2023 COMMUNITY HEALTH NEEDS ASSESSMENT

Houston County, Georgia

Sponsored by

HOUSTON HEALTHCARE

2023-0063-02

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2011, 2014, 2017, and 2020, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Houston County, the service area of Houston Healthcare. 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 Houston Healthcare by PRC, Inc., 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

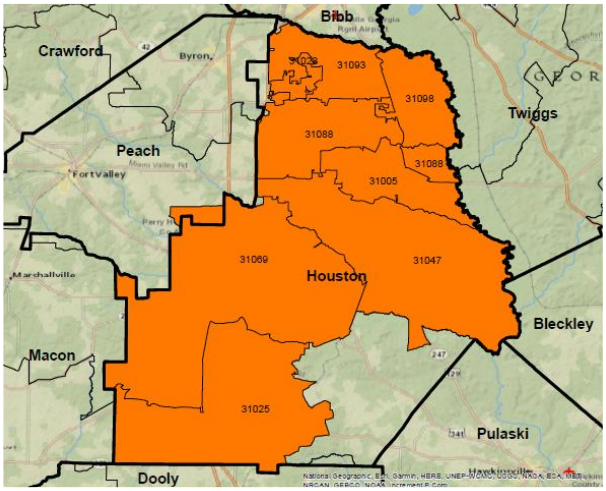
Survey Instrument

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 Houston Healthcare 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 "Houston County" in this report) is defined as each of the residential ZIP Codes predominantly associated with Houston County, Georgia. This community definition

represents the primary service area of Houston Healthcare and includes those ZIP Codes in which more than 70% of its patients reside.

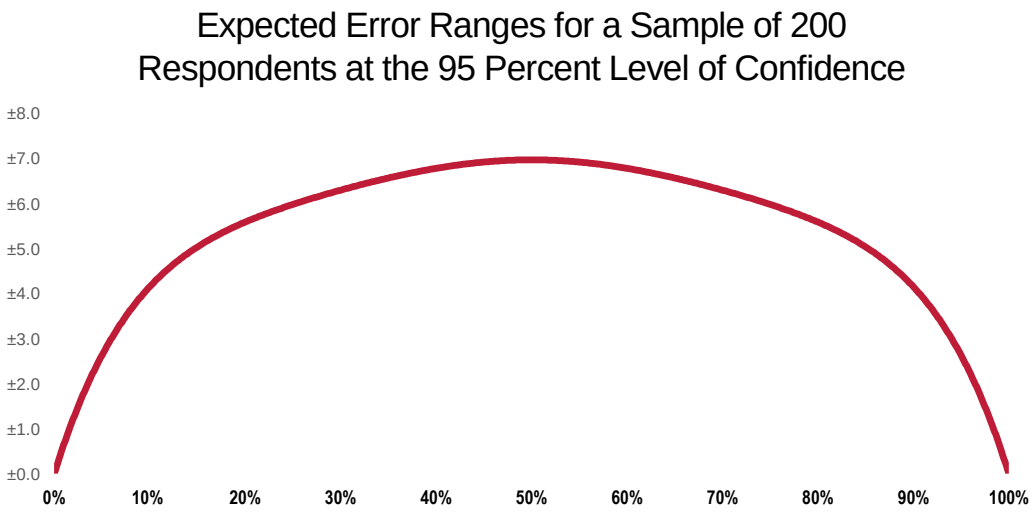


Sample Approach & Design

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

The sample design used for this effort consisted of a random sample of 200 individuals age 18 and older in the targeted ZIP Codes ("Houston County"). Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Houston County as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 200 respondents is ±6.9% at the 95 percent confidence level.



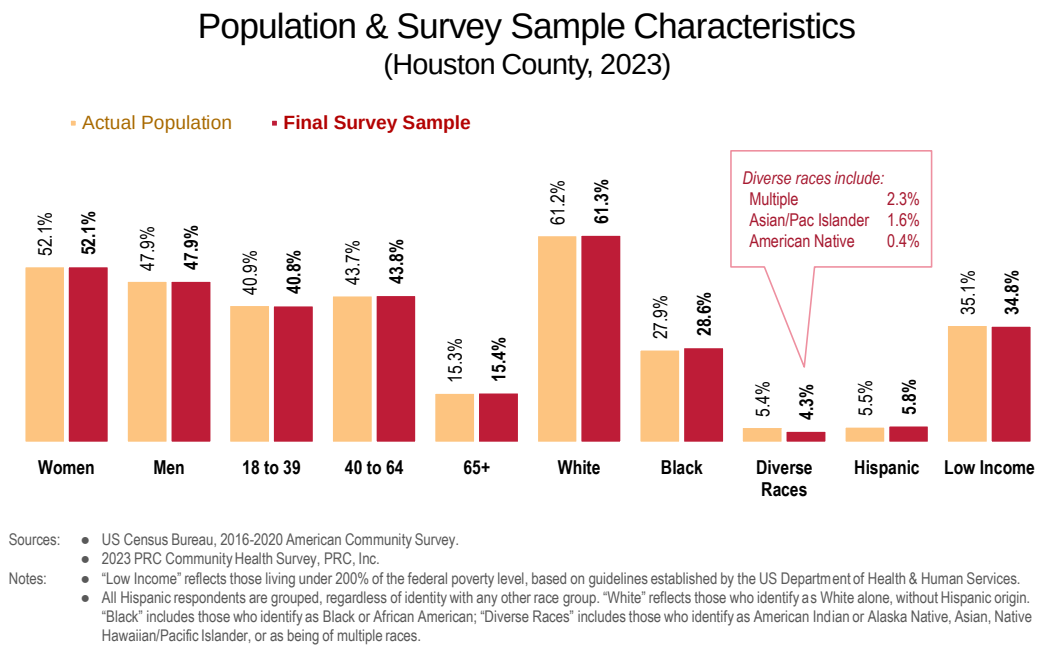
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 200 respondents answered a certain question with a "yes," it can be asserted that between 5.8% and 14.2% (10% ± 4.2%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 43.1% and 56.9% (50% ± 6.9%) of the total population would respond "yes" if asked this question.

Sample Characteristics

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

The following chart outlines the characteristics of the Houston County 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.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2023 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic respondents are grouped, regardless of identity with any other race group. "White" reflects those who identify as White alone, without Hispanic origin. "Black" includes those who identify as Black or African American; "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races.

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

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Houston Healthcare; 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, 53 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	3
Public Health Representatives	0
Other Health Providers	5
Social Services Providers	14
Other Community Leaders	31

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Area Agency on Aging
- Camp Big Heart
- Central Georgia Cancer Care
- Central Georgia Technical College
- City of Centerville
- City of Perry
- City of Warner Robins
- Community Health Works
- District Public Health
- Elberta Head Start
- First Choice Primary Care
- Flint Energies
- Fort Valley State University
- Georgia National Fairgrounds & Agricenter
- Graphic Packaging
- Happy Hour Service Center
- Heart of Georgia Hospice
- Houston County
- Houston County Board of Education
- Houston County Development Authority
- Houston County Health Department
- Houston Healthcare
- Middle Georgia State University
- North Central Health District
- Perry Volunteer Outreach
- Rainbow House - Children's Resource Center
- Rehoboth Life Care Ministries
- Robins Financial Credit Union
- Robins Regional Chamber of Commerce
- Synovus Bank
- United Way of Central Georgia
- Volunteer Medical Clinic
- Warner Robins Housing Authority
  - Warner Robins Senior Center

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.

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 Houston County 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, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Comparisons

Trending

Similar surveys were administered in Houston County in 2011, 2014, 2017, and 2020 by PRC on behalf of Houston Healthcare. 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.

Georgia Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

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.

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 receiving feedback from individuals and organizations and input from subject matter experts, the US 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, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be individually identifiable or might not comprise a large-enough sample 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

Houston Healthcare 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, Houston Healthcare 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. Houston Healthcare 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 (2022)	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	28
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	167
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	13
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	176
Part V Section B Line 3h The process for consulting with persons representing the community's interests	8
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)	200

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 key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Appointment Availability – Lack of Transportation ▪ Primary Care Physician Ratio ▪ Eye Exams ▪ Use of Advance Directive Documents
CANCER	▪ Leading Cause of Death ▪ Lung Cancer Deaths ▪ Prostate Cancer Incidence
DIABETES	▪ Diabetes Prevalence ▪ Blood Sugar Testing [Non-Diabetics] ▪ Kidney Disease Deaths ▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Activity Limitations ▪ Alzheimer's Disease Deaths
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ High Blood Cholesterol Prevalence ▪ Overall Cardiovascular Risk ▪ Key Informants: *Heart Disease & Stroke* ranked as a top concern.

— *continued on the following page* —

AREAS OF OPPORTUNITY (continued)	
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths ▪ Teen Births
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Receiving Treatment for Mental Health ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Low Food Access ▪ Fruit/Vegetable Consumption ▪ Meeting Physical Activity Guidelines ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity [Adults] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Flu Vaccination [Age 65+]
SEXUAL HEALTH	▪ Chlamydia Incidence ▪ Gonorrhea Incidence
SUBSTANCE USE	▪ Unintentional Drug-Induced Deaths ▪ Sought Help for Alcohol/Drug Issues

Finalizing the Priority Areas for 2024- 2026

This information was presented to Executive Leadership for review and discussion on September 11, 2023. The information was presented to the Hospital Board and final priority approval on November 15, 2023. Below are the final priorities for the implementation plan.

- **Promote Population Health and Wellness**

  Improve Modifiable Risk factors by focusing on promotion of healthy weights, decreasing tobacco/vaping usage, and controlling blood pressure, blood sugar and lipids through lifestyle changes.

- **Improve Access to Appropriate Health Care and Service**

  Improve the ease of access to health care by addressing possible barriers.

- **Chronic Disease Management**

  Improve individual's management of chronic diseases. Provide disease management programs to equip individuals with a chronic disease with self-management skills needed to decrease complications, decrease medical cost and improve their quality of life.

- **Vulnerable Populations**

  Provide Additional Assistance to Vulnerable Populations Improve the health of populations at higher risk for poor health, specifically targeting older adults, women with a higher risk pregnancy, individuals with behavioral health challenges and those noted to have frequent hospital visits due to behavioral or other underlying causes.

See Appendix - PHASE TWO: PLANNING AND ESTABLISHING PRIORITIES

Hospital Implementation Strategy

Houston Healthcare 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, Houston County results are shown in the larger, gray column.
- The columns to the right of the Houston County column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether Houston County compares favorably (), unfavorably (), or comparably () to these external data.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2011 (or earliest available data).

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

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

SOCIAL DETERMINANTS	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	1.0	2.7	4.0		
Population in Poverty (Percent)	10.3	13.9	12.6	8.0	
Children in Poverty (Percent)	12.8	19.6	17.1	8.0	
No High School Diploma (Age 25+, Percent)	7.0	11.8	11.1		
Unemployment Rate (Age 16+, Percent)	2.7	2.8	3.3		
% Unable to Pay Cash for a $400 Emergency Expense	21.2		34.0		
Housing Cost Exceeds 30% of Income (Percent)	25.2	29.1	30.3	25.5	
% Worry/Stress Over Rent/Mortgage in Past Year	24.0		45.8		
% Unhealthy/Unsafe Housing Conditions	7.6		16.4		
Population With Low Food Access (Percent)	35.0	30.9	22.2		
% Food Insecure	30.4		43.3		16.2
		better	similar	worse	

OVERALL HEALTH	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	19.7	18.1	15.7		11.7
		better	similar	worse	

ACCESS TO HEALTH CARE	Houston County	HOUSTON COUNTY vs. BENCHMARKS			
		vs. GA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**14.6**	17.1	8.1	7.6	13.2
% Difficulty Accessing Health Care in Past Year (Composite)	**45.5**		52.5		35.2
% Cost Prevented Physician Visit in Past Year	**15.6**	15.5	21.6		12.2
% Cost Prevented Getting Prescription in Past Year	**14.9**		20.2		13.0
% Difficulty Getting Appointment in Past Year	**22.8**		33.4		10.8
% Inconvenient Hrs Prevented Dr Visit in Past Year	**10.8**		22.9		16.2
% Difficulty Finding Physician in Past Year	**14.9**		22.0		9.4
% Transportation Hindered Dr Visit in Past Year	**8.5**		18.3		3.2
% Language/Culture Prevented Care in Past Year	**1.6**		5.0		2.4
% Stretched Prescription to Save Cost in Past Year	**14.9**		19.4		13.8
% Difficulty Getting Child's Health Care in Past Year	**5.7**		11.1		7.9
Primary Care Doctors per 100,000	**72.7**	87.6	107.3		
% Have a Specific Source of Ongoing Care	**72.0**		69.9	84.0	75.0
% Routine Checkup in Past Year	**71.0**	76.3	65.3		75.6
% [Child 0-17] Routine Checkup in Past Year	**93.1**		77.5		91.6
% Two or More ER Visits in Past Year	**16.5**		15.6		12.9

ACCESS TO HEALTH CARE (continued)	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% Eye Exam in Past 2 Years	**59.4**		55.5	61.1	69.0
% Low Health Literacy	**18.0**		25.1		13.3
% Have Completed Advance Directive Documents	**26.9**				36.3
% Rate Local Health Care "Fair/Poor"	**14.8**		11.5		12.1
		better	similar	worse	

CANCER	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)	**149.9**	150.5	146.5	122.7	169.4
Lung Cancer Deaths per 100,000 (Age-Adjusted)	**39.5**	35.7	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)	**19.0**	20.2	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)	**18.4**	20.6	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)	**14.0**	14.0	13.1	8.9	
Cancer Incidence per 100,000 (Age-Adjusted)	**482.6**	468.6	449.4		
Lung Cancer Incidence per 100,000 (Age-Adjusted)	**62.1**	59.8	56.3		
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	**133.1**	129.1	128.1		
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	**145.1**	132.6	109.9		

CANCER (continued)	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	**40.4**	40.4	37.7		
% Cancer	**7.1**	11.2	7.4		6.1
% [Women 50-74] Breast Cancer Screening	**90.9**	78.1	64.0	80.5	75.3
% [Women 21-65] Cervical Cancer Screening	**83.7**	76.5	75.4	84.3	82.8
% [Age 50-75] Colorectal Cancer Screening	**75.6**	69.8	71.5	74.4	70.9
		better	similar	worse	

DIABETES	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000 (Age-Adjusted)	**22.9**	22.2	22.6		23.7
% Diabetes/High Blood Sugar	**20.0**	12.3	12.8		14.0
% Borderline/Pre-Diabetes	**7.2**		15.0		6.7
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	**48.5**		41.5		61.0
Kidney Disease Deaths per 100,000 (Age-Adjusted)	**28.7**	18.4	12.8		20.7
% Kidney Disease	**6.3**	4.2	4.1	12.8	5.0
		better	similar	worse	

DISABLING CONDITIONS	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	41.5		38.0		47.7
% Activity Limitations	31.9		27.5		16.0
% High-Impact Chronic Pain	20.2		19.6	6.4	25.2
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	56.6	44.8	30.9		28.6
% Caregiver to a Friend/Family Member	23.2		22.8		27.6
		better	similar	worse	

HEART DISEASE & STROKE	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000 (Age-Adjusted)	214.0	178.3	164.4	127.4	164.4
% Heart Disease	10.0	7.0	10.3		6.2
Stroke Deaths per 100,000 (Age-Adjusted)	38.2	42.8	37.6	33.4	43.7
% Stroke	7.6	3.7	5.4		5.2
% High Blood Pressure	43.3	36.6	40.4	42.6	41.7
% High Cholesterol	45.6		32.4		28.5
% 1+ Cardiovascular Risk Factor	99.1		87.8		88.0
% CPR Training in Past Year	14.9				
% "Extremely/Very" Interested in Free Training for Hands-Only CPR	37.3				
		better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)	**19.1**	26.1	22.3		24.2
Teen Births per 1,000 Females 15-19	**25.2**	22.5	19.3		
Low Birthweight (Percent of Births)	**9.0**	9.8	8.2		
Infant Deaths per 1,000 Births	**10.0**	6.7	5.5	5.0	7.7
		better	similar	worse	

INJURY & VIOLENCE	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	**37.3**	44.9	51.6	43.2	34.9
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	**12.4**	14.4	11.4	10.1	
[65+] Fall-Related Deaths per 100,000 (Age-Adjusted)	**53.1**	51.4	67.1	63.4	
Homicide Deaths per 100,000 (Age-Adjusted)	**4.7**	8.8	6.1	5.5	4.6
Violent Crimes per 100,000	**374.5**	373.1	416.0		
% Victim of Violent Crime in Past 5 Years	**0.5**		7.0		3.1
% Victim of Intimate Partner Violence	**10.9**		20.3		13.9
		better	similar	worse	

MENTAL HEALTH	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	22.5		24.4		6.9
% Diagnosed Depression	30.0	17.7	30.8		15.5
% Symptoms of Chronic Depression	43.2		46.7		23.3
% Typical Day Is "Extremely/Very" Stressful	11.2		21.1		9.3
Suicide Deaths per 100,000 (Age-Adjusted)	17.9	14.3	13.9	12.8	11.3
Mental Health Providers per 100,000	71.5	73.7	146.6		
% Receiving Mental Health Treatment	21.2		21.9		11.6
% Unable to Get Mental Health Services in Past Year	7.9		13.2		5.4

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	26.9		30.0		21.3
% 5+ Servings of Fruits/Vegetables per Day	22.0		29.1		44.1
% 7+ Sugar-Sweetened Drinks in Past Week	34.0				33.9
% No Leisure-Time Physical Activity	30.6	23.7	30.2	21.8	24.9
% Meet Physical Activity Guidelines	16.8	24.1	30.3	29.7	28.5
% [Child 2-17] Physically Active 1+ Hours per Day	58.2		27.4		53.1

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Recreation/Fitness Facilities per 100,000	6.7	10.8	11.9		
% Overweight (BMI 25+)	78.5	68.0	63.3		68.9
% Obese (BMI 30+)	45.8	33.9	33.9	36.0	30.7
		better	similar	worse	

ORAL HEALTH	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% Have Dental Insurance	76.1		72.7	75.0	70.1
% Dental Visit in Past Year	64.3	60.7	56.5	45.0	67.8
% [Child 2-17] Dental Visit in Past Year	82.8		77.8	45.0	82.9
		better	similar	worse	

RESPIRATORY DISEASE	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000 (Age-Adjusted)	56.9	43.1	38.1		42.3
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	13.9	13.4	13.4		17.8
% [Age 65+] Flu Vaccine in Past Year	54.2	63.2	70.9		
COVID-19 Deaths per 100,000 (Age-Adjusted)	66.5	81.7	85.0		
% Asthma	11.6	9.4	17.9		8.0

RESPIRATORY DISEASE (continued)	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% [Child 0-17] Asthma	9.0		16.7		18.8
% COPD (Lung Disease)	6.2	6.6	11.0		7.7
		better	similar	worse	

SEXUAL HEALTH	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	339.4	643.5	379.7		
Chlamydia Incidence per 100,000	639.8	589.4	481.3		
Gonorrhea Incidence per 100,000	268.0	221.0	206.5		
		better	similar	worse	

SUBSTANCE USE	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	7.8	8.5	11.1		6.7
Cirrhosis/Liver Disease Deaths per 100,000 (Age-Adjusted)	13.0	11.8	13.0	10.9	
% Excessive Drinking	10.5	16.0	34.3		13.6
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)	7.4	13.3	21.0		5.6
% Used an Illicit Drug in Past Month	1.4		8.4		2.4
% Used a Prescription Opioid in Past Year	18.3		15.1		24.6

SUBSTANCE USE (continued)	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% Ever Sought Help for Alcohol or Drug Problem	3.3		6.8		3.6
% Personally Impacted by Substance Use	32.5		45.4		28.5
		better	similar	worse	

TOBACCO USE	Houston County	HOUSTON COUNTY vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	12.3	15.0	23.9	6.1	18.6
% Someone Smokes at Home	7.0		17.7		12.1
% Use Vaping Products	7.0	7.8	18.5		5.8
		better	similar	worse	

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Houston County, the focus of this Community Health Needs Assessment, encompasses 376.05 square miles and houses a total population of 161,177 residents, according to latest census estimates.

Total Population
(Estimated Population, 2017-2021)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Houston County	**161,177**	**376.05**	**429**
Georgia	10,625,615	57,717.11	184
United States	329,725,481	3,533,041.03	93

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

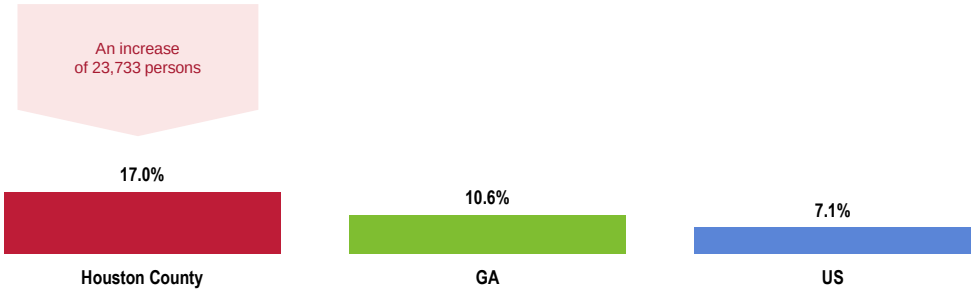
Population Change 2010-2020

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

Between the 2010 and 2020 US Censuses, the population of Houston County increased by 23,733 persons, or 17.0%.

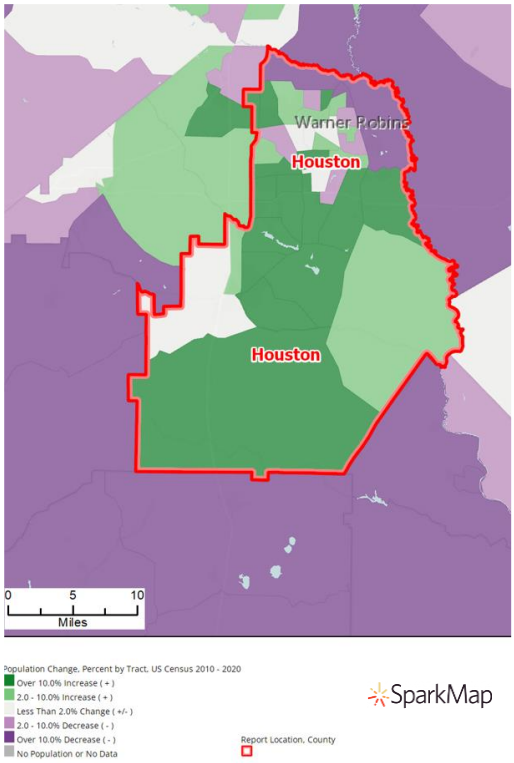
BENCHMARK ▶ A higher proportional increase than found statewide or nationally.

Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

This map shows the areas of greatest increase or decrease in population between 2010 and 2020.

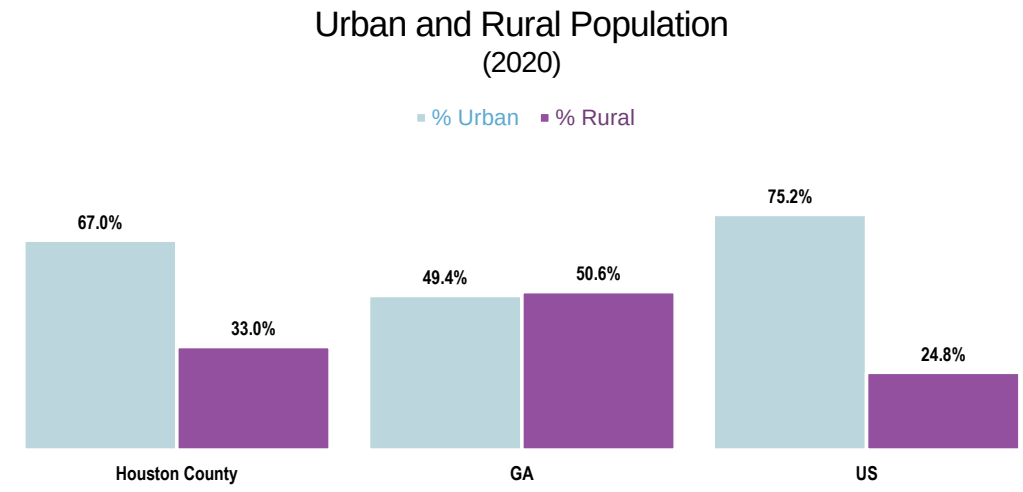


Urban/Rural Population

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.

Houston County is predominantly urban, with 67.0% of the population living in areas designated as urban.

BENCHMARK ► More urban than the state of Georgia.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

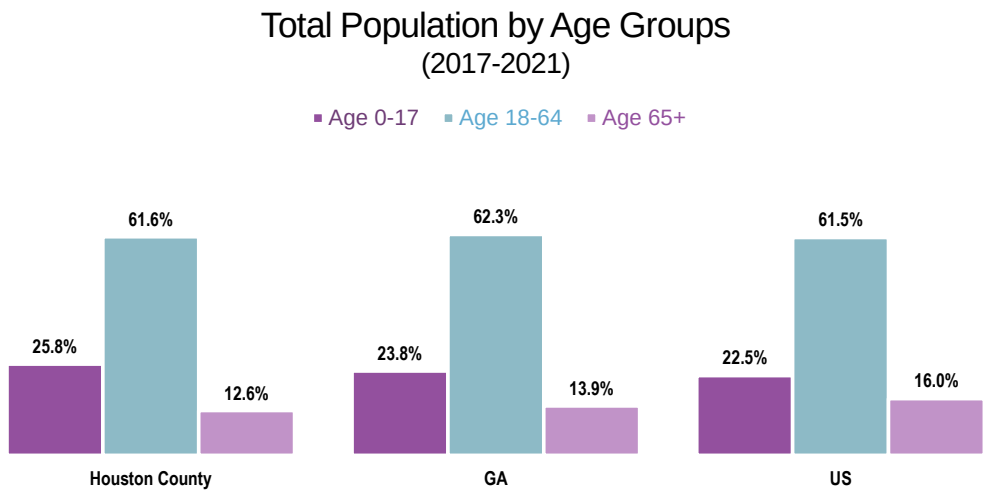
Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are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

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 Houston County, 25.8% of the population are children age 0-17; another 61.6% are age 18 to 64, while 12.6% are age 65 and older.

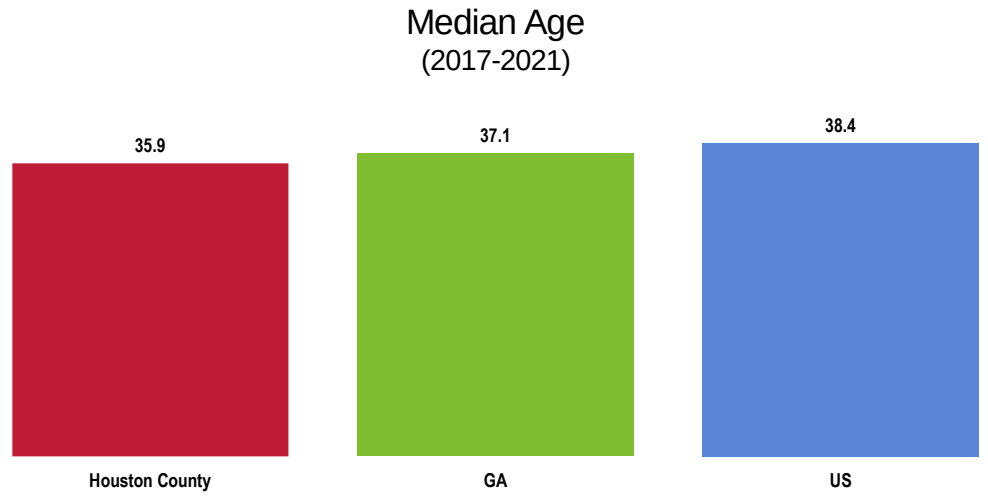
BENCHMARK ► Houston County has a slightly higher proportion of children than the state or US.



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

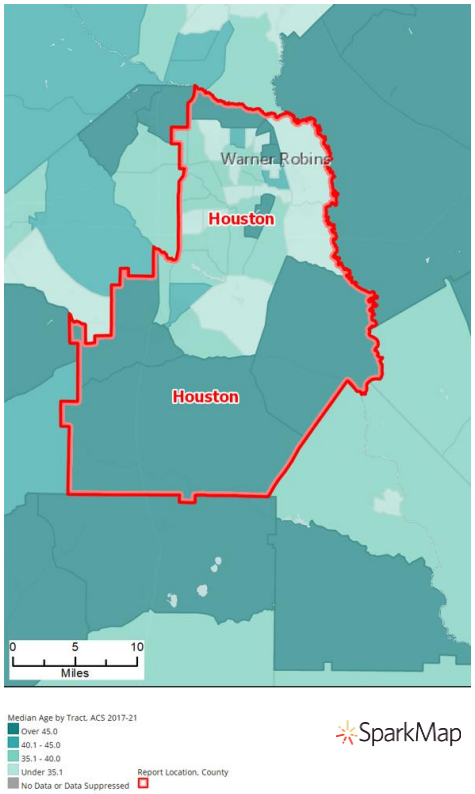
Median Age

Houston County is "younger" than the state and the nation in that the median age is lower.



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age by census tract throughout Houston County.



