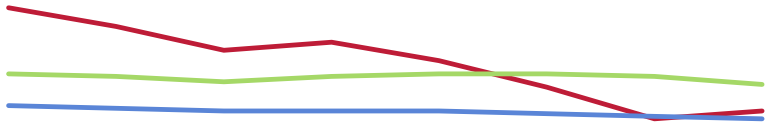
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.

Infant Mortality Trends

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

Healthy People 2030 = 5.0 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	9.8	9.1	8.2	8.5	7.8	6.8	5.6	5.9
IN	7.3	7.2	7.0	7.2	7.3	7.3	7.2	6.9
US	6.1	6.0	5.9	5.9	5.9	5.8	5.7	5.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2021.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

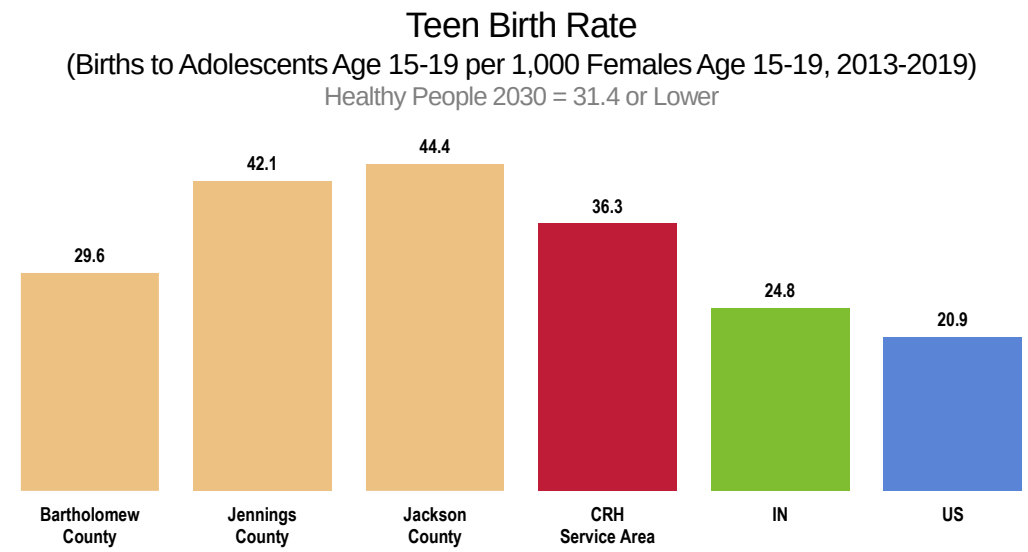
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2013 and 2019, there were 36.3 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Columbus Regional Health Service Area.

BENCHMARK ► Considerably higher than state and US rates.

DISPARITY ► Lower in Bartholomew County than in the other counties.

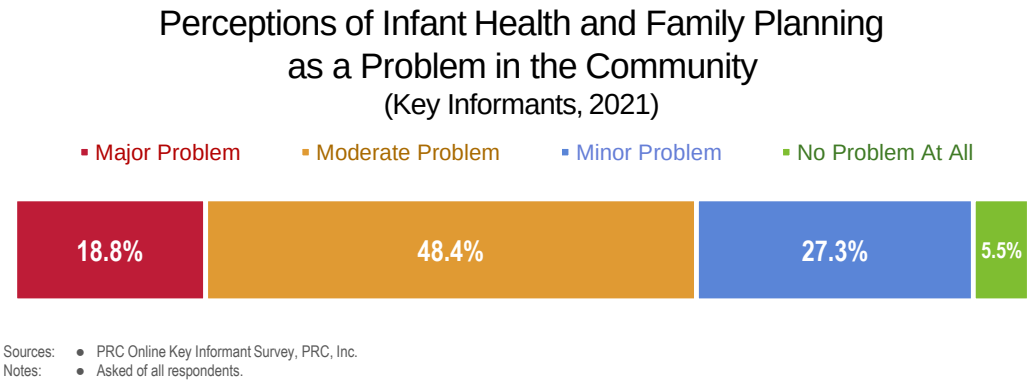


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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: Infant Health & Family Planning

Key informants taking part in an online survey largely characterized *Infant Health & Family Planning* as a "moderate problem" in the community.



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

Contributing Factors

> I see so many families in crisis through my work, so it is possible my view of this issue is skewed. With that said, I so frequently see young mothers who are facing losing their children (through court proceedings) and are struggling with how to effectively transition into parenthood. I think the primary way young mothers facing an unplanned pregnancy seem to cope is by reaching out to extended family for support. When extended family supports aren't available, all too often they end up involved with DCS and the court system. – Community/Business Leader
>
> No comprehensive sex education or relationship education in the schools, outdated beliefs regarding what healthy relationships are, magical beliefs that obscure accountability for gestational health and wellness. Lack of dedicated Drs for moms receiving Medicaid – Community/Business Leader
>
> I have no idea where to go for information on family planning if I needed this type of support. Infant mortality numbers are not high just because of unsafe sleep, there are so many other factors that I don't see being addressed. – Other Health Provider
>
> I believe the community has many options for family planning and health, I think the problem lies in getting more people involved. I love seeing the marketing for these programs and events, but also wonder how to get more people to participate! – Community/Business Leader
>
> Personally, I see a large number of our low-income population in regard to infant and maternal health. I think high quality access to breastfeeding support during covid 19 has been reduced and less moms are breastfeeding their babies. A decrease in breastfeeding initiation and duration is going to have tremendous health effects on our infants and children. We need to talk more about this issue in our community. As far as family planning, I see low-income clients who need more education, support, and guidance on family planning. I feel like it is a problem in our community where young women are having many unplanned pregnancies, and they are lacking support in so many areas. – Other Health Provider

Infant Mortality

> We have a high infant mortality rate; worse than Indiana and nation I believe. – Community/Business Leader
>
> Data for our county indicate we have major challenges with our infant mortality rate. – Community/Business Leader
>
> Infant and maternal mortality in our county is above the state and national average. – Community/Business Leader
>
> High infant death rate. – Community/Business Leader
>
> Infant mortality rate is very high in Bartholomew County. – Other Health Provider
>
> Indiana has some of the highest infant mortality rates in the country and relatively high unplanned pregnancy rate. – Other Health Provider
>
> High infant mortality. – Physician
>
> We have a high infant mortality rate. – Social Services Provider

Access to Care/Services

> Infant mortality rates and maternal death rates are higher than the national and state average. There is little access to pregnancy resources for those who choose abortion. – Community/Business Leader
>
> Bartholomew County has an unacceptably high infant mortality rate. Physician access is limited, which then limits patient access to contraception. No local or regional access to elective pregnancy termination. – Other Health Provider
>
> There is limited access to family planning resources. In addition, infant mortality is a concern in our community. – Social Services Provider
>
> Lack of birthing options for local families. The only option is to birth in a hospital. There are no options for families to deliver in a birthing center unless they travel at least an hour north or south to have the type of birth they desire. – Other Health Provider

Unplanned Pregnancy

> High rate of unplanned pregnancy in both teens and women with substance use disorder. – Physician
>
> Too many underage/unplanned pregnancies and the babies that are born meth addicts, we need to educate better in the community and in our schools. – Community/Business Leader

Awareness/Education

> I am concerned about pre-natal care for both mom and baby. Along with parents understanding the importance of checkup for infants. For family planning we DO NOT educate our young people about family planning or birth control in high school or beyond. While I hope abstinence is a consideration for young people it is not practical or safe for a young person's health to only education on abstinence. Also, more conversations about spacing of children between a woman and her doctor. – Social Services Provider

Income/Poverty

> I believe that people living in poverty have need for support in this area. – Community/Business Leader

Government/Policy

> Some of these issues seem to be influenced more by politics than facts and science. – Community/Business Leader

Homeless Children

> Homeless children. Bartholomew County has twice the rate of homeless children than the rest of the state. Homelessness is a barrier to health. – Other Health Provider

Language Barriers

> Not enough information in Spanish. – Community/Business Leader

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

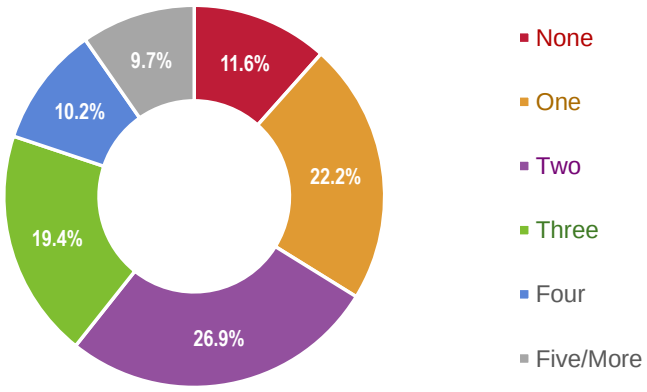
Daily Recommendation of Fruits/Vegetables

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.

A total of 9.7% of Columbus Regional Health Service Area adults report eating five or more servings of fruits and/or vegetables yesterday.

DISPARITY ► Unfavorably low in Jennings ZIP Code 47265. Those less likely to report eating fruits and vegetables include men and Black respondents.

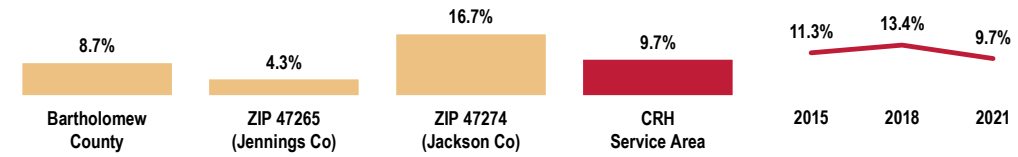
Servings of Fruits and Vegetables Eaten Yesterday
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 332]
Notes: ● Asked of all respondents.

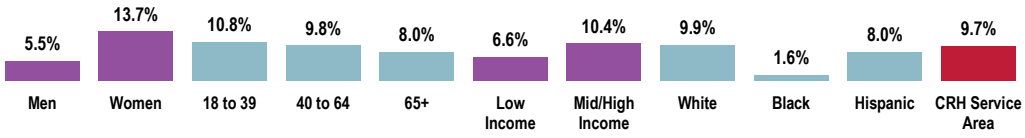
Ate 5+ Servings of Fruits and Vegetables Yesterday

CRH Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 332]
Notes: ● Asked of all respondents.
● For this issue, respondents were asked to recall their food intake on the previous day.

Ate 5+ Servings of Fruits and Vegetables Yesterday
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 332]
Notes: ● Asked of all respondents.
● For this issue, respondents were asked to recall their food intake on the previous day.

Family Meals

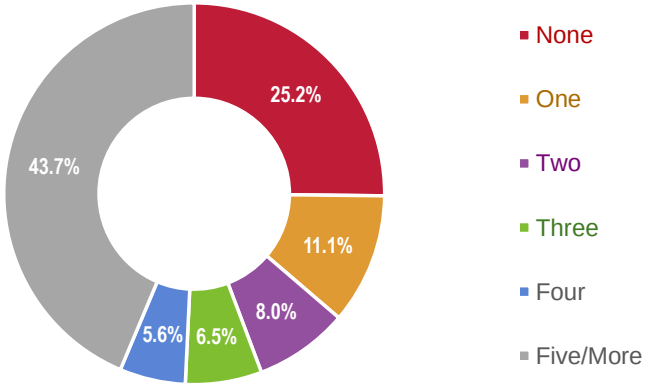
"How many meals per week does your entire household sit down together, without the television set on, for a family meal? Please include breakfasts, lunches, and dinners."

Among survey respondents, 43.7% report eating at least five meals together as a family on a weekly basis.

TREND ► Significantly higher than the 2012 baseline.

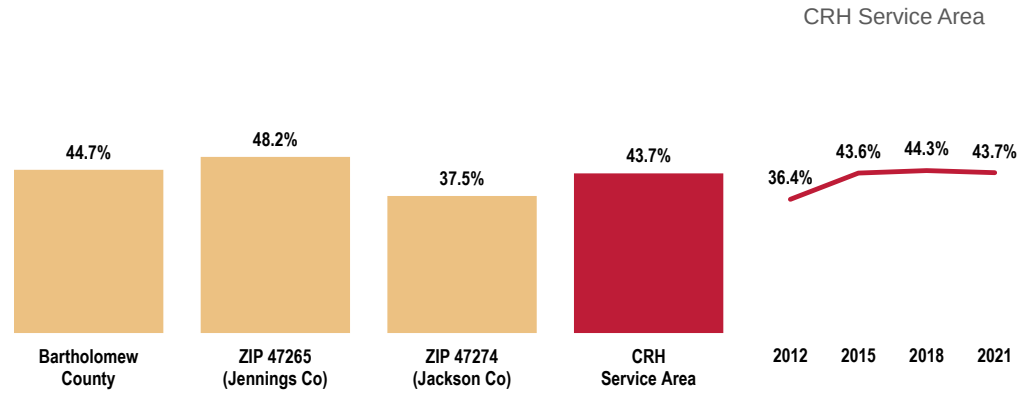
DISPARITY ► Those less likely to eat together include adults younger than 65, Black residents, and Hispanic residents.

Number of Weekly Meals Shared as a Family
(CRH Service Area, 2021)



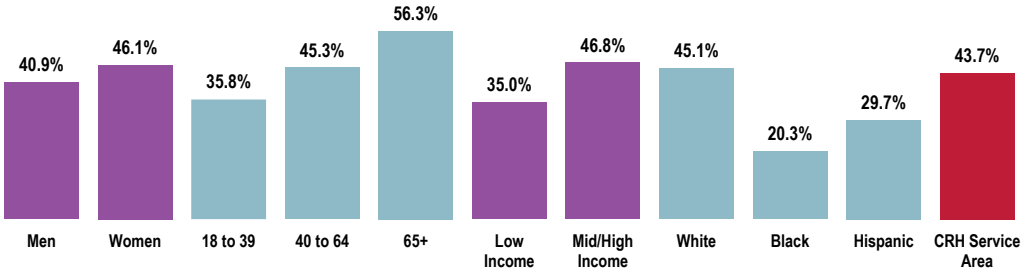
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 333]
Notes: • Asked of all respondents.
• Does not include meals during which the television is on.

Eat 5+ Weekly Meals Together as a Family



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 333]
Notes: • Asked of all respondents.
• Does not include meals during which the television is on.

Eat 5+ Weekly Meals Together as a Family
(CRH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 333]
Notes: • Asked of all respondents.
• Does not include meals during which the television is on.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

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.

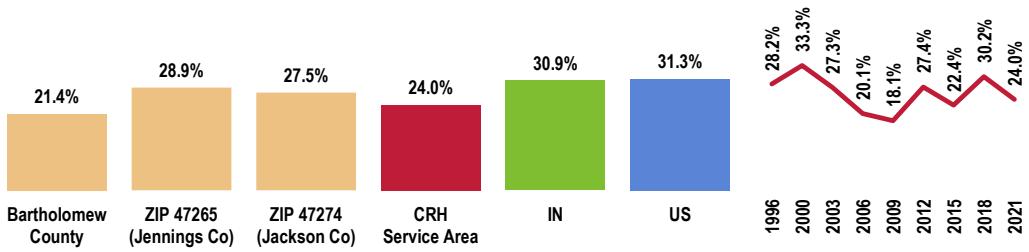
A total of 24.0% of Columbus Regional Health Service Area adults report no leisure-time physical activity in the past month.

BENCHMARK ► Better than state and national findings. Similar to the Healthy People 2030 objective.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower

CRH Service Area



Sources:
- 2021 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): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Activity Levels

Adults

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

A total of 21.4% of Columbus Regional Health Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

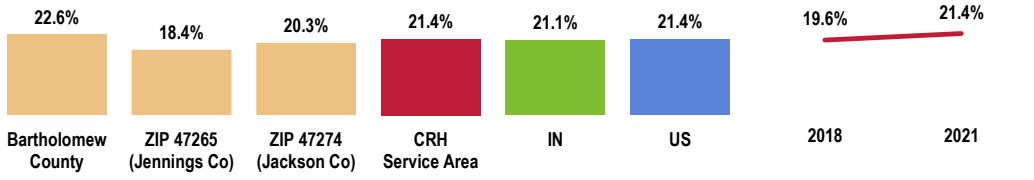
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Adults age 40+ were less likely to report meeting the activity recommendations.

Meets Physical Activity Recommendations

Healthy People 2030 = 28.4% or Higher

CRH Service Area



Sources:
- 2021 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): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.

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

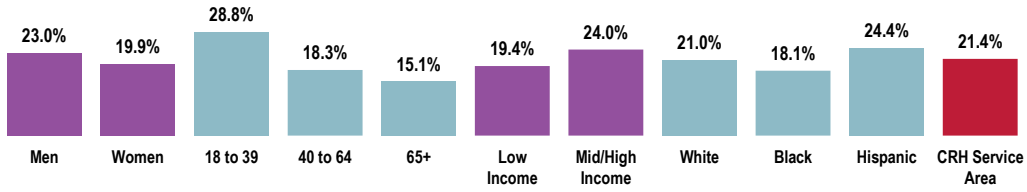
Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

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

Meets Physical Activity Recommendations

(CRH Service Area, 2021)

Healthy People 2030 = 28.4% or Higher



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 152]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.

Children

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

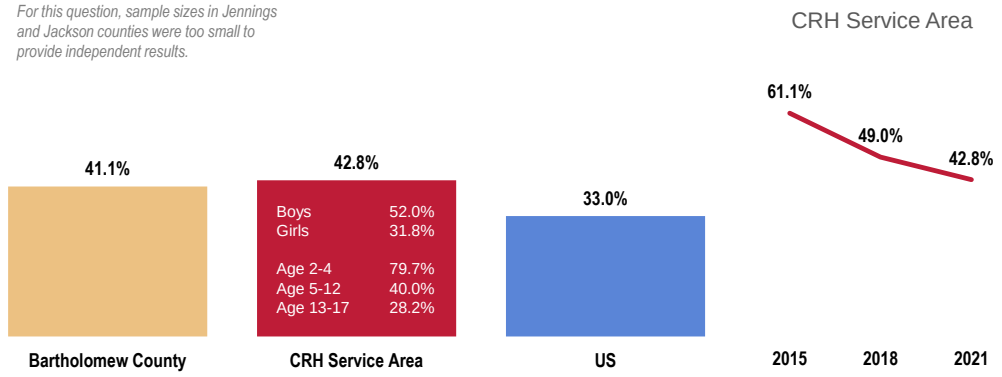
Among Columbus Regional Health Service Area children age 2 to 17, 42.8% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

BENCHMARK ► Better than the US finding.

TREND ► Represents a significant decline within the service area.

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

For this question, sample sizes in Jennings and Jackson counties were too small to provide independent results.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 124]
- 2020 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.

Screen Time

"During the school year on an average school day, about how many hours or minutes does this child spend looking at a screen, such as watching TV, playing video games, using a computer, or using the internet for entertainment?"