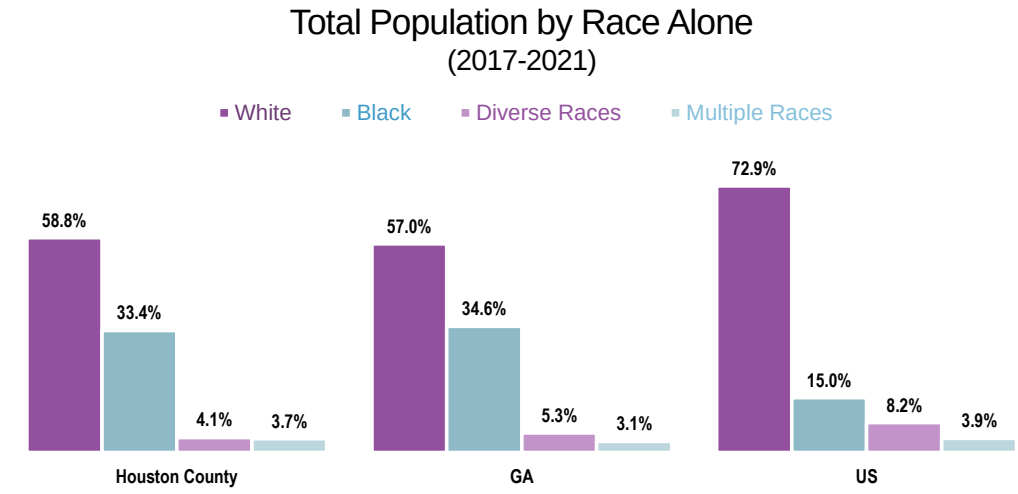
Race & Ethnicity

Race

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

In looking at race independent of ethnicity (Hispanic or Latino origin), 58.8% of residents of Houston County are White and 33.4% are Black.

BENCHMARK ► More diverse than the US population.



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

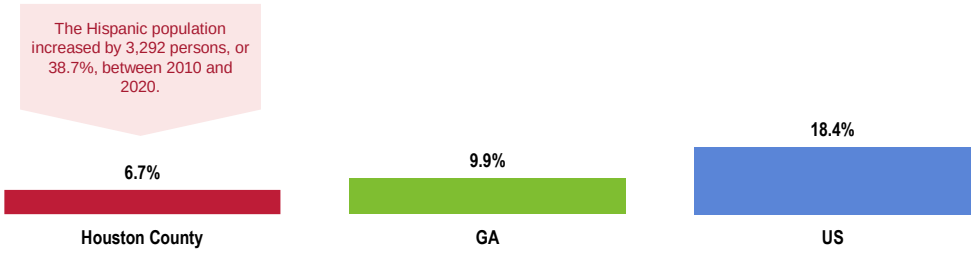
Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

Ethnicity

A total of 6.7% of Houston County residents are Hispanic or Latino.

BENCHMARK ► Much lower than the national proportion.

Hispanic Population
(2017-2021)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

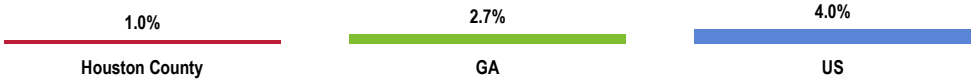
Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

A total of 1.0% of the Houston County 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 state and US findings.

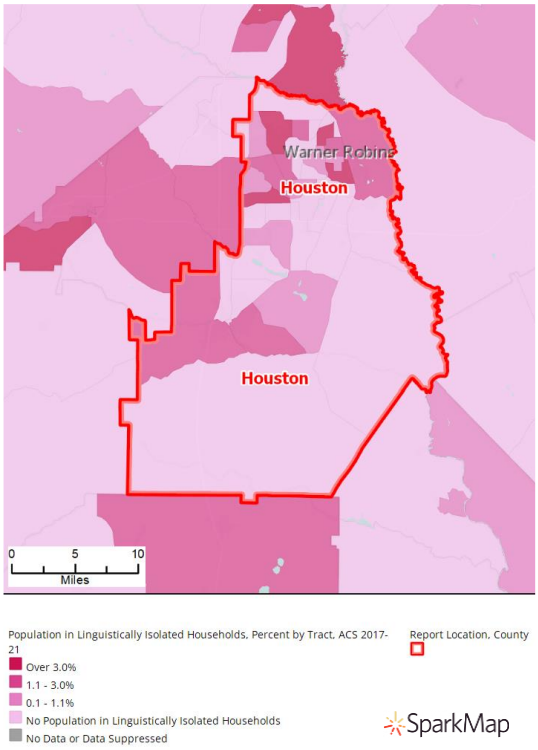
Linguistically Isolated Population
(2017-2021)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 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+ speaks a non-English language and speak English "very well."

Note the following map illustrating linguistic isolation throughout Houston County.



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

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to overall health.

The latest census estimate shows 10.3% of the Houston County total population living below the federal poverty level.

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

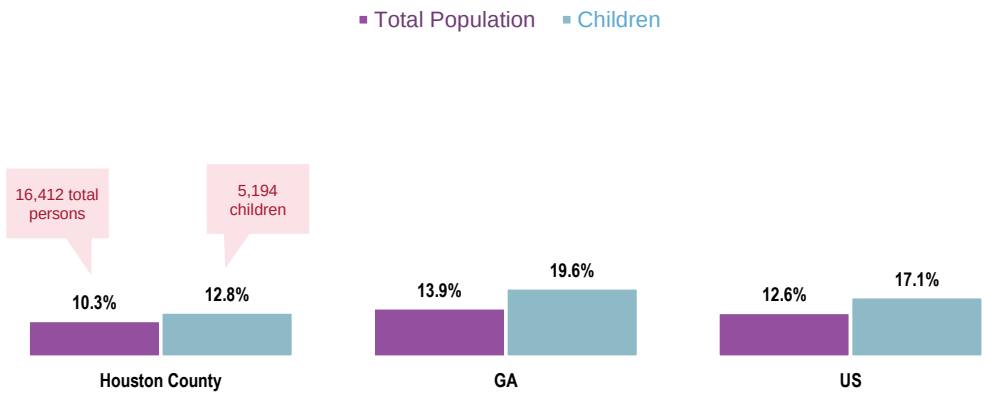
Among just children (ages 0 to 17), this percentage in Houston County is 12.8% (representing an estimated 5,194 children).

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

Percent of Population in Poverty

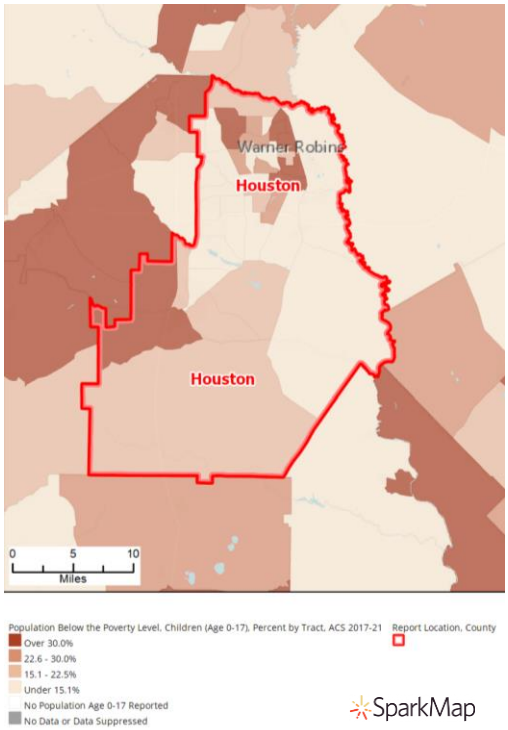
(2017-2021)

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 April 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

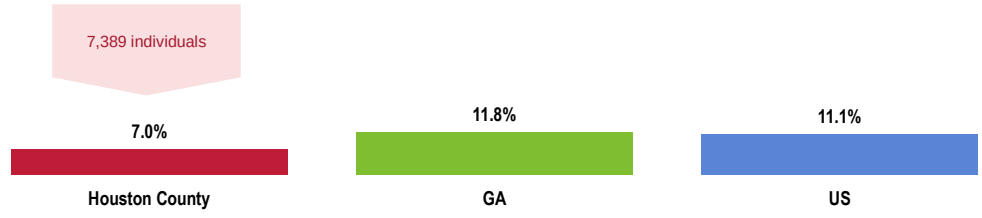


Education

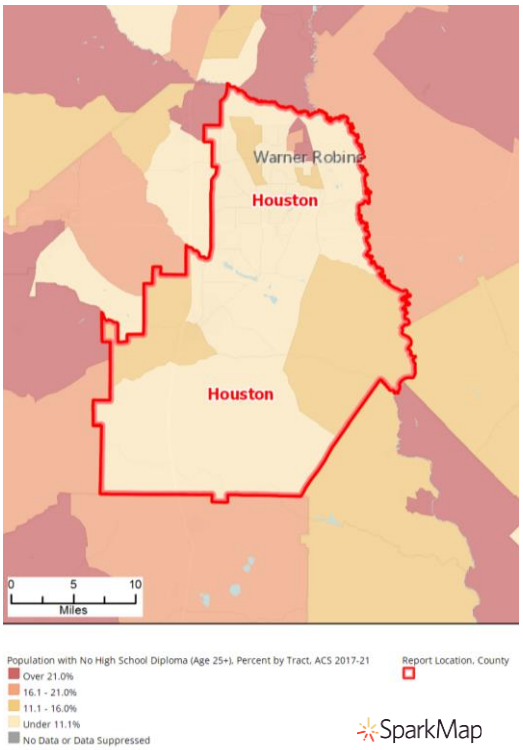
Among the Houston County population age 25 and older, an estimated 7.0% (over 7,000 people) do not have a high school education.

BENCHMARK ► Lower than found across Georgia and the US.

Population With No High School Diploma
(Adults Age 25 and Older; 2017-2021)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

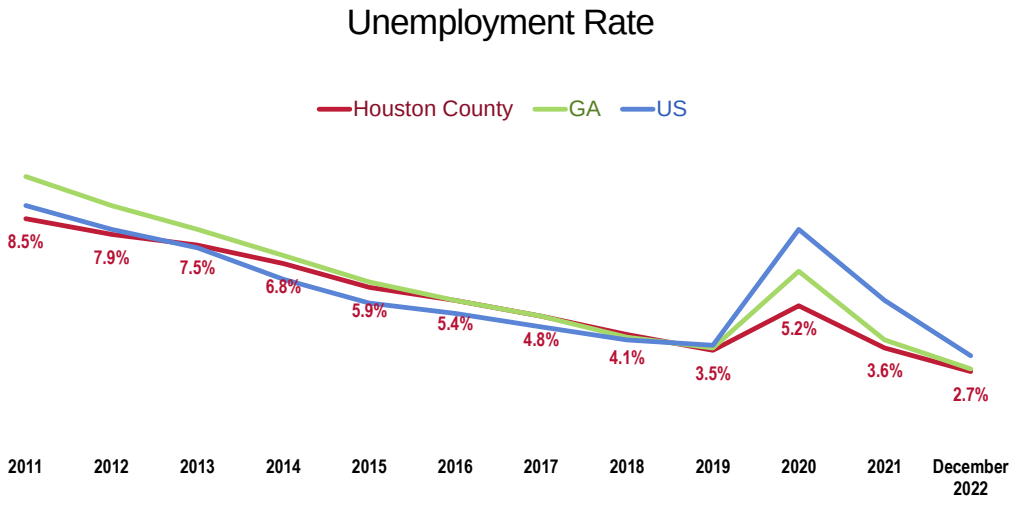


Employment

According to data derived from the US Department of Labor, the unemployment rate in Houston County as of December 2022 was 2.7%.

BENCHMARK ► Similar to the statewide unemployment rate but lower than the national rate.

TREND ► Following significant increases in 2020 (attributed to the COVID-19 pandemic), unemployment has dropped below pre-pandemic levels, and much lower than found a decade ago.



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

Respondents were asked: "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from

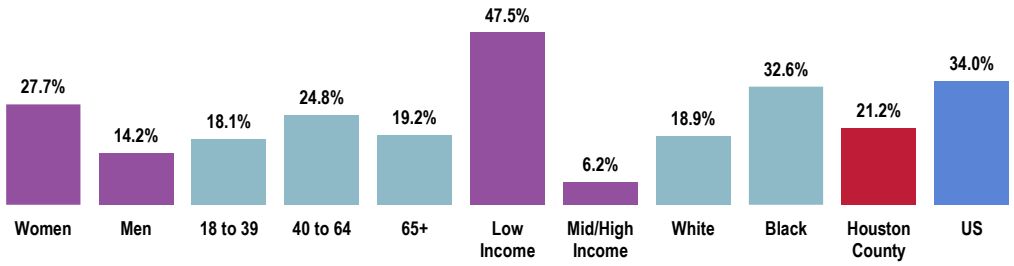
NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically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

A total of 21.2% of Houston County residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.

BENCHMARK ► Well below the national percentage.

DISPARITY ► More often reported among women and especially among lower-income households.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Houston County, 2023)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

INCOME ► In sample segmentation: "low income" refers to community members living in households with annual incomes under $52,000, regardless of the number of household members; "mid/high income" refers to those households with annual incomes of $52,000 or more.

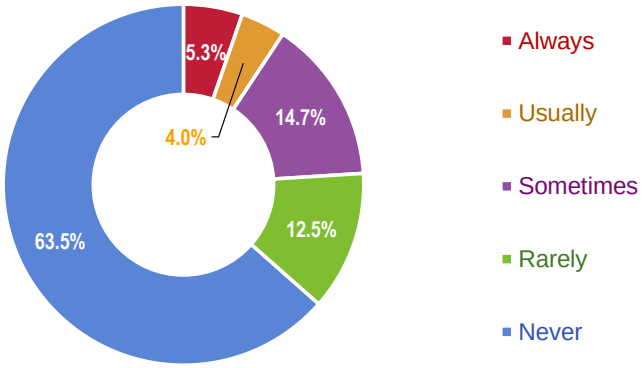
RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. Data are detailed for individuals identifying with a race category, without Hispanic origin. "White" reflects those who identify as White alone, without Hispanic origin; "Black" reflects those who identify as Black alone, without Hispanic origin.

Housing

Housing Insecurity

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

Frequency of Worry or Stress
Over Paying Rent or Mortgage in the Past Year
(Houston County, 2023)



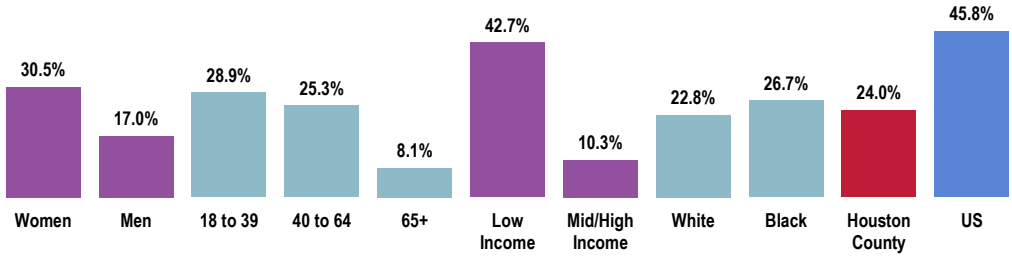
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

However, a considerable share (24.0%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

BENCHMARK ► Much lower than found across the US.

DISPARITY ► More often reported among women, adults younger than 65, and lower-income adults.

"Always/Usually/Sometimes" Worried
About Paying Rent/Mortgage in the Past Year
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 56]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

A total of 7.6% of Houston County residents report living in unhealthy or unsafe housing conditions during the past year.

BENCHMARK ► Less than half the national percentage.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Houston County, 2023)

Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Access

Low Food Access

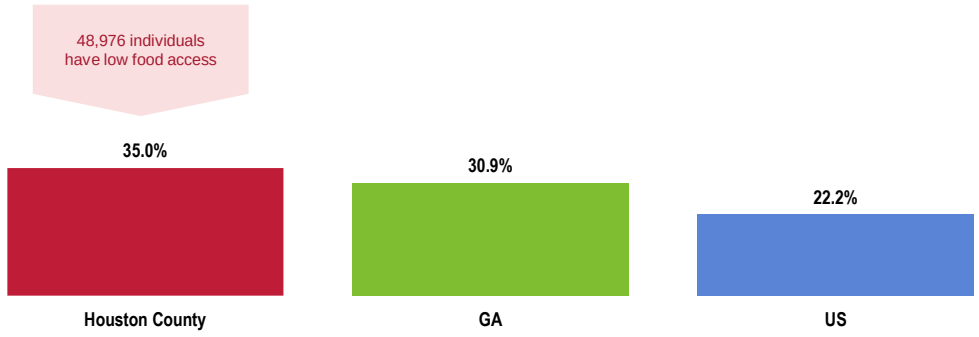
Low food access is defined as living more than 1 mile (in urban areas, or 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

RELATED ISSUE
See also Difficulty Accessing Fresh Produce in the *Nutrition, Physical Activity & Weight* section of this report.

US Department of Agriculture data show that 35.0% of the Houston County population (representing almost 49,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

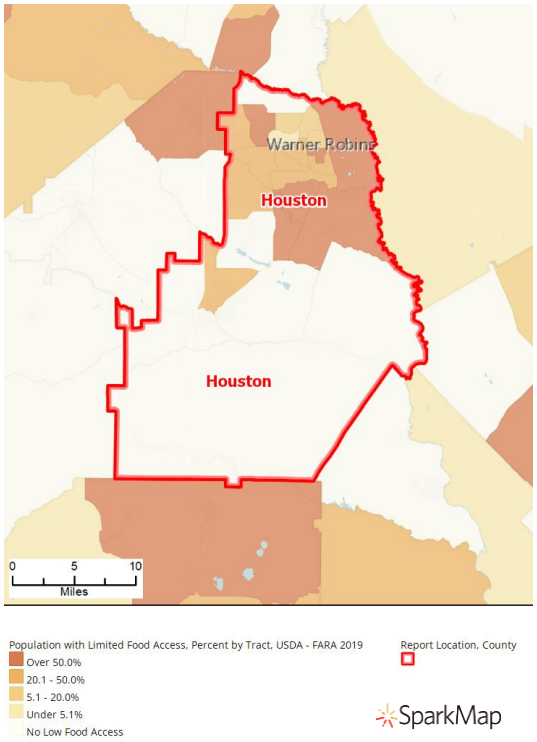
BENCHMARK ► Much higher than found nationally.

Population With Low Food Access
(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 April 2023 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.



Food Insecurity

Overall, 30.4% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

BENCHMARK ► Lower than the US finding.

TREND ► Represents a dramatic increase from previous surveys.

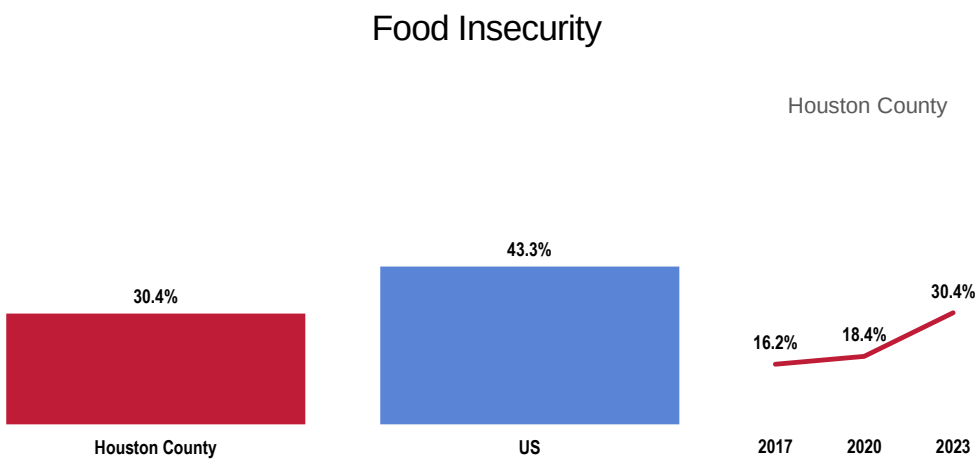
DISPARITY ► Especially high among those with lower incomes. Also high among adults younger than 65.

Surveyed adults were asked: "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "often true," "sometimes true," or "never true" for you in the past 12 months:

I worried about whether our food would run out before we got money to buy more.

The food that we bought just did not last, and we did not have money to get more."

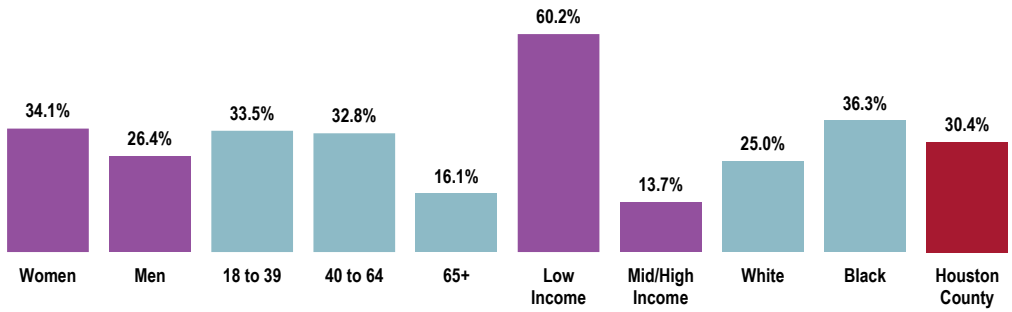
Those answering "often" or "sometimes" true for either statement are considered to be food insecure.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2023 PRC National Health Survey, PRC, Inc.

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

Food Insecurity
(Houston County, 2023)



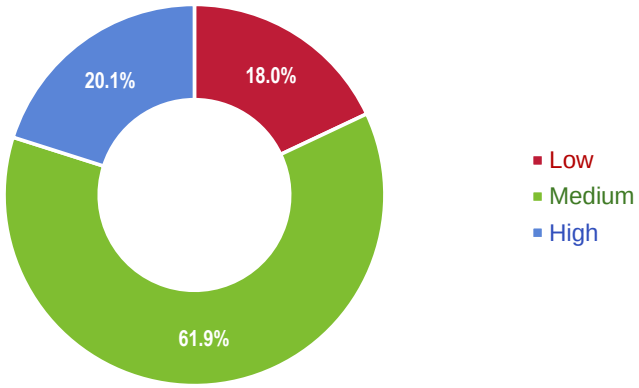
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Health Literacy

Most surveyed adults in Houston County are found to have a moderate level of health literacy.

Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Level of Health Literacy
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 321]
Notes: ● Asked of all respondents.
● Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

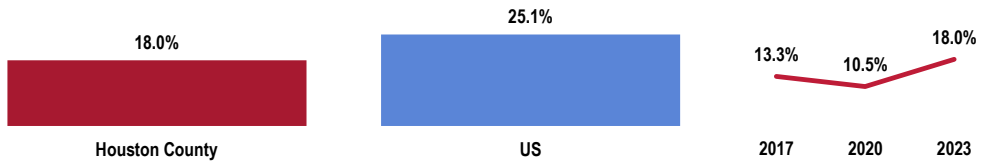
A total of 18.0% are determined to have low health literacy.

BENCHMARK ► Lower than the national percentage.

DISPARITY ► Higher among those with lower incomes.

Low Health Literacy

Houston County



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 321]
- 2023 PRC National Health Survey, PRC, Inc.

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

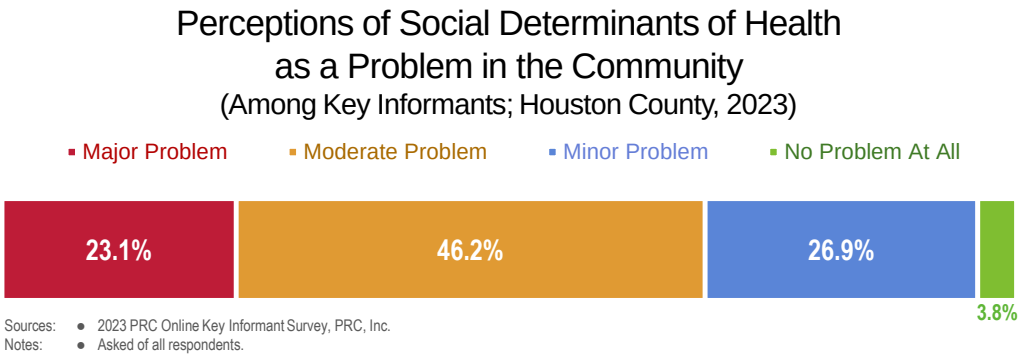
Low Health Literacy
(Houston County, 2023)

Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 321]

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

Key Informant Input: Social Determinants of Health

Key informants taking part in an online survey most often characterized *Social Determinants of Health* as a "moderate problem" in the community.



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

Income/Poverty

> Poverty and racism create toxic stress that can have direct physical impact on the body, creating both physical and mental health disparities. Transportation has a huge impact on access to services, as does income. – Other Health Provider
>
> Social determinants of health are a major problem in our community because health inequities still exist. In addition, economic stability, access to education, consistent and reliable transportation, access to health care and other factors are not equal among all socioeconomic and minority groups. – Community/Business Leader
>
> We have a sizable "working poor" population. – Community/Business Leader
>
> They have been proven to have a greater influence on health than either genetic factors or access to healthcare services, primarily among those in poverty, and we live in a higher poverty area. – Community/Business Leader
>
> Like most communities, Houston County has a stark division in access to goods and services based on income that is evident and divided regionally in the county. While areas with the highest SES have ready access to personal vehicles, health insurance, medical care, and recreation, those with lower SES live in areas where resources, if available, are difficult to access and cost prohibitive. School district divisions by area and proximity to schools lend school inclusion to those with similar SESs. – Community/Business Leader

Housing

> Housing, single parents, education in early childhood. – Physician
>
> Affordable housing challenges and other barriers to basic needs cause undue stress and exacerbate health conditions. – Community/Business Leader

Spirituality

> Spirituality. If a person is spiritually sound, they will be more content in their lives, happier, and more likely to have healthy habits. This person is more likely to have direction and contentment in their life. – Community/ Business Leader

Access to Care/Services

> Lack of facilities in the immediate area, and without public transportation people do not have a way to access these facilities. – Community/Business Leader

Co-Occurrences

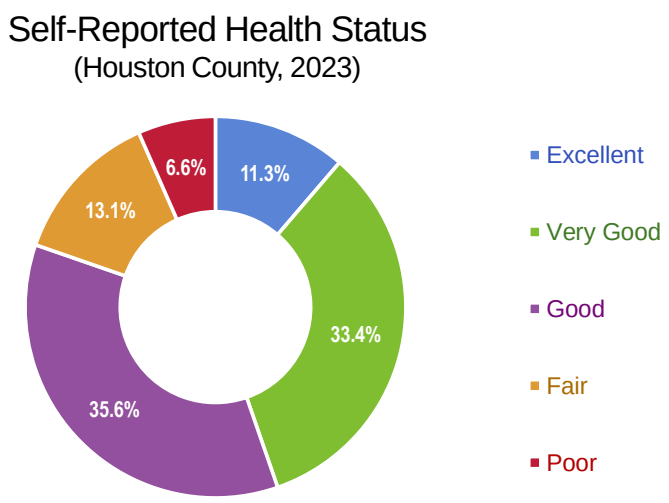
> If your physical, mental, and oral health is not good, you are hungry, homeless or house is need of repairs, no electricity/water and are being judged by the color of your skin, it's a major problem. – Community/Business Leader

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 Houston County residents rate their overall health favorably (responding "excellent," "very good," or "good").

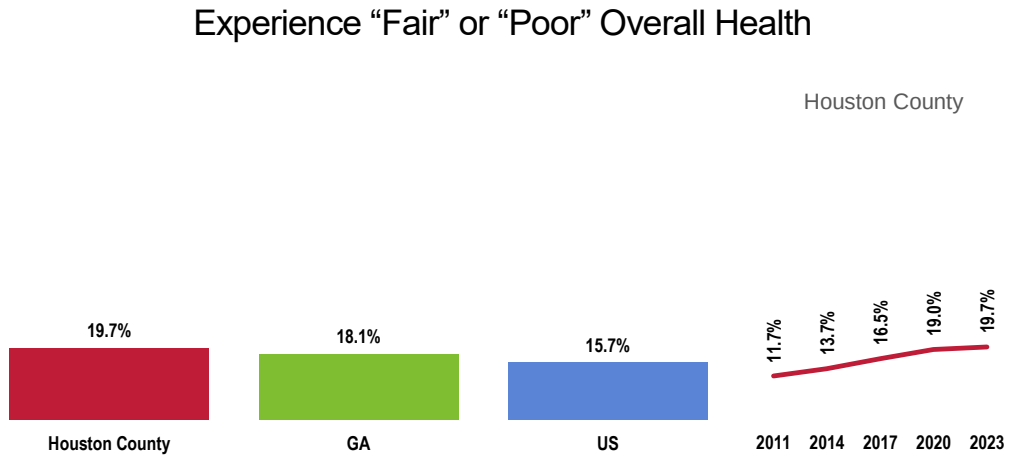


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.

However, 19.7% of Houston County adults believe that their overall health is "fair" or "poor."

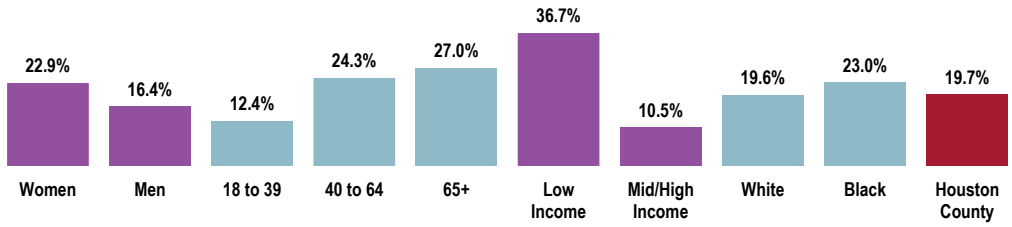
TREND ► Trending significantly higher over time.

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



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Houston County, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 4]
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 ages 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.

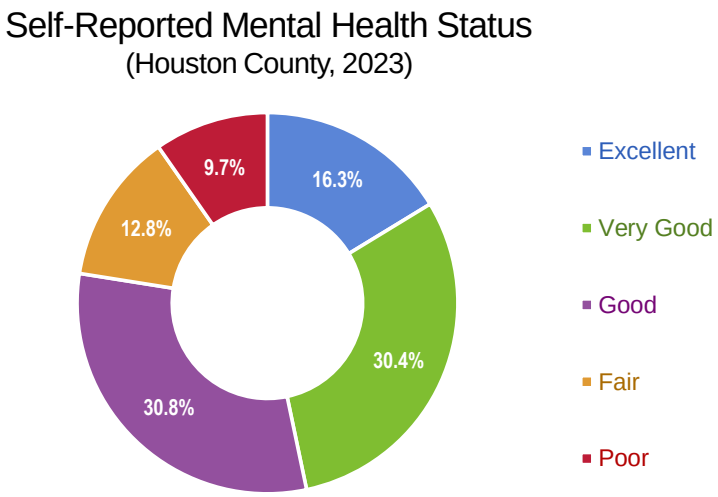
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening 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 Houston County adults rate their overall mental health favorably ("excellent," "very good," or "good").



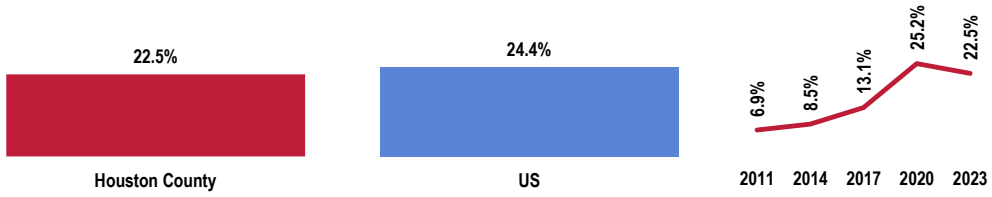
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

However, 22.5% believe that their overall mental health is "fair" or "poor."

TREND ► Statistically similar to that found in 2020 but marks a significant increase from the 2011 baseline.

Experience "Fair" or "Poor" Mental Health

Houston County



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression

Diagnosed Depression

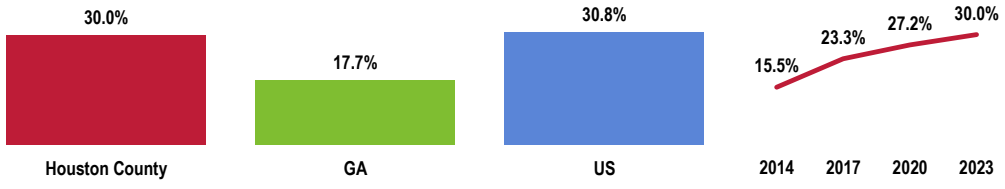
A total of 30.0% of Houston County adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

BENCHMARK ► Higher than the statewide percentage.

TREND ► Rising significantly higher over time.

Have Been Diagnosed With a Depressive Disorder

Houston County



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

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

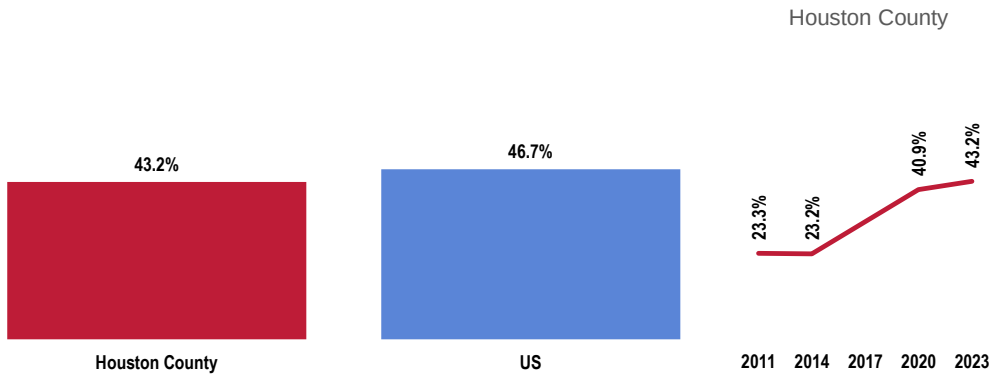
Symptoms of Chronic Depression

A total of 43.2% of Houston County adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

TREND ► Although similar to 2020 findings, denotes a dramatic increase from the 2011 baseline.

DISPARITY ► Especially high among lower-income adults.

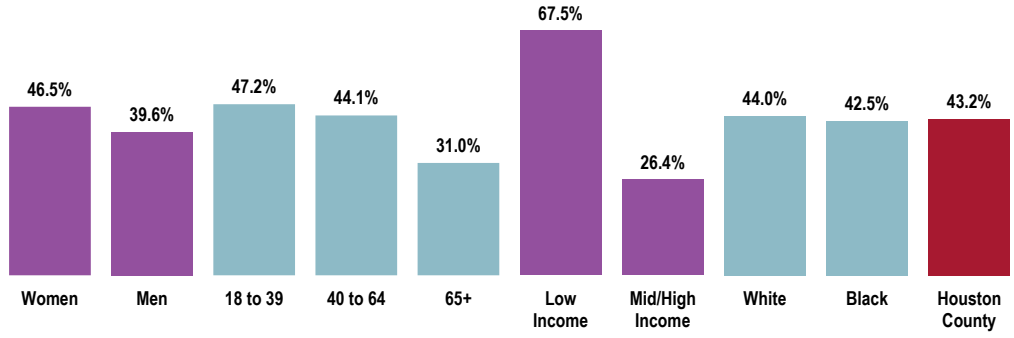
Have Experienced Symptoms of Chronic Depression



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

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

Have Experienced Symptoms of Chronic Depression
(Houston County, 2023)

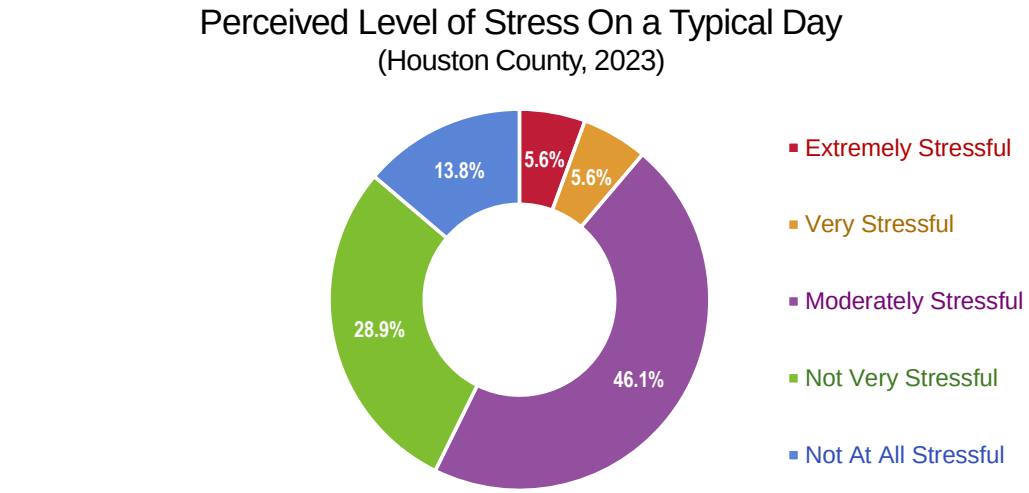


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 78]

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

Stress

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

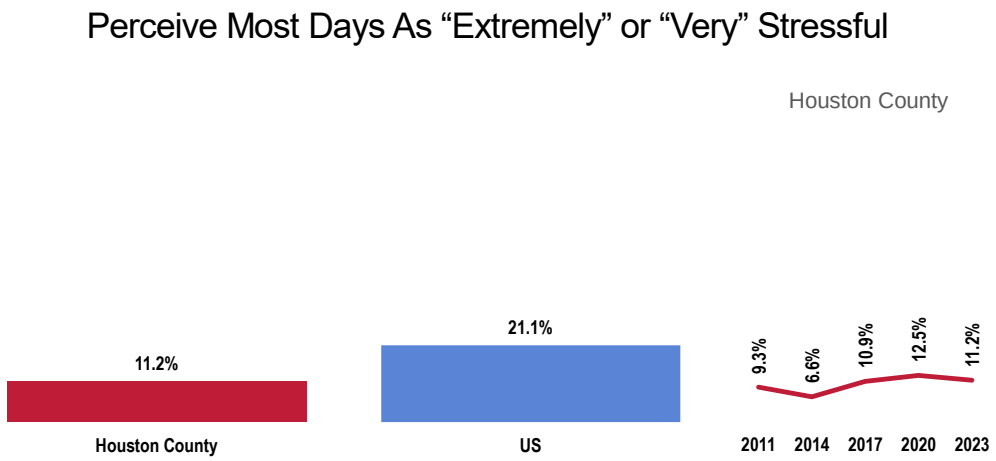


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

In contrast, 11.2% of Houston County adults feel that most days for them are "very" or "extremely" stressful.

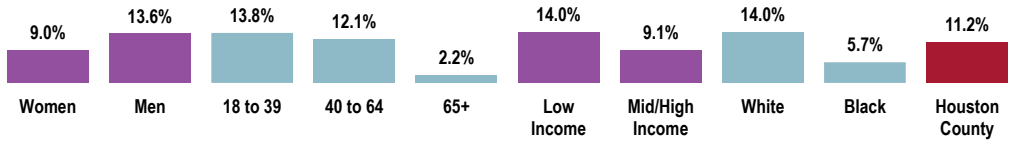
BENCHMARK ► Well below the US percentage.

DISPARITY ► More often reported among adults younger than 65.



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

Suicide

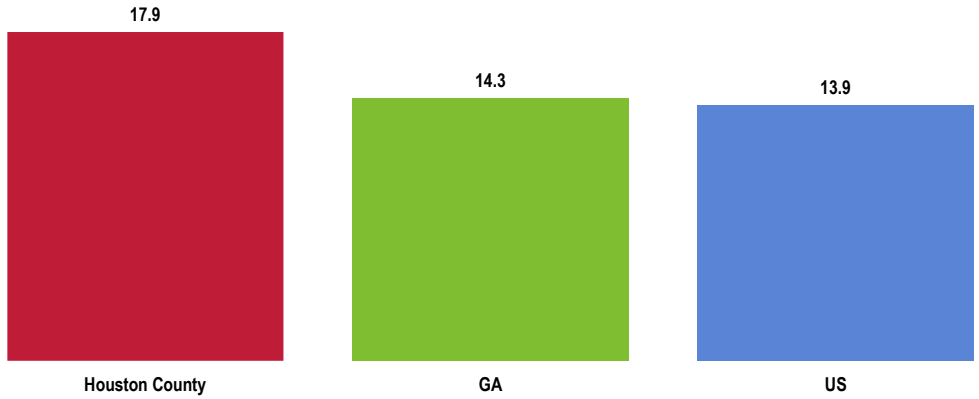
Refer to “Leading Causes of Death” for an explanation of the use of age-adjusting for these rates.

In Houston County, there were 17.9 suicides per 100,000 population (2018-2020 annual average age-adjusted rate).

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

TREND ► Rising significantly to the highest level recorded within the county in nearly a decade.

Suicide: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower

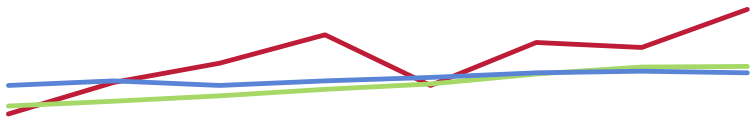


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	11.3	13.3	14.5	16.3	13.1	15.8	15.5	17.9
GA	11.8	12.1	12.4	12.9	13.2	13.8	14.3	14.3
US	13.1	13.4	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Mental Health Treatment

Mental Health Providers

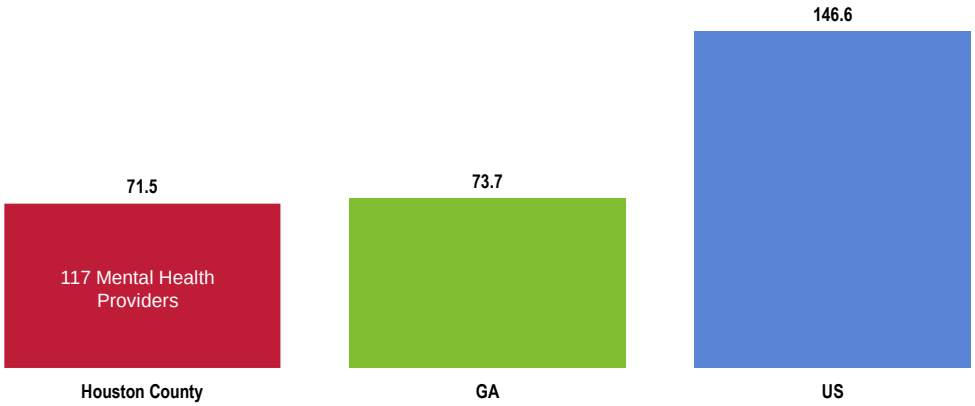
Note that this indicator only reflects providers practicing in Houston County and residents in Houston County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

In Houston County in 2023, there were 71.5 mental health providers (including psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) for every 100,000 population.

BENCHMARK ► Roughly half of the US proportion.

Number of Mental Health Providers per 100,000 Population

(2023)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 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 counselors that specialize in mental health care.

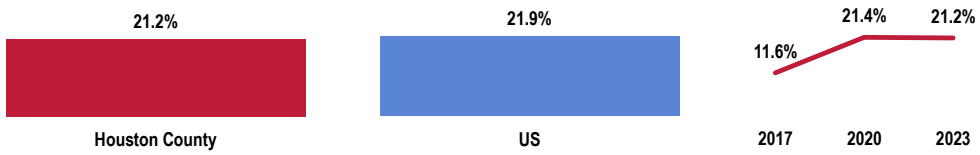
Currently Receiving Treatment

A total of 21.2% are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

TREND ► Marks a significant increase from the 2017 baseline.

Currently Receiving Mental Health Treatment

Houston County



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

Difficulty Accessing Mental Health Services

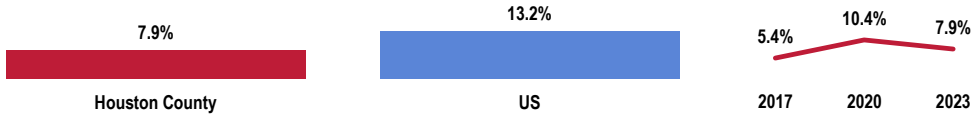
A total of 7.9% of Houston County adults report a time in the past year when they needed mental health services but were not able to get them.

BENCHMARK ► Lower than the national percentage.

DISPARITY ► More often reported among respondents age 18 to 39 and among lower-income adults.

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

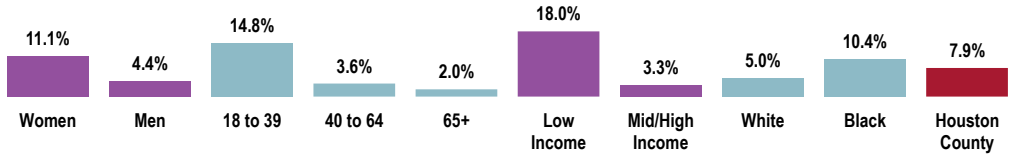
Houston County



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 82]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(Houston County, 2023)

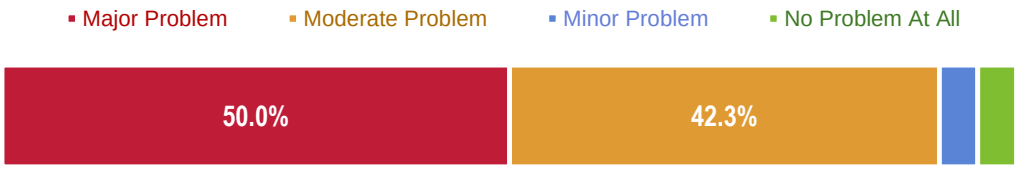


Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 82]
Notes: • Asked of all respondents.

Key Informant Input: Mental Health

One-half of key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.

Perceptions of Mental & Emotional Health as a Problem in the Community
(Among Key Informants; Houston County, 2023)



Sources: • 2023 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/Services

> No access. The insured can see front-line general practitioners, but they are not experts in these areas. There are no meaningful resources to accommodate those suffering from a mental health crisis. – Community/Business Leader
>
> Houston Health is no longer an emerging receiving facility. Law enforcement is tasked with transporting patients suffering from a mental health crisis under a 10-13, and they are forced to travel great distances, despite being short-staffed. – Community/Business Leader
>
> Access to mental health services. Non-compliance with patient care. – Other Health Provider
>
> Access to care and providers. Placement of those needing inpatient care. Our emergency departments are overrun with people needing mental health care. – Community/Business Leader
>
> Access to mental health counselors, therapists, facilities, and medications. Not enough providers or case managers who are able to follow up on the care plans that are provided. – Community/Business Leader
>
> Access to mental health care is limited and many who need it do not actively seek it out. – Community/Business Leader

> Not enough facilities or services available. – Community/Business Leader
>
> There is no place for people to go. Our homeless population is clearly growing, and many of them have drug, alcohol and/or mental issues. – Social Services Provider
>
> Resources being readily available, interested in helping those with mental health issues, and encouraging those with those issues to speak out. – Community/Business Leader
>
> Access to affordable care in a timely manner, affordable care and affordable medication, transportation, affordable and accessible therapy, stigmatization of mental health issues. – Community/Business Leader
>
> Access to mental health treatment facilities, coupled with the lack of public transportation. – Community/Business Leader
>
> Not many mental health facilities to help the amount of people who suffer with mental health. – Social Services Provider

Lack of Mental Health Providers

> This is a problem throughout the country, as not enough psychiatrists are available. – Physician
>
> Lack of mental health professionals such as psychiatrists, mental health extenders, nurse practitioners, physician assistants and therapists. Lack of mental health inpatient facilities. Lack of half-way houses for those recovering from drug and alcohol addictions, especially places for men. – Community/Business Leader
>
> Access to care. I know patients who have tried to get appointments and have been unable to or been told the doctor is not taking any new patients. – Other Health Provider
>
> Not enough providers and inpatient facilities are available. Professionally licensed individuals often have long wait times before a person can get an appointment to be seen; and then if inpatient treatment is needed, there are few if any options available. This is an even bigger problem for persons with no or insufficient insurance. – Other Health Provider

Diagnosis/Treatment

> Getting proper treatment. – Community/Business Leader
>
> Proper identification of those needing counseling. – Community/Business Leader
>
> The quickness to respond to anxiety and depression by the medical community to prescribe mood-altering medications. – Community/Business Leader

Awareness/Education

> Lack of education, motivation, transportation, and financial support to pursue mental health support services. – Community/Business Leader
>
> Lack of understanding about mental illness and the paucity of providers. – Community/Business Leader

Affordable Care/Services

> Difficulty with finding affordable services or inpatient facilities. – Social Services Provider

Addiction

> Addictions and getting help for those who suffer from addictions. Helping those with addictions. – Community/Business Leader

Follow-Up/Support

> Failure to follow up with outpatient services. Failure to get diagnosed and use illegal substances to medicate. Don't follow through with treatment and/or don't take prescribed medications. – Community/Business Leader

Suicide Rates

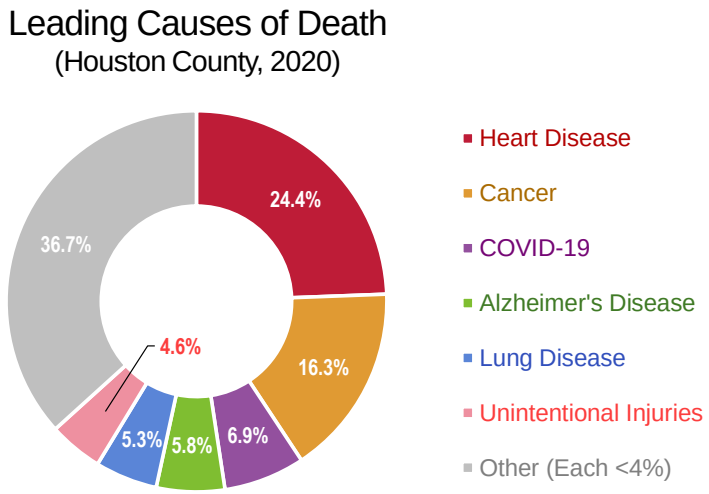
> We have an alarming suicide rate in this community. I hear this from counselors and pastors. We also have homeless people, including veterans, who live on the street and get little care. – Social Services Provider

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for 4 of every 10 deaths in Houston County in 2020. COVID-19 emerged as the third-leading cause.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
Notes: ● Lung disease includes deaths classified as 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, Georgia 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 2018-2020 annual average age-adjusted death rates per 100,000 population for selected causes of death in Houston County.

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

Leading causes of death are discussed in greater detail in subsequent sections of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Houston County	GA	US	Healthy People 2030
Heart Disease	214.0	178.3	164.4	127.4*
Cancers (Malignant Neoplasms)	149.9	150.5	146.5	122.7
COVID-19 (Coronavirus Disease) [2020]	66.5	81.7	85.0	—
Lung Disease (Chronic Lower Respiratory Disease)	56.9	43.1	38.1	—
Alzheimer's Disease	56.6	44.8	30.9	—
Falls [Age 65+]	53.1	51.4	67.1	63.4
Stroke (Cerebrovascular Disease)	38.2	42.8	37.6	33.4
Unintentional Injuries	37.3	44.9	51.6	43.2
Kidney Disease	28.7	18.4	12.8	—
Diabetes	22.9	22.2	22.6	—
Septicemia	22.9	15.3	9.8	—
Suicide	17.9	14.3	13.9	12.8
Pneumonia/Influenza	13.9	13.4	13.4	—
Cirrhosis/Liver Disease	13.0	11.8	13.0	10.9
Motor Vehicle Deaths	12.4	14.4	11.4	10.1
Alcohol-Induced Deaths	7.8	8.5	11.1	—
Unintentional Drug-Induced Deaths	7.4	13.3	21.0	—
Homicide [2011-2020]	4.7	8.8	6.1	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 April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

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

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

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

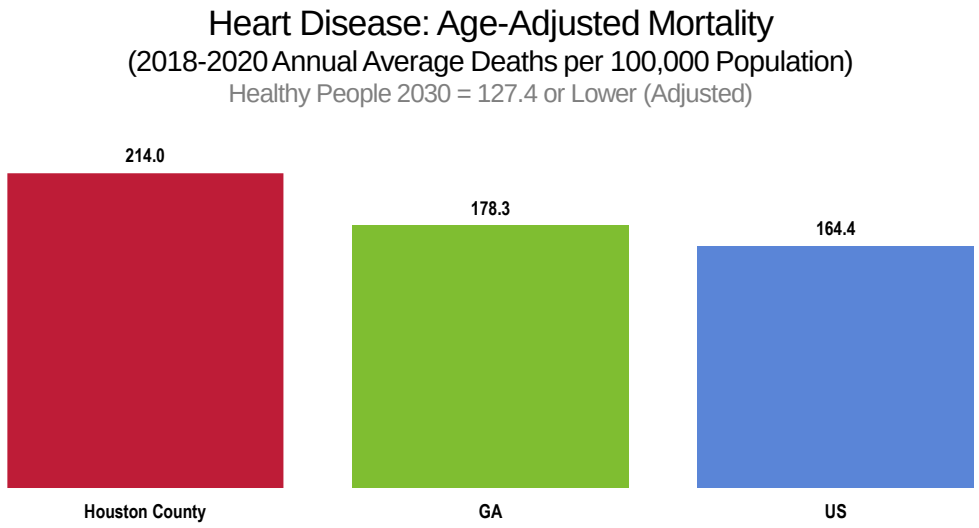
The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2018 and 2020, there was an annual average age-adjusted heart disease mortality rate of 214.0 deaths per 100,000 population in Houston County.

BENCHMARK ► Worse than state and national rates. Far from satisfying the Healthy People 2030 objective.

TREND ► Rising significantly to the highest level recorded within the county in nearly a decade.

DISPARITY ► Higher among Black residents than among White residents.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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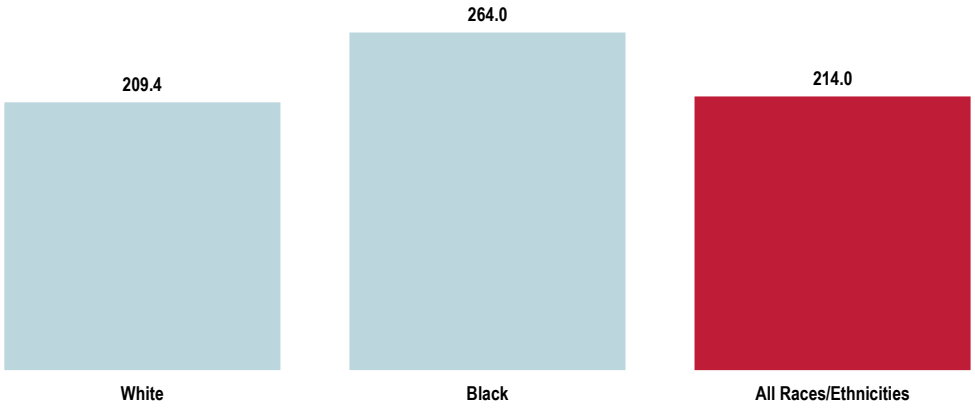
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Heart Disease: Age-Adjusted Mortality by Race/Ethnicity

(2018-2020 Annual Average Deaths per 100,000 Population; Houston County)

Healthy People 2030 = 127.4 or Lower (Adjusted)



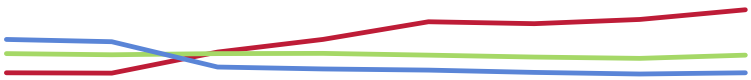
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- 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.
- Race categories reflect individuals without Hispanic origin.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	164.4	164.0	180.8	190.8	204.6	203.2	206.3	214.0
GA	179.6	178.7	179.5	179.6	178.3	176.9	175.7	178.3
US	190.6	188.9	168.9	167.5	166.3	164.7	163.4	164.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

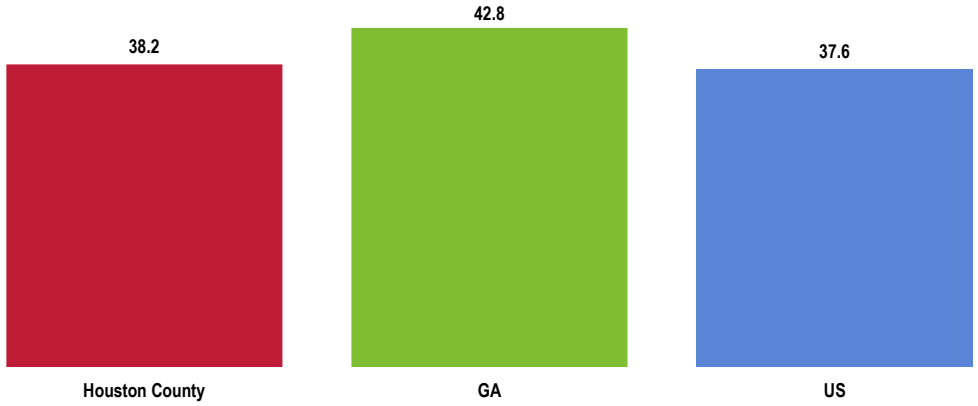
Stroke Deaths

Between 2018 and 2020, there was an annual average age-adjusted stroke mortality rate of 38.2 deaths per 100,000 population in Houston County.