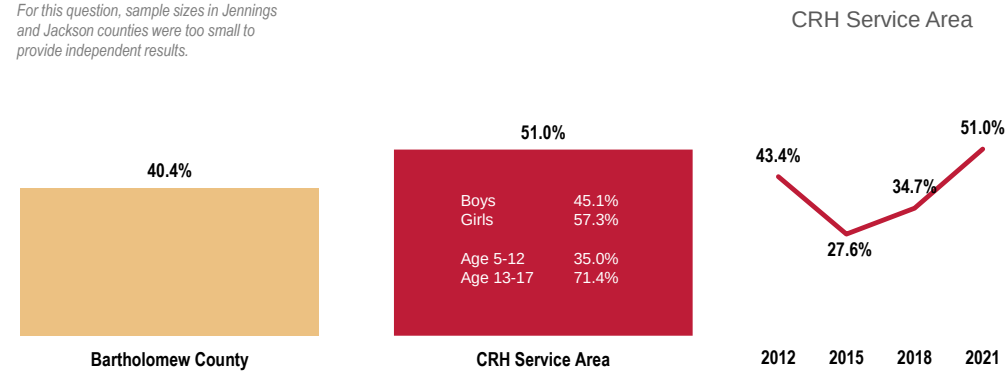
Among service area children age 5 to 17, 51.0% are reported to spend three or more hours on screen time during a typical school day.

TREND ► Denotes an all-time high within the service area.

DISPARITY ► Favorably lower in Bartholomew County than in the other county areas (not shown).

3+ Hours of Total Screen Time on School Days
(Parents of Children Age 5-17)

For this question, sample sizes in Jennings and Jackson counties were too small to provide independent results.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 350]

Notes:
- Asked of all respondents with children age 5-17 at home.
- Screens include television, computer, video games, etc. used for entertainment.

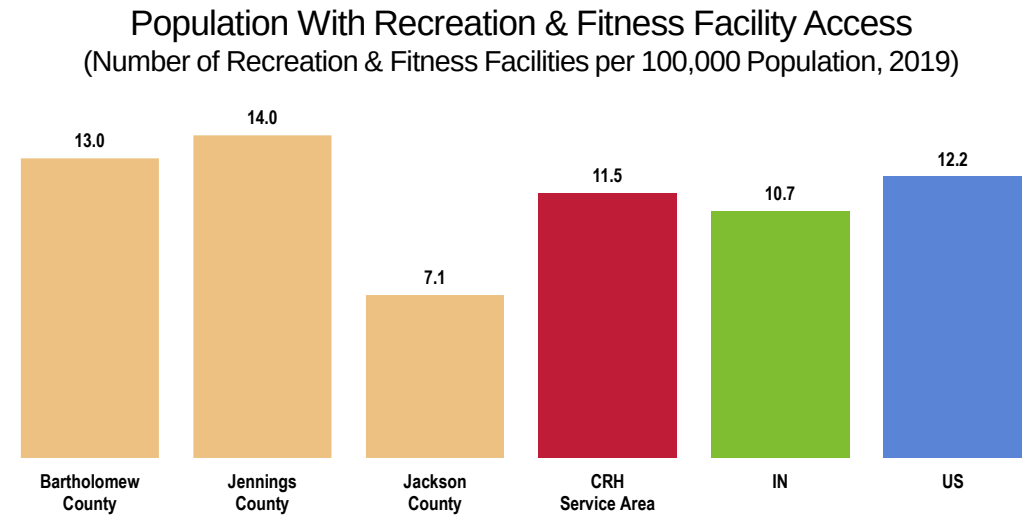
Access to Physical Activity

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.

In 2019, there were 11.5 recreation/fitness facilities for every 100,000 population in the Columbus Regional Health Service Area.

DISPARITY ► Lowest in Jackson County.



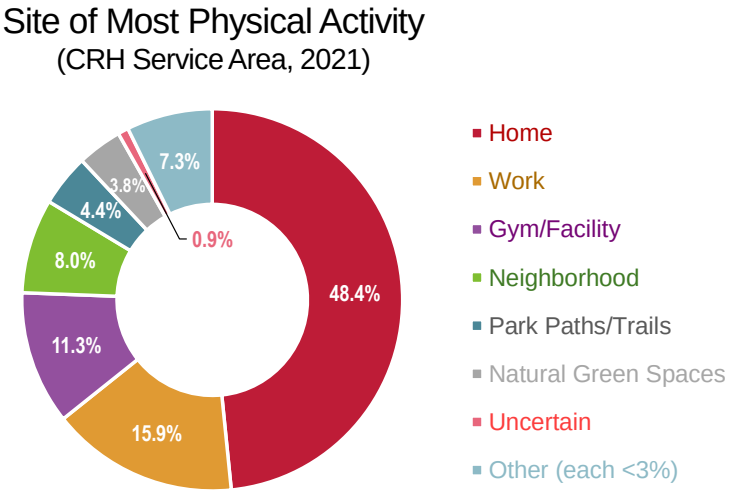
Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

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.

Site of Most Physical Activity

Among service area respondents, nearly half (48.4%) indicate that most of their physical exercise happens at home.

► Other sites mentioned included work (mentioned by 15.9%), a gym or fitness facility (11.3%), neighborhood streets or sidewalks (8.0%), people trails (4.4%), and natural green spaces (3.8%).



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 335]

Notes:
- Asked of all respondents.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

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.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

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

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

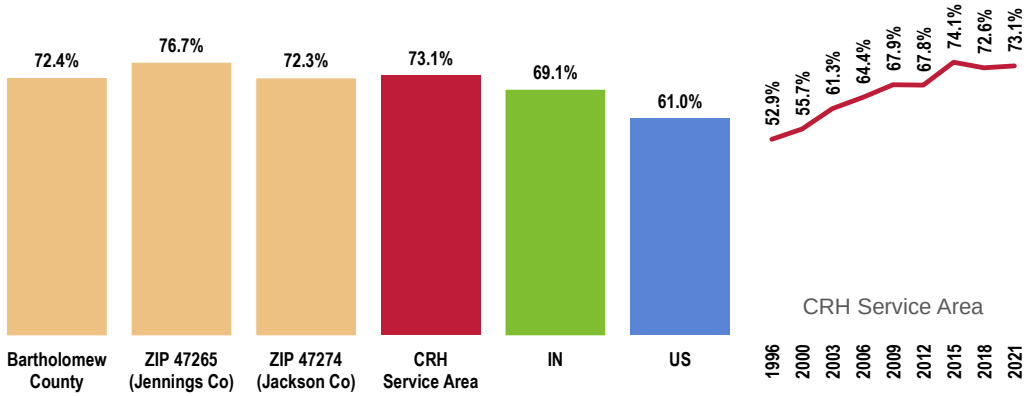
Overweight Status

A total of 7 in 10 Columbus Regional Health Service Area adults (73.1%) are overweight.

BENCHMARK ► Worse than was found across the state and nation.

TREND ► Trending significantly higher over time.

Prevalence of Total Overweight (Overweight and Obese)



Sources:
- 2021 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): 2019 Indiana data.
- 2020 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.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

The overweight prevalence above includes 42.7% of Columbus Regional Health Service Area adults who are obese.

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

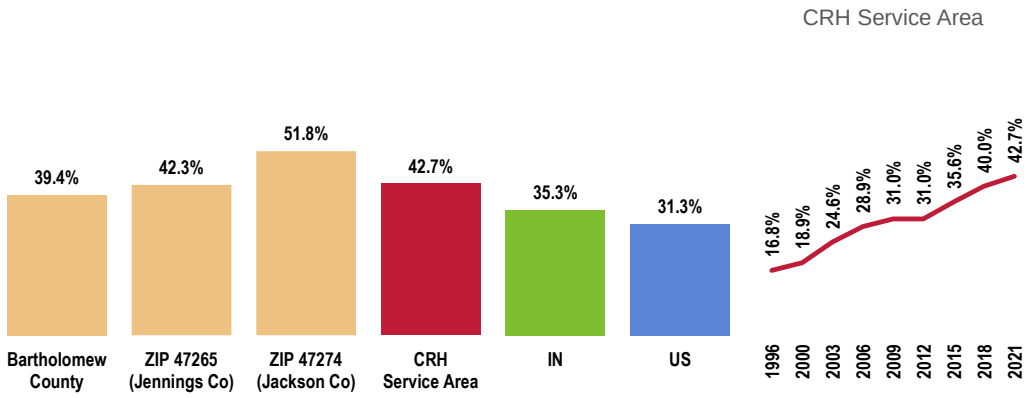
BENCHMARK ► Worse than was found across the state and nation. Fails to satisfy the Healthy People 2030 objective.

TREND ► Trending significantly higher over time.

DISPARITY ► Especially high in Jackson County ZIP Code 47274. Also higher among adults age 40 to 64 and especially Black residents.

Prevalence of Obesity

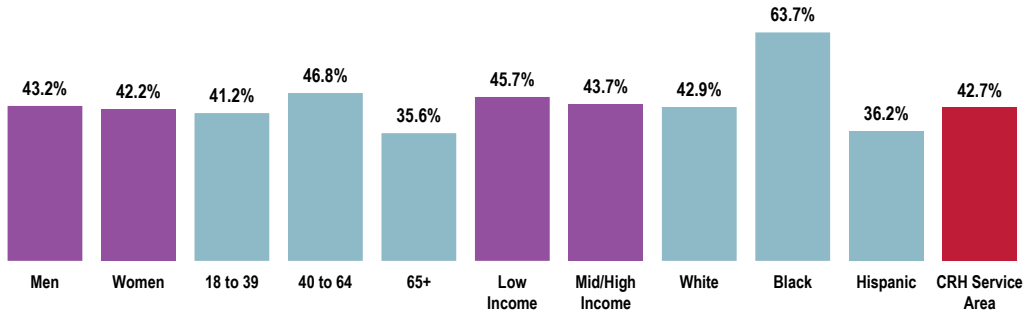
Healthy People 2030 = 36.0% or Lower



Sources:
- 2021 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): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Prevalence of Obesity
(CRH Service Area, 2021)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 154]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

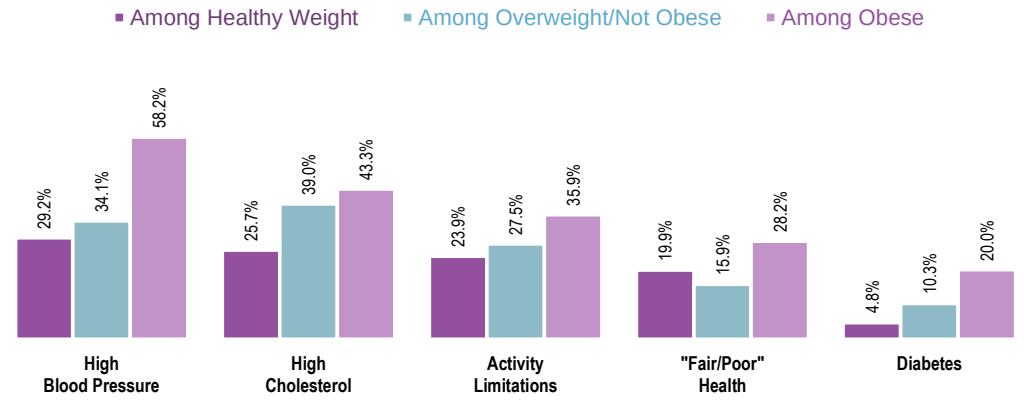
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Relationship of Overweight With Other Health Issues

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

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

Relationship of Overweight With Other Health Issues
(CRH Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 154]

Notes:
- Based on reported heights and weights, asked of all respondents.

Workplace Support

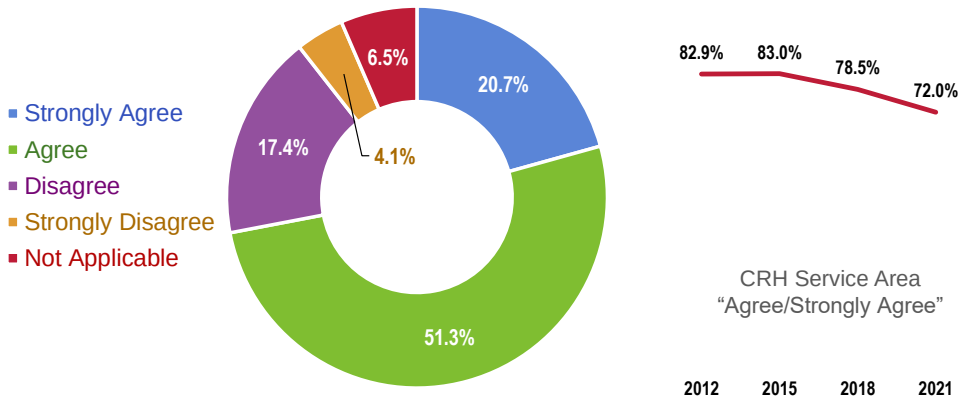
"Please tell me your level of agreement or disagreement with the following statement: Over the past three years, my workplace has become more supportive of living a healthy lifestyle."

Most employed respondents (72.0%) agree that their workplace has become more supportive of a healthy lifestyle in recent years (giving "agree" or "strongly agree" responses).

TREND ► Represents a decrease within the service area.

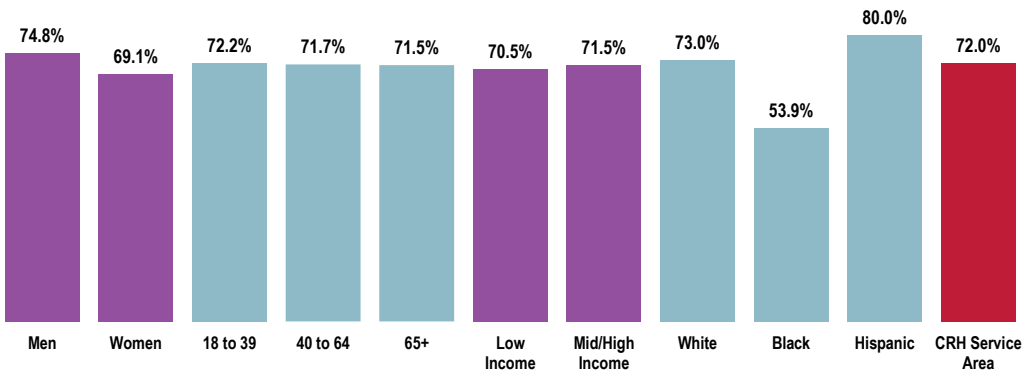
DISPARITY ► Black respondents were less likely to agree.

Agreement With Workplace as More Supportive of Healthy Lifestyles Over the Past 3 Years
(CRH Service Area Employed Respondents, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 339]
Notes: ● Asked of all respondents who are currently employed.

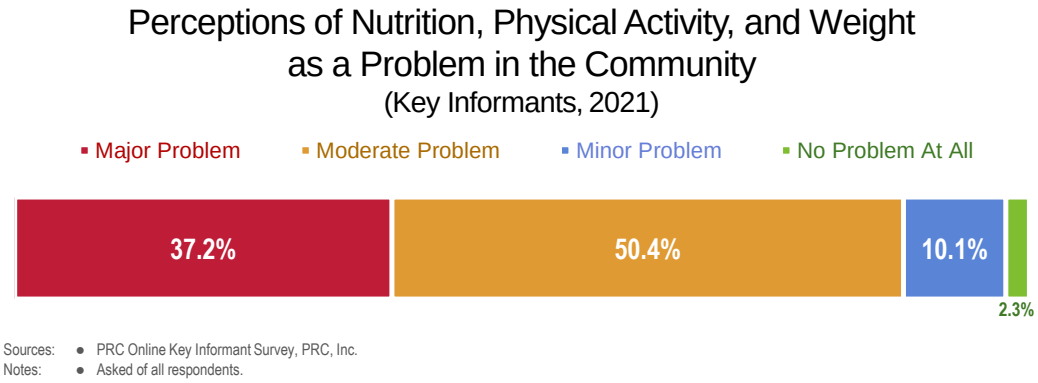
Agree/Strongly Agree That Workplace Has Become More Supportive of Healthy Lifestyles Over the Past 3 Years
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 339]
Notes: ● Asked of all respondents who are currently employed.

Key Informant Input:
Nutrition, Physical Activity & Weight

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



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

Contributing Factors

Obesity and smoking are now viewed as culturally acceptable lifestyles in certain demographics. – Community/Business Leader

Healthy eating habits. Some food desserts in our community. Comprehensive, systems-based approach could be even more comprehensive (e.g. Shape Up Summerville, MA). – Community/Business Leader

There is a lack of cooking and practical nutrition education; not only to kids, there is no ongoing educational opportunities for adults. With busy lifestyles, many families don't have the skills to produce quick, healthy meals and fast foods are easy options. For people with mobility problems related to their weight, there is a lack of exercise opportunities. They can be referred to physical therapy, but otherwise there are no classes or zero entry pools easily available for a low cost. There are people who are unable to use community resources like the people trails or bike lanes. The rural areas of the community have limited access to fresh fruits and vegetables; the main grocery options are Dollar General. These areas also do not have routine access to the food pantry and hot meals as they are not on the bus line (Taylorsville, Waymansville, etc...) – Social Services Provider

More access to physical activities, more information in Spanish. – Community/Business Leader

No supervised play at the schools, kids need more recesses to get out and walk, stretch and be active not all kids are in sports so maybe have something after or before school for kids' to be active. Teach healthy habits, eating, drinking, walking, movement is good for everything. – Community/Business Leader

The people themselves stand in their own way. How do we break a sedentary culture? Adults are working long hours too. It is hard to find the time. However, I have found a new app that focuses on 15-45 min exercises done every day and I have seen a significant change in my body and self-confidence. Maybe we need to focus on the quick and easy things? – Social Services Provider

Middle to low-income individuals / families that can't afford healthier food. Foods that contain preservatives may be cheaper and have a longer shelf life. Almost 30% of adults in Bartholomew County are overweight, which could be contributed to low income, lack of insurance, and lack of time to make a nutritious meal. Especially active families always on the run. Fast food is more convenient. There are healthier foods on the fast food menus, but many times, that is not chosen. Lack of support system or resources in place to enable individuals to make the lifestyle change to eat healthier and exercise. – Community/Business Leader

IMO, there are degrees of intractability here, and a lot of it is socio-economic: Living a healthy lifestyle not only takes commitment, but it is also not cheap. As well, there are peer-group related challenges to overcome: Is there someone who wants to buck their peer group norms? It might be aspirational, but stigma and social standing within the group are tall hurdles to surmount. Sadly, I have no easy suggestions beyond saying this is clearly something that needs to be instilled in the young, because once someone leaves school, the effort will by necessity become more focused on the individual, rather than the group and you lose focus on the big picture. Even here, the kids who need the most guidance are likely those in peers groups that don't value what "experts" have to offer. [See COVID Vaccination, Fauci, Tony] – Other Health Provider

> The community is not set up to be walker friendly as a true lifestyle. There are multiple food deserts in Columbus/Bartholomew County. Produce and fresh food here locally is both expensive and deteriorates very quickly. I can't go to the grocery store multiple times a week just to get produce that doesn't rot. That's not feasible for me. – Community/Business Leader