Stroke: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



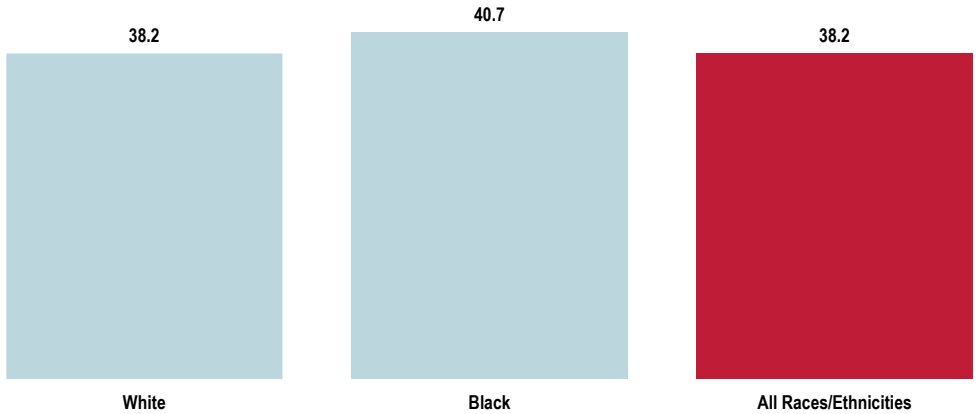
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Stroke: Age-Adjusted Mortality by Race/Ethnicity

(2018-2020 Annual Average Deaths per 100,000 Population; Houston County)

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 April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Race categories reflect individuals without Hispanic origin.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	43.7	41.5	43.2	44.0	41.3	41.7	39.2	38.2
GA	41.9	41.9	43.1	44.1	44.4	43.7	42.9	42.8
US	40.7	40.6	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Prevalence of Heart Disease & Stroke

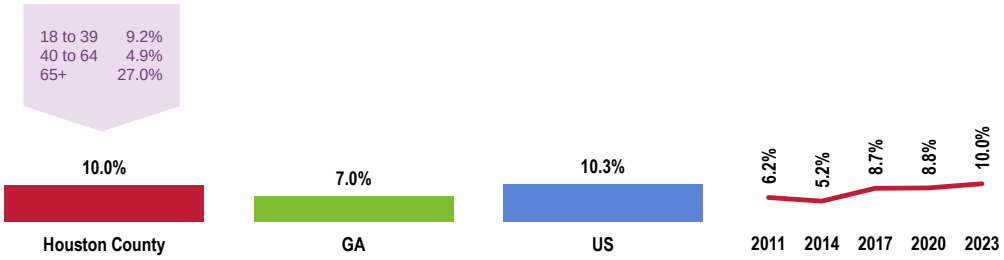
Prevalence of Heart Disease

A total of 10.0% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

DISPARITY ► Especially high among adults age 65+.

Prevalence of Heart Disease

Houston County

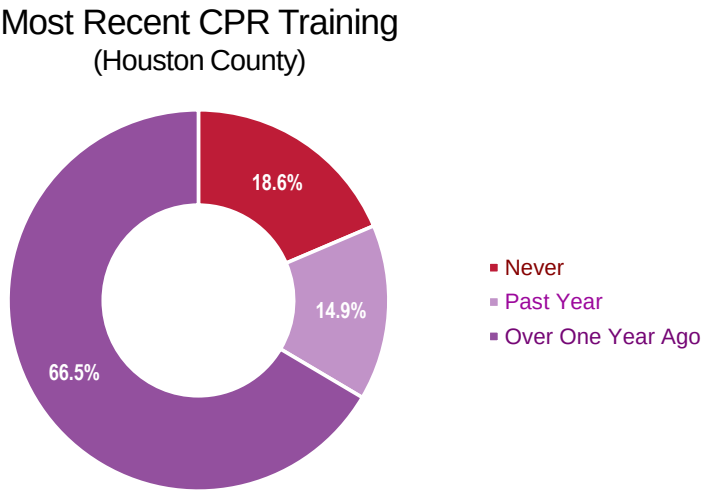


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

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

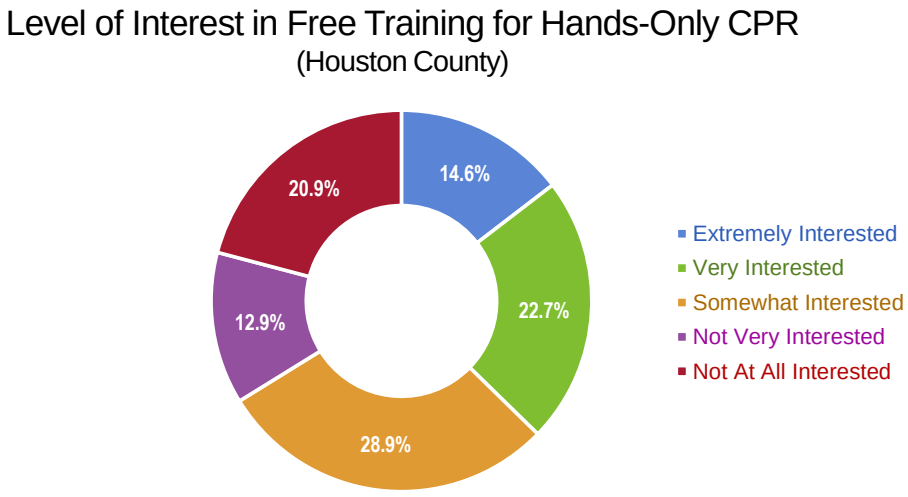
CPR Training

Among Houston County adults, 14.9% report receiving training for cardiopulmonary resuscitation, or CPR, within the past year. Another 66.5% report receiving CPR training more than one year ago.



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 317]
Notes: ● Asked of all respondents.
● CPR is cardiopulmonary resuscitation, a lifesaving technique that is useful in emergencies where someone's breathing has stopped.

More than one-third (37.3%) of Houston County adults say they would be "extremely" or "very" interested in receiving free, local training for hands-only CPR, which does not include rescue breathing.



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: ● Asked of all respondents.
● CPR is cardiopulmonary resuscitation, a lifesaving technique that is useful in emergencies where someone's breathing has stopped. Hands-only CPR involves performing chest compressions without rescue breathing.

Prevalence of Stroke

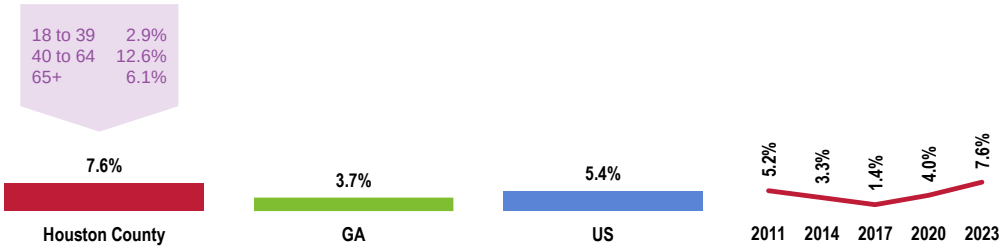
A total of 7.6% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

BENCHMARK ► Two times the statewide percentage.

DISPARITY ► More often reported among adults age 40 to 64.

Prevalence of Stroke

Houston County



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

A total of 43.3% of Houston County adults have been told by a health professional at some point that their blood pressure was high.

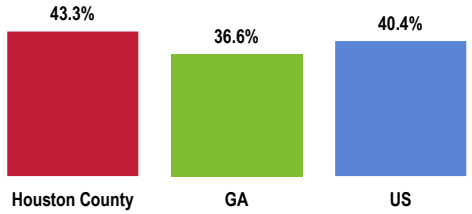
A total of 45.6% of adults have been told by a health professional that their cholesterol level was high.

BENCHMARK ► High cholesterol prevalence is worse than the national finding.

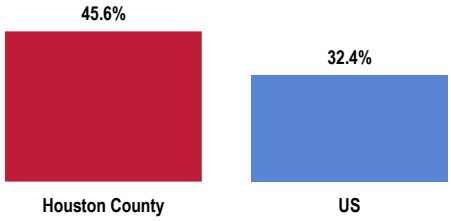
TREND ► High cholesterol prevalence is trending significantly higher over time.

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol

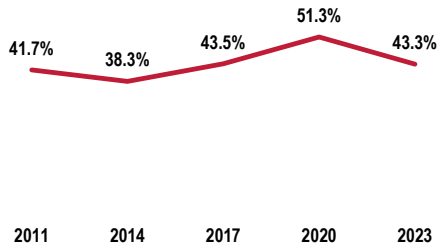


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

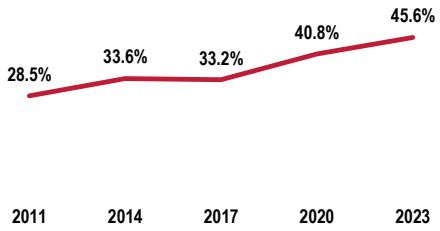
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure (Houston County)

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol (Houston County)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

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.

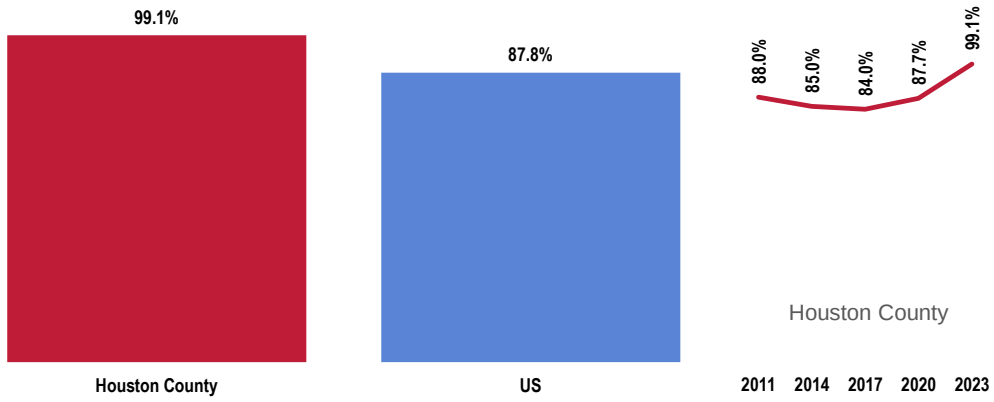
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Nearly all Houston County adults surveyed (99.1%) report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

BENCHMARK ► Considerably higher than the US percentage.

TREND ► Represents a significant increase from previous surveys.

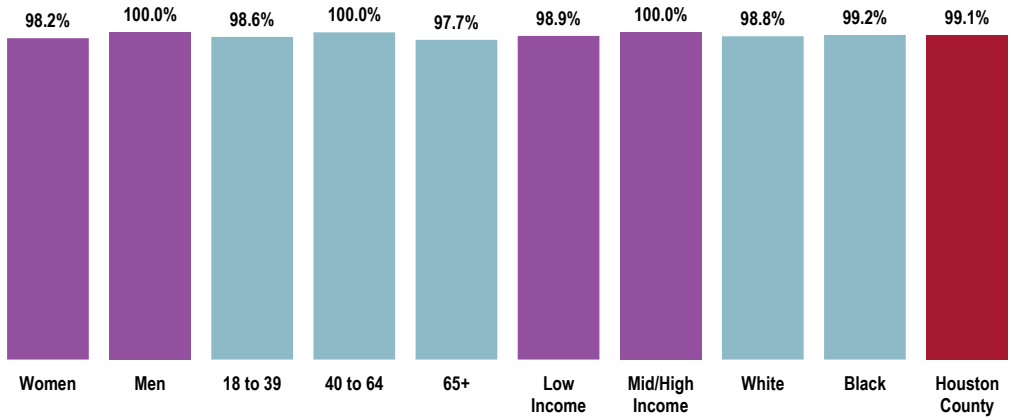
Exhibit One or More Cardiovascular Risks or Behaviors



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 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.

Exhibit One or More Cardiovascular Risks or Behaviors
(Houston County, 2023)

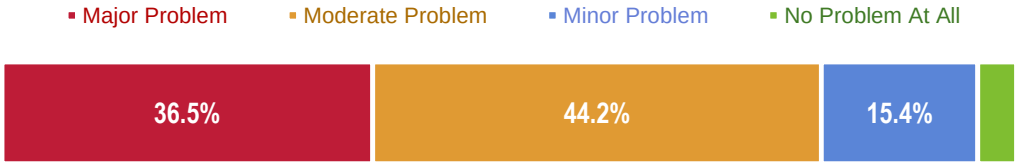


Sources: 2023 PRC Community Health Survey, PRC, Inc. [Item 100]
Notes: Reflects all respondents.
Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

Key informants taking part in an online survey most often characterized *Heart Disease & Stroke* as a "moderate problem" in the community.

Perceptions of Heart Disease & Stroke as a Problem in the Community
(Among Key Informants; Houston County, 2023)



Sources: 2023 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

> Heart disease and stroke continue to be among the leading causes of death for the nation, including our community. According to the Institute for Health Metrics, Bibb County exceeded the state and national averages over the past years. Houston County is slightly below the state and national rates for heart disease. – Community/Business Leader
>
> It's not JUST our community, but this continues to be a leading cause of death across our nation. I am reasonably healthy and blessed, but I take 3 medications for hypertension, and I encounter many others who share similar situations. In my relationships, I often hear of those having open-heart surgery, are in rehab to overcome the effects of a stroke, etc. – Social Services Provider
>
> National statistics. – Social Services Provider
>
> Heart disease and stroke are regularly listed as the major issues on community health assessments and negative health indicators in Houston County and Middle Georgia. Clinical experience working in health care also supports this as BMI, HgB A1C, health history, cardiac related blood work, and waist circumferences are assessed. – Community/Business Leader
>
> Heart disease remains the leading cause of death in adults over 45. Stroke is also a major cause of disability and death in the older adult population. – Community/Business Leader

> High blood pressure. – Social Services Provider

Obesity

> Obesity rates and the sedentary nature of our community. – Community/Business Leader
>
> People tend to be overweight, and that contributes to the perception, as does the number of people diagnosed. – Community/Business Leader
>
> Obesity is causing more heart problems. – Physician

Comorbidities

> With obesity and diabetes being problems, we undoubtedly have issues with heart disease and stroke. I hear about younger and younger people having to seek medical advice and treatment from cardiac specialists in our area. Oftentimes, the wait for an appointment is lengthy – so it's obvious that many people are being referred for heart problems. We are in close proximity to two hospitals where invasive cardiac surgery is performed and where stroke protocols are preached. These areas of medicine wouldn't be so prominent if there weren't local needs. – Other Health Provider
>
> Uncontrolled blood pressure and diabetes. – Community/Business Leader

Lifestyle

> Because as a community, we are plagued with folks with unhealthy habits and do not exercise and eat right. – Community/Business Leader
>
> Poor diet and lack of preventative care. – Social Services Provider

Uninsured/Underinsured Populations

> Uninsured, low-income seniors and residents who have uncontrolled hypertension, hyperlipidemia, and obesity are high-risk candidates for these types of problems. – Community/Business Leader

Awareness/Education

> I feel we need more education on obesity and exercise to get people more aware of what they need to do to stay healthy. – Community/Business Leader

CANCER

ABOUT CANCER

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)

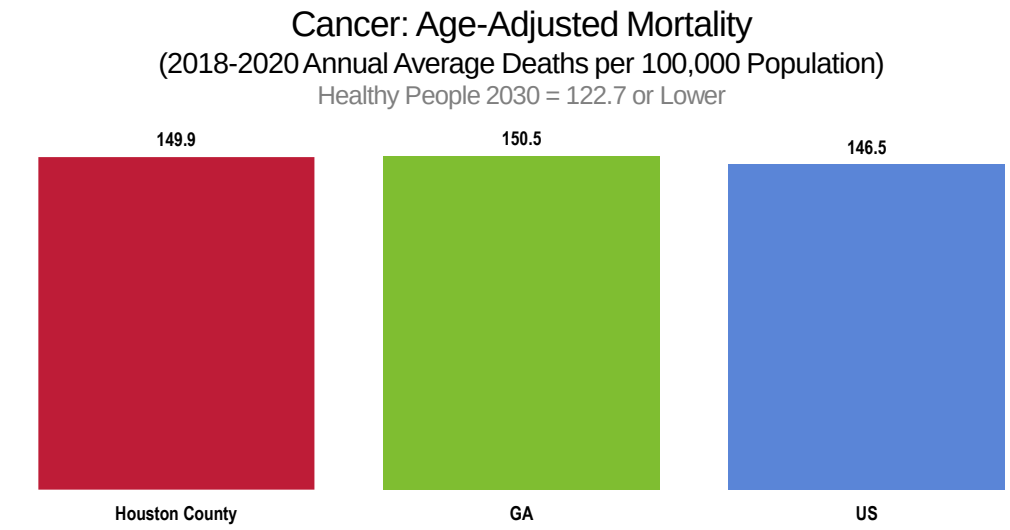
Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2018 and 2020, there was an annual average age-adjusted cancer mortality rate of 149.9 deaths per 100,000 population in Houston County.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Higher among Black residents than among White residents.



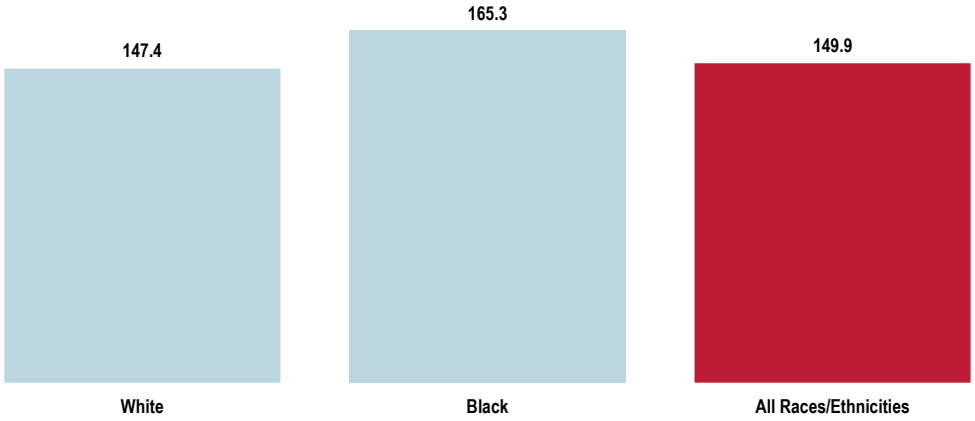
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Cancer: Age-Adjusted Mortality by Race/Ethnicity

(2018-2020 Annual Average Deaths per 100,000 Population; Houston County)

Healthy People 2030 = 122.7 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 April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
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- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Race categories reflect individuals without Hispanic origin.

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	169.4	156.8	161.8	159.4	162.9	154.7	153.5	149.9
GA	169.0	167.4	165.4	162.9	159.4	155.8	152.9	150.5
US	171.5	168.0	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in Houston County.

Other leading sites include female breast cancer, prostate 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 ► Fails to satisfy the Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

	Houston County	GA	US	Healthy People 2030
ALL CANCERS	**149.9**	**150.5**	**146.5**	**122.7**
Lung Cancer	**39.5**	**35.7**	**33.4**	**25.1**
Female Breast Cancer	**19.0**	**20.2**	**19.4**	**15.3**
Prostate Cancer	**18.4**	**20.6**	**18.5**	**16.9**
Colorectal Cancer	**14.0**	**14.0**	**13.1**	**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 April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

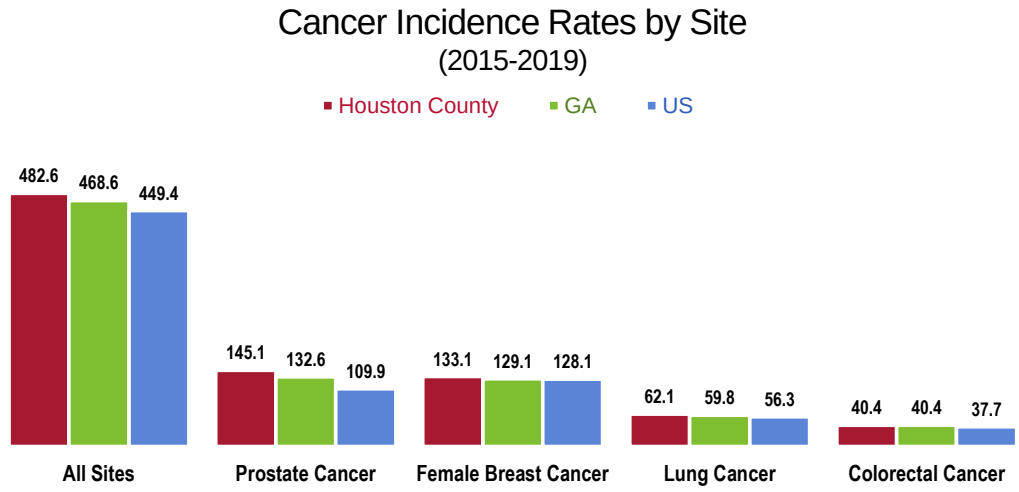
Cancer Incidence

"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 are for prostate cancer and female breast cancer.

BENCHMARK

Prostate Cancer ► Higher than the national rate.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

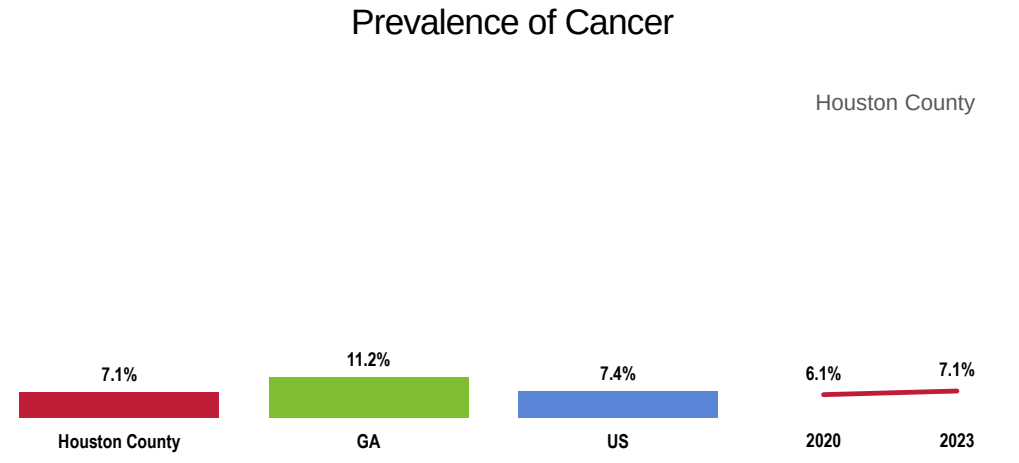
Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population.

Prevalence of Cancer

A total of 7.1% of surveyed Houston County adults report having ever been diagnosed with cancer.

BENCHMARK ► Lower than found across Georgia.

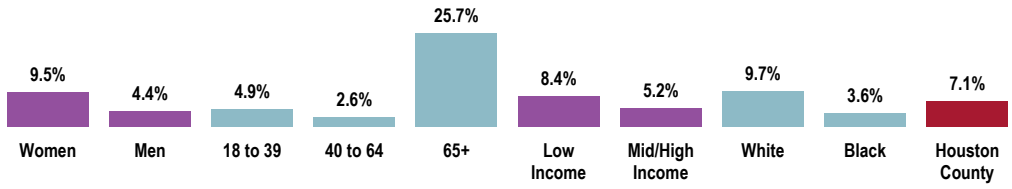
DISPARITY ► Particularly high among adults age 65+.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Cancer
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: ● Asked of all respondents.

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 the following cancer sites:

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 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 age 21 to 29 years. For women age 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.

COLORECTAL CANCER

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

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

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

Among women age 50 to 74, 90.9% have had a mammogram within the past 2 years.

BENCHMARK ► More favorable than the state and especially the national percentage.

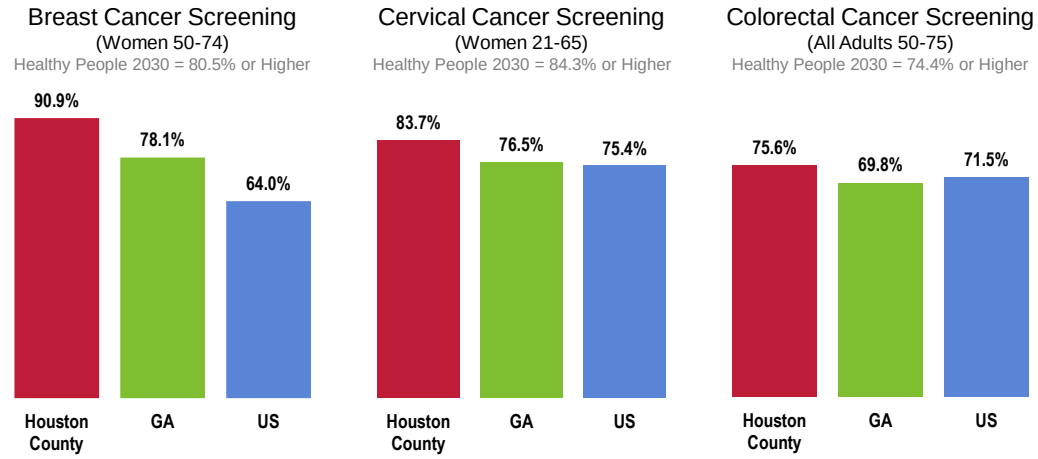
TREND ► Rising significantly higher over time.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every 3 years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Among Houston County women age 21 to 65, 83.7% have had appropriate cervical cancer screening.

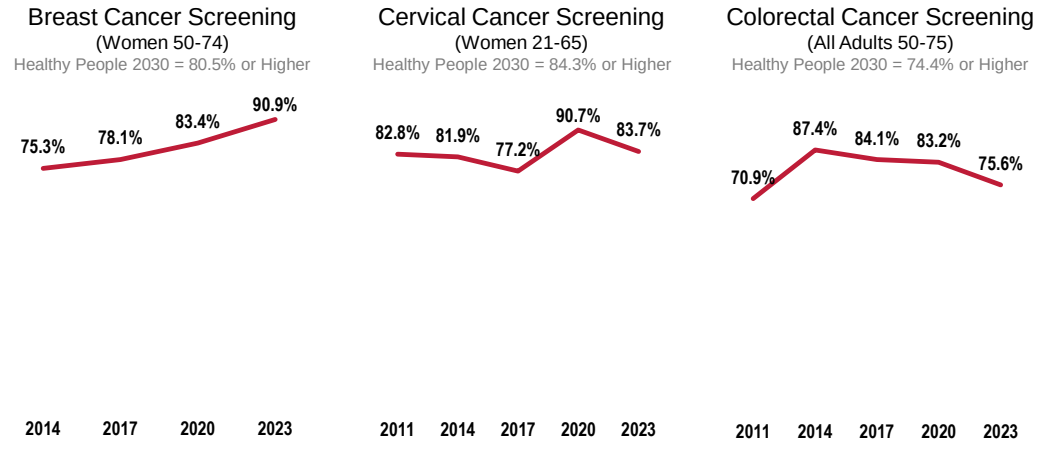
Among all adults age 50 to 75, 75.6% have had appropriate colorectal cancer screening.

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



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

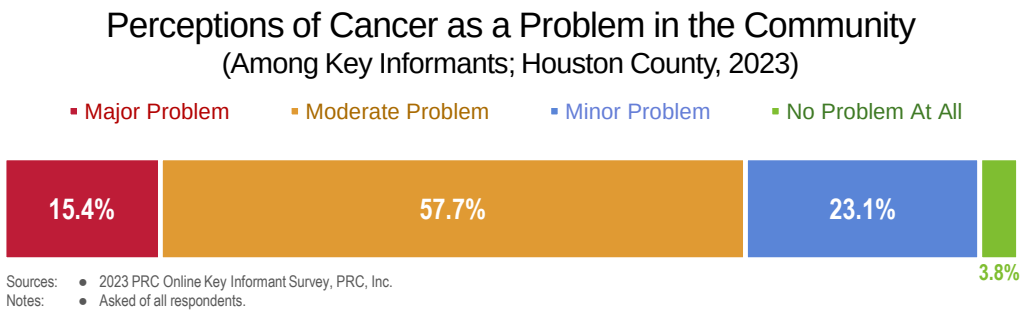


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.



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

Incidence/Prevalence

> Too many cases. – Community/Business Leader
>
> Many different types of cancers in Bibb County, Georgia exceed the state and national rates. – Community/Business Leader
>
> We continually hear of people being diagnosed with cancer, particularly pancreatic, which is often devastating. In my personal circle of friends and acquaintances, I know at least ten people battling cancer or who have died in recent years. – Social Services Provider
>
> Occurring way too often. I know at least ten people dealing with cancer right now. – Social Services Provider
>
> The number of people who have been diagnosed and/or passed away is significant. – Community/Business Leader
>
> Rates are increasing and the quality of care in Houston County is decreasing. – Community/Business Leader

Access to Care for Uninsured/Underinsured

> There are no resources for cancer patients if you are uninsured. Women do have access to cancer treatment for breast cancer provided by the state of Georgia. – Community/Business Leader

Access to Care/Services

> Residents have to travel too far to access novel treatments. Winship at Emory even has deficiencies. – Community/Business Leader

Follow-Up/Support

> Because there isn't enough support for cancer treatment. – Social Services 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.

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

Note that this section also includes data relative to COVID-19 (coronavirus disease).

Age-Adjusted Respiratory Disease Deaths

Lung Disease Deaths

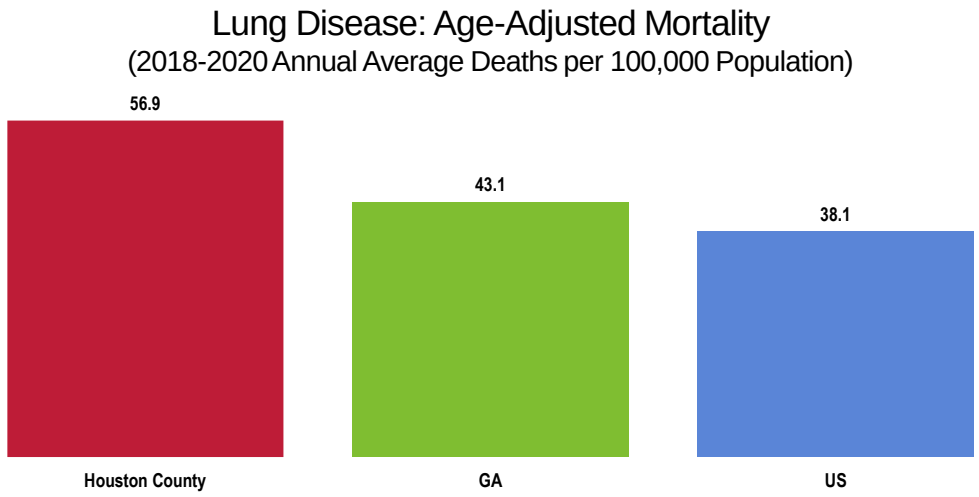
Note: Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

Between 2018 and 2020, Houston County reported an annual average age-adjusted lung disease mortality rate of 56.9 deaths per 100,000 population.

BENCHMARK ► Worse than state and national rates.

TREND ► Marks a significant increase within the county over time (counter to state and national trends).

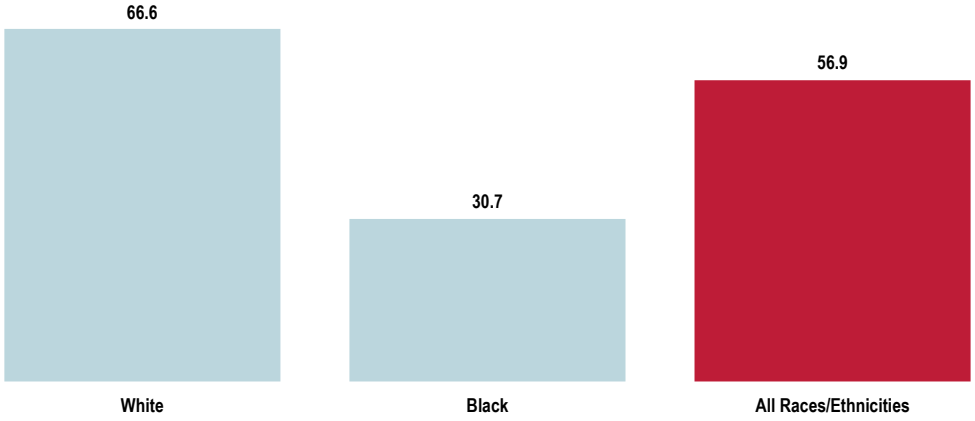
DISPARITY ► The rate among White residents is more than twice the rate among Black residents.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- 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.

Lung Disease: Age-Adjusted Mortality by Race/Ethnicity
(2018-2020 Annual Average Deaths per 100,000 Population; Houston 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 April 2023.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- 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.
- Race categories reflect individuals without Hispanic origin.

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

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	42.3	43.7	48.8	53.5	53.7	57.2	58.3	56.9
GA	45.2	45.3	45.9	46.5	46.7	46.4	44.7	43.1
US	46.5	46.2	41.8	41.3	41.0	40.4	39.6	38.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

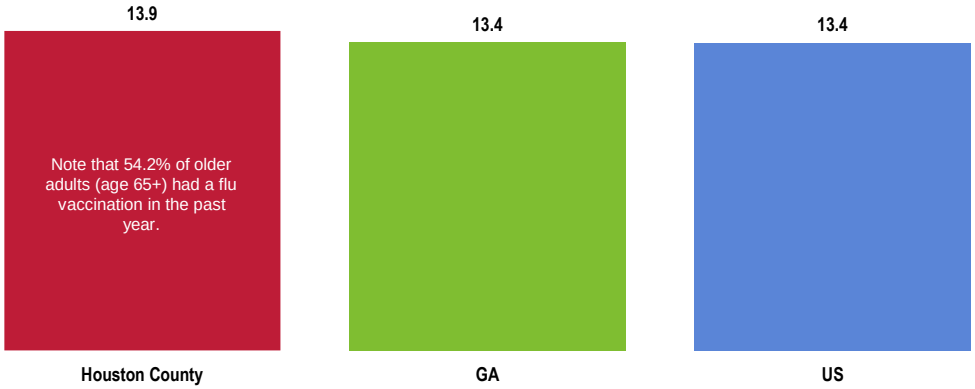
Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Pneumonia/Influenza Deaths

Between 2018 and 2020, Houston County reported an annual average age-adjusted pneumonia/influenza mortality rate of 13.9 deaths per 100,000 population.

TREND ► Declining significantly to the lowest level recorded within the county in nearly a decade.

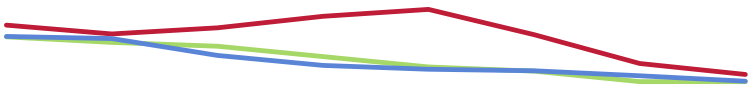
Pneumonia/Influenza: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 108]
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	17.8	17.1	17.6	18.5	19.1	17.1	14.8	13.9
GA	16.9	16.5	16.2	15.3	14.5	14.2	13.4	13.4
US	16.9	16.8	15.4	14.6	14.3	14.2	13.8	13.4

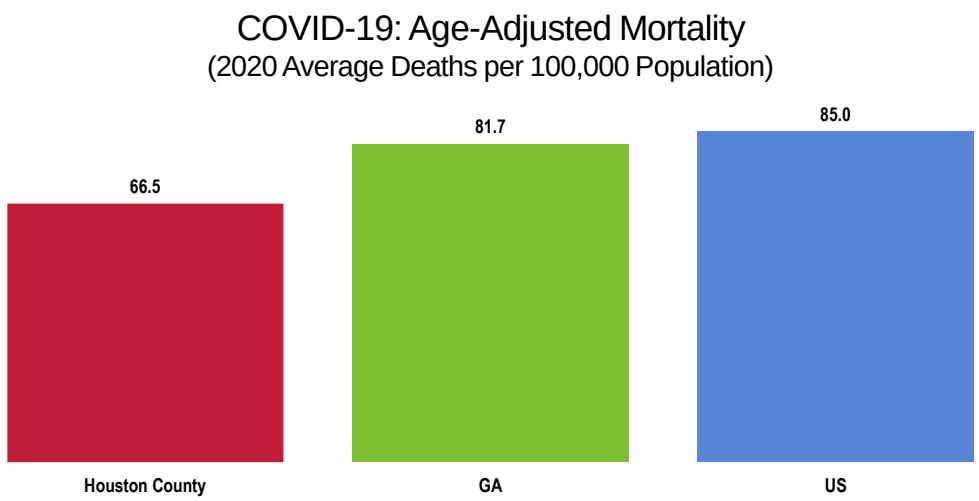
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

COVID-19 (Coronavirus Disease) Deaths

The 2020 age-adjusted COVID-19 mortality rate was 66.5 deaths per 100,000 population in Houston County.

BENCHMARK ► Lower than state and national rates.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

Prevalence of Respiratory Disease

Asthma

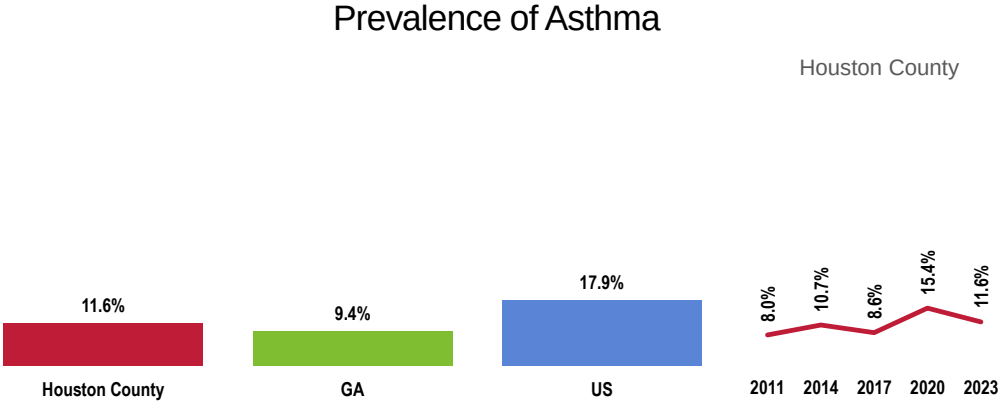
Adults

A total of 11.6% of Houston County adults have asthma.

BENCHMARK ► Lower than the US prevalence.

DISPARITY ► More often reported among women.

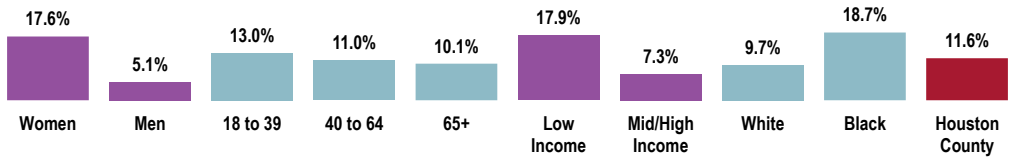
Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Asthma
(Houston County, 2023)

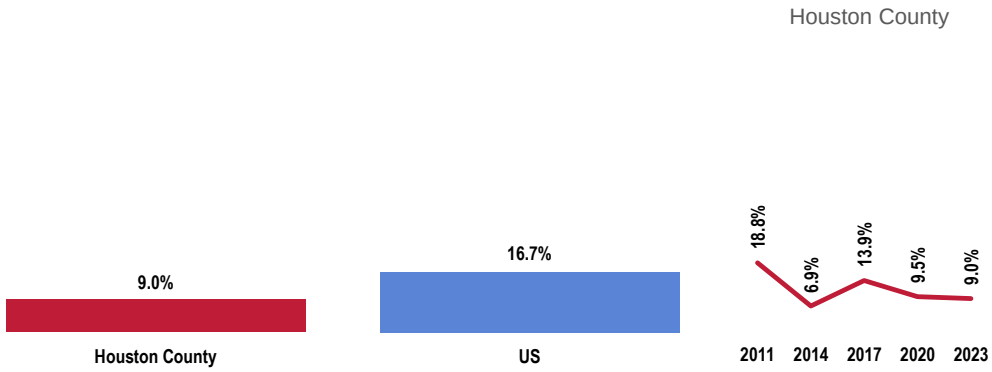


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 26]
Notes: ● Asked of all respondents.

Children

Among Houston County children under age 18, 9.0% have been diagnosed with asthma.

Prevalence of Asthma in Children
(Children 0-17)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 92]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

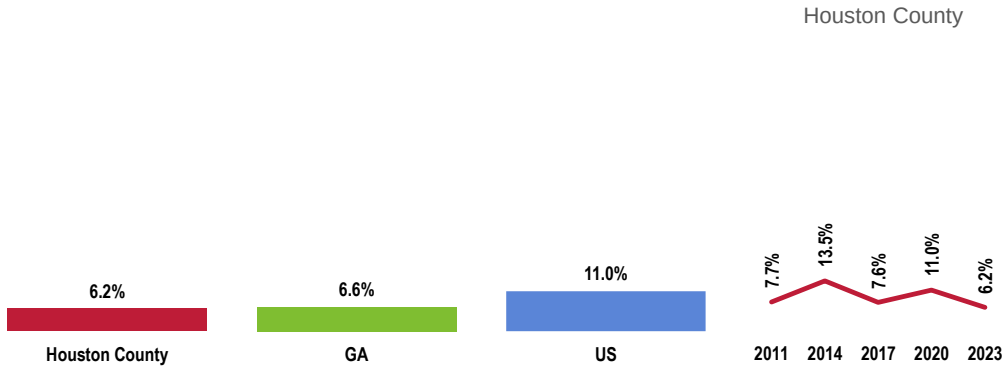
Chronic Obstructive Pulmonary Disease (COPD)

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

A total of 6.2% of Houston County adults suffer from chronic obstructive pulmonary disease (COPD).

BENCHMARK ▶ Lower than found nationally.

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)



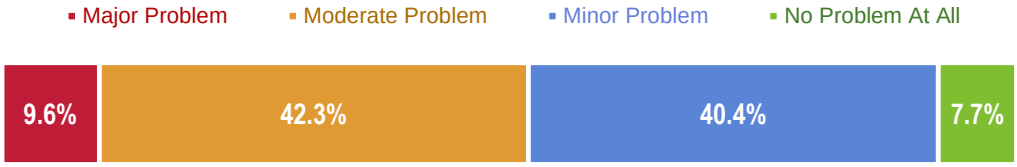
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

Key informants taking part in an online survey most often characterized *Respiratory Disease* as a "moderate problem" in the community.

Perceptions of Respiratory Disease as a Problem in the Community
(Among Key Informants; Houston County, 2023)



Sources:
- 2023 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

> Respiratory diseases such as COVID-19, COPD, asthma, and other respiratory illnesses have been a major problem in our community since the beginning of the pandemic. These conditions continue to be a problem due to lack of vaccination, lack of health literacy, smoking habits, environmental factors (e.g., exposure to secondhand smoke), and other reasons. – Community/Business Leader

Due to COVID-19

> Seem to be on the other side of the pandemic, but it is still an issue. Lost work, businesses suffered, etc. – Community/Business Leader

Affordable Medications/Supplies

> Having asthma and COPD, cannot afford medication or have access to specialty services. – Community/Business Leader

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 2018 and 2020, there was an annual average age-adjusted unintentional injury mortality rate of 37.3 deaths per 100,000 population in Houston County.

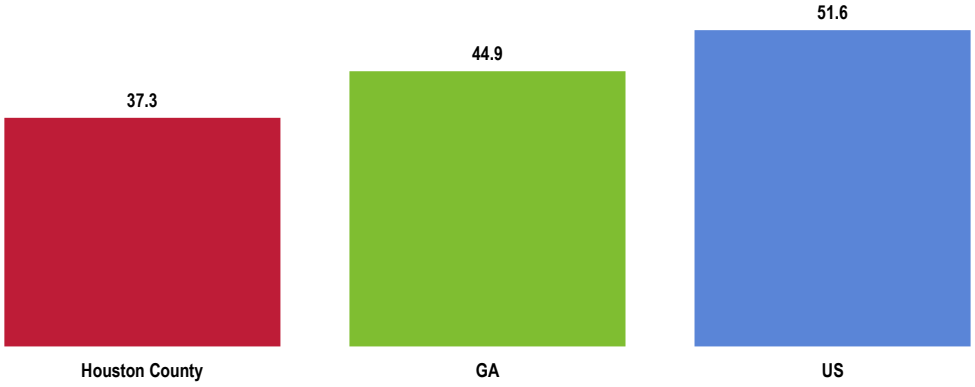
BENCHMARK ► Lower than state and national rates. Satisfies the Healthy People 2030 objective.

DISPARITY ► Higher among White residents than among Black residents.

Unintentional Injuries: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



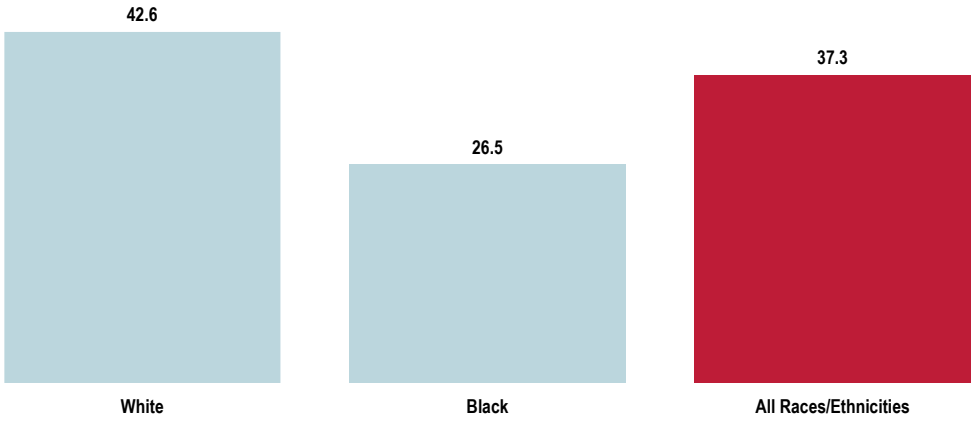
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Unintentional Injuries: Age-Adjusted Mortality by Race/Ethnicity

(2018-2020 Annual Average Deaths per 100,000 Population; Houston County)

Healthy People 2030 = 43.2 or Lower



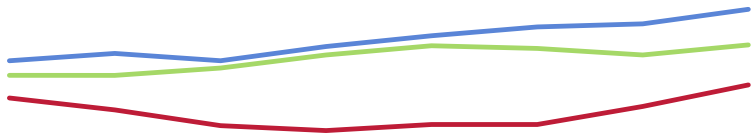
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Race categories reflect individuals without Hispanic origin.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	34.9	32.6	29.6	28.7	29.9	29.9	33.2	37.3
GA	39.2	39.1	40.5	43.0	44.7	44.2	43.0	44.9
US	41.9	43.3	41.9	44.6	46.7	48.3	48.9	51.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

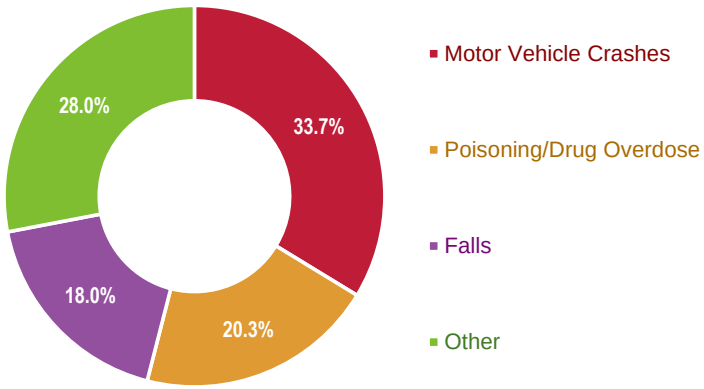
Leading Causes of Unintentional Injury Deaths

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

Motor vehicle crashes, poisoning (including unintentional drug overdose), and falls accounted for most unintentional injury deaths in Houston County between 2018 and 2020.

Leading Causes of Unintentional Injury Deaths

(Houston County, 2018-2020)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

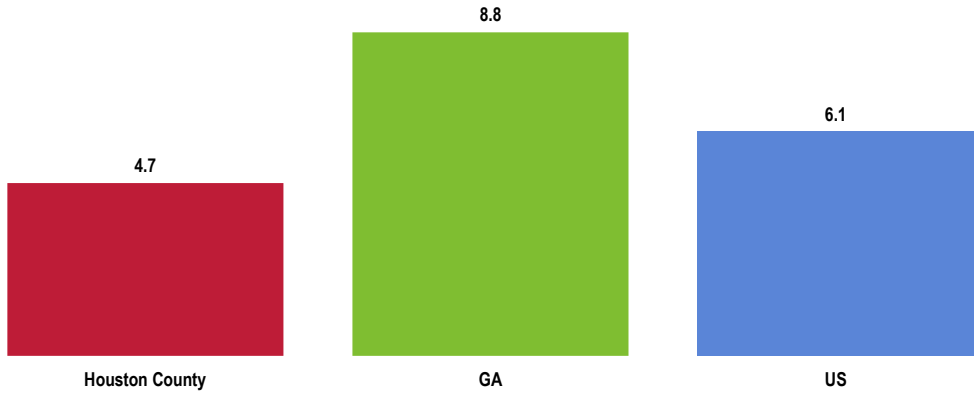
RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

In Houston County, there were 4.7 homicides per 100,000 population (2011-2020 annual average age-adjusted rate).

BENCHMARK ► Lower than found across Georgia and the US. Satisfies the Healthy People 2030 objective.

DISPARITY ► Higher among Black residents than among White residents.

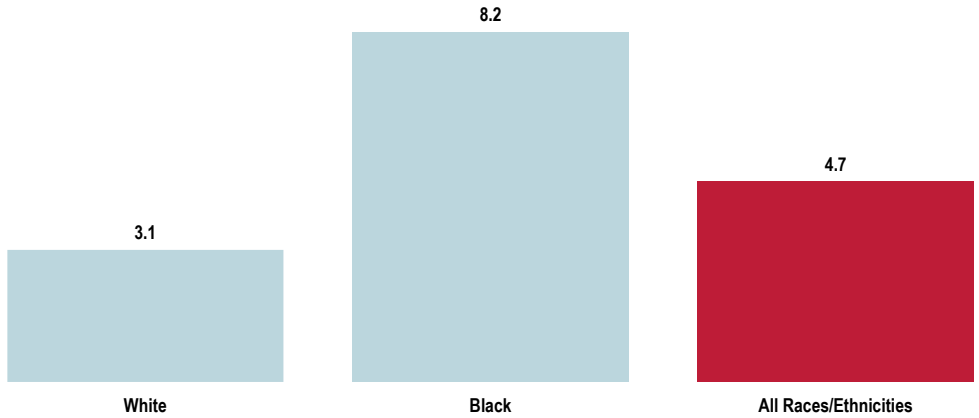
Homicide: Age-Adjusted Mortality
(2011-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Homicide: Age-Adjusted Mortality by Race/Ethnicity
(2018-2020 Annual Average Deaths per 100,000 Population; Houston County)
Healthy People 2030 = 5.5 or Lower



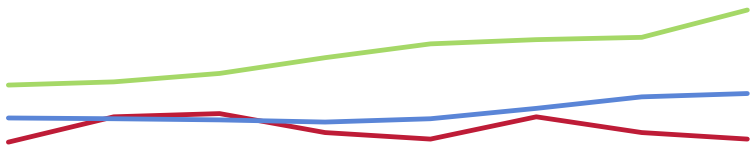
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Race categories reflect individuals without Hispanic origin.

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 5.5 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	4.6	5.4	5.5	4.9	4.7	5.4	4.9	4.7
GA	6.4	6.5	6.8	7.3	7.7	7.8	7.9	8.8
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Violent Crime

Violent Crime Rates

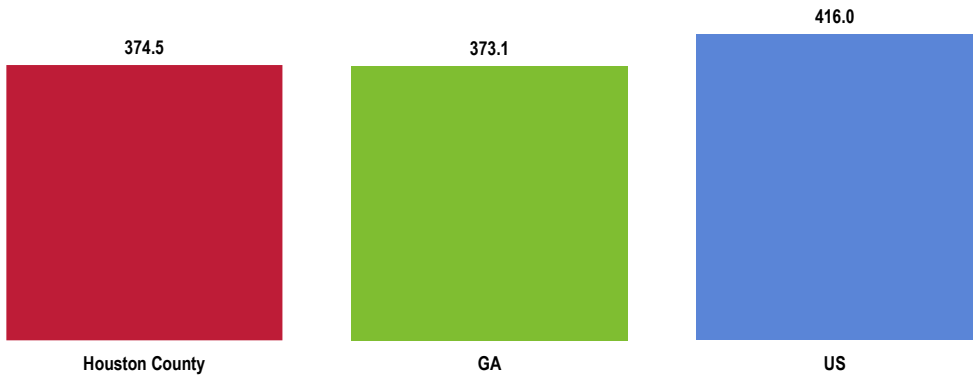
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

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

Between 2015 and 2017, Houston County reported 374.5 violent crimes per 100,000 population.

Violent Crime Rate

(Reported Offenses per 100,000 Population, 2015-2017)



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 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, forcible rape, robbery, and aggravated assault.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

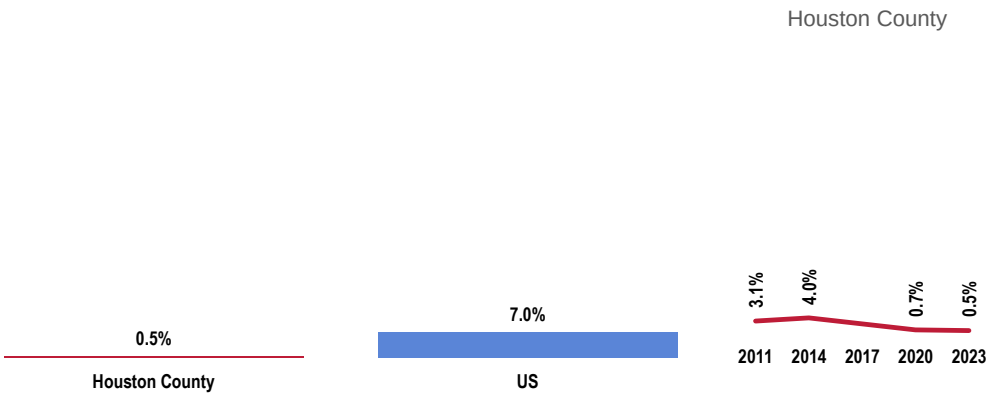
Community Violence

Fewer than 1.0% of surveyed adults (0.5%) acknowledge being the victim of a violent crime in the area in the past five years.

BENCHMARK ► Well below the national percentage.

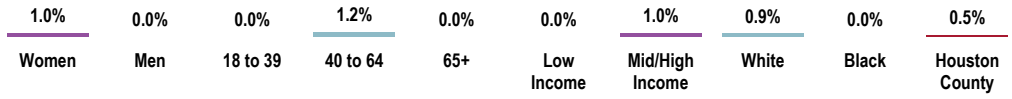
TREND ► Decreasing significantly over time.

Victim of a Violent Crime in the Past Five Years



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 32]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Victim of a Violent Crime in the Past Five Years
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 32]
Notes: ● Asked of all respondents.

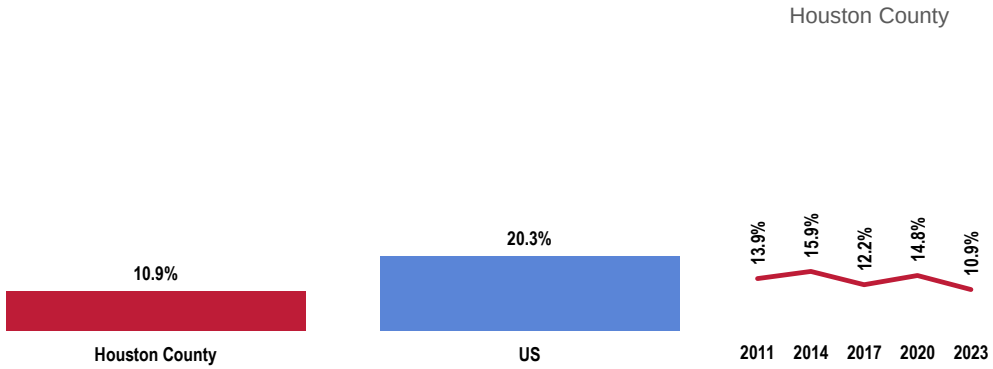
Intimate Partner Violence

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 10.9% of Houston County adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

BENCHMARK ► Lower than the US percentage.

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



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

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

Perceptions of Injury & Violence as a Problem in the Community
(Among Key Informants; Houston County, 2023)

Sources: ● 2023 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 rates of injury and violence in Houston County exceed the national rate, according to the U.S. News and World Report Healthiest Communities Report for 2022. – Community/Business Leader
>
> Based on the news, violence is reported daily, but no strategy mentioned. – Social Services Provider
>
> As Warner Robins grows, it brings big-city problems like violence to town. Not as bad as Macon, but it will not take long to get there. – Social Services Provider

Gun Violence

> Increasing number of gunshots and stab wounds. Crime has increased. – Community/Business Leader

Law Enforcement

> With uncontrolled growth and poor planning by our municipalities, there are too few resources focusing on community policing. We must have more robust and effective law enforcement, aggressive DA officials, and firm judges. – Community/Business Leader

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.

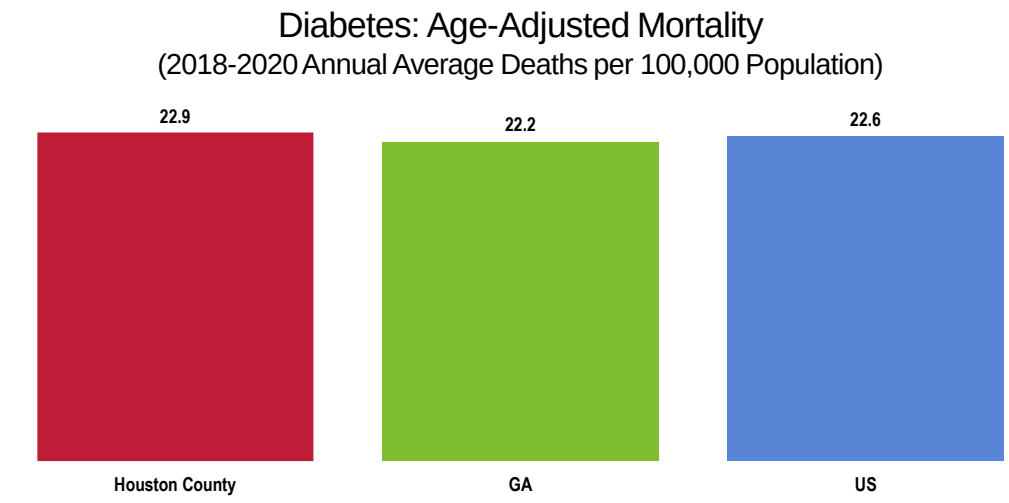
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity,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

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

Age-Adjusted Diabetes Deaths

Between 2018 and 2020, there was an annual average age-adjusted diabetes mortality rate of 22.9 deaths per 100,000 population in Houston County.