Obesity

> Our community rate of obesity is too high. High rate of childhood obesity. Too many people have lack of access to high quality, fresh foods and do not know how to cook or eat healthy. – Community/Business Leader
>
> It appears a large segment of our population is overweight and not physically fit with limited or no physical activity. I've observed many who seem uninformed about good nutrition. – Community/Business Leader
>
> Overweight people. – Community/Business Leader
>
> The vast majority of the population of Bartholomew County is overweight as defined by BMI. Being overweight leads to others issues, heart, diabetes, which also impact our community. – Other Health Provider
>
> Overweight and obesity. – Other Health Provider
>
> Indiana's obesity ranking is #12 out of 50. Childhood obesity continues to trend up. Physical activity continues to trend down, especially in childhood. – Other Health Provider
>
> Obesity epidemic, sedentary lifestyle, poor food choices. – Physician
>
> Obesity. – Community/Business Leader
>
> Obesity is associated with most causes of death, especially early death. Not enough knowledge about healthy eating, expense of healthy food. – Other Health Provider
>
> I think childhood obesity is a very importance issue in our community. Research studies from the past year are already estimating that childhood obesity rates in 5-11 year olds have increased significantly. – Other Health Provider
>
> Obesity/inactivity: too many Hoosiers and residents of Bartholomew County are (or are close to) obese. Many don't understand the importance of being active and maintaining a healthy weight. As one who struggles with this myself, I believe we need more affordable options for many people. – Community/Business Leader

Nutrition

> Poor eating habits and diets. Not engaged in moderate exercise, such as walking and social bike riding. Too much recreational time in front of screen. – Community/Business Leader
>
> A culture of fast food and already prepared foods in a built environment that promotes driving rather than walking. – Community/Business Leader
>
> Southern Indiana eating habits are poor, fried foods, lots of meat, few vegetables and lots of sugar. These habits are passed down from generation to generation. Columbus is not set up as walkable for ADLs, i.e. walking to grocery store, bank, etc. – Other Health Provider
>
> Local food pantries and community feeding locations should be more conscious of what is provided in feeding those who visit their feeding sites. – Social Services Provider
>
> Fewer people prepare food at home. There is a heavy reliance on fast food among young people. Love Chapel reports that fresh fruit and vegetables often go to waste, because people don't know how to use/prepare them. Schools have cut back on the amount of recess time, and fewer kids are physically active after school. Video games and electronic devices increasingly replace unstructured active play. Gym memberships can be cost prohibitive to low-income families and individuals. – Social Services Provider
>
> It is challenging for individuals to prioritize good nutrition, physical activity, and weight management, even though we all know we should! – Social Services Provider
>
> Poor food options. More poor food options than nutritional food options. Sedentary lifestyle, especially in COVID environment. – Community/Business Leader

Awareness/Education

> People receiving education prior to illness. – Public Health Representative
>
> Nutritional education and awareness are low and not an area of focus in Bartholomew County. Majority of families are not nutritionally educated, the school systems nutrition education is weak, CRHs wellness program while good does not reach enough people, the Cummins Wellness program is good but limited to employees and their families. – Community/Business Leader
>
> Educating our youth. – Community/Business Leader
>
> Not sure how to refer people/where to refer people for help in these areas. – Social Services Provider

Social Norms/Community Attitude

> Acceptance of obesity as being the norm, over-committed lifestyles limiting physical activity and making good nutrition choices. – Public Health Representative

> The biggest challenges are the growing notion that being obese is not unhealthy. This is largely pushed by social media. I'm 100% against any type of body shaming; however, it is incorrect that being obese is just as healthy as being of a "normal" weight. Obesity contributes to diabetes, high blood pressure, high cholesterol, and the downstream effects of those problems (e.g., heart attacks). – Physician

Lifestyle

> People don't seem motivated to change their diet/exercise/activity levels. – Other Health Provider
>
> The unhealthy choice is the easiest choice for adults and children across the community. – Other Health Provider

Access to Affordable Healthy Food

> For those in moderate to low income it is hard to eat nutritiously, get physical activity. With rising food prices I am concerned about children and older adults having enough food. – Social Services Provider

Affordable Care/Services

> Lack of exercise programs that are cost effective for lower income families. Increased availability of low cost, high calorie junk food. Still need more connectivity of neighborhoods to safe routes to school and work to encourage walking or biking. – Physician

Diagnosis/Treatment

> The Bariatric Clinic will not treat with medications and limit which insurances they see, so access is not equitable. – Other Health Provider

Work Related

> Employer incentives for wellness. To attend appointments, engage in fitness and wellness programs. To lose weight. – Community/Business Leader

Insufficient Physical Activity

> Sedentary lifestyle and poor food choices that have increased since pandemic (possibly related to mental health as well). – Other Health Provider

Income/Poverty

> Poverty level incomes. – Other Health Provider

Electronic Screens

> Screens! I am concerned for our children. – Social Services Provider

SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

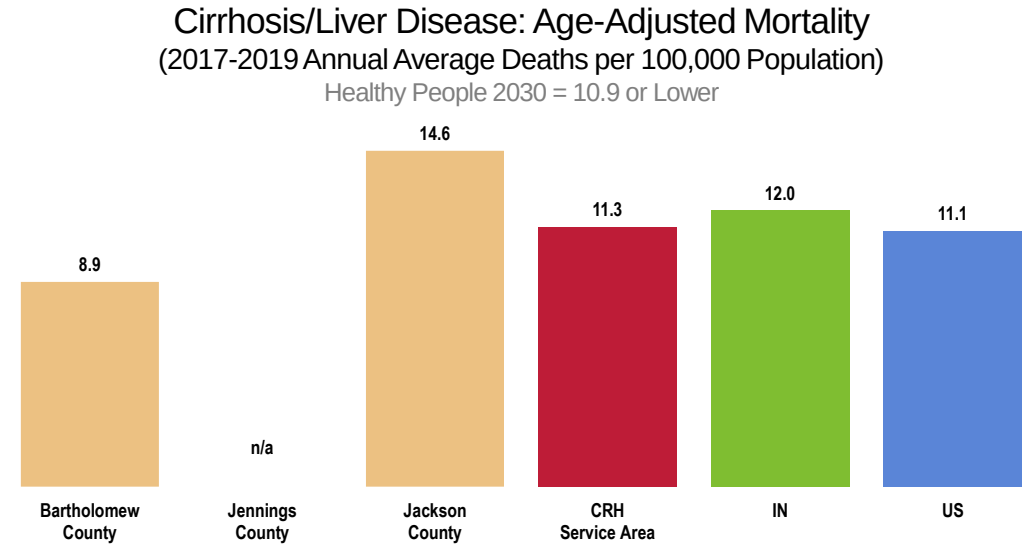
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2017 and 2019, the Columbus Regional Health Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 11.3 deaths per 100,000 population.

DISPARITY ► Highest in Jackson County.

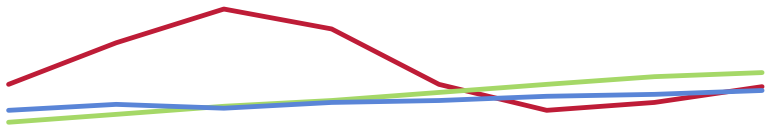


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	11.4	13.5	15.2	14.2	11.4	10.1	10.5	11.3
IN	9.5	9.9	10.3	10.6	11.0	11.4	11.8	12.0
US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Alcohol Use

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

A total of 23.8% of area adults are excessive drinkers (heavy and/or binge drinkers).

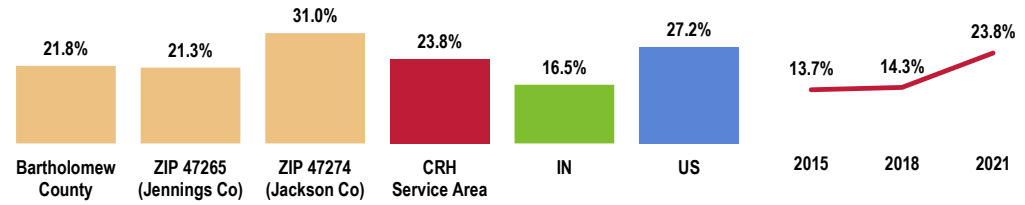
BENCHMARK ► Worse than the state finding.

TREND ► Marks a significant increase since 2015.

DISPARITY ► More often reported among men and young adults.

Excessive Drinkers

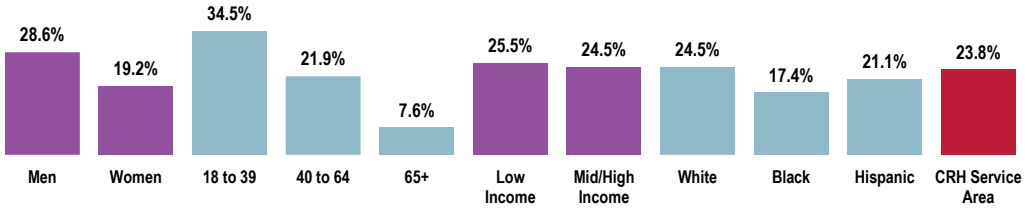
CRH Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 168]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers
(CRH Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 168]

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Age-Adjusted Unintentional Drug-Related Deaths

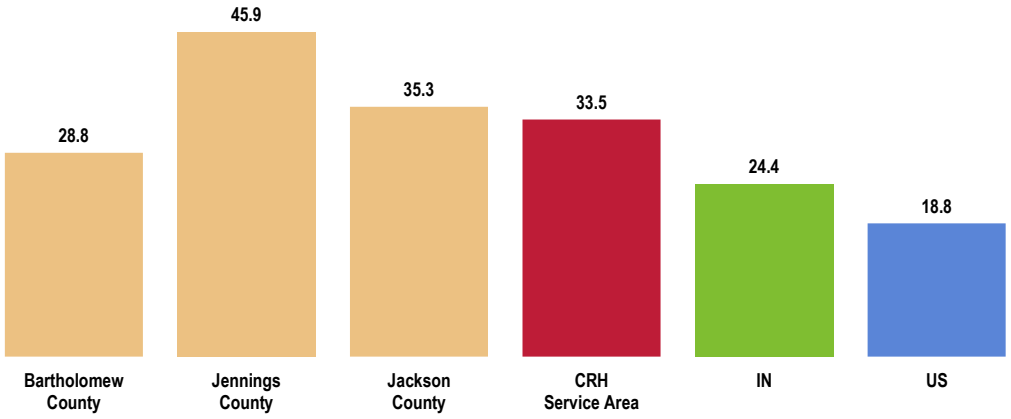
Between 2017 and 2019, there was an annual average age-adjusted unintentional drug-related mortality rate of 33.5 deaths per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Higher than Indiana and US rates.

TREND ► Marks a dramatic rise within the service area over time.

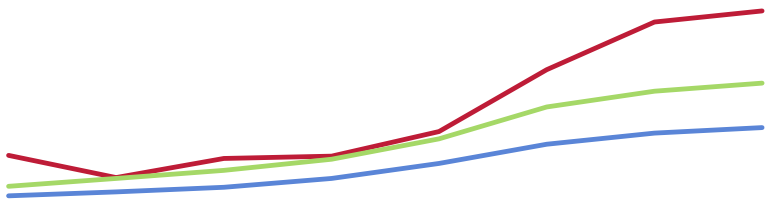
DISPARITY ► Particularly high in Jennings County.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality
(2017-2019 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 2021.

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
CRH Svc Area	15.3	12.5	14.9	15.2	18.3	26.1	32.1	33.5
IN	11.4	12.4	13.4	14.8	17.4	21.4	23.4	24.4
US	10.2	10.7	11.3	12.4	14.3	16.7	18.1	18.8

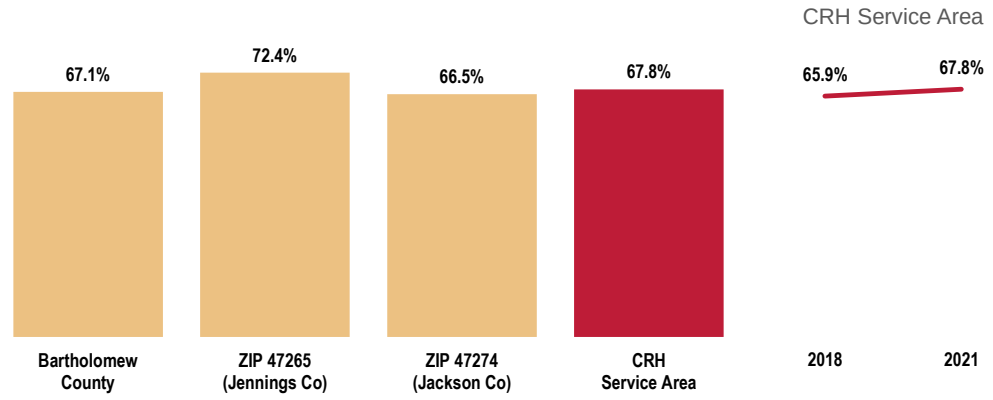
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Drug-Related Treatment

Two in three service area residents (67.8%) report that they know where to access alcohol- or drug-related services if they needed treatment.

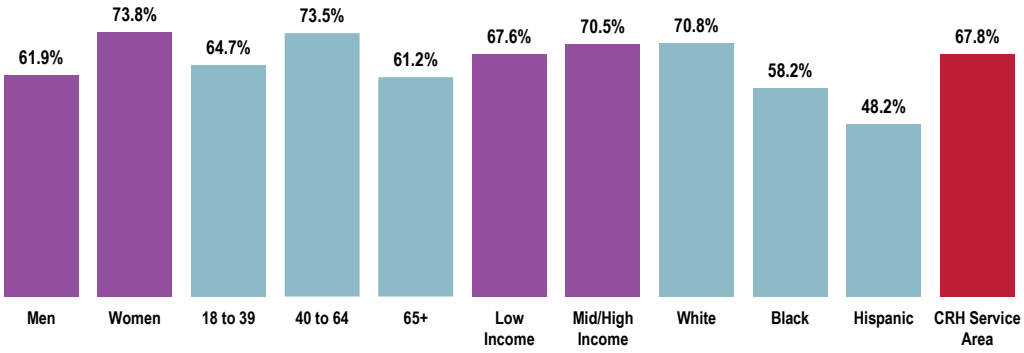
DISPARITY ► Those less likely to express awareness include men, young adults (age 18 to 39), seniors (age 65+), and Hispanic respondents.

Know Where to Access Drug-Related Treatment



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: ● Asked of all respondents.

Know Where to Access Drug-Related Treatment
(CRH Service Area, 2021)



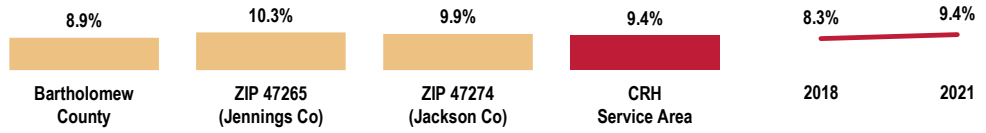
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: ● Asked of all respondents.

Of the total sample of CRH Service Area survey respondents, 9.4% acknowledge a time in the past year when they or a family member needed professional help for an addiction but were unable to get it.

DISPARITY ► More often reported among adults age 18 to 39, low-income households, White respondents, and Black respondents.

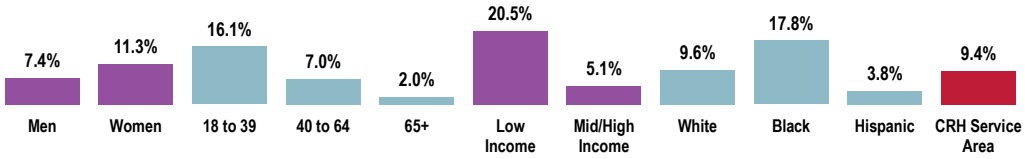
Family Member Was Unable to Access Professional Help for an Addiction in the Past Year

CRH Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: ● Asked of all respondents.

Family Member Was Unable to Access Professional Help for an Addiction in the Past Year
(CRH Service Area, 2021)



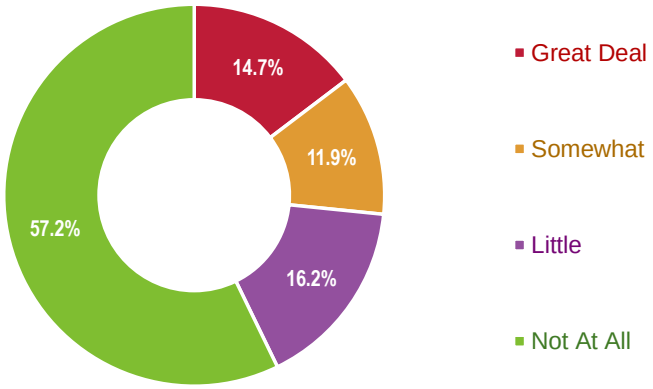
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: ● Asked of all respondents.

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).

More than one-half of Columbus Regional Health 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)
(CRH Service Area, 2021)



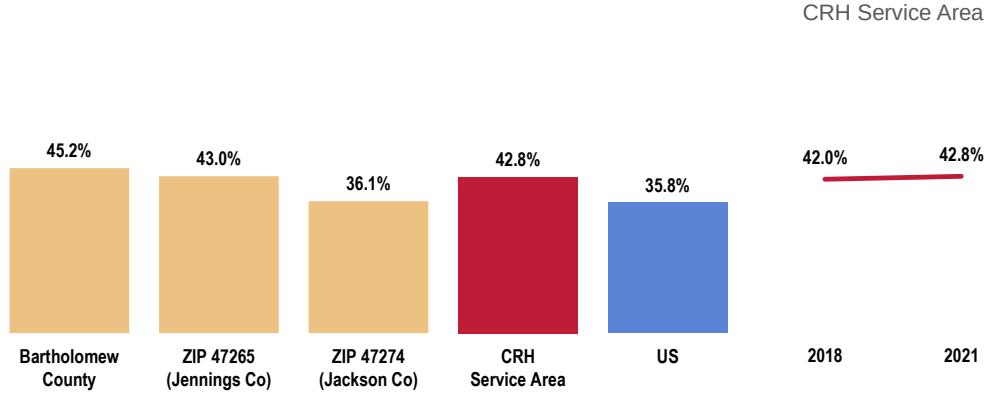
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 61]
Notes: ● Asked of all respondents.

However, 42.8% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

BENCHMARK ► Higher than the national percentage.

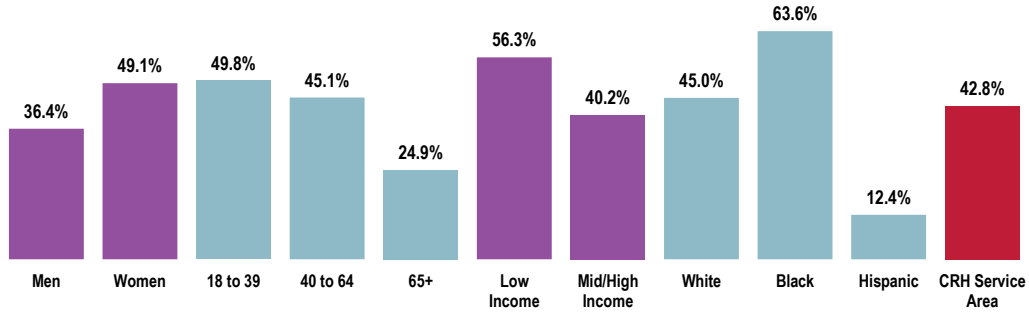
DISPARITY ► More often reported among women, adults younger than 65, low-income respondents, White residents, and Black residents.