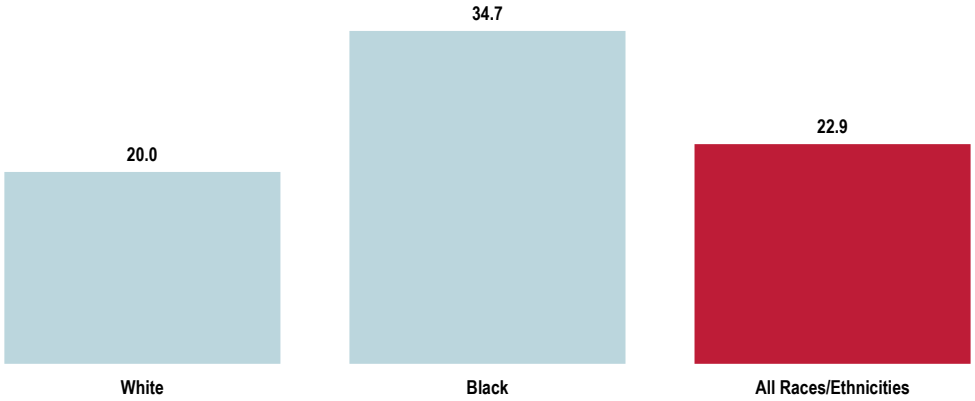
DISPARITY ► Higher among Black residents than among White residents.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

Diabetes: Age-Adjusted Mortality by Race/Ethnicity
(2018-2020 Annual Average Deaths per 100,000 Population; Houston 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 April 2023.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Race categories reflect individuals without Hispanic origin.

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

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	23.7	22.3	25.9	24.5	24.8	22.1	19.9	22.9
GA	23.1	22.6	22.2	21.6	21.4	21.6	21.4	22.2
US	22.4	22.3	21.3	21.2	21.3	21.3	21.5	22.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

Prevalence of Diabetes

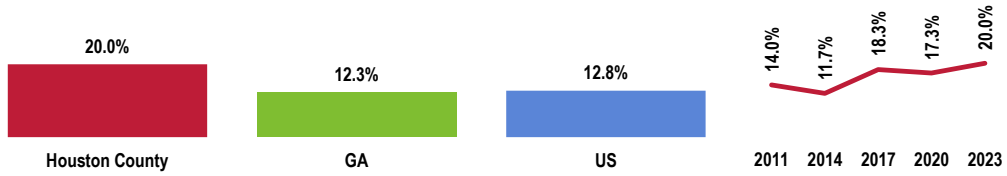
A total of 20.0% of Houston County adults report having been diagnosed with diabetes.

BENCHMARK ► Higher than found across Georgia and the US.

DISPARITY ► More often reported among men and among those age 40+ (note the correlation with age).

Prevalence of Diabetes

Another 7.2% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

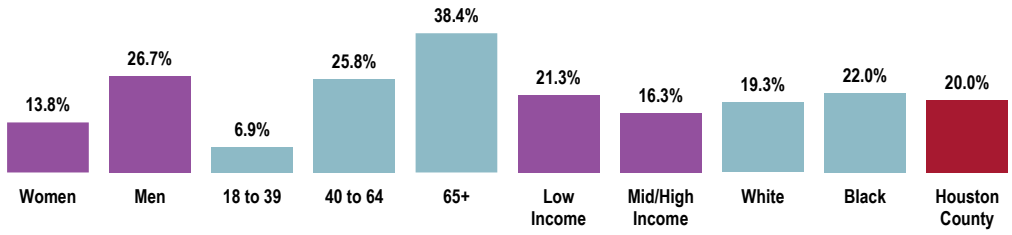


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(Houston County, 2023)

Note that among adults who have not been diagnosed with diabetes, 48.5% report having had their blood sugar level tested within the past three years.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 106, 304]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Age-Adjusted Kidney Disease Deaths

ABOUT KIDNEY DISEASE & DIABETES

Chronic kidney disease (CKD) is common in people with diabetes. Approximately one in three adults with diabetes has CKD. Both type 1 and type 2 diabetes can cause kidney disease. CKD often develops slowly and with few symptoms. Many people don't realize they have CKD until it's advanced and they need dialysis (a treatment that filters the blood) or a kidney transplant to survive.

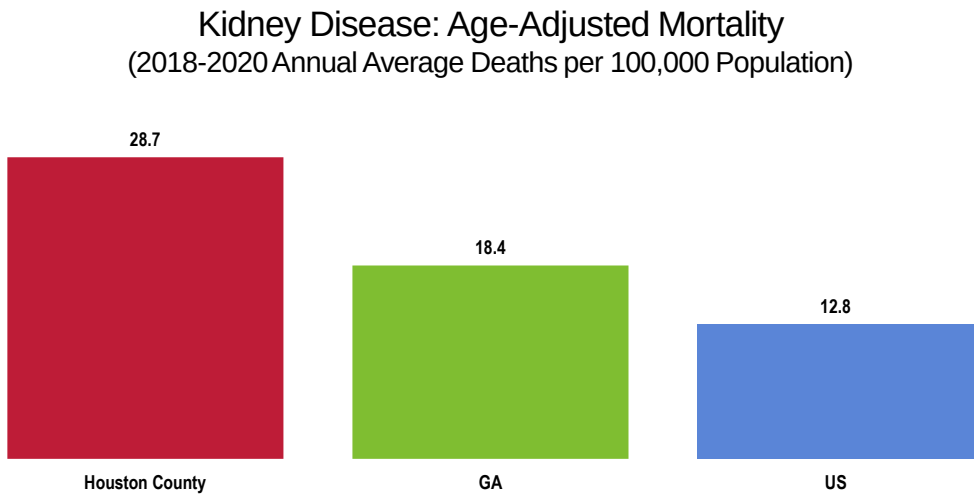
– Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html

Between 2018 and 2020, there was an annual average age-adjusted kidney disease mortality rate of 28.7 deaths per 100,000 population in Houston County.

BENCHMARK ► Higher than the statewide rate and especially the national rate.

TREND ► Marks a significant increase within the county over time.

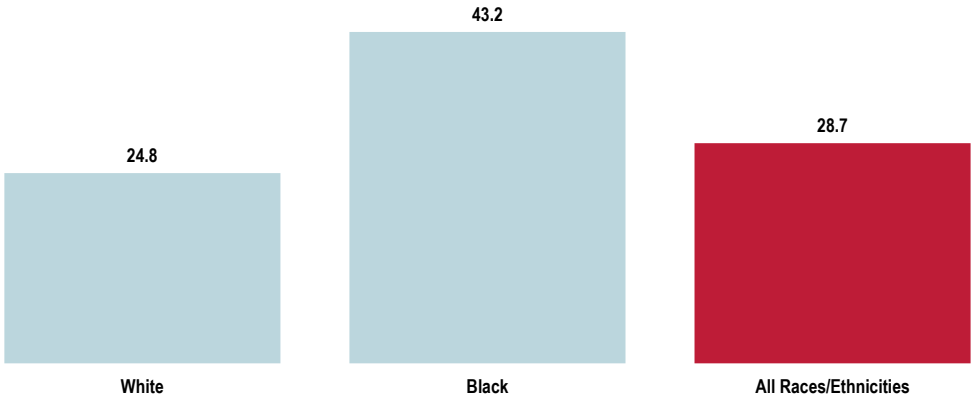
DISPARITY ► Higher among Black residents than among White residents.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

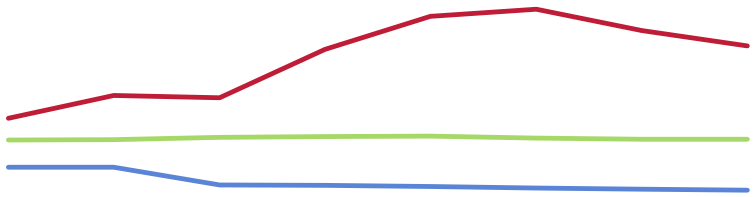
Kidney Disease: Age-Adjusted Mortality by Race/Ethnicity
(2018-2020 Annual Average Deaths per 100,000 Population; Houston County)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Race categories reflect individuals without Hispanic origin.

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	20.7	23.2	23.0	28.3	31.9	32.7	30.4	28.7
GA	18.3	18.3	18.6	18.7	18.7	18.5	18.4	18.4
US	15.3	15.3	13.3	13.3	13.2	13.0	12.9	12.8

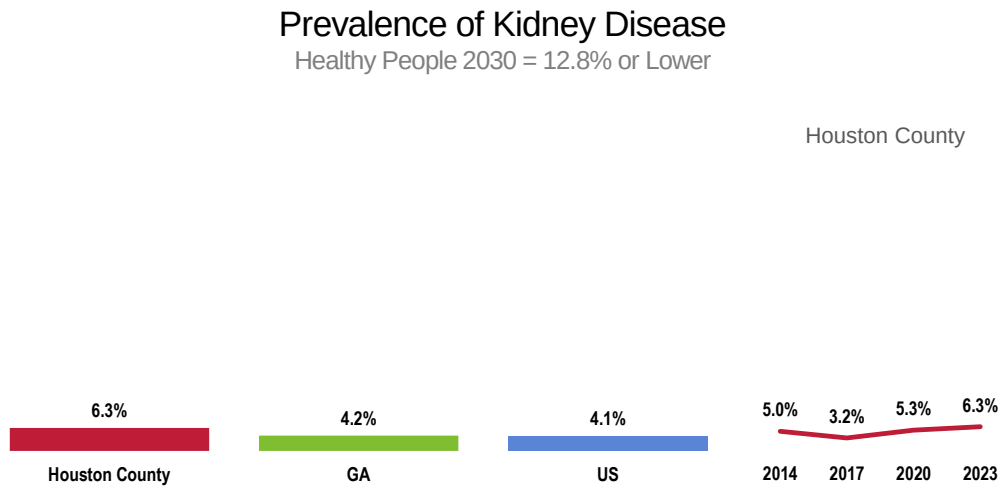
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

Prevalence of Kidney Disease

A total of 6.3% of Houston County adults report having been diagnosed with kidney disease.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

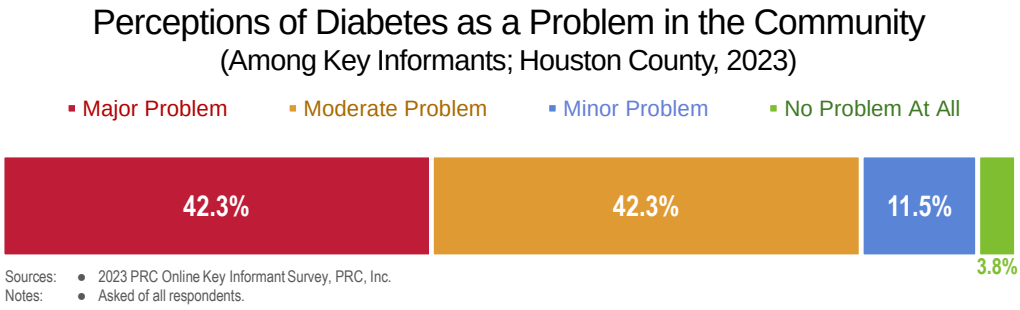


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 303]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Key Informant Input: Diabetes

Key informants taking part in an online survey were equally likely to characterize *Diabetes* as a "major problem" or a "moderate problem" in the community.



Sources:
- 2023 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:

Awareness/Education

> I believe the biggest challenge for people with diabetes is the lack of education regarding foods and how it affects one's blood sugar. I feel that health care providers often assign diagnoses and give follow up appointments but fail to educate their patients on how to effectively manage their disease. We are limited in the number of diabetes specialists in this area, which therefore limits the amount of time and resources that providers are able to invest in this area. Classes on food selection and preparation, as well as how those foods directly relate to blood sugar, would be highly beneficial. – Other Health Provider

> Diabetes is a complicated diagnosis. It takes a lot of time and effort for people to learn how to manage their diabetes. Making diabetes education, as well as prevention information, more readily available would be good. Classes at Educare are great, but we need to find multiple ways to get information out. – Other Health Provider
>
> Education. – Social Services Provider
>
> Education and prevention, particularly among the working uninsured. Limited access to endocrinologists in Houston County. Appointments take forever. – Community/Business Leader
>
> Understanding of and adherence to diet and nutrition guidelines. – Community/Business Leader
>
> Getting information about the correct diet and treatments. – Community/Business Leader
>
> Education and change of lifestyle where they do regular exercises. – Physician

Nutrition

> Nutrition. Many diabetics do not feel the need to seek out information on how to maintain a healthy lifestyle to prevent diabetes. The other challenge is care for diabetics who do not have insurance or the finances to afford healthy food. Houston County is considered a food desert. There are more fast food and unhealthy food choices than food choices for our county. Therefore, this leads to issues with not only diabetes, but hypertension. Lack of insurance means patients who struggle with finances will eventually incur health bills because they have put off caring for themselves. I also believe education in the community at the elementary level will encourage healthy eating early. – Physician
>
> Diet, the knowledge of correct foods and amounts of food to eat. Access to a diabetologist or endocrinologist. Access to the latest innovations in diabetic care. Weight loss. – Community/Business Leader
>
> Disciplining themselves in maintaining a proper diet. Accompanying illnesses such as kidney failure, heart disease, etc. Also, the strain placed on those who care for them, especially family. – Community/Business Leader

Affordable Medications/Supplies

> Being able to afford insulin and diabetic products. – Community/Business Leader
>
> Cost of medication. Lack of health literacy concerning prediabetes, the importance of screening and other diabetes-related education. – Community/Business Leader
>
> The lack of affordable medication and education on diabetes. – Social Services Provider

Lifestyle

> Poor diet and lack of exercise all lead to people being heavier. This sedentary lifestyle, coupled with lack of available health care to monitor one's health, exacerbates the problem. – Social Services Provider
>
> Weight, lack of exercise and early intervention is needed. – Community/Business Leader

Cultural/Personal Beliefs

> Cultural norms for diet and food preferences, food deserts in North Houston County, very easy access to low quality, inexpensive convenience foods like fast foods. Also, lack of ability to obtain health insurance due to cost for preventive care. Physical access to medical care is due to lack of reliable and efficient transportation. – Community/Business Leader

Disease Management

> Not being compliant with their treatment of care and the plan that their physicians or primary care providers have recommended for them. – Community/Business Leader

Follow-Up/Support

> Professional support to incorporate lifestyle changes. – Social Services Provider

Income/Poverty

> Lower-income families do not have financial resources to eat healthy. Declining physical exercise by younger residents. – Community/Business Leader

Lack of Providers

> Not enough specialists. – Community/Business Leader

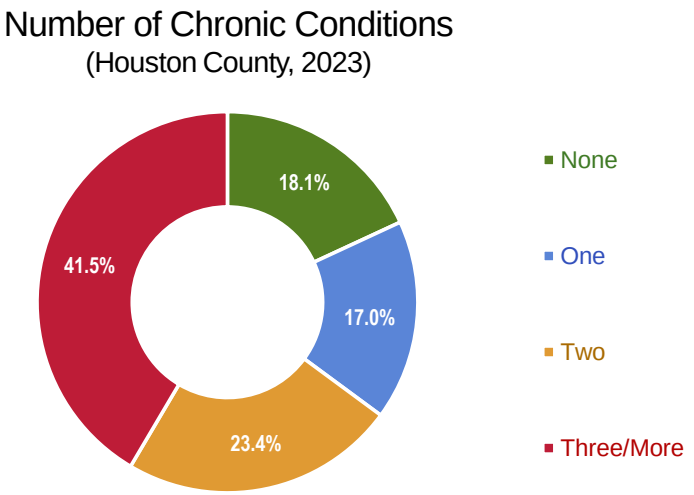
DISABLING CONDITIONS

Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

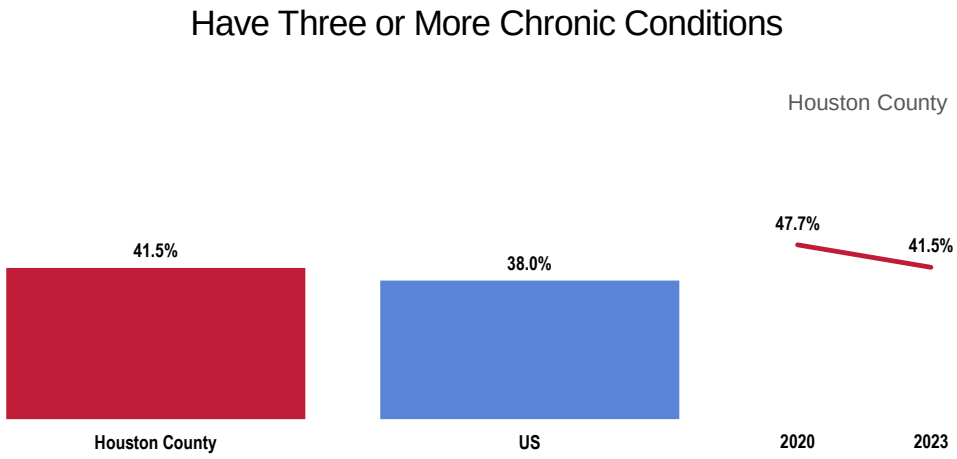
Among Houston County survey respondents, most report having at least one chronic health condition.



Sources: 2023 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: Asked of all respondents.
In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

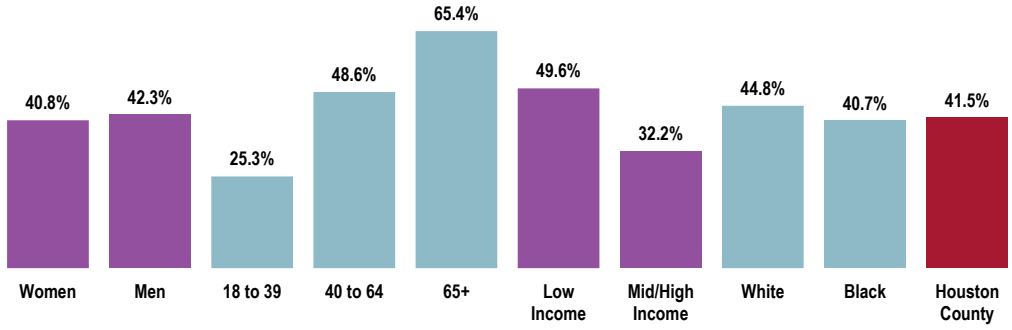
In fact, 41.5% of Houston County adults report having three or more chronic conditions.

DISPARITY ► More often reported among lower-income adults and adults age 40+ (note the correlation with age).



Sources: 2023 PRC Community Health Survey, PRC, Inc. [Item 107]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Have Three or More Chronic Conditions
(Houston County, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: • Asked of all respondents.
• In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

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.

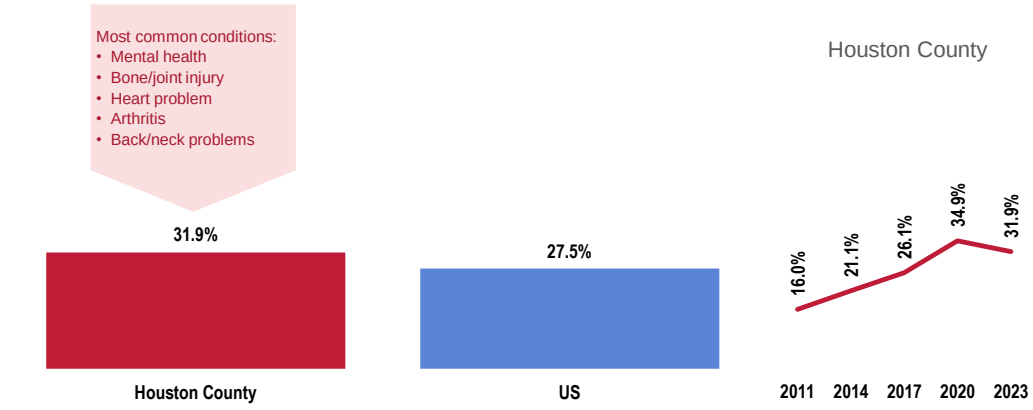
– Healthy People 2030 (https://health.gov/healthypeople)

A total of 31.9% of Houston County adults are limited in some way in some activities due to a physical, mental, or emotional problem.

TREND ► Trending significantly higher over time.

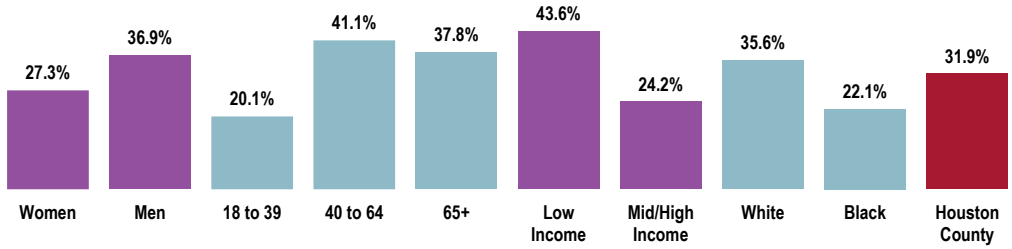
DISPARITY ► More often reported among adults age 40+ and those with lower incomes.

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



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

Chronic Pain

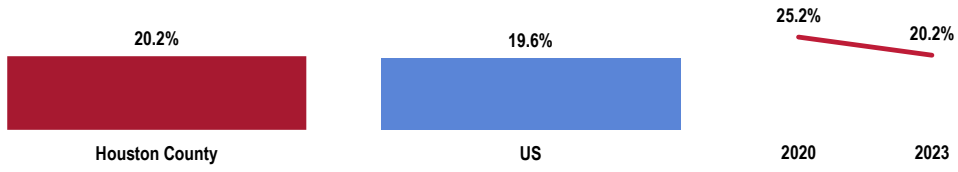
A total of 20.2% of Houston County adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months.

BENCHMARK ► Far from satisfying the Healthy People 2030 objective.

DISPARITY ► More often reported among adults age 40+ and especially those with lower incomes.

Experience High-Impact Chronic Pain

Healthy People 2030 = 6.4% or Lower



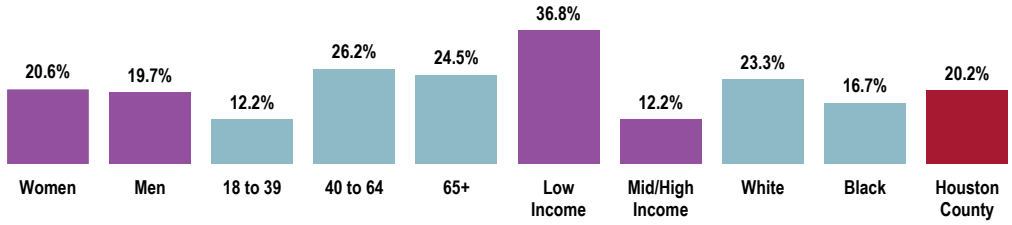
Sources:
- YRNOW PRC Community Health Survey, PRC, Inc. [Item 31]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain

(Houston County, 2023)

Healthy People 2030 = 6.4% or Lower

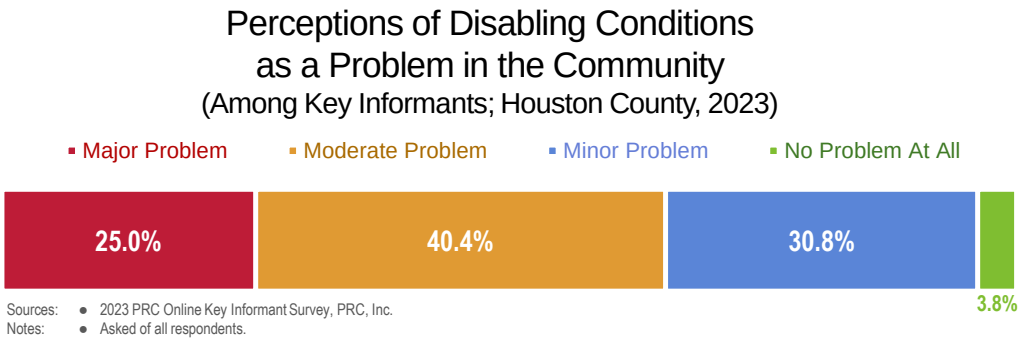


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 31]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disabling Conditions

Key informants taking part in an online survey most often characterized *Disabling Conditions* as a "moderate problem" in the community.



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

Incidence/Prevalence

> These are not unique to Houston County. – Community/Business Leader
>
> Dementia seems to be increasing. – Community/Business Leader
>
> We have a large number of older people with accompanying health issues. – Community/Business Leader

Access to Care for Uninsured/Underinsured

> These are conditions that insurance often does not assist with, the cost of long-term management. Families are often responsible for the care of their loved ones, which affects their ability to continue working outside the home. This is a problem because families often lose their quality of life due to their disability, as well as loss of income. – Social Services Provider
>
> For those without good insurance coverage, access to pain management services is a real challenge. Self-medication can lead to big substance use disorder problems, as well as mental health challenges. Uncontrolled diabetes can also lead to vision loss, amputation of lower extremities, etc. – Other Health Provider

Access to Care Services

> This requires continuous, long-term care, and is difficult to obtain. – Physician
>
> Access to free gym membership, adult day care programs for uninsured, low-income, and senior residents. Safe community parks within walking distance in targeted areas. Vision/hearing exams, glasses and hearing aids are not available for uninsured, low-income and seniors who's on fixed incomes. – Community/Business Leader

Alcohol/Drug Use

> We have an opioid problem, like many other communities. This often begins in trying to battle chronic pain but escalates to addiction or dependence. I know a number of families dealing with Alzheimer's and/or dementia. I've encountered many RAFB workers who have suffered hearing loss due to their exposure to weapons systems and/or airplanes. – Social Services Provider

Awareness/Education

> Need additional education and community resources to care for people dealing with dementia. – Social Services Provider

Due to COVID-19

> Mental health issues are a growing problem for all communities; especially since the COVID-19 pandemic began. As a result, more efforts and resources are being put forth to increase access to Certified Mental Health Counselors and Behavioral Health Specialists. These unique challenges are displayed in our news and media more often. – Community/Business Leader

Caregiving Support

> So many people are caring for a loved one with dementia, Alzheimer's, etc. and feel they have no support. Many people need help but can't afford sitters, and their loved ones aren't ready for hospice care. – Social Services Provider

Transportation

> The lack of public transportation to help people get to areas where they can get exercise, like senior centers or recreation centers, seems to be a big problem. Sidewalk safety is a problem as well in the north side of the county. – Social Services Provider

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia. 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)

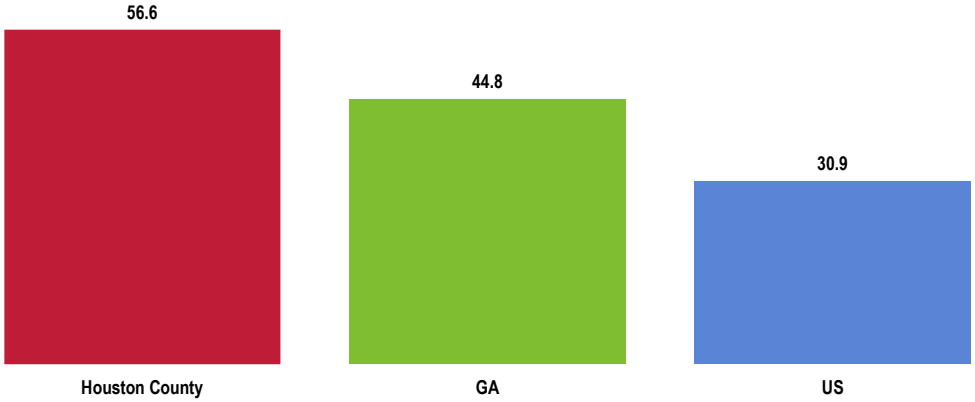
Age-Adjusted Alzheimer's Disease Deaths

Between 2018 and 2020, there was an annual average age-adjusted Alzheimer's disease mortality rate of 56.6 deaths per 100,000 population in Houston County.

BENCHMARK ► Higher than state and national rates.

TREND ► Marks a dramatic increase within the county over time.

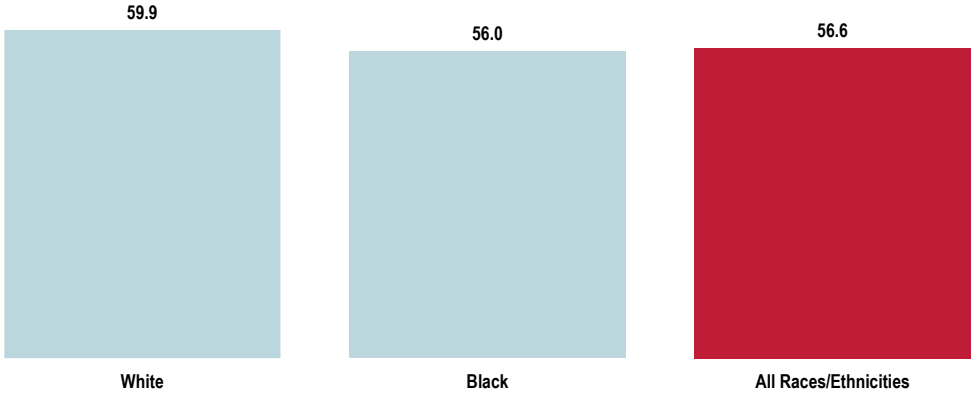
Alzheimer's Disease: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

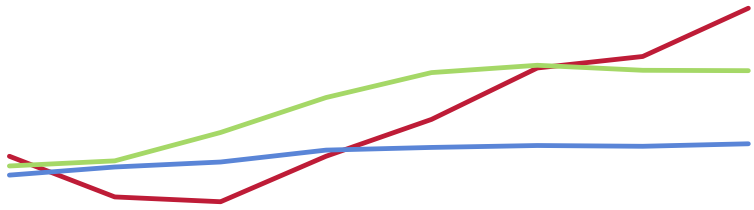
Alzheimer's Disease: Age-Adjusted Mortality by Race/Ethnicity
(2018-2020 Annual Average Deaths per 100,000 Population; Houston County)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Race categories reflect individuals without Hispanic origin.