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



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 195]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes response of "a great deal," "somewhat," and "a little."

Life Has Been Negatively Affected
by Substance Abuse (by Self or Someone Else)
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 195]
Notes: ● Asked of all respondents.
● Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

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

Perceptions of Substance Abuse
as a Problem in the Community
(Key Informants, 2021)

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

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

Contributing Factors

> Much progress has been made, since ASAP was first created. We now have the ASAP Hub, ASAP Houses, TASC, and more employers than ever who will hire people with nonviolent felonies. These changes have made tangible differences in the lives of many; however, important challenges remain. Women to have children often can't get to treatment because they can't find affordable childcare. Patients, in general, often do not have transportation to get to appointments. The COVID pandemic has taken a toll, as can be seen in the overdose numbers in Bartholomew County for 2021 (31 OD deaths—the most ever). More people have turned to alcohol to cope with the loneliness of being isolated, unemployed, etc. We are making progress, and now is the time to double-down to knock down barriers for those who cannot access treatment for whatever reason. – Physician
>
> Not enough coordinated services for the demand. Not enough community will to address the sources of substance abuse: mental health, poverty, support for parents and families striving to help a family member. Very important: not enough collaboration and help (time, effort, and money) from the manufacturing and other industry around our community... which is where these individuals work, and where most of the drug 'traffic' happens. – Other Health Provider

Access, money, stigma. – Social Services Provider

Lack of residential rehabilitation, easy access to opioids. – Social Services Provider

Stigma, lack of payer, lack of support/transportation to services. – Other Health Provider

Individuals unaware (denial) that they have a drug abuse problem. Finances to go to a treatment center. – Social Services Provider

Stigma. Lack of wrap around services once out of the initial detox/rehab. – Physician

Stigma associated with substance abuse, interruption of services due to COVID, immediate access to treatment when the person asks for help, local detox, lack of strong support for families struggling with substance abuse issues, jobs for those in recovery – Community/Business Leader

Some people don't think they need the help. Some people use illegal substances to self-treat their mental illness. But our community is working hard to provide resources through recovery programs and recovery homes. But we sure could use an inpatient treatment facility. I also know those are very expensive. – Social Services Provider

Lack of understanding of where to go for help / same environment for the addicts / lack of support to encourage them to keep going / lack of adequate insurance to cover treatment programs / forgetting those individuals were once a member of the community and they need love, understanding and a safe space. – Community/Business Leader

The community is improving but substance abuse episodes continue to increase. Finding affordable resources seems difficult for many. There's also a lack of understanding on the part of many in the community about the nature of substance abuse, thus stigmatizing those who acknowledge they are abusing substances but want to stop the cycle. – Community/Business Leader

Not enough MAT providers. Lack of access at the right time (when the crisis occurs and/or individual is ready). Lack of insurance. Co-occurring mental health barriers. – Other Health Provider

During COVID 19, essential in-person services were stripped away from those suffering with substance use disorder. I believe we are going to see negative effects related to substance use in our community for many years to come. And another huge factor is that mental health resources are already severely lacking in our community, and substance use and mental health go hand in hand- they are one in the same. Also, there is an incredible stigma associated with people suffering from substance abuse. Specifically, I see pregnant and post-partum moms that simply want to hide their history and/or current use because they are afraid they will be judged. – Other Health Provider

Access to Care/Services

The ASAP coalition has done a great job mapping out the treatment infrastructure (places and services) needed for people to successfully access treatment. Now we need to build adequate capacity. Appropriate housing is in short supply. People in treatment needs access to employment. Our community needs to be broadly educated to welcome, rather than "NIMBY," treatment facilities and participants. – Social Services Provider

Long-term treatment facilities, insurance coverage, not much treatment help for alcohol versus drugs, Lack of social work support for other issues that surround substance abuse, especially for longer term in-patient care, Transportation, Facilities that don't have a waiting list to meet the need for someone that is ready for treatment now- no time to change mind, Funding – Other Health Provider

System that helps sustain positive lifestyle changes while in recovery. The fear our community has of opening doors/programs/facilities to those that are in recovery. Homelessness is a big area where substance abuse is occurring and access to those individuals as its occurring is hard to ensure. – Community/Business Leader

Availability of inpatient treatment when needed. – Community/Business Leader

Qualified mental health professionals. – Social Services Provider

Lack of resources. Lack of education for the general population. – Other Health Provider

I believe we need more inpatient substance abuse rehab options. – Public Health Representative

Meeting times, convenience of meetings, transportation to meetings, childcare for meetings, and support. – Other Health Provider

Lack of availability. – Other Health Provider

Lack of trained professionals. Lack of insurance coverage to pay for needed care. – Community/Business Leader

Great activity in this field. CRH gives a lot of verbiage, however that's it. We don't even treat patients in Columbus, we send them out elsewhere. Most good activity coming from the Courts, the Hail, and CRH only gives talk. – Community/Business Leader

No inpatient options. – Social Services Provider

Lack of facilities and funding. – Community/Business Leader

Awareness/Education

Getting people to take advantage of the resources available. Safe places for women to stay while working on recovery, especially if they have kids in their care. – Other Health Provider

Awareness of the access to services. They exist, e.g., ASAP and court work is really excellent. Need to keep moving this work forward, even more systemically. – Community/Business Leader

I feel our community as a whole does not recognize that there is a substance abuse problem in our community despite the increase in accidental drug overdose cases and deaths. I feel we need access in our community to inpatient care and not just outpatient-based facilities. – Public Health Representative

People not aware of services offered to them. – Public Health Representative

I think this is improving greatly; however, we need to continue the push of education and access to treatment. – Other Health Provider

The local effort has been amazing, but the need still is so great. So, education and prevention are strongly needed, in addition to efforts to curtail availability of drugs and enhance existing treatment services and recovery efforts. – Community/Business Leader

Awareness and personal desire for change, based on struggle with addiction. – Community/Business Leader

Identifying it is a problem within the family and why they are using, which always leads back to extreme stress and mental health. – Social Services Provider

Incidence/Prevalence

The volume of people struggling with addiction is greater than the resources available. – Other Health Provider

Although great strides have been made in combating this problem, it appears there is still much work to be done. Long term treatment/support needs to be strengthened. – Community/Business Leader

Our hospitals and mental health services are overrun with substance abuse problems daily. – Other Health Provider

We have a high overdose rate. We have ASAP, but it's not focused on prevention. Prevention is fragmented and primarily aimed at children. – Community/Business Leader

This is an area where I actually feel Bartholomew County is doing a GREAT job. There have been changes over the past 5 years that have made Bartholomew County one of the most resource-rich communities for people struggling with addiction. That being said, the work is not done. Addiction is such a huge problem that, while we have made and continue to make great strides, we are still far from where we need to be. – Community/Business Leader

Substance abuse is too high. The challenge is how to prevent it in the first place. – Community/Business Leader

Follow-Up/Support

I believe there is a gap in hospitalized patients being released without making adequate connections to substance abuse treatment. This causes them to withdrawal in the hospital but revert back to substance use as soon as they leave. There are many resources in the community, but people are not informed or do not know how to access them. – Community/Business Leader

Substance abuse support has made some great strides, but still needs to increase in support. Support in a timely manner, not by scheduling an appointment next week. – Other Health Provider

In short, effective follow-up is still lacking. Law enforcement and EMS deal with a large amount of drug overdoses daily. These are the individuals at high risk for overdose death. Some will decline the life raft, but there should be a robust system for trying to reach these people for effective addiction treatment. Like mental health, those with support systems get the help while those w/out support systems don't. – Community/Business Leader

Denial/Stigma

The stigma around substance abuse is intense. Also, people talk as if a linear progression is expected. There is not a lot of grace for slip-ups, so if any problem occurs then the response is to cover it up rather than seek help. Any successes are still kept quiet because it is seen as a major flaw to have anything untoward in your history. – Community Member

Stigma. – Public Health Representative

Stigma. – Other Health Provider

Stigma, desire to seek treatment. – Other Health Provider

Stigma and lack of knowledge on how to recognize and address issues. – Public Health Representative

Income/Poverty

Financial ability, access to treatment, job insecurity if you go for treatment. – Community/Business Leader

Money, we need to build a facility away from the normal traffic where there can be treatment programs including extended stays. – Community/Business Leader

Financial needs, ongoing aftercare. – Community/Business Leader

Lack of Providers

Not enough providers. – Public Health Representative

> Since the creation of ASAP and the opioid epidemic, I am not sure there are many barriers to accessing treatment in the community for adults. We do not have adequate treatment providers for adolescent substance use. – Community/Business Leader

Affordable Care/Services

> Thankfully, there has been some work done to decrease barriers. However, accessing long-term, affordable/free treatment is not always an option. The community also needs more supportive sober-living environments. – Social Services Provider

> Cost of transportation and childcare. – Other Health Provider

Diagnosis/Treatment

> Relatively few treatment options, no inpatient/residential treatment options. – Physician

> Lack of early diagnosis and treatment of emotional issues that can lead to substance abuse. Punitive restrictions and actions for admitting to a problem. Too many churches. – Community/Business Leader

Due to COVID

> COVID-19, resources not being available, people not knowing what resources exist. – Other Health Provider

Access to Care for Uninsured/Underinsured

> Patients not having insurance or able to find or afford inpatient treatment facilities. Patients also have difficulty affording the medications such as Suboxone and these are not available for help with township trustees and MAP. – Other Health Provider

Addiction

> The addiction itself is a barrier, lack of knowledge of available resources, lack of inpatient treatment center in the community. – Community/Business Leader

Government/Policy

> Legal challenges. – Community/Business Leader

Lack of Coordinated Care

> Current options do not coordinate care and address underlying causes for substance use, which is the root of the problem. – Other Health Provider

Transportation

> Transportation for clients. – Other Health Provider

Most Problematic Substances

Key informants (who rated this as a “major problem”) identified both **heroin/other opioids** and **alcohol** as causing the most problems in the community, followed by **methamphetamine/other amphetamines**, **cocaine or crack**, **prescription medications**, and **over-the-counter medications**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a “Major Problem”)	
HEROIN OR OTHER OPIOIDS	34.7%
ALCOHOL	34.7%
METHAMPHETAMINE OR OTHER AMPHETAMINES	24.0%
COCAINE OR CRACK	4.0%
PRESCRIPTION MEDICATIONS	1.3%
OVER-THE-COUNTER MEDICATIONS	1.3%

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

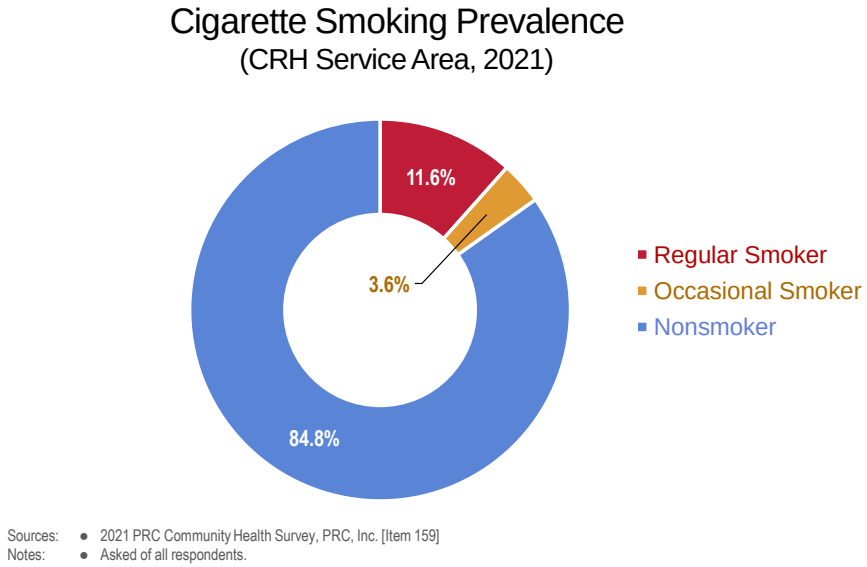
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 15.2% of Columbus Regional Health Service Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 159]
Notes: ● Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the Columbus Regional Health Service Area.

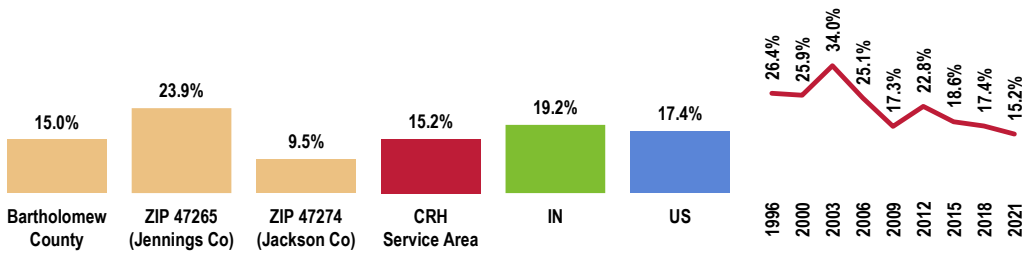
BENCHMARK ► Lower than the statewide prevalence but fails to satisfy the Healthy People 2030 objective.

TREND ► Improving within the service area.

DISPARITY ► Highest in Jennings County ZIP Code 47265. Cigarette smoking is higher among young adults and lower-income respondents.

Current Smokers

Healthy People 2030 = 5.0% or Lower



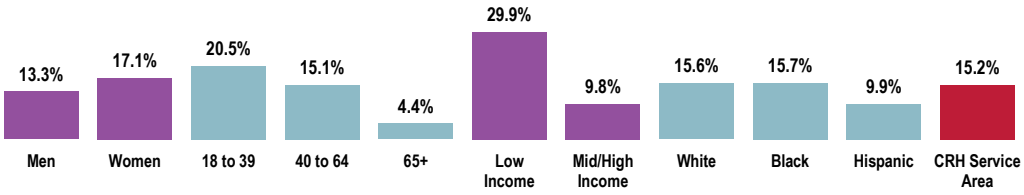
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 159]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Current Smokers

(CRH Service Area, 2021)

Healthy People 2030 = 5.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 159]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

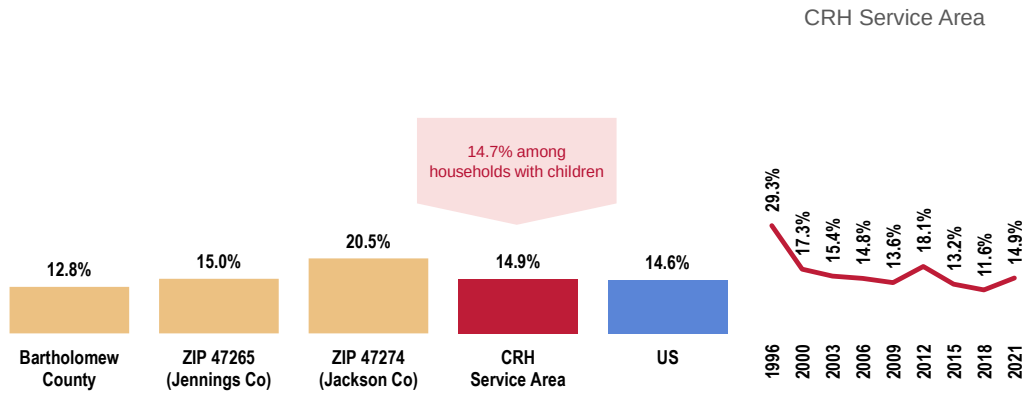
Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (every day and some days).

Environmental Tobacco Smoke

Among all surveyed households in the Columbus Regional Health Service Area, 14.9% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

TREND ► Denotes a significant decrease since 1996.

Member of Household Smokes at Home



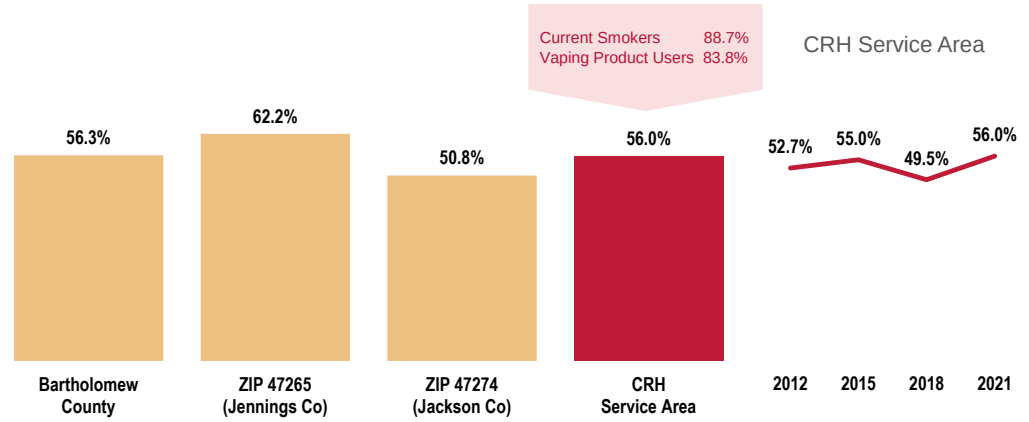
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 52, 162]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Awareness of the Indiana Tobacco Quit Line

Half of survey respondents (56.0%) are aware of the Indiana Tobacco Quit Line (1-800-QUIT-NOW).

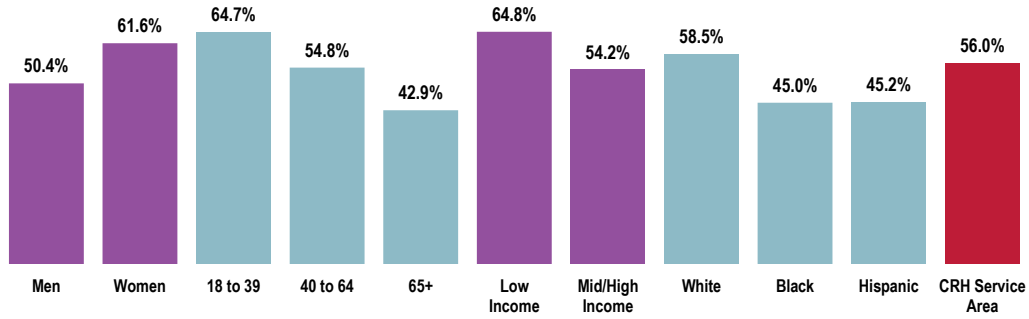
DISPARITY ► Awareness of the quit line is lower among male respondents, adults age 65+, those with higher incomes, Black residents, and Hispanic residents.

Aware of the Indiana Tobacco Quit Line: 1-800-QUIT-NOW



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 315]
Notes: ● Asked of all respondents.

Aware of the Indiana Tobacco Quit Line: 1-800-QUIT-NOW
(CRH Service Area, 2021)



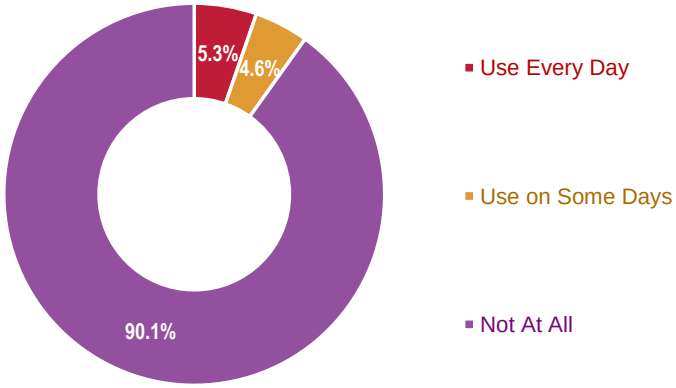
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 315]
Notes: • Asked of all respondents.