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	28.6	20.8	19.9	28.5	35.5	45.3	47.4	56.6
GA	26.7	27.6	33.0	39.6	44.4	45.8	44.8	44.8
US	25.0	26.5	27.4	29.7	30.2	30.6	30.4	30.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

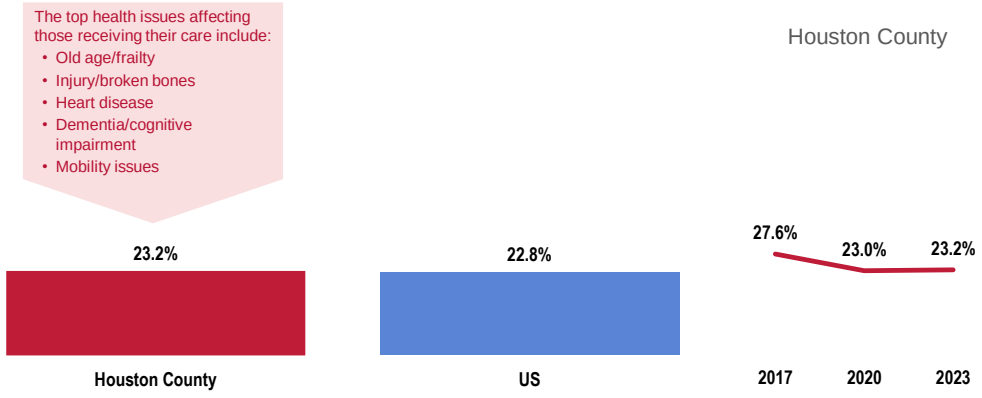
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Caregiving

A total of 23.2% of Houston County adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

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

The top health issues affecting those receiving their care include:
- Old age/frailty
- Injury/broken bones
- Heart disease
- Dementia/cognitive impairment
- Mobility issues



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 85-86]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

BIRTHS

PRENATAL CARE

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

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

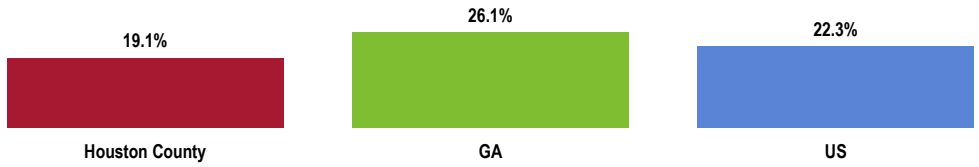
Early and continuous prenatal care is the best assurance of infant health.

Between 2018 and 2020, 19.1% of all Houston County births did <u>not</u> receive prenatal care in the first trimester of pregnancy.

BENCHMARK ► Lower than found across Georgia and the US.

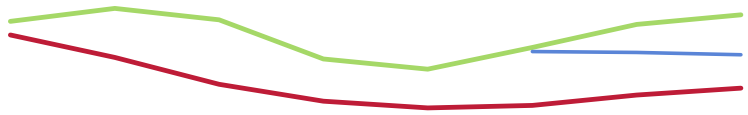
DISPARITY ► Denotes a significant decrease within the county over time.

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births, 2018-2020)



Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: ● This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	24.2%	22.0%	19.5%	17.9%	17.3%	17.5%	18.5%	19.1%
GA	25.5%	26.7%	25.6%	21.9%	20.9%	23.0%	25.2%	26.1%
US						22.6%	22.5%	22.3%

Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: ● This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

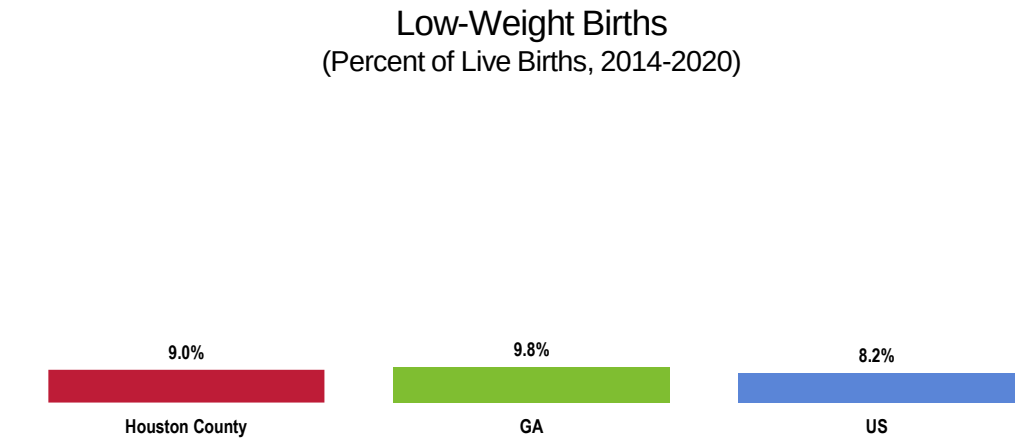
BIRTH OUTCOMES & RISKS

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 9.0% of 2014-2020 Houston County births were low-weight.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2023.
Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

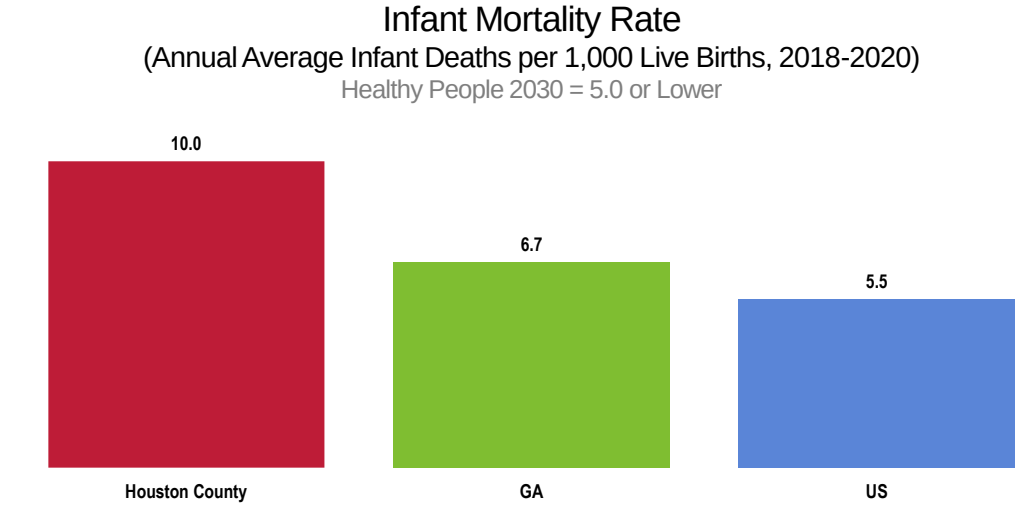
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2018 and 2020, there was an annual average of 10.0 infant deaths per 1,000 live births.

BENCHMARK ► Higher than state and US rates. Fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing significantly to the highest level recorded within the county in nearly a decade.

DISPARITY ► Twice as high among Black mothers as among White mothers.

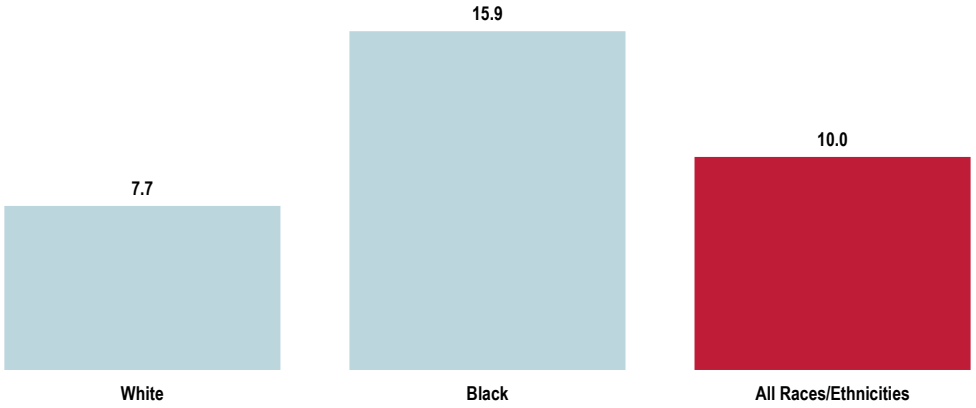


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2023.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Infant deaths include deaths of children under 1 year old.

Infant Mortality Rate by Race/Ethnicity

(2018-2020 Annual Average Infant Deaths per 1,000 Live Births; Houston County)

Healthy People 2030 = 5.0 or Lower



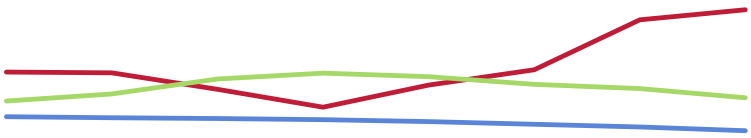
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Infant deaths include deaths of children under 1 year old.
- Race categories reflect individuals without Hispanic origin.

Infant Mortality Trends

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

Healthy People 2030 = 5.0 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	7.7	7.6	7.0	6.3	7.2	7.8	9.6	10.0
GA	6.6	6.8	7.4	7.6	7.5	7.2	7.0	6.7
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2023.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

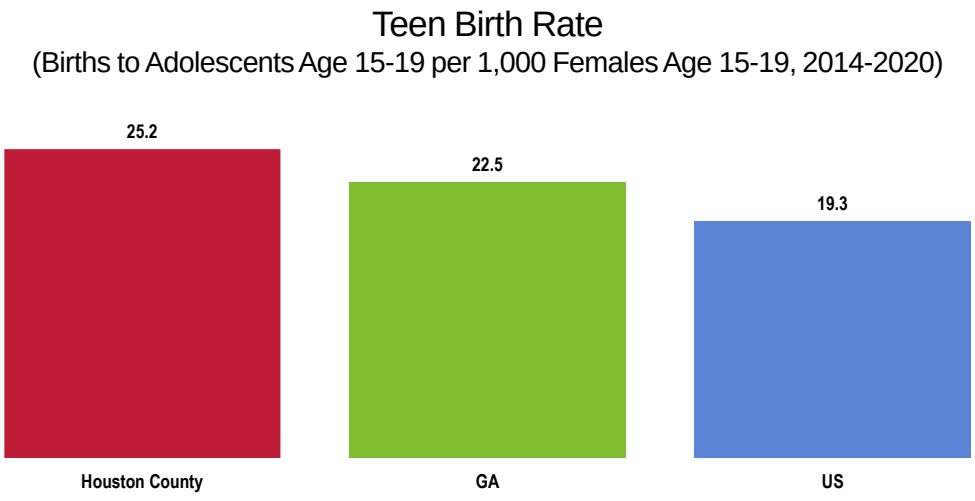
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2014 and 2020, there were 25.2 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in Houston County.

BENCHMARK ► Higher than the US rate.

DISPARITY ► Higher among Hispanic and Black female adolescents.

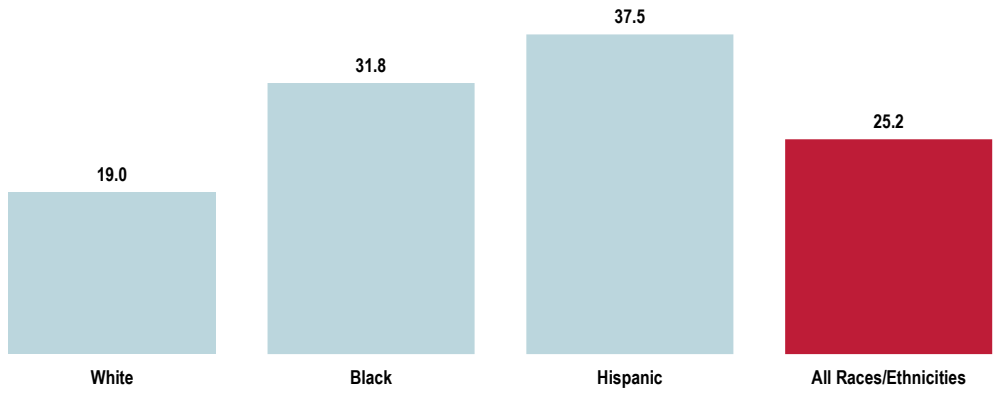


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Teen Birth Rate by Race/Ethnicity

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19; Houston County, 2014-2020)



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

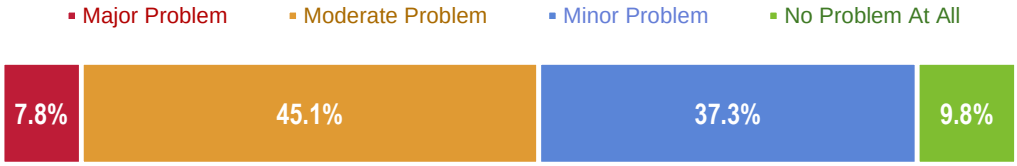
Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.
- Race categories reflect individuals without Hispanic origin.

Key Informant Input: Infant Health & Family Planning

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

Perceptions of Infant Health & Family Planning as a Problem in the Community

(Among Key Informants; Houston County, 2023)



Sources:
- 2023 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:

Maternal Health – Morbidity and Mortality

> Reduction in maternal morbidity/mortality and infant morbidity/mortality is not adequately addressed in Houston County, particularly among underinsured citizens and non-citizen residents of the county. – Social Services Provider

> Maternal health, morbidity and mortality. This is an issue for the entirety of the state of Georgia. Not as impactful in Houston County, but certainly a problem within our catchment area. – Community/Business Leader

Access to Care/Services

> Lack of access to doctors. – Community/Business Leader

Lack of Family Planning

> There is no family planning. It's seeking physical pleasure first and dealing with consequences, such as unplanned pregnancy, later. – Community/Business Leader

Low Birth Weight

> According to the U.S. News and World Report for 2022, Bibb County exceeded the state and national rate for babies born with low birth weight. In addition, Bibb County exceeded the state and national rate for teen birth rate. Houston County had a similar trend in these rates. – Community/Business Leader

Teen Pregnancy

> We have many young people (often teenagers) who are having children. This creates a dilemma for them and the children they parent -- if they are not prepared and ready, if they have a deficient education, their opportunities for earning a decent living are limited. – Social Services Provider

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)

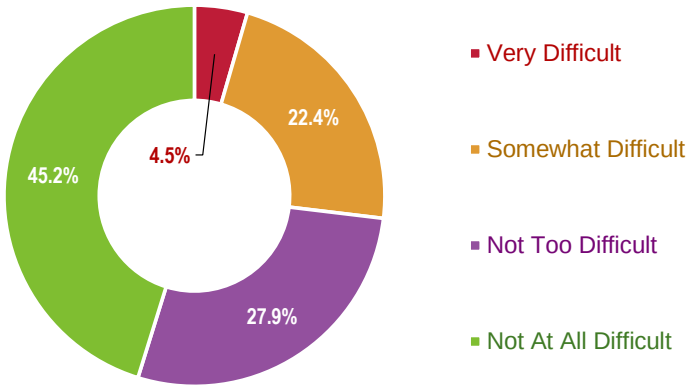
Difficulty Accessing Fresh Produce

Most Houston County adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked, "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say very difficult, somewhat difficult, not too difficult, or not at all difficult?"

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

Level of Difficulty Finding Fresh Produce at an Affordable Price
(Houston County, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: • Asked of all respondents.

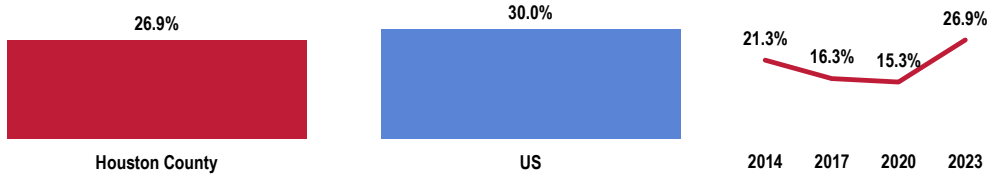
However, 26.9% of Houston County adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

TREND ► A significant increase since 2020.

DISPARITY ► More often reported among adults age 18 to 39 and those with lower incomes.

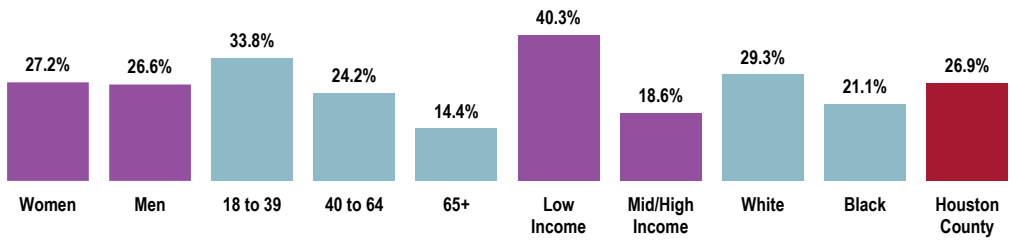
Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce

Houston County



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

Daily Recommendation of Fruits/Vegetables

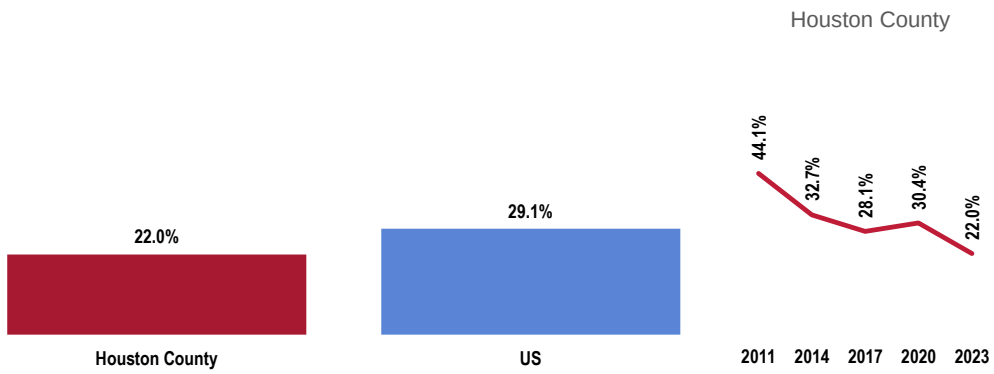
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 22.0% of Houston County adults report eating five or more servings of fruits and/or vegetables per day.

BENCHMARK ► Lower than found nationally.

TREND ► Marks a significant decline over time.

Consume Five or More Servings of Fruits/Vegetables Per Day



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Houston County, 2023)

Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 109]

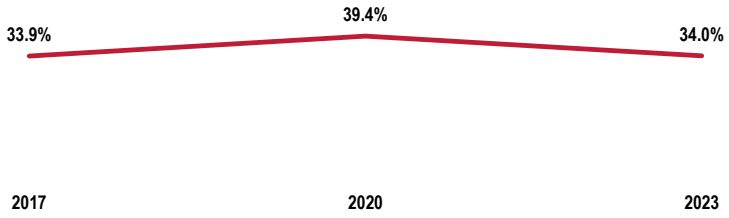
Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Sugar-Sweetened Beverages

A total of 34.0% of Houston County adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

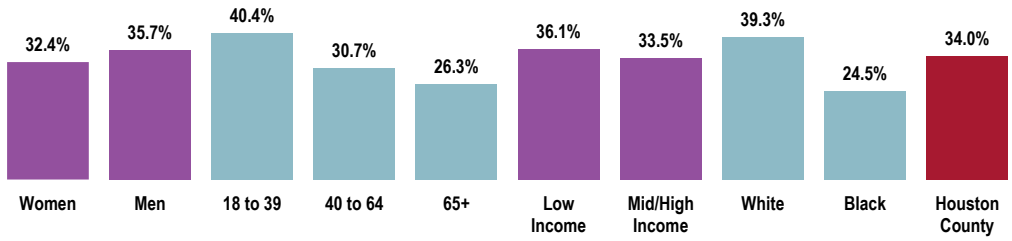
DISPARITY ► Higher among White respondents.

Had Seven or More
Sugar-Sweetened Beverages in the Past Week
(Houston County)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 320]
Notes: • Asked of all respondents.

Had Seven or More
Sugar-Sweetened Beverages in the Past Week
(Houston County, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 320]
Notes: • Asked of all respondents.

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

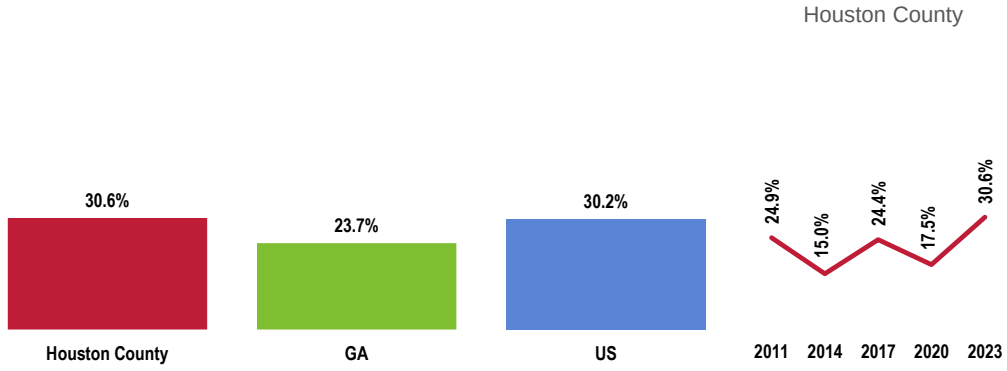
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

A total of 30.6% of Houston County adults report no leisure-time physical activity in the past month.

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

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

For adults, "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 (such as walking), 75 minutes per week of vigorous activity (such as jogging), or an equivalent combination of both.
- **Strengthening activity** is at least two sessions per week of exercise designed to strengthen muscles (such as push-ups, sit-ups, or activities using resistance bands or weights).

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

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

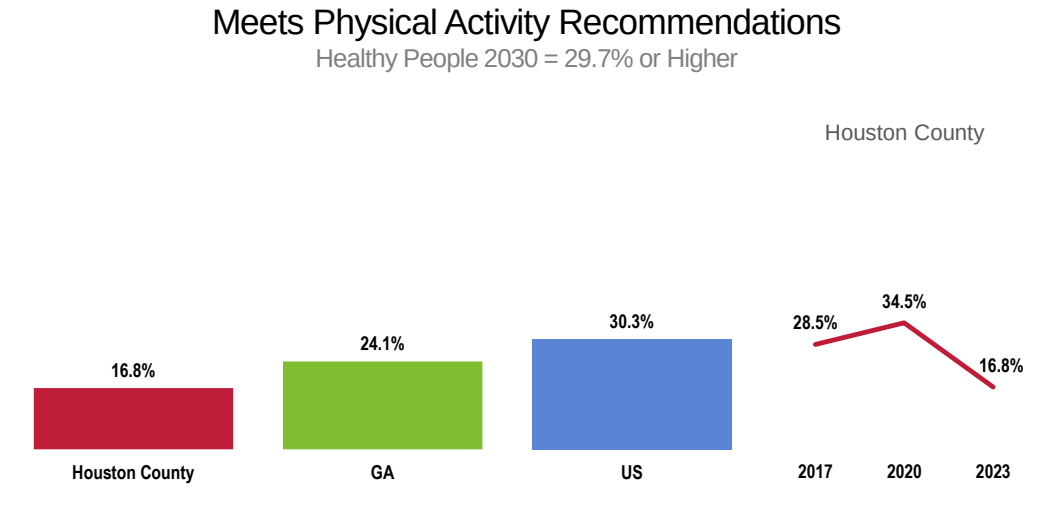
Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

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

A total of 16.8% of Houston County adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

BENCHMARK ► Lower than state and national findings. Fails to satisfy the Healthy People 2030 objective.

TREND ► Marks a significant decrease from previous surveys.



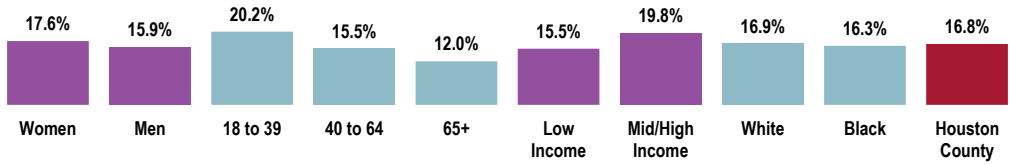
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Meets Physical Activity Recommendations

(Houston County, 2023)

Healthy People 2030 = 29.7% or Higher



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 110]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

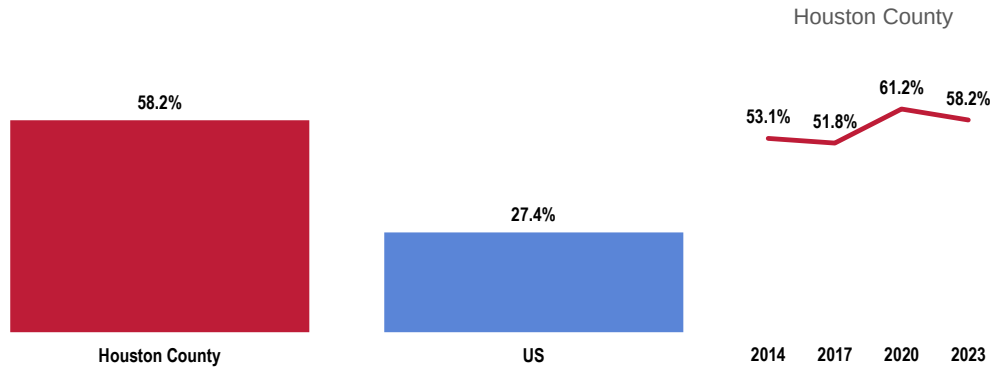
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among Houston County children age 2 to 17, 58.2% 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 ► More than two times the national percentage.

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



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity Facilities

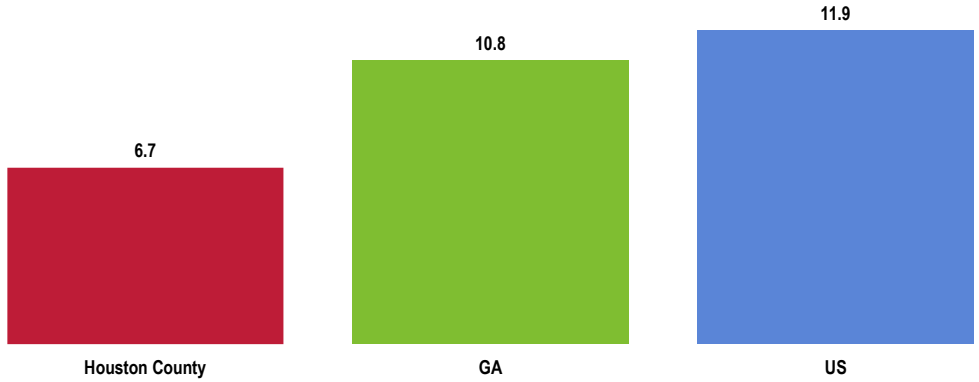
In 2020, there were 6.7 recreation/fitness facilities for every 100,000 population in Houston County.

BENCHMARK ► Lower than found statewide and nationally.

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.

Number of Recreation & Fitness Facilities per 100,000 Population
(2020)



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 April 2023 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.*

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
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

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

Overweight Status

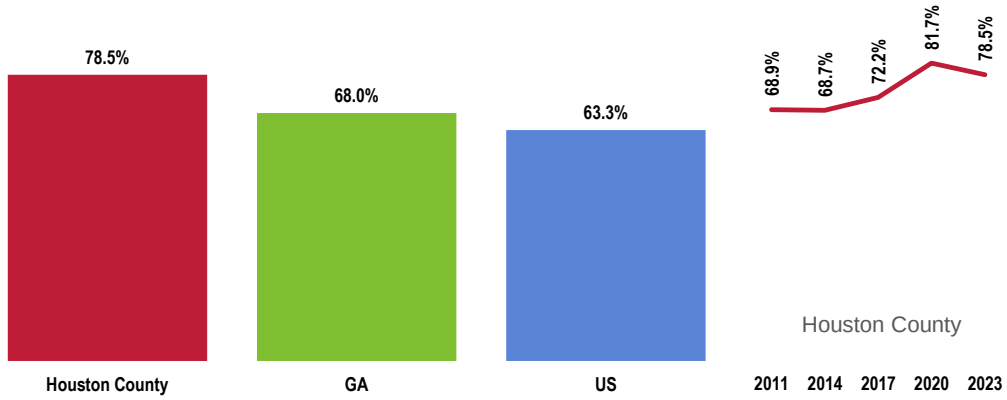
Here, "overweight" includes those respondents with a BMI value ≥25.

Nearly 8 in 10 Houston County adults (78.5%) are overweight.