Other Tobacco Use

Use of Vaping Products

Most Columbus Regional Health Service Area adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.

Use of Vaping Products
(CRH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 54]
Notes: • Asked of all respondents.

However, 9.9% currently use vaping products either regularly (every day) or occasionally (on some days).

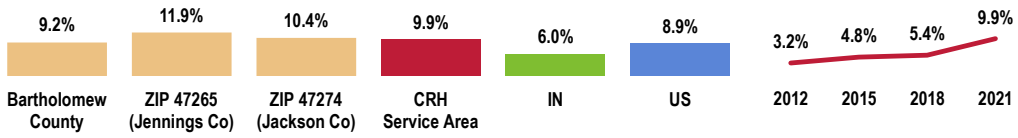
BENCHMARK ► Higher than was found statewide.

TREND ► Increasing significantly over time.

DISPARITY ► Higher among young adults and lower-income adults.

Currently Use Vaping Products
(Every Day or on Some Days)

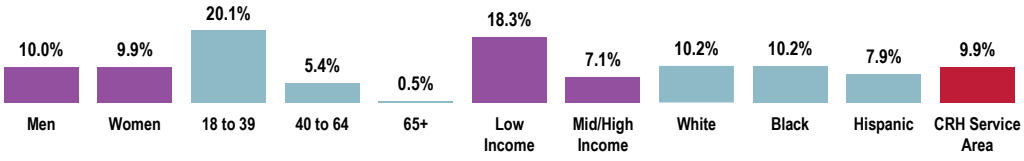
CRH Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 54]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.

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

Currently Use Vaping Products
(CRH Service Area, 2021)

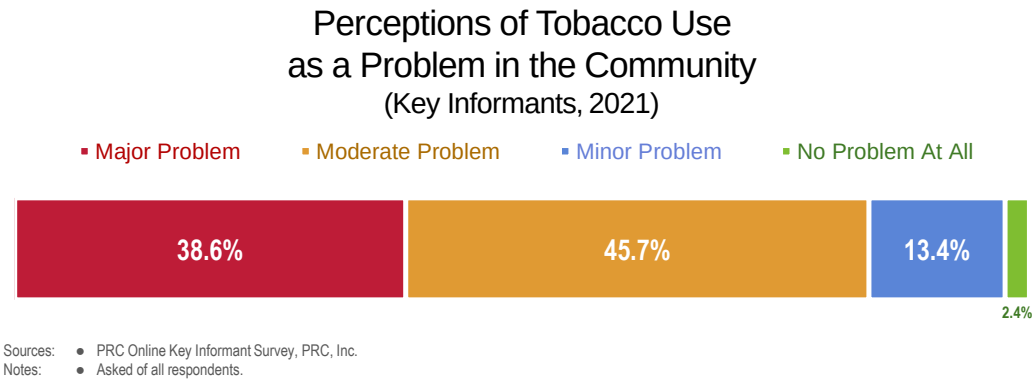


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 54]

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

Key Informant Input: Tobacco Use

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



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

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

Incidence/Prevalence

> Lots of people smoke. – Social Services Provider
>
> Too many people smoke! – Other Health Provider
>
> I see a lot of tobacco using pregnant women and parents. – Other Health Provider
>
> High smoking rates. – Physician
>
> Very high rate of adult smokers and cancer. – Other Health Provider
>
> The percentage of adults who smoke is above the national average and with the advent of vaping, the percentage of youth using tobacco products is increasing. – Community/Business Leader
>
> Any use of tobacco products is a major health problem. – Other Health Provider
>
> It is still everywhere. – Other Health Provider
>
> Tobacco is responsible for more deaths than any substance. It is a leading (or maybe the leading) cause of cancer, heart disease, stroke, and lung disease. Despite the fact that people cannot smoke in most public places, they continue to smoke at high rates. – Physician
>
> Too many people still smoke. – Community/Business Leader
>
> Daily interacting with individuals who smoke and their respiratory problems. – Social Services Provider
>
> Tobacco use, despite its declining popularity is still prevalent in our community, especially in the low-income groups that use this as a relief from their stress and discontent, the "factory workers" that use smoking as a means to stay awake during long manufacturing shifts, and the populations from other nationalities where smoking is still considered a social activity. – Other Health Provider
>
> Still too much smoking in our community. – Community/Business Leader
>
> I still see (and smell) many people smoking. I am particularly concerned when they are with or near places where children congregate, even outside. With so many families with young children concentrated on being outside until their children can be vaccinated against COVID-19, it's discouraging to see smokers still standing near enough that second-hand smoke may affect the children. – Community/Business Leader
>
> Specifically, I see a tremendous number of pregnant women who are smoking. This is extremely detrimental to fetal growth and development. The part that is concerning to me is that many women do not see this as a negative health threat towards their baby. – Other Health Provider
>
> Bartholomew County has higher rates of teens smoking, pregnant women smoking, etc. than the state and national averages. – Other Health Provider
>
> High rates of vaping among youth, high rates of smoking among pregnant women, and high rates within the general population. – Public Health Representative

Teen/Young Adult Usage

> Too many young people using and the vaping is considered "hip." – Social Services Provider
>
> Tobacco use and vaping are common in this area, especially with the younger ages. These lead to more health problems, such as respiratory issues. – Other Health Provider

> Data shows our young people are still major tobacco users. – Community/Business Leader
>
> I cannot understand how many young people are still smoking. We clearly know it actively causes cancer, yet our tobacco usage is still high. – Other Health Provider
>
> It starts at an early age and is the doorway to other substances. – Community/Business Leader
>
> Tobacco and nicotine (vaping) are major problems, especially among youth. They perceive vaping as not as dangerous, not realizing it is very addicting. – Community/Business Leader

Impact on Quality of Life

> The scope of the burden of disease and death that cigarette smoking and tobacco use imposes on the public's health is extensive. Cigarette smoking is a major public health problem, as well as secondhand smoke exposure, smoking of other combustible tobacco, chew, etc. – Community/Business Leader
>
> People continue to smoke, knowing it is a leading cause of cancer and it is highly addictive. – Public Health Representative
>
> Indiana has a high rate of tobacco users. Tobacco use has been linked to cancer, heart diseases, diabetes, etc. It is very costly to the state and insurance. – Other Health Provider
>
> Chronic use causes a myriad of health problems. – Community/Business Leader
>
> It continues to be a prime risk factor for multiple types of cancer as well as cardiovascular diseases. – Public Health Representative
>
> The long-term health effects of tobacco usage are widespread. The use of vaping has become popular as a way around tobacco, but only makes matters worse. – Public Health Representative

Environmental Tobacco Smoke

> Smokers do not respect the laws that no longer permits them to smoke in public areas, like local fairs, celebrations, etc. – Other Health Provider
>
> Tobacco is such a known-to-be-awful substance and yet people still smoke. People who smoke outdoors are not considerate of others in their vicinity and may become belligerent if reminded of the presence of "young lungs" or anyone who doesn't want to breathe the second-hand smoke. A walk downtown or by a number of the manufacturing plants in town will yield a view of several people on smoke breaks. – Community Member

E-Cigarettes

> I answered this question based on the extensive use of vaping devices by our youth. This is a huge problem of which we don't completely know the long-term health effects. While smoking and smokeless tobacco continue to be prevalent, it is the vaping that is most concerning to me. – Community/Business Leader
>
> Vape and smoking. – Community/Business Leader

Contributing Factors

> Easy access for younger, friends buying for younger age, lack of education on quitting. – Public Health Representative
>
> Obesity and smoking are now viewed as culturally acceptable lifestyles in certain demographics. Non-smokers have no lever to pull when attempting to support smoking cessation. It's part of sub-culture as much as it is an addiction. – Community/Business Leader

Social Norms/Community Attitude

> More socially acceptable than any other drug use. – Physician

Vulnerable Population

> High-risk population. – Other Health Provider

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

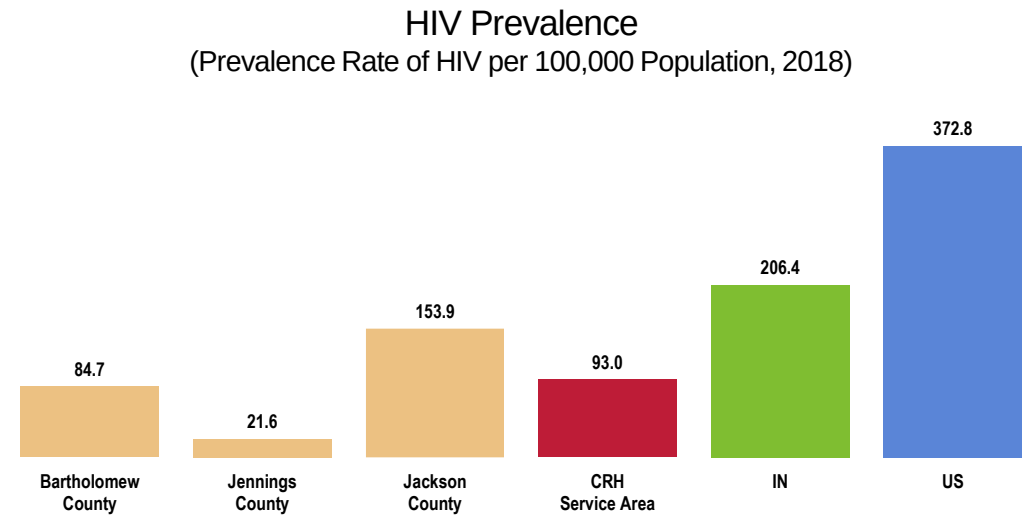
HIV

HIV Prevalence

In 2018, there was a prevalence of 93.0 HIV cases per 100,000 population in the Columbus Regional Health Service Area.

BENCHMARK ► Considerably lower than state and national rates.

DISPARITY ► Highest in Jackson County.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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.

Sexually Transmitted Infections (STIs)

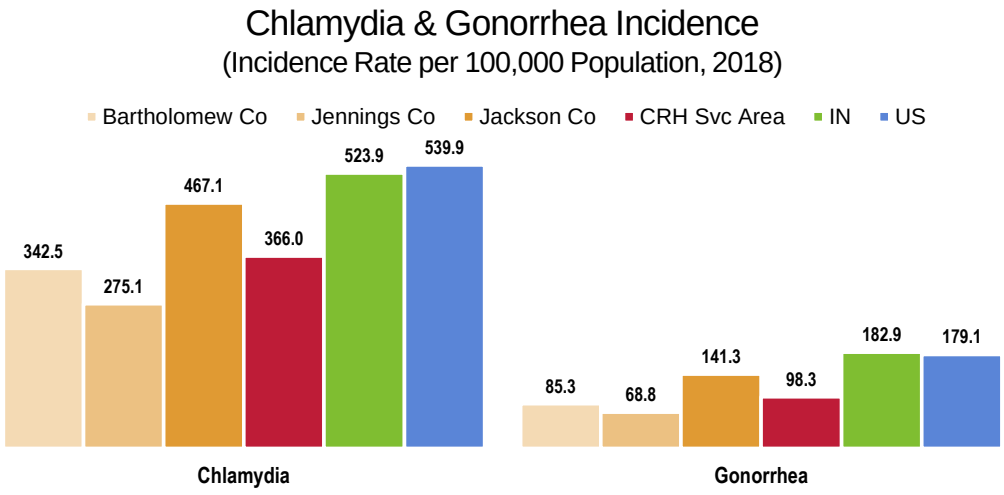
Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in the Columbus Regional Health Service Area was 366.0 cases per 100,000 population.

The Columbus Regional Health Service Area gonorrhea incidence rate in 2018 was 98.3 cases per 100,000 population.

BENCHMARK ► Both are considerably lower than corresponding state and US rates.

DISPARITY ► Both are highest in Jackson County.

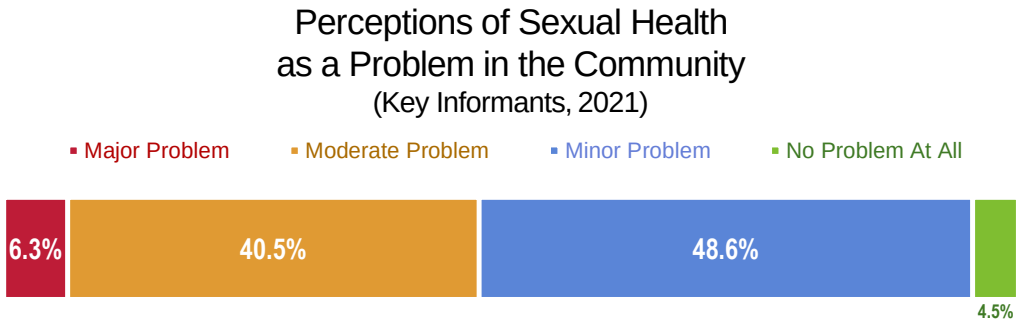


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

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: Sexual Health

A plurality of key informants taking part in an online survey characterized *Sexual Health* as a "minor problem" in the community.



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

Notes:
- Asked of all respondents.

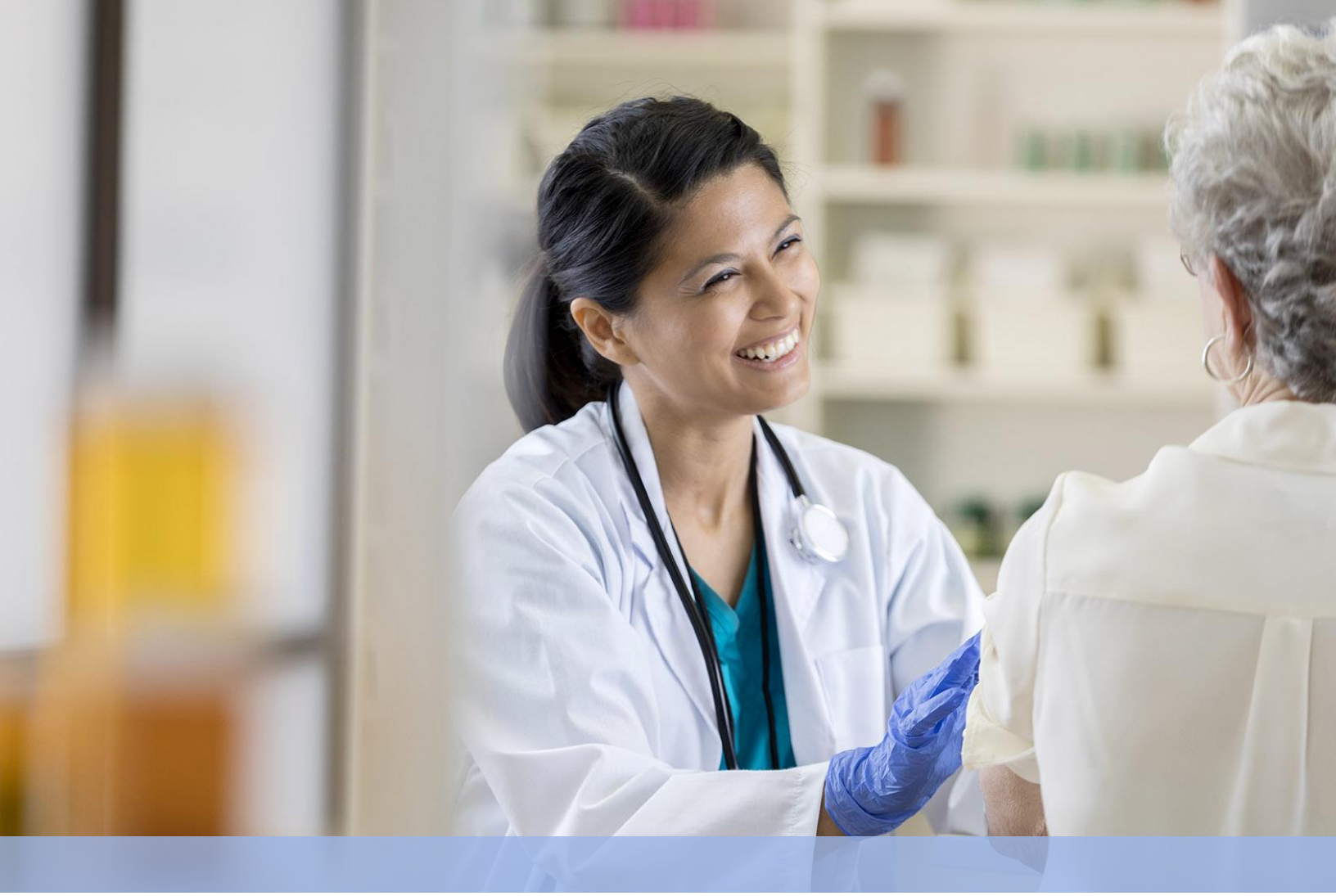
Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> The rate of STDs is increasing more and more in our area. I don't believe patients truly know what resources are available for such products as condoms. – Other Health Provider
>
> Cases of chlamydia and gonorrhea have increased every year in the last 11 years I have been working in public health. Most notably gonorrhea cases have increased so much. We have also had 4 different treatment changes in that time as well due to resistance. The age group most affected is in 15- to 25-year-olds. – Public Health Representative
>
> Increase in cases of gonorrhea and other STIs. – Public Health Representative

Awareness/Education

> It's not talked about openly, there are no clinics. Local student education is about abstinence and not realistic for today's teens. – Other Health Provider



ACCESS TO HEALTH CARE

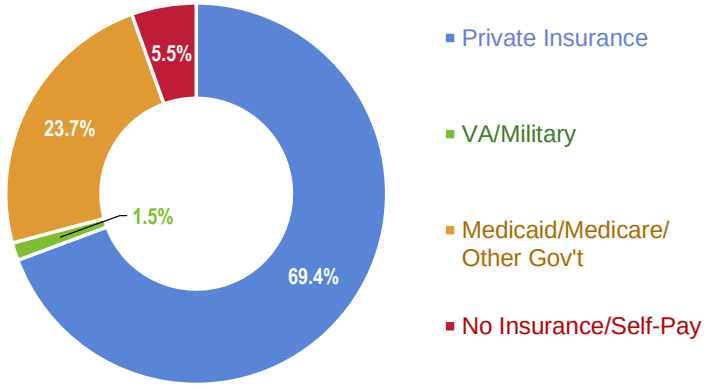
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 69.4% of Columbus Regional Health Service Area adults age 18 to 64 report having health care coverage through private insurance. Another 25.2% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage
(Adults Age 18-64; CRH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 169]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

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

Among adults age 18 to 64, 5.5% report having no insurance coverage for health care expenses.

BENCHMARK ► Better than state and national findings. Satisfies the Healthy People 2030 objective.

TREND ► Significantly lower (better) than baseline findings.

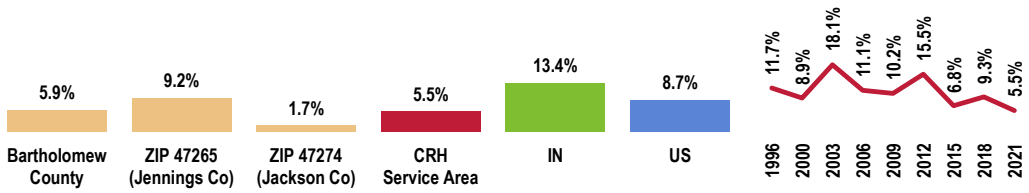
DISPARITY ► Favorably lower in Jackson County ZIP Code 47274. Lack of coverage was more often reported among lower-income households, and Hispanic respondents.

Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower

CRH Service Area



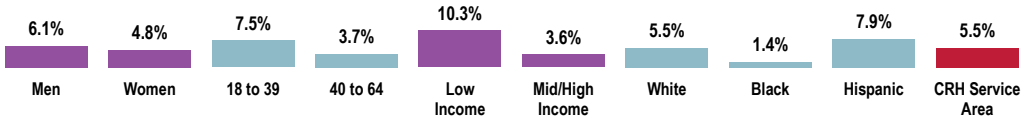
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 169]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; CRH Service Area, 2021)

Healthy People 2030 = 7.9% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 169]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

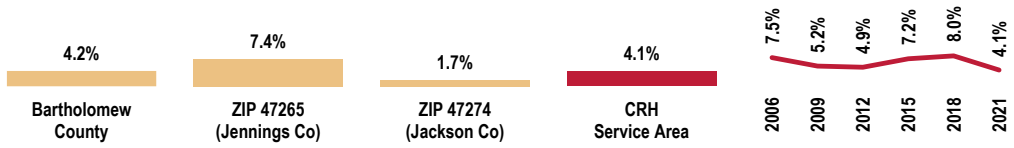
Insurance Instability

Among insured respondents in the service area, 4.1% experienced a time without healthcare coverage at some point in the past year.

TREND ► Favorably declining within the service area.

Went Without Healthcare Insurance Coverage in the Past Year
(Among Insured Adults ; CRH Service Area, 2021)

CRH Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 328]
Notes: ● Asked of all insured respondents.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Barriers to Health Care Access

Of the tested barriers, appointment availability impacted the greatest share of Columbus Regional Health Service Area adults.

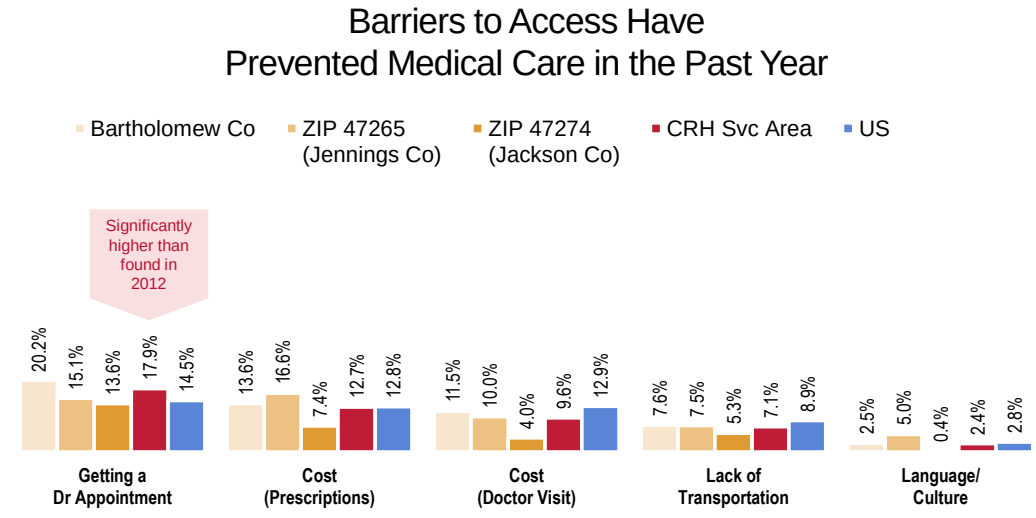
To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

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

BENCHMARK ► **Cost** (doctor visit) affects service area adults significantly less than it does adults across the US, as well as across the state (not shown).

TREND ► Mention of **appointment availability** as a barrier has increased significantly since 2012.

DISPARITY ► Mention of **cost** (doctor visit) was highest in Bartholomew County. **Cost** (prescriptions) and **language/culture** were favorably lower in Jackson County ZIP Code 47274.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 8-10, 13, 302]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Accessing Health Care for Children

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

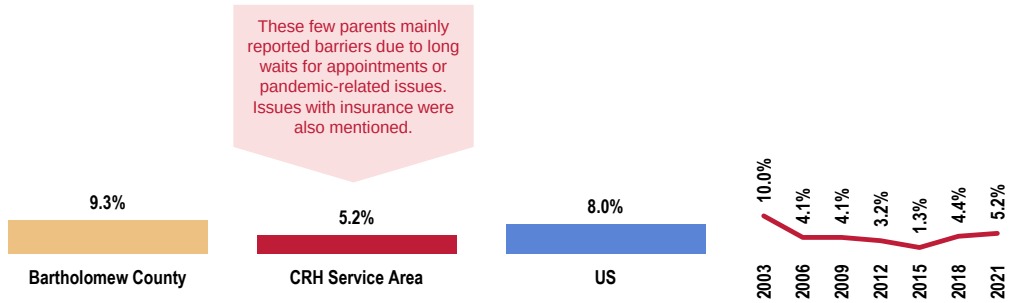
A total of 5.2% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

TREND ► Significantly lower than the 2003 benchmark.

DISPARITY ► Unfavorably higher in Bartholomew County.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

For this question, sample sizes in Jennings and Jackson counties were too small to provide independent results.



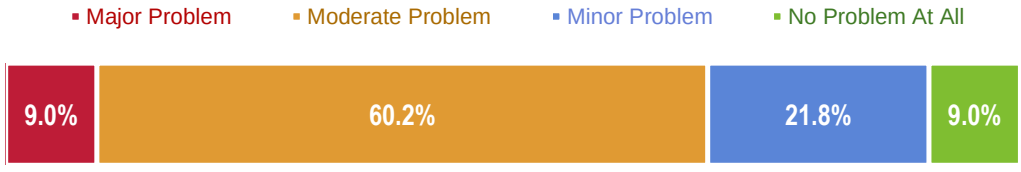
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 118-119]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants, 2021)



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

Notes:
- Asked of all respondents.

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

Contributing Factors

> Substance abuse. Mental health. Homeless. – Other Health Provider
>
> Health care access to those without health insurance and those who do not speak English is an issue. Also, the education to this community (uninsured and non-English speaking) about the resources that are available is lacking. – Other Health Provider
>
> Cost, transportation. – Public Health Representative
>
> Continue to link the health, education, human service and justice system work and employers. It is paying dividends to connect and build relationships among these stakeholders and others. – Community/Business Leader
>
> CRH monopoly of local healthcare system. Without competition there is complacency. It is difficult to obtain a primary care provider and certain specialists are non-existent. Our community deserves options. – Other Health Provider
>
> No health insurance for people who work at small businesses or nonprofits. Many of these people live slightly above the HIP threshold and pay ridiculous amounts for bare minimum health insurance. Our small nonprofit employs nurses, one who pays $600 a month for the ACA. It does not cover prescriptions well and she has to wean off meds that work simply because she cannot afford them. This affects her job performance as well as personal life. Older adults are not able to access healthcare because there is no door-to-door transportation. City buses and call a bus are only available for a limited time and do not go outside of city limits. Many older adults and disables people cannot drive. Medicabs are not handicap accessible. The Medicaid provider for transportation is notorious for not showing up, which is not an option when the patient is on dialysis. Dialysis patients also have to attend their appointments early or late in the day, which takes city transit out of the equation. – Community/Business Leader
>
> Gender affirming care. Religion. – Community/Business Leader
>
> Transportation (someone with a car and outside of the bus line cannot get there yet they have valet service?) and lack of health insurance. At a national level the industry is not designed with the patient as the central focus. Billing is entirely based on the coverage (or lack thereof) of the patient. Have you ever asked a doctor's or dentist's office what a procedure is going to cost? They will not tell you until they have looked it up with your insurance. – Social Services Provider

Access to Care/Services

> Not nearly enough primary care physicians that are taking new patients. First available appointment dates are months away. Not enough physicians, too many mid-level providers (nurse practitioners, PAs). – Other Health Provider
>
> I believe the system is stretched. We hear people saying they can't get in with a doctor's office because they are not able to accept more patients. I realize some of this is a shortage of medical providers. – Social Services Provider
>
> The CRH processes and systems are too slow and not as responsive to patients. Immediate needs. Example, your told you need an ultrasound and doctor’s office schedules it … 4 days later, results come back ... 2 days later and My Chart communication says you to schedule an abdominal scan … you call the scheduler and 4 days later they call you back and schedule a scan 7 days later. 17 days later you have our scan and receive the results 2 days later; so 19 days. The system has no sense of urgency; people are just following the CRH process and when you raise questions it is obvious the doctors, nurse practitioners, nurses and staff are not capable of changing the process. At the Mayo Clinic the above process would take 1–2 days not 19. – Community/Business Leader

Cost of Care

> Lack of universal health care coverage is still a major problem to access. Even though the American Affordable Care Act (aka "Obamacare") was supposed to make sure every American has coverage, I know of people who cannot afford insurance on the marketplace. Even though employers may offer coverage, the rising costs are often passed on to the employee who may not be able to afford the premiums, let alone co-pays, etc. – Community/Business Leader

Politics

> Obviously, this is a national, rather than regional or local issue to be solved. Until people who vote against their economic self-interest, to include healthcare, have a change of heart, there is not much to look forward to in terms of solving the bigger-picture issues. To that end, we as a community will continue having to address the worst holes in the social safety net with programs like VIM Care—a great program, but a small bandage in the larger scheme. – Other Health Provider

Language Barriers

> To provide Spanish services. – Community/Business Leader

> Inequities in access to healthcare due to language, cultural barriers. – Public Health Representative

Misinformation

> Misinformation contributes to our health issues locally. We have to combat the misinformation collectively as a community in order to be able to effectively reach people. – Community/Business Leader

Diagnosis/Treatment

> Individuals not seeking medical assistance. – Social Services Provider

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

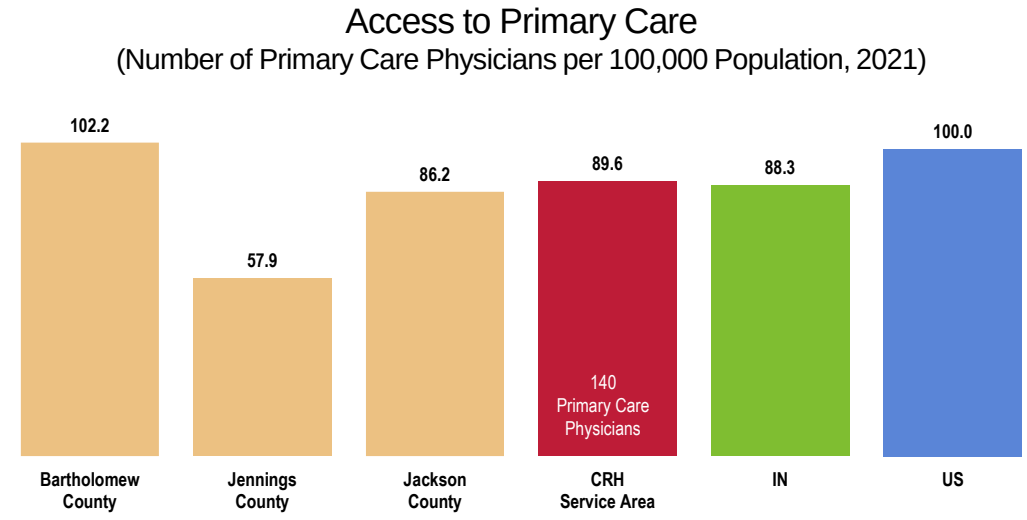
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

In 2021, there were 140 primary care physicians in the Columbus Regional Health Service Area, translating to a rate of 89.6 primary care physicians per 100,000 population.

DISPARITY ► Particularly low in Jennings County.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.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.

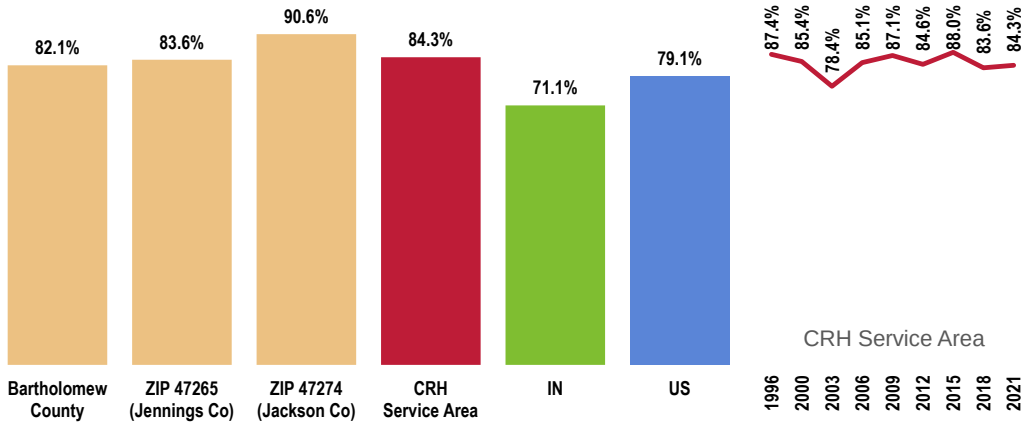
Regular Place for Medical Care

More than 8 in 10 service area adults (84.3%) have a particular place they usually go to if they are sick or need advice about their health.

BENCHMARK ► Better than the statewide and national percentages.

DISPARITY ► Favorably highest in Jackson County ZIP Code 47274. Those less likely to have a regular place for care include men and Hispanic residents.

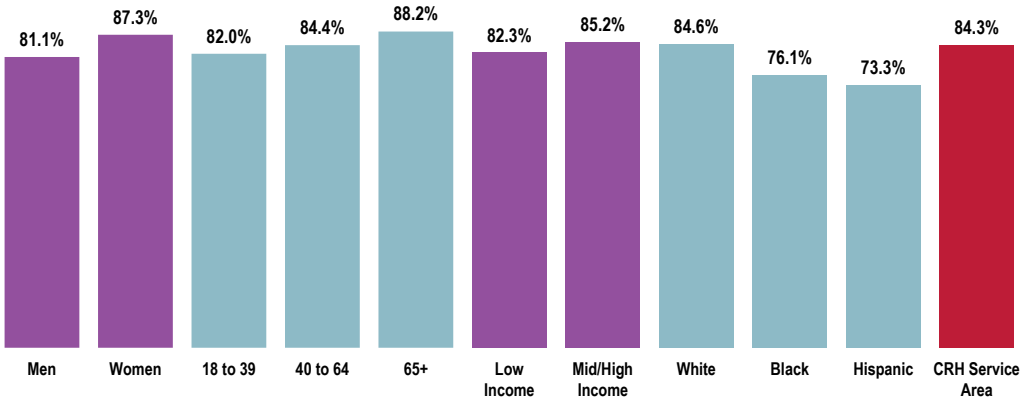
Have a Regular Place to Go for Medical Care



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Have a Regular Place to Go for Medical Care
(CRH Service Area, 2021)



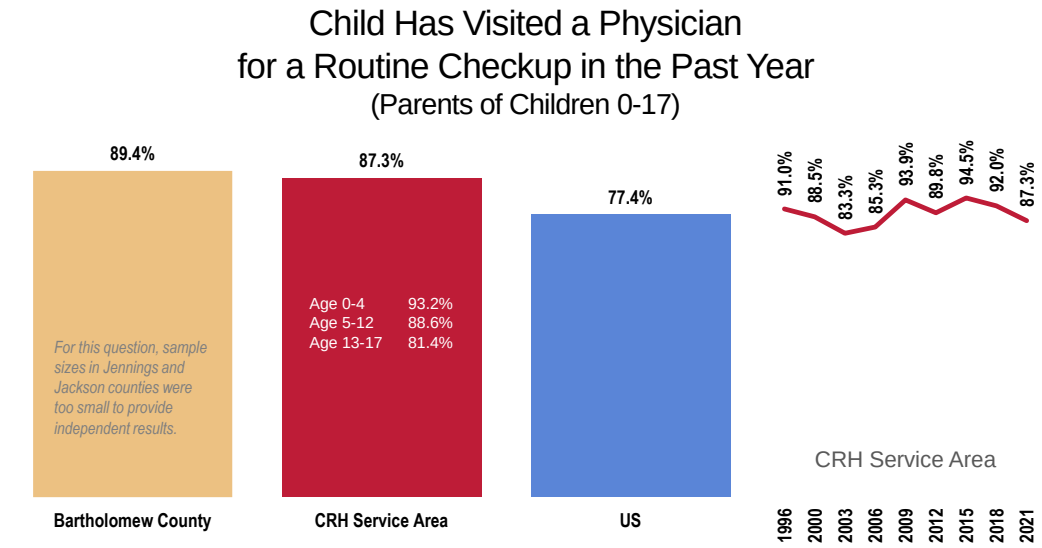
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 16]

Notes:
- Asked of all respondents.

Children's Routine Care

Among surveyed parents, 87.3% report that their child has had a routine checkup in the past year.

BENCHMARK ► Better than the US finding.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

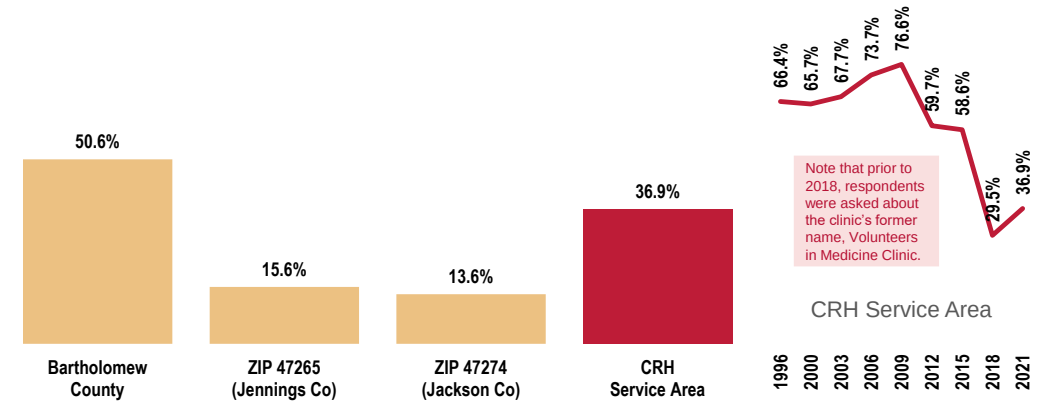
Awareness of VIMCare Clinic

Just over one in three (36.9%) survey respondents are aware of the VIMCare Clinic at Columbus Regional Hospital.

TREND ► Awareness is lowest in ZIPs 47265 and 47274. Reported less often among men and Hispanic residents.

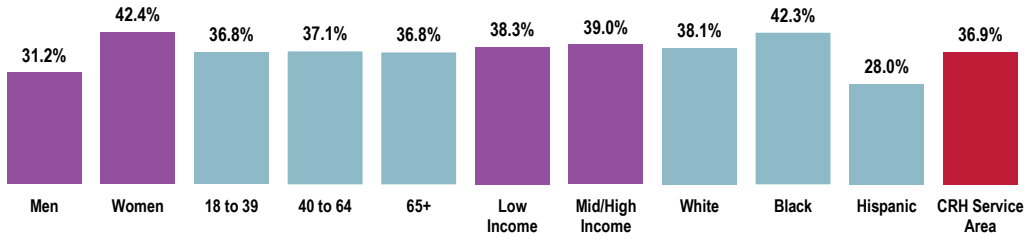
DISPARITY ► Awareness of the clinic has decreased considerably among service area residents (note that prior to 2018, respondents were asked about the clinic's former name, Volunteers in Medicine Clinic).

Aware of the VIMCare Clinic at Columbus Regional Hospital



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 346]
Notes: ● Asked of all respondents.
● Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Aware of the VIMCare Clinic at Columbus Regional Hospital
(CRH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 346]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

Adults

A total of 63.6% of Columbus Regional Health Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

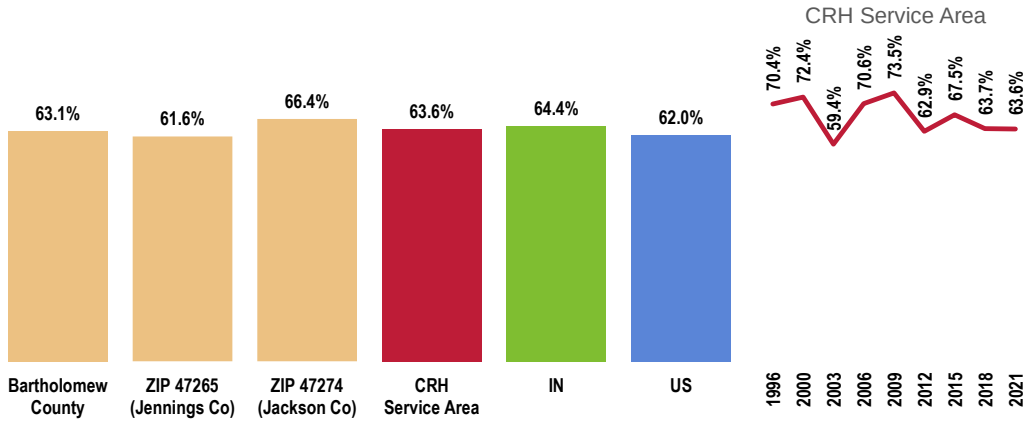
BENCHMARK ► Satisfies the Healthy People 2030 objective.

TREND ► Denotes a significant decrease from 1996.

DISPARITY ► Those less likely to receive dental care include lower-income households and Black residents.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



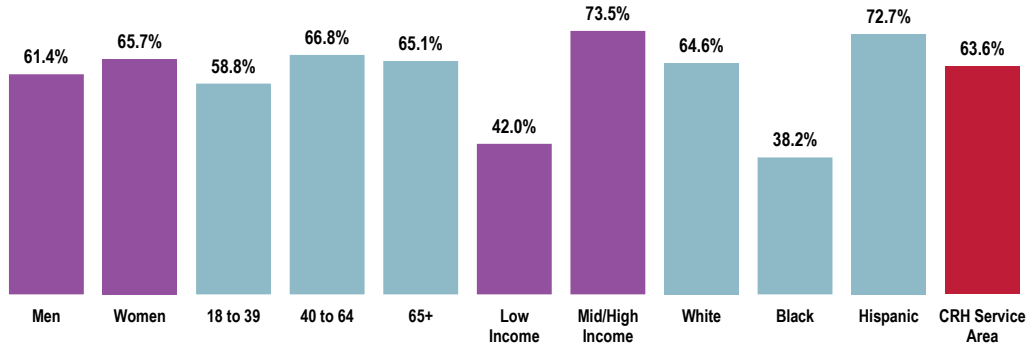
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Indiana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

Have Visited a Dentist or Dental Clinic Within the Past Year

(CRH Service Area, 2021)

Healthy People 2030 = 45.0% or Higher



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Children

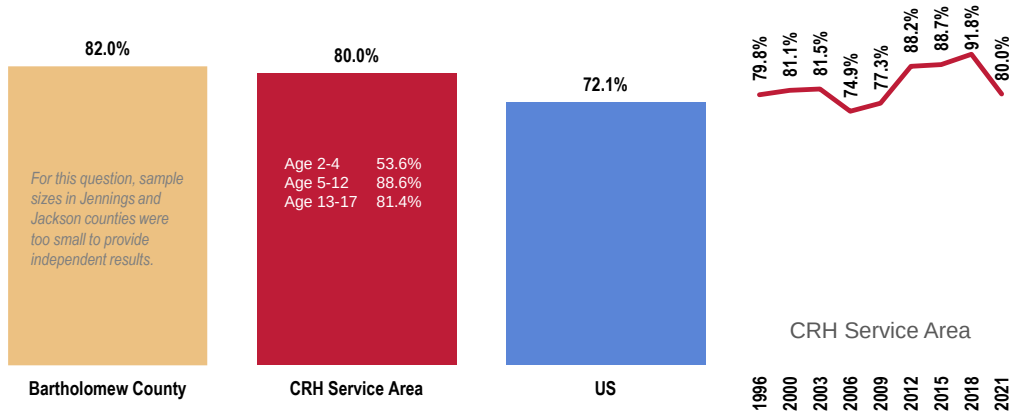
A total of 80.0% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Better than the national finding. Satisfies the Healthy People 2030 objective.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Parents of Children Age 2-17)

Healthy People 2030 = 45.0% or Higher

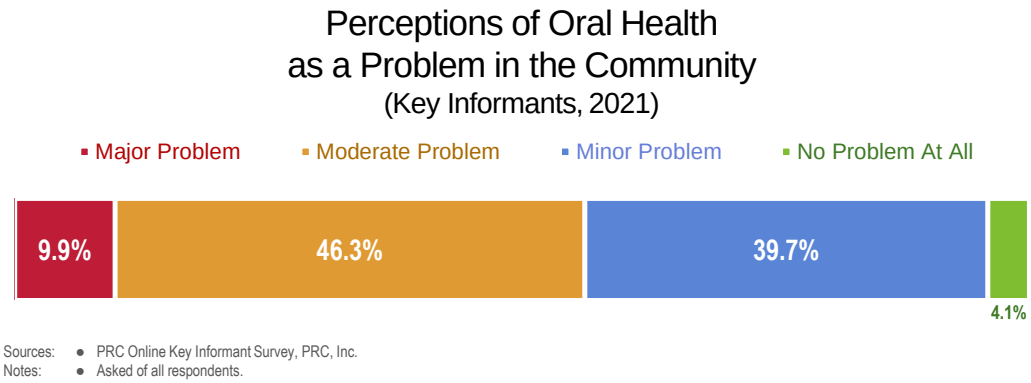


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 2 through 17.
- Beginning in 2012, note the addition of survey data from ZIP codes 47265 and 47274 to service area results.

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.

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

Access to Care for Uninsured/Underinsured

> There are limited resources for uninsured or under insured. – Other Health Provider
>
> I discuss oral health with my patients, and I am surprised by the number of people, including young adults, who are missing teeth or who have broken or painful teeth. They are unable to have these issues addressed due to the cost and not having insurance coverage. These issues lead to them choosing poor food choices and declining health in the elderly. – Social Services Provider
>
> Many patients that don't have insurance or have limited insurance benefits are not able to see dentists for their oral health. Therefore, patients are becoming septic due to infections in their mouth and snowballing from that. – Other Health Provider

Contributing Factors

> Lack of dental coverage. Treated and priced as a luxury, soda consumption. – Community/Business Leader

Access for Medicare/Medicaid Patients

> There are 2 places in town that accept Medicaid for dental care. One of them is terrible – a client went in with severe periodontal disease and the dentist only used a waterpik. This is not standard care for this disease. Our agency takes people to Franklin for dental care and denture work. – Community/Business Leader

Diagnosis/Treatment

> I see more and more people without teeth. The low-income choices for dental services are ones that just pull teeth. No preventative anything. – Other Health Provider

Nutrition

> Increased intake of high sugar beverages. Lack of knowledge about early dental care in toddlers. – Physician

Affordable Care/Services

> People don't have access to affordable dentistry. – Other Health Provider

Appearance

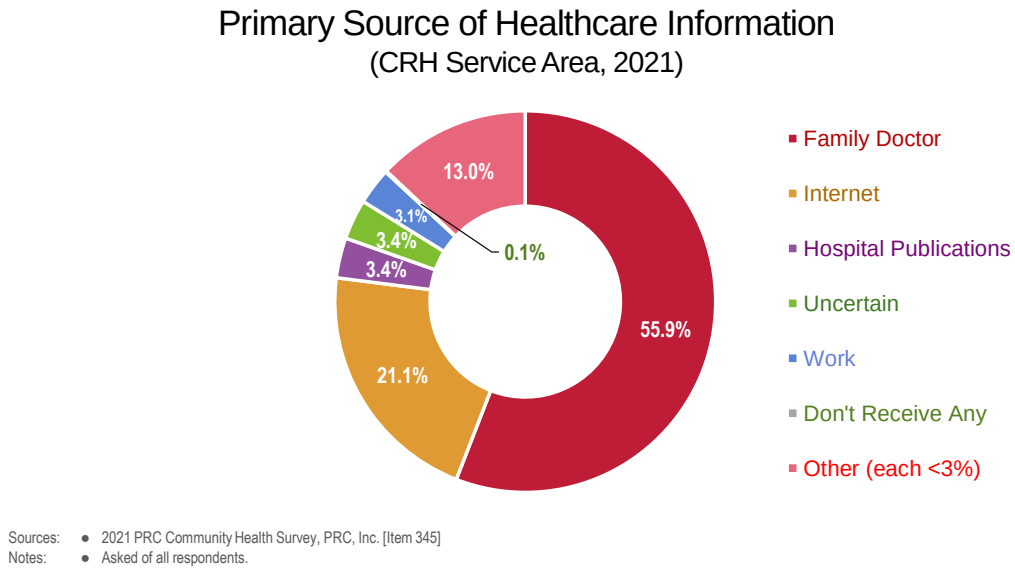
> Visual appearance. – Community/Business Leader

LOCAL RESOURCES

HEALTHCARE INFORMATION SOURCES

Family physicians and the internet are residents' primary sources of healthcare information.

- 55.9% of service area adults cited their **family physician** as their primary source of healthcare information.
- The **internet** received 21.1% of responses.
- Other sources include **hospital publications** and the **workplace**.

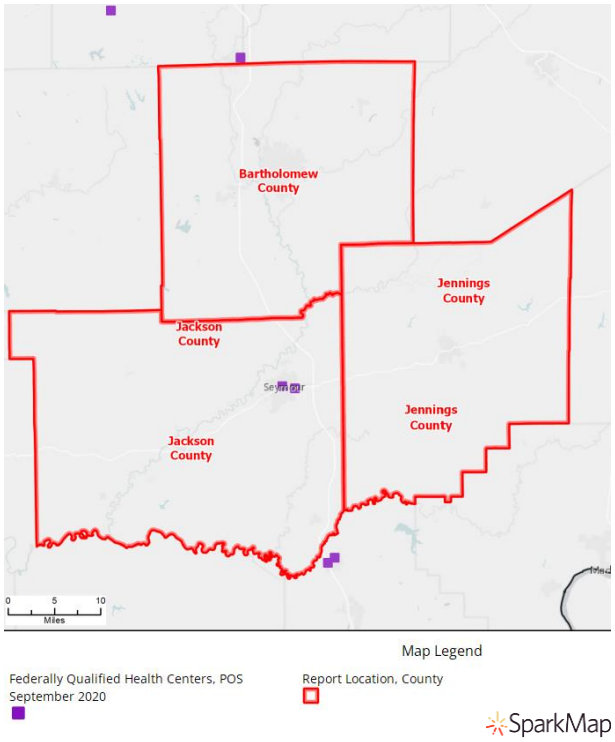


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 345]
Notes: ● Asked of all respondents.

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the Columbus Regional Health Service Area as of September 2020.



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 Health Care Services

- Alliance for Substance Abuse Progress
- Bus System
- Centerstone
- Clarify
- ColumBUS
- Columbus Regional Health
- Columbus Regional Health TASC
- Covering Kids and Families
- Cummins
- Doctor's Offices
- Healthy Communities
- Just Friends
- Turning Point
- United Way
- VIMCare
- Well Connect
- Windrose

Cancer

- American Cancer Society
- Columbus Regional Health
- Columbus Regional Health Cancer Center
- Doctor's Offices
- Healthy Communities
- Hospice of South Central Indiana

Coronavirus

- Bartholomew Consolidated School Corporation
- Bartholomew County COVID Task Force
- Bartholomew County Health Department
- Bartholomew Consolidated School Corporation
- Center for Disease Control and Prevention
- Chamber of Commerce
- City Council
- City Government
- City of Columbus
- City, County and State Officials
- Columbus Regional Health
- Contact Tracing
- County Health Organization
- COVID-19 Task Force
- CVS
- Doctor's Offices
- Employee Assistance Programs
- Facebook
- Family Service, Inc.
- Federal Government
- Governor Holcomb
- Health Department
- Healthcare Workers
- Hospitals
- IMPACT Team, Cancer Center
- Ivy Tech Community College
- Kroger
- Media
- Newspaper
- Northside Pediatrics
- Pharmacies
- Politicians
- Public Health Department
- Retailers
- School System
- Social Distancing
- St. Francis
- State Web Page
- Task Force
- United Way
- Vaccination and Testing Sites
- VIMCare
- Walgreens
- Wal-Mart
- Widespread COVID Messaging
- Windrose

Chronic Kidney Disease

- Columbus Regional Health
- Doctor's Offices

Dementia/Alzheimer's Disease

- AARP
- Alzheimer's Association

- ChoiceGuard of Columbus
- Columbus Regional Health
- Doctor's Offices
- Faith Based Organizations
- Just Friends
- Memory Care Facilities
- Mill Race Center
- Thrive Alliance

Diabetes

- 211
- Bartholomew County Extension Office
- Bartholomew County Health Department
- Claim Aide
- CMI Wellness
- Columbus Regional Health
- Columbus Regional Health Diabetes Educators
- Columbus Regional Health Endocrine Center
- Columbus Regional Health Wellness Program
- Copay Cards
- Cummins LiveWell Center
- Diabetes Association
- Diabetes Care Concept
- Diabetes Coaches
- Dining With Diabetes
- Doctor's Offices
- Employee Assistance Programs
- Extension Service
- Foundation for Youth Columbus
- Food Insecurity Coalition
- Food Pantries
- Health Department
- Healthy Communities
- Hospitals
- Insulin Pharmaceutical Companies
- Just Friends
- Love Chapel
- Lucina Kessler, CNS, Diabetes Expert
- Medication Assistance Program
- Nutrition Services
- Parks and Recreation
- Pharmacies
- Planet Fitness
- Purdue Extension
- SNAP
- Su Casa Columbus Community Health Workers
- Thrive Alliance
- Total Fitness
- Township Trustee
- VIMCare
- Williams Bros

Disabilities

- ASAP
- Columbus Housing Authority
- Columbus Regional Health
- Doctor's Offices
- Indiana Family and Social Services Administration
- Pain Clinics
- Palliative Care and Hospice
- Physical Therapy
- Social Security Office
- SSA
- Thrive Alliance
- Trustee
- VIMCare
- Wellspring

Infant Health and Family Planning

- All Options Pregnancy Center
- Bartholomew County Health Department
- Clarity
- Columbus Regional Health
- Columbus Regional Health Birthing Center
- Columbus Regional Health Women's and Children's Services
- Doctor's Offices
- Family Nursing Partnerships
- Family Service, Inc.
- Health Department
- Healthy Communities
- Healthy Families
- Infant Mortality Prevention Action Team
- Lactation
- Our Whole Lives Sex Ed
- Planned Parenthood
- Public Health Department
- Route 21
- Su Casa Columbus Community Health Workers
- United Way
- WIC

Heart Disease

- 4H Extension Educator
- American Heart Association
- Bartholomew Consolidated School Corporation
- Cardiac Rehab
- Columbus Regional Health
- Columbus Regional Health Cardiac Care
- Doctor's Offices

- Employee Assistance Programs
- Foundation for Youth Columbus
- Fitness Centers/Gyms
- Healthy Communities
- Hospitals
- Local Resources to Manage Acute Care Needs
- Love Chapel
- Mill Race Center
- Nutrition Services
- Parks and Recreation
- Public Health Department
- Purdue Extension
- Restaurants
- South Indiana Heart and Vascular
- VIMCare
- Volunteers in Medicine

Injury and Violence

- ASAP
- Bartholomew County Sheriff's Department
- CASA for Kids
- Columbus Police Department
- Columbus Regional Health
- Columbus Regional Health TASC
- Cornerstone
- Employee Assistance Programs
- Family Service, Inc.
- Human Service Organizations
- Turning Point

Mental Health

- Adult and Child Health
- Angie Nelson, Mental Health Therapist
- ASAP
- Balance Wellness
- Bartholomew County Community Corrections
- Bartholomew Consolidated School Corporation
- Centerstone
- Children Inc.
- Churches
- Columbus Behavioral Center
- Columbus Regional Health
- Columbus Regional Health Mental Health
- Columbus Regional Health Stress Center
- Columbus Regional Health TASC
- Community Church of Columbus
- Community Downtown
- Cornerstone
- Council for Youth Development
- Counseling Counts
- Counseling Services
- Cummins EAP
- Doctor's Offices
- Drug/Alcohol Treatment Centers
- Employee Assistance Programs
- Family Service, Inc.
- Healthy Families
- Hospitals
- IUPUC Mental Health Counseling Program
- LifeWorks
- Mental Health First Aid
- Mental Health Services
- Milestones Clinic
- Parochial Counseling Support
- Quinco Behavioral Systems
- Rau Family Medicine
- Safe Places
- Sandcrest
- Sandcrest Family Medicine
- St. Peter's
- Suicide Hotline
- Support Groups
- Thrive Alliance
- Turning Point
- United Way
- Valle Vista
- VIMCare

Nutrition, Physical Activity, and Weight

- Am I Hungry Program
- Bariatric Clinic
- Bartholomew Consolidated School Corporation
- Boys and Girls Clubs
- Churches
- Columbus Regional Health
- Columbus Regional Health Wellness Program
- Community Gardens
- Cummins
- Cummins LiveWell Center
- Doctor's Offices
- Employee Assistance Programs
- Farmer's Market
- Fee for Service Programs Independent
- Fitness Centers/Gyms
- Food Insecurity Coalition
- Food Pantries
- Food Stamps
- Foundation for Youth
- Grocery Stores
- Healthy Communities
- Heritage Fund

- Indiana Nutrition Group
- Insurance Programs
- Library
- Love Chapel
- Mill Race Center
- Nutrition Services
- Parks and Recreation
- Planet Fitness
- Purdue Extension
- School System
- Senior Citizen Center
- South Central Metabolic Research Center
- Sports Teams
- Total Fitness
- Weight Loss Institute of Columbus Regional Health
- Weight Watchers
- WIC

Oral Health

- 24/7 Dental
- Dentist's Offices
- Department of Family Resources
- Don't Know
- Health Department
- Retail Doctor of Dental Surgery Columbus
- VIMCare
- White River Dental

Respiratory Diseases

- Better Breathers Club
- Columbus Regional Health
- Columbus Regional Health Lung Center
- Doctor's Offices
- Employee Assistance Programs
- Healthy Communities
- Indoor Smoking Ban
- Lung Institute
- Smoking Cessation Programs
- Tobacco Awareness Program
- Tobacco Quit Line
- VIMCare

Sexual Health

- Bartholomew County Health Department
- Clarity
- Columbus Regional Health
- Doctor's Offices
- Health Department
- Kroger
- Planned Parenthood

Substance Abuse

- AA/NA
- American Bikers Aimed Toward Education
- Alliance for Substance Abuse Progress
- Bartholomew County Drug Court
- Bartholomew County Jail
- Bartholomew County Sheriff's Department
- Bartholomew Consolidated School Corporation
- Brighter Days Transitional Housing Shelter
- Bus System
- Celebrate Recovery
- Centerstone
- Churches
- Columbus Police Department
- Columbus Regional Health
- Columbus Regional Health Mental Health
- Columbus Regional Health TASC
- Columbus Regional Health Treatment and Support Center
- Columbus Township Trustee
- Community Church of Columbus
- Community Corrections and Jail Treatment Programs
- Community Downtown
- County Jail System
- Court Services
- DARE Program
- Doctor's Offices
- Drug Court
- Drug/Alcohol Treatment Centers
- Faith Based Organizations
- Fresh Start Recovery
- Groups
- Groups Recover Together
- Health Department
- Healthy Communities
- Healthy Families
- LifeWorks
- Medicab
- Parks and Recreation
- Problem Solving Courts
- Recreational Therapy
- Recovery Enables a Life For Men
- Recovery Housing
- Residential Centers
- Sober Houses
- St. Peter's
- Tara Treatment Center Columbus
- Turning Point
- United Way
- Volunteers of America

- Women Recovering With a Purpose

Tobacco Use

- 1-800-QUIT-NOW
- American Heart Association
- American Lung Association
- Baby and Me Tobacco Free
- City and County No Smoking Ordinances
- Clarity
- Columbus Regional Health
- Columbus Regional Health Smoking Cessation
- Columbus Regional Health Wellness Program
- Communities That Care
- Cummins
- DARE Program
- Doctor's Offices
- Healthy Communities
- Mommy and Me Tobacco Free
- Prescription Drugs
- School System
- Smoking Cessation Programs
- Tobacco Awareness Program
- Tobacco Quit Line
- Tobacco Treatment Specialist Indiana
- VIMCare

APPENDIX

2020-2022 COMMUNITY HEALTH STRATEGY IMPLEMENTATION PLAN
(Based on 2018 Community Health Needs Assessment)

December 2021 Progress Report
(Progress & updates on each goal are noted in red below.)

Introduction

Columbus Regional Hospital (CRH) is a community health system located in Columbus, Indiana whose mission is to improve the health and well-being of the people we serve and whose vision is to be, for all those we serve, their health and wellness partner for life.

For over 20 years, CRH has conducted Community Health Needs Assessments periodically to guide its community health promotion activities. CRH's CHNA studies--conducted in 1996, 2000, 2003, 2006, 2009, 2012, 2015, and 2018 – employ a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the primary service area of Columbus Regional Hospital. This information is used to inform and determine CRH's CHNA Implementation Strategies.

CRH addresses community health needs primarily through its Healthy Communities Initiative (HCI) organization. Healthy Communities' mission is to achieve radical improvement in our community members' long-term quality of life through local action. HCI accomplishes this by collaborating with a diverse network of partners to develop and respond to data-driven community health priorities.

HCI deploys Action Teams, comprised of paid staff and community volunteers, to address the most urgent community health issues. Healthy Communities' Action Teams address community health issues in three general priority areas: Access to Health Care for All; Promoting Healthy Lifestyles; and Promoting Healthy Relationships. Most HCI Action Teams are standing committees, but from time-to- time, when new community health priorities arise and are identified by the CHNA, new Action Teams are deployed. Specific activities of the Action Teams are informed by a combination of the CHNA results and a Key Informant Survey and are prioritized by the Healthy Communities Council, a community collaborative comprised of health, civic, business, faith, social service, education, and other leaders from across the community.

CHNA Methodology

CRH's CHNA incorporates data from both quantitative and qualitative sources. Quantitative data input

Includes primary research (a 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.

Survey

Survey Instrument

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

Community as Defined for This Assessment

The study area for the survey effort (referred to as the "Columbus Regional Hospital Service Area" or "CRH Service Area" in this report) includes each of the residential ZIP Codes primarily associated with Bartholomew County, Indiana, as well as ZIP Codes 47274 in Jackson County and 47265 in Jennings County.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Columbus Regional Hospital; 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, 104 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

Key Informant Type	Number Invited	Number Participating
Community/Business Leaders	124	77
Other Health	82	52
Physicians	18	13
Public Health	42	28
Social Services	19	11

Information Gaps

While CRH's CHNA 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, the CHNA assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

2020-2022 Implementation Plan

Among 14 “Areas of Opportunity” identified by the 2018 CHNA results, wherein local results differed significantly from state and/or national benchmarks, CRH has prioritized 13 areas of opportunity for the 2020-2022 period. The area not addressed in the implementation strategy, Sexually Transmitted Diseases, is being addressed by the Bartholomew County Health Department.

Thirteen (13) “Areas of Opportunity”

1. **Access to Healthcare Services** (primary care)
2. **Cancer** (deaths, incidence, screenings)
3. **Tobacco Use** (cigarette smoking & smokeless tobacco use prevalence)

4 & 5. **Diabetes & Kidney Disease** (prevalence, kidney disease deaths)

6 & 7. **Heart Disease & Stroke** (stroke deaths, high blood pressure prevalence, overall CV risk)

8. **Injury & Violence** (unintentional injury deaths, bike helmet usage, firearm deaths, firearm prevalence in homes with children)
9. **Nutrition, Physical Activity & Weight**
10. **Respiratory Diseases** (CLRD, COPD & Asthma prevalence)

11 & 12. **Substance Abuse** (disease- and drug-induced deaths) & Mental Health (depression prevalence, suicide deaths)

13. **Infant Mortality**

CHNA Implementation Plan Approach

Recognizing that population health outcomes are inter-related and that efforts to improve outcomes in one area also have the potential to improve outcomes in another, our 2020-2022 CHNA Strategy combines and attacks the 13 Areas of Opportunity into Four Priority Strategies:

FOUR PRIORITY STRATEGIES:

1. Increase Access to Primary Care
2. Prevent Disease & Injury
3. Reduce Substance Abuse
4. Reduce Infant Mortality

The goals for each Area of Opportunity are outlined in the following 2020-2022 Strategy.

PRIORITY STRATEGY I: INCREASE ACCESS TO PRIMARY CARE

Opportunity 1: Primary Care Access

Goal 1: Increase access to primary health care.

a) Increase number of Medicaid and uninsured patients using VIMCare Clinic as their medical home.

2020 unique patients: 1240
2021 unique patients: 1400

b) Increase net number of primary care physicians in CRH primary and secondary service areas by 22.

2020 net new primary care providers:
2021 net new primary care providers:
2022 recruitment target:

c) Continue support for combined Medication Assistance Program (community and VIMCare Clinic patients) at VIMCare.

2020 funding for MAP: $100K
2021 funding for MAP: $105K
2022 funding for MAP: $110K

d) Evaluate options for community-based primary dental care services. Suspended due to Covid.

e) Continue support for United Way's Premium Link HIP 2.0 and marketplace health insurance subsidy program for low-income people in Bartholomew County.

2020 funding for PremiumLink: $125K
2021 funding for PremiumLink: $135K
2022 funding for PremiumLink: $140K

f) Continue support for health insurance navigators in the community.

Funded training for 2 navigators in 2020-2021.

g) Develop and implement a community-wide Medicaid enrollment and retention strategy to respond to new work requirement/Gateway to Work .

No longer applicable. Federal court enjoined implementation of Indiana's Medicaid work requirement.

PRIORITY STRATEGY II: PREVENT DISEASE & INJURY

Opportunities 2 & 3: Cancer and Tobacco Use

Goal 1: Increase local cancer treatment options to lower cancer deaths.

a) Expand access to local oncology providers and state-of-the-art treatments.

Purchased second Linear Accelerator.
Recruited 1 oncology MD & 1 NP in 2020-2021.
Increased number of unique patients served, especially from outside Bartholomew County.

Goal 2: Increase screening for skin and lung cancer.

Suspended in 2020-2021 due to Covid.
No screening events scheduled for 2022 due to Covid.

Goal 3: Accelerate tobacco & e-cigarette control efforts to prevent youth initiation.

a) Lead and re-invigorate efforts to prevent youth initiation. In 2021, Healthy Communities hired a youth tobacco coordinator to lead efforts from Foundation for Youth and in local school systems.

b) Continue High School Heroes program at local high schools. In school tobacco education efforts were suspended in 2020-2021. Due to be re-started in 2022.

d) Lead advocacy and education efforts to lower e cigarette initiation. In 2021, Healthy Communities began providing tobacco and vaping education to students as alternative to suspension resulting from violations of school tobacco and vaping policies. This will continue in 2022.

Goal 4: Increase referrals to Indiana Quitline.

1. Leverage EHR across CRH Physician practices. Paused in 2020 due to Covid. In 2021, CRH and CRHP adopted the Epic electronic health record (EHR) system Social Determinants of Health (SDOH) module to begin tracking barriers to smoking cessation among CRHP patients. In 2022, training will begin in CRHP practices to utilize Epic to increase referrals to Indiana Quitline.
2. Coordinate efforts with inSpire network tobacco quality goals. CRHP tobacco population health metrics and goals are aligned with inSpire.

Goal 5: Increase adult participation in tobacco cessation courses.

a) Fully implement US Public Health Service clinical practice guidelines for treating Tobacco Use and Dependence at VIMCare Clinic. Suspended due to Covid.

b) Expand adoption of tobacco USPHS clinical practices inSPIRE practices. Suspended due to Covid.

Opportunities 4 & 5: Diabetes & Kidney Disease

Goal 1: Increase prevention behaviors in persons who are at high risk for diabetes or have been diagnosed with pre-diabetes.

1. In 2020, evaluate regional adoption of Blue Zones. Suspended due to Covid.
2. In 2021-2022, begin implementation of Blue Zones. Suspended due to Covid.

Goal 2: Promote adoption of healthy lifestyle behaviors through efforts that make the healthy choice the easy choice in the workplace, at home, and throughout the community.

a) Adopt and implement policies and practices at CRH that promote healthy eating and beverage consumption among employees and visitors. Expansion of current policies and practices suspended due to Covid. Healthy Communities Nutrition Team lead provided “Am I Hungry” virtual workshops to CRH employees in 2021.

b) Continue Healthy Lifestyles Action Team leadership in creating a pedestrian and bicycle friendly built environment throughout Bartholomew County. Healthy Communities Active Transportation Team lead participated on city of Columbus’s planning to update its Bicycle/Pedestrian Plan. New plan to be presented for approval to Plan Commission & City Council in 2022.

Opportunities 6 & 7: Heart Disease & Stroke

Goal 1: Increase prevention behaviors in persons who are at high risk for heart disease or stroke.

a) See Diabetes Goal 1 initiatives.

b) Conduct Cardiovascular and Stroke screening events in community. No screening events were conducted in 2020-2021 due to Covid. Virtual Heart Health Risk Assessments were promoted with 145 community members participating in 2020 and 245 participants in 2021. Virtual Heart HRAs will continue to be promoted in 2022.

Goal 2: Promote adoption of healthy lifestyle behaviors through efforts that make the healthy choice the easy choice in the workplace, at home, and throughout the community.

a) See efforts for Diabetes.

b) Add a Cardiovascular physician to the Healthy Communities Council. Paused due to Covid.

Opportunity 8: Injury & Violence

Goal 1: Eliminate Shaken Baby Syndrome (unintentional infant injury and deaths to infants resulting from caregivers shaking them.)

a) Continue Crying Education to all delivering at the CRH Birthing Center. CRH Birthing Center-based crying and shaken baby prevention education of parents delivering at CRH transferred from an external educator to the OB unit nurses in 2020-2021 due to Covid. Will continue this practice into 2022.

b) Continue providing Period of Purple Crying (to prevent injury due to shaking) DVD's to all who give birth at CRH Birthing Center. Discontinued DVDs in 2020 due to technology preference changes. Booklet distributed to every mom in Prepare visits, at delivery, and in the Daddy 101 classes. Booklet has QR code for easy linking to video and information on mobile devices.

c) Continue cooperative efforts with Family Services in support of home visits to new moms in Bartholomew County. In 2020-2022, due to Covid, home visits were suspended. Instead, Healthy Communities provided support of $20K annually to Family Services to conduct virtual post-partum depression support groups.

Goal 2: Increase understanding of safe biking practices.

- Support safety initiatives of the Columbus Bike Co-op.

2020 support for Co-Op: $8250
2021 support for Co-Op: $5000
2022 support for Co-Op: $5000

Goal 3: Make Bartholomew County safer for pedestrians and bicyclists.

a) CRH HCI staff serves on City of Columbus Bike & Infrastructure Team & CAMPO Citizens Advisory Team. Yes. 2020-2022

b) CRH HCI staff serves on Bartholomew County Safe Routes to Schools Task Force. Task force suspended in 2020-2021 but Healthy Communities will continue to staff the Task Force once it has re-started.

- CRH leadership serves on Columbus Planning Commission Yes. 2020-2022
- CRH leadership serves on Columbus Park Board. Yes. 2020-2022

Opportunity 9: Nutrition, Physical Activity & Weight

Goal 1: Increase access to and consumption of plant-based foods throughout the community.

a) Support efforts of Bartholomew County Hunger Coalition. Coalition mapped food deserts by census tract but then paused its work in 2020-2021. Will reinitiate work to enroll more local Hoosiers in SNAP program in 2022 through a partnership with Parks Department and its Farmers Market.

b) Implement Blue Zones strategy. Suspended due to Covid.

c) Partner with Purdue Extension Service Local Food efforts. Many activities were suspended due to Covid but Healthy Communities Nutrition Team continues to partner on their efforts.

d) See Diabetes, Heart Disease, and Stroke priority area efforts above.

Goal 2: Increase initiation and duration of breastfeeding.

a) Continue Nurse & Chat program. Suspended in 2020, Reinstated virtually in 2021. Will continue to support the program by supporting lactation consultant to facilitate communication and engagement.

b) Educate moms on safe milk storage. Suspended in 2020, Reinstated virtually in 2021. Will continue to support lactation consultant to facilitate this education and milk bank support.

c) Provide Lactation Station at county fairs. Suspended in 2020. Reinstated in a Covid-safe way in 2021.

d) Sustain and expand access to Nurse Family Partnership services. Fully funded a full-time NFP nurse to serve Bartholomew County and intentionally integrate her work with the other Healthy Communities priorities.

Goal 3: Increase use of bicycling and walking for recreation and routine transportation.

1. See efforts above in Injury & Violence.
2. Implement Blue Zones strategy in CRH service region. Suspended due to Covid.

Opportunity 10: Respiratory Diseases

Goal 1: Decrease prevalence and deaths related to CLRD, COPD, and asthma.

a) Increase pulmonary provider access. Zero net new pulmonology providers 2020-2021. In 2022, aiming to recruit 1-2 APPs and potentially 1 new MD.

b) Conduct screenings in 2020-2022. Promoted $25 lung screens but suspended screening events due to Covid.

c) See Cancer & Tobacco Use goals and strategies.

PRIORITY STRATEGY III: REDUCE SUBSTANCE ABUSE

Opportunities 11 & 12: Substance Use Disorder & Mental Health

Goal 1: Reduce suicide rate.

a) Promote universal screening for depression and suicide risk throughout the CRH health system. Suspended due to Covid.

b) Promote standard protocols in the health, school, and criminal justice systems for handling those at risk for suicide. Suspended due to Covid.

c) Support Counseling Counts efforts at local school corporations. Continued to support virtually.

Goal 2: Increase local access to treatment for substance use disorder (SUD).

1. Expand CRH Medication-Assisted treatment to 11 counties. Expanded to 6 counties by end of 2021.
2. Increase local access to medically-managed detox services. Suspended in 2020-2021 due to Covid. Reevaluating options in 2022.
3. Integrate CRH's Treatment and Support Center (TASC) with all local treatment providers. TASC staff attend drug court and meet routinely with ASAP Hub staff to coordinate care for mutual clients and to create seamless referral pathways into treatment and recovery support services.
4. Create care continuum TASC with ASAP Hub and community corrections treatment services. See #3 above.

5. Develop and implement SUD services for local employers. In 2021, finalized MOUs with three (3) local employers to employ, provide transportation and at-work supports for participants in the ASAP Sober Living houses who are their employees.
6. Pilot adolescent telehealth SUD with Riley Children's Hospital. Suspended due to Covid.

Goal 3: Decrease stigma to increase help-seeking behaviors.

a) Lead and support ASAP Prevention Team efforts. New school curricula implemented. Harm reduction interventions implemented (widespread Narcan distribution). 10 new recovery mutual support groups implemented in the community. Peer recovery coaches being trained. Education and empowerment efforts with youth being led by Council for Youth Development. Although not a Prevention Team effort, CRH will conduct evidence-based NASCEND stigma reduction training for 117 CRH staff members in Q1 2022 (planned for 2021 but paused due to Covid.)

PRIORITY STRATEGY IV: REDUCE INFANT MORTALITY

Opportunity 13: Infant Mortality

Goal 1: Implement Infant Mortality work plan toward achieving the targets below.

Indicator	Baseline	2019 Actual	2020 Target	2020 Actual	2020 Actual	2020 Actual	2021 Target	2021 YTD (Through Q 3)	2021 YTD	2022 Target
Source		Barth. Cty (IDOH)*		NFP	CRH BC	Barth. Cty (IDOH)		NFP	CRH BC	
Infant Mortality Deaths	11	11***	7	NA			6	NA		5
Maternal Smoking rates	-20%	15.2%	15%	0%			12%	0%**		10%
% First prenatal visit < 12 wks	80%	80%	85%	92%			87%	10% (9 of 10)		90%
Breastfeeding Initiation		79.8%	80%	81%	81%		85%	86%**	81%	90%
Healthy Birth Weight		93%	90%	88%			90%	100%**		90%

*From IDOH Birth Outcomes https://gis.in.gov/apps/isdh/meta/stats_layers.htm

**Based on 7 total births for that period

*** From IDOH Mortality Stats Explorer https://gis.in.gov/apps/isdh/meta/stats_layers.htm?q=VAR_ID%20like%20%27DEATH%%27&prof=18

Barth Cty IDOH 2020 - 2021 data not available as of 12/9/21

Goal 2: Sustain and expand Nurse Family Partnership services. Developing an endowment to sustain 1 NFP nurse and add a second nurse in 2027.