BENCHMARK ► Higher than found across Georgia and the US.

TREND ► Denotes a significant increase from the 2011 benchmark.

Prevalence of Total Overweight (Overweight and Obese)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 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,. The definition for obesity is a BMI greater than or equal to 30.0.

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

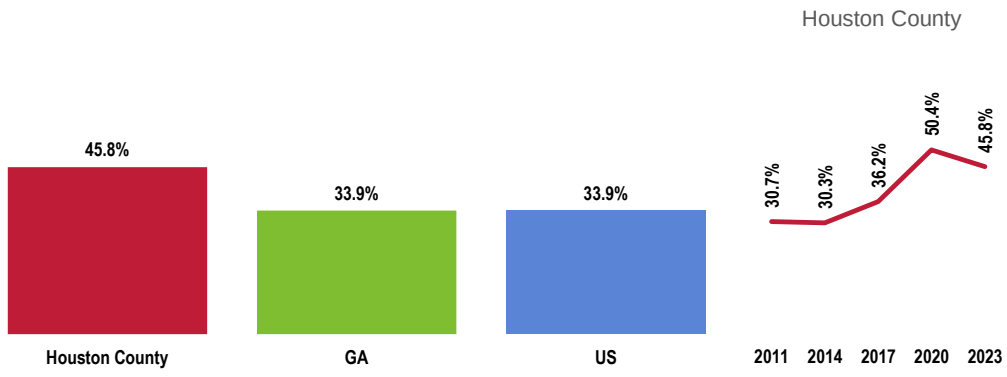
The overweight prevalence above includes 45.8% of Houston County adults who are obese.

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

TREND ► Represents a significant increase from the 2011 benchmark.

Prevalence of Obesity

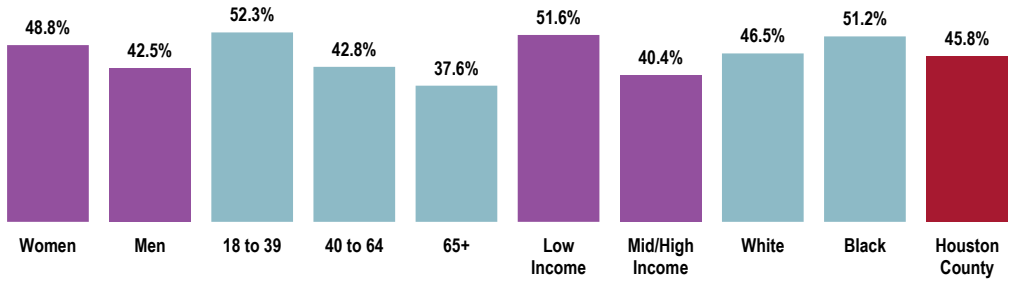
Healthy People 2030 = 36.0% or Lower



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

Prevalence of Obesity
(Houston County, 2023)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

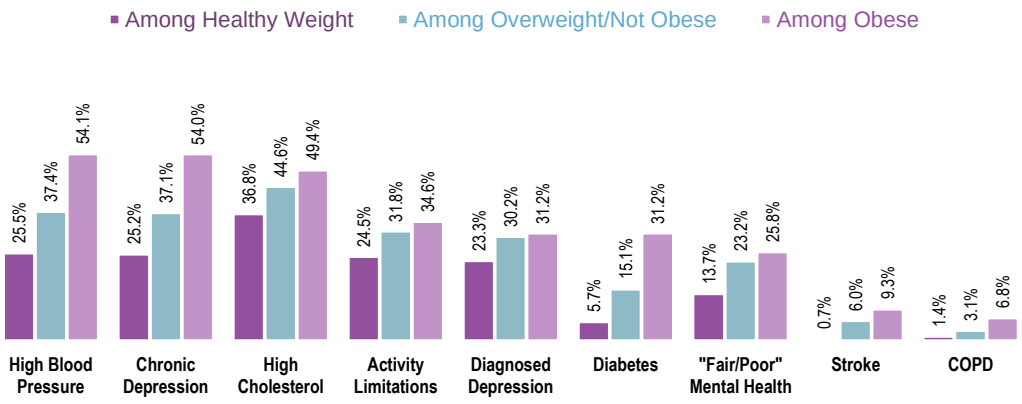
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

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
(Houston County, 2023)

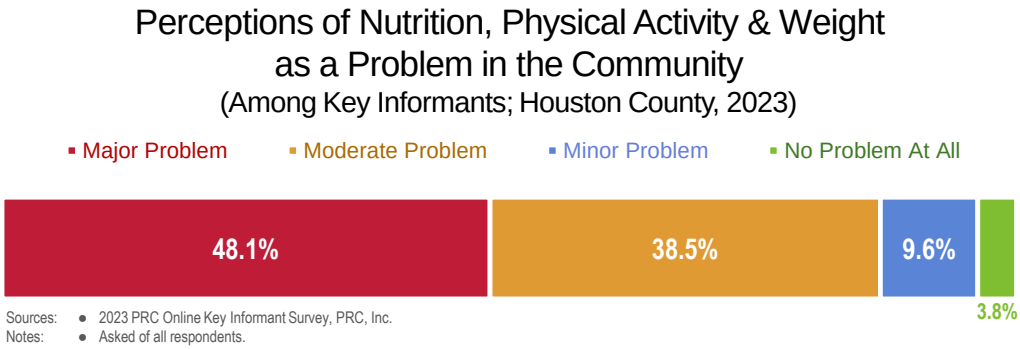


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 112]

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

Key Informant Input:
Nutrition, Physical Activity & Weight

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



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

Lifestyle

> Obesity rates and the sedentary nature of our community. – Community/Business Leader
>
> Too few people take physical activity and weight control seriously. Lack of quality nutritious food is available in many Houston County neighborhoods. The costs associated with meaningful and nutritious food are too high. It's cheaper to eat chips and boxed foods. – Community/Business Leader
>
> Houston County is not an easy county to access goods and services through walking. So, regular exercise is not normalized in everyday lifestyle. Exercise and recreational facilities are spread out and not easily accessible if someone doesn't own a personal vehicle. Recreational facilities often charge for participation, making access impossible for some. Fast food establishments are plentiful, while access to fresh foods is limited, especially in low-economic areas. Low-quality, low-nutritional value foods are the most accessible and affordable. Access to affordable health care is limited, so access to early detection and early education is limited. – Community/Business Leader
>
> Overcoming traditional diets. General propensity for people to use digital platforms and stay indoors and not go outside for recreation or exercise. Food insecurity for some of the population, especially children in single-parent households. – Community/Business Leader
>
> Lack of exercise and proper diet. – Community/Business Leader
>
> Lack of exercise, ease of eating out, lack of education. – Other Health Provider

Prevalence of Obesity

> Obesity in children and adults. – Physician
>
> Obesity is a huge and growing problem with a lack of action and exercise. – Community/Business Leader
>
> Obesity in the United States. – Social Services Provider
>
> Obesity is at an alarming high. Diabetic and prediabetic conditions affect many adults, and even children and teens. – Social Services Provider
>
> Houston County, at 34.9%, is slightly above the state, at 33.9%, for obesity prevalence according to the U.S. News and World Report for 2022. This data is a result of lack of physical activity and nutrition. – Community/Business Leader
>
> Obesity. – Community/Business Leader

Awareness/Education

> Lack of engagement in available health education. – Community/Business Leader
>
> Lack of education as it relates to proper nutrition. – Community/Business Leader
>
> Education about nutrition and access to healthy food. How to make healthy meals on a budget, the impact of nutrition and movement on chronic illnesses. – Other Health Provider

Nutrition

> Not a lack of access, but a lack of desire to eat healthy foods. – Community/Business Leader
>
> Because of the vast number of fast foods, drive-thru, etc., I believe that this contributes to nutritional challenges and deficiencies in the population. – Other Health Provider

Physical Activity

> Getting participation from the community programs that are available. – Community/Business Leader
>
> Getting people to do it. – Community/Business Leader

Access to Affordable Healthy Food

> Access to fresh vegetables, fruits, and meats in targeted areas where there are no grocery stores. Community parks and nutritional education. No transportation. – Community/Business Leader
>
> The biggest challenge I believe is the cost of fresh, nutritious food. It is often cheaper to pick up fast food than it is to purchase fresh ingredients. Regarding physical activity – I believe opportunities are plentiful. I just think people are not challenged enough. I believe this is due to limited education and exposure to different types of activities. With decreased physical activities comes an increase in weight. – Other Health Provider

Affordable Care/Services

> Every program is very expensive, and many people can't afford the treatment. – Social Services Provider

Transportation

> Lack of public transportation. – Social Services Provider

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

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.

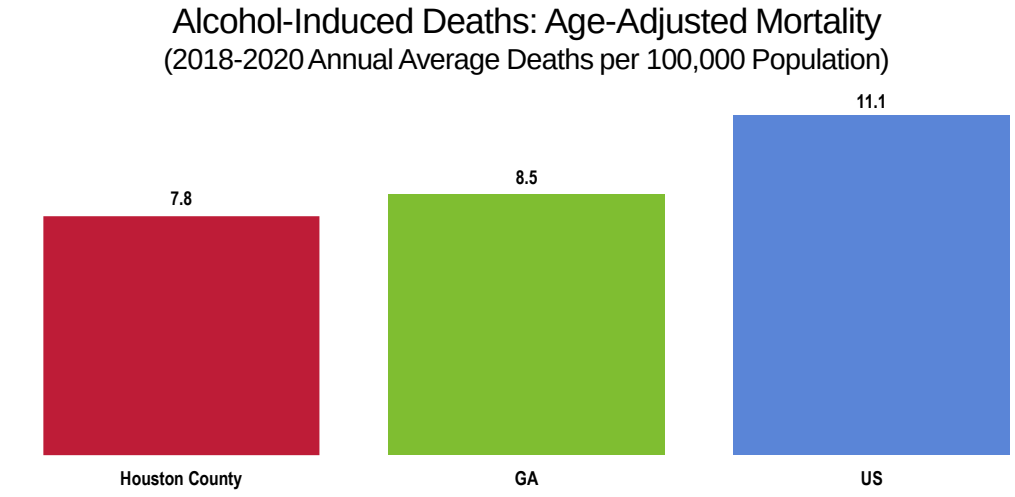
– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol Use

Age-Adjusted Alcohol-Induced Deaths

Between 2018 and 2020, Houston County reported an annual average age-adjusted mortality rate of 7.8 alcohol-induced deaths per 100,000 population.

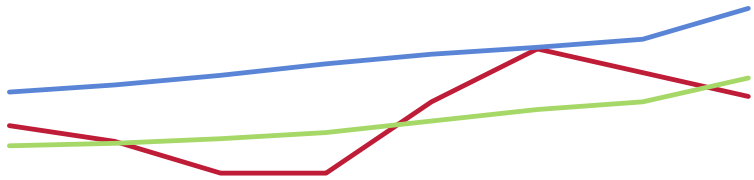
BENCHMARK ► Lower than the national rate.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	6.7	6.1	4.9	4.9	7.6	9.6	8.7	7.8
GA	5.9	6.0	6.2	6.4	6.9	7.3	7.6	8.5
US	8.0	8.2	8.6	9.0	9.4	9.7	10.0	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 April 2023.

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

Excessive Drinking

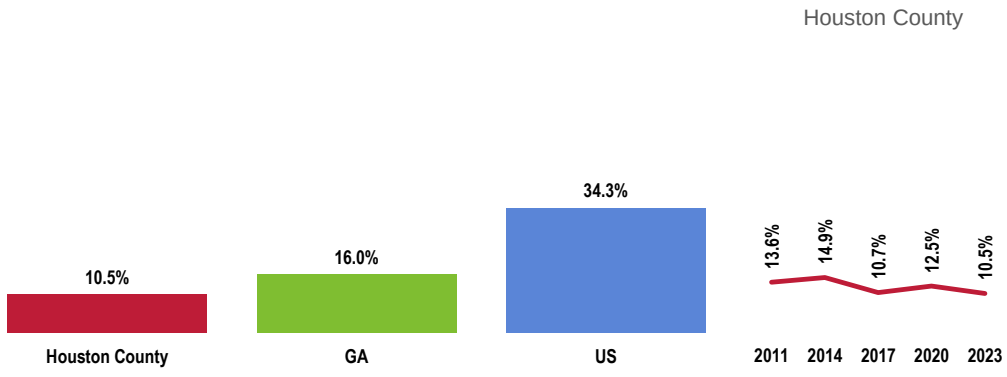
Excessive drinking includes heavy and/or binge drinkers:

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

A total of 10.5% of area adults engage in excessive drinking (heavy and/or binge drinking).

BENCHMARK ► Lower than found across the state and especially the nation.

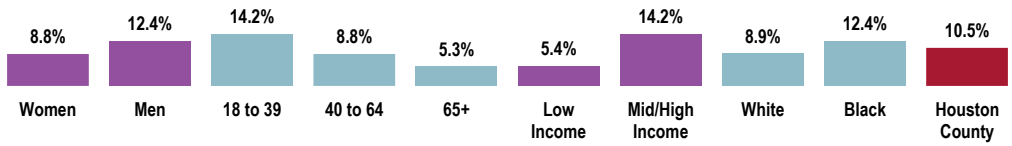
Engage in Excessive Drinking



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 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.

Engage in Excessive Drinking
(Houston County, 2023)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 116]

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 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.

Drug Use

Age-Adjusted Unintentional Drug-Induced Deaths

Between 2018 and 2020, there was an annual average age-adjusted mortality rate of 7.4 unintentional drug-induced deaths per 100,000 population in Houston County.

BENCHMARK ► Lower than state and US rates.

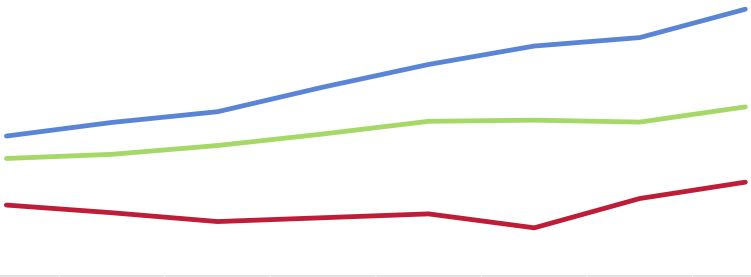
TREND ► Increasing significantly to the highest level recorded within the county in nearly a decade.

Unintentional Drug-Induced Deaths: Age-Adjusted Mortality
(2018-2020 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 April 2023.

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Houston County	5.6	5.0	4.3		4.9	3.8	6.1	7.4
GA	9.3	9.6	10.3	11.2	12.2	12.3	12.1	13.3
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

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

Illicit Drug Use

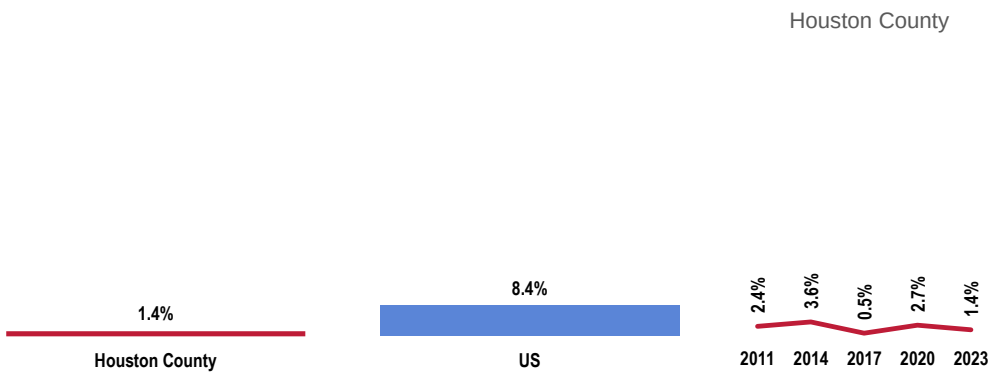
A total of 1.4% of Houston County adults acknowledge using an illicit drug in the past month.

BENCHMARK ► Lower than the national percentage.

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

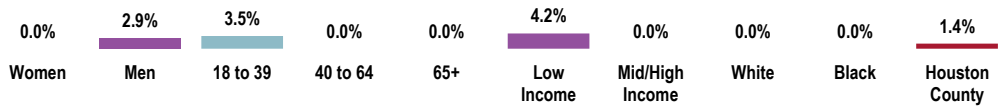
Illicit Drug Use in the Past Month



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Illicit Drug Use in the Past Month
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.

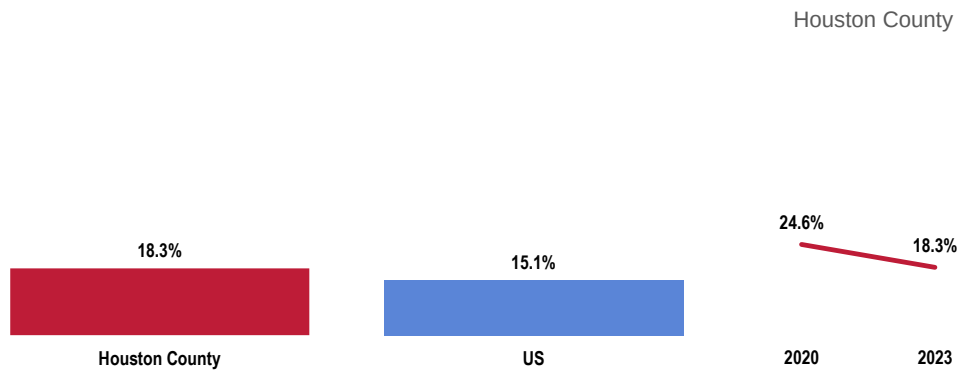
Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

A total of 18.3% of Houston County adults report using a prescription opioid drug in the past year.

DISPARITY ► More often reported among White respondents.

Used a Prescription Opioid in the Past Year



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 41]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Used a Prescription Opioid in the Past Year
(Houston County, 2023)

Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 41]
Notes: ● Asked of all respondents.

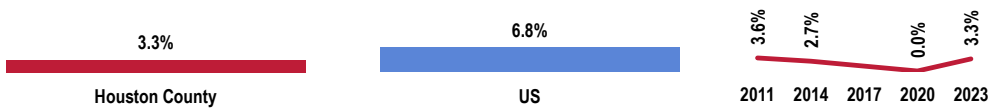
Alcohol & Drug Treatment

A total of 3.3% of Houston County adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

BENCHMARK ► Lower than the national finding.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Houston County

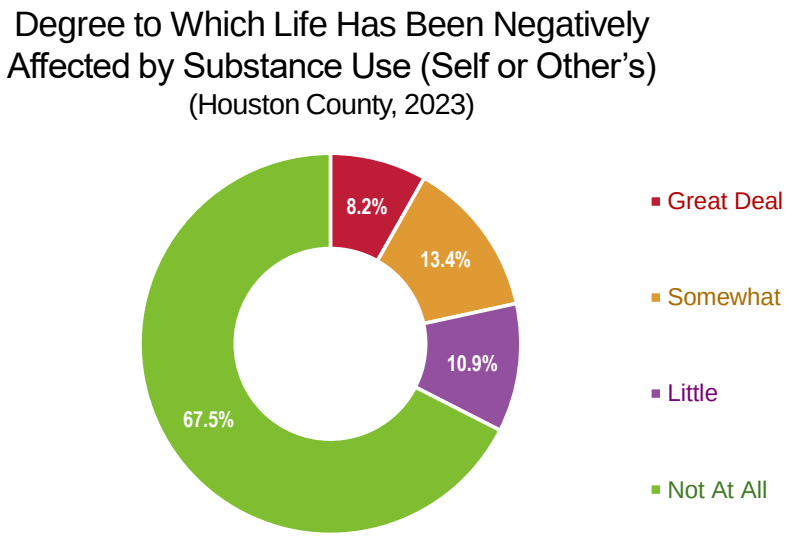


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 42]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Personal Impact From Substance Use

Surveyed adults were also asked to what degree their lives have been impacted by substance use (whether their own use or that of another).

Most Houston County residents' lives have <u>not</u> been negatively affected by substance use (either their own or someone else's).

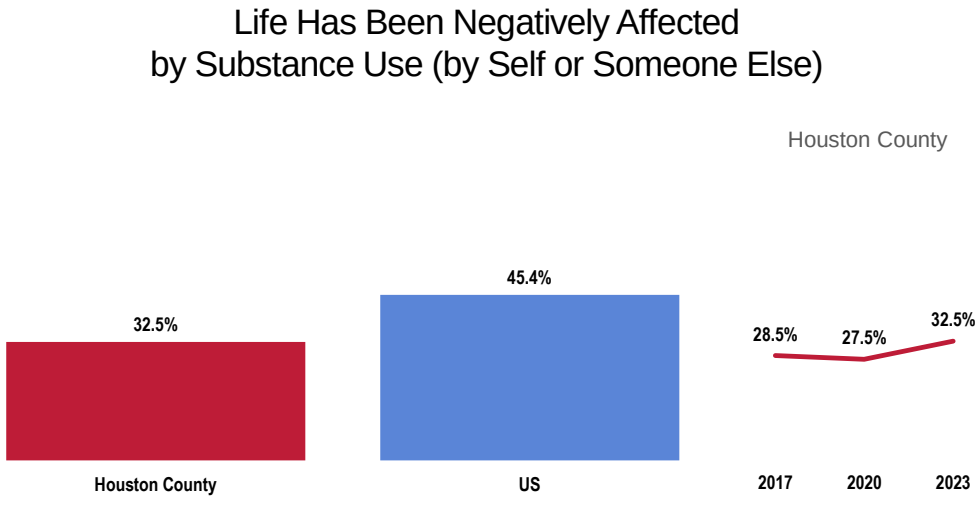


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 43]
Notes: ● Asked of all respondents.

However, 32.5% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

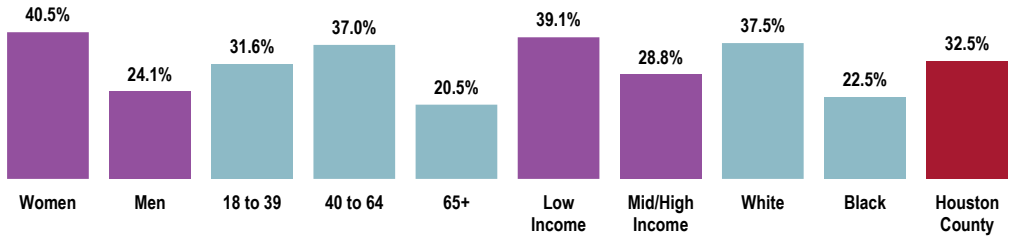
BENCHMARK ► Lower than found nationally.

DISPARITY ► More often reported among women, adults age 40 to 64, and White residents.



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 43]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes those responding "a great deal," "somewhat," or "a little."

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(Houston County, 2023)

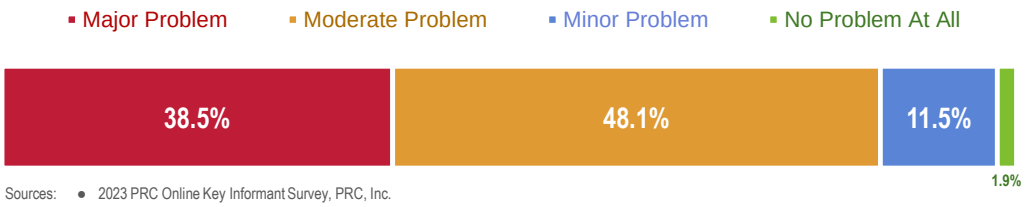


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 43]
Notes: ● Asked of all respondents.
● Includes those responding "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

Key informants taking part in an online survey most often characterized *Substance Use* as a "moderate problem" in the community.

Perceptions of Substance Use as a Problem in the Community
(Among Key Informants; Houston County, 2023)



Sources: ● 2023 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/Services

> Lack of facilities offering this in various parts of town for those who may not have reliable transportation. – Other Health Provider
>
> Limited funding; limited professional resources – therapists and no professional addictionologist in the community; limited halfway house rehab areas – especially for men but also women (especially with closing of Grace Village in Perry), very limited resources for adolescent addiction problems. Poor understanding by most in the community of the scope of the problem unless they actually have family members who are afflicted by this problem. Too much emphasis on apprehension of drug users instead of education and rehabilitation. – Community/Business Leader
>
> Not enough treatment centers and/or facilities. – Community/Business Leader
>
> Lack of facilities and accessibility. – Other Health Provider
>
> I do not know of anything other than programs sponsored by churches. – Community/Business Leader

Affordable Care/Services

> A lack of financial resources, finding good treatment options, not knowing how to find treatment, and understanding the need for treatment, such as education regarding substance abuse. – Community/Business Leader
>
> Families can't afford treatment and feel there is nowhere to go. – Social Services Provider
>
> Treatment facilities are extremely limited and expensive. They are often unreachable for those without insurance. More often than not, substance use becomes a law enforcement issue rather than a mental health issue. Reduction in police staffing increases the likelihood of unchecked drug accessibility in the community so access becomes easier. Lack of mental health treatment facilities and access to mental health medications leads to self-treatment with drugs and medications that are accessible. Often, these attempts to self-medicate lead to illicit drug use or inappropriate prescription use. – Community/Business Leader

Awareness/Education

> Education, no available centers to help. – Physician
>
> The lack of a sense of value and purpose in people. If they are not taught the truth, they will look in the wrong place. – Community/Business Leader
>
> Lack of health literacy, general education, housing for those in need of treatment and transportation. – Community/Business Leader

Denial/Stigma

> The stigma of being labeled an addict. We also often treat the immediate and surface-level chemical or substance addiction but fail to address the underlying pain that caused a person to become a user. This is why we see such a repeated pattern of abuse. – Social Services Provider
>
> Willingness for help. – Other Health Provider
>
> Users do not want treatment. – Community/Business Leader

Overdose

> People want to partake. More and more overdoses are evident and occur regularly here. – Community/Business Leader

Transportation

> Transportation and the lack of public awareness. – Community/Business Leader

Most Problematic Substances

Key informants (who rated this as a "major problem") identified **alcohol** as causing the most problems in the community, followed by **heroin/other opioids**, **methamphetamine/other amphetamines**, and **marijuana**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a "Major Problem")	
ALCOHOL	24.6%
HEROIN OR OTHER OPIOIDS	19.3%
METHAMPHETAMINE OR OTHER AMPHETAMINES	17.5%
MARIJUANA	14.0%
COCAINE OR CRACK	10.5%
PRESCRIPTION MEDICATIONS	10.5%
CLUB DRUGS (e.g. MDMA, GHB, Ecstasy, Molly)	1.8%
OVER-THE-COUNTER MEDICATIONS	1.8%

TOBACCO USE

ABOUT TOBACCO USE

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.

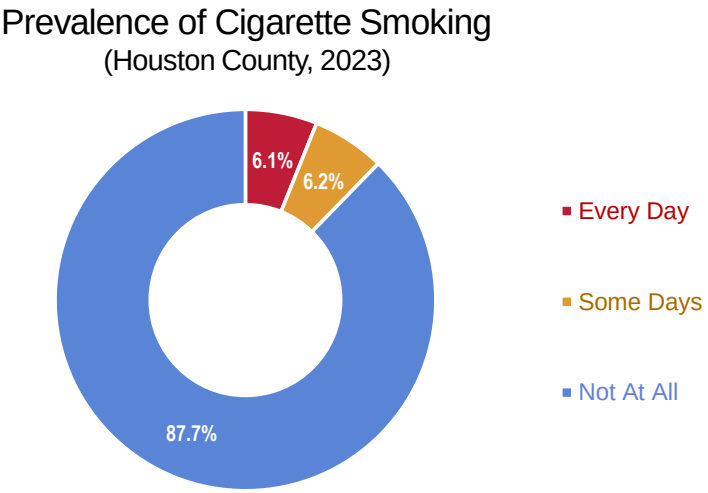
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

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

Cigarette Smoking

Prevalence of Cigarette Smoking

A total of 12.3% of Houston County adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in Houston County.

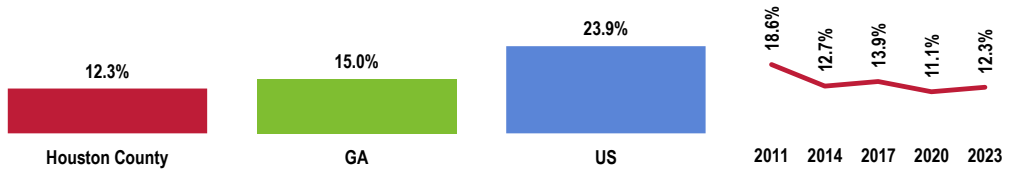
BENCHMARK ► Much lower than the national percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Women are more likely to report smoking cigarettes.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

Houston County



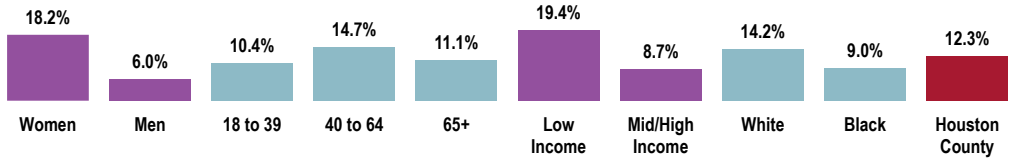
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

Currently Smoke Cigarettes

(Houston County, 2023)

Healthy People 2030 = 6.1% or Lower



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 34]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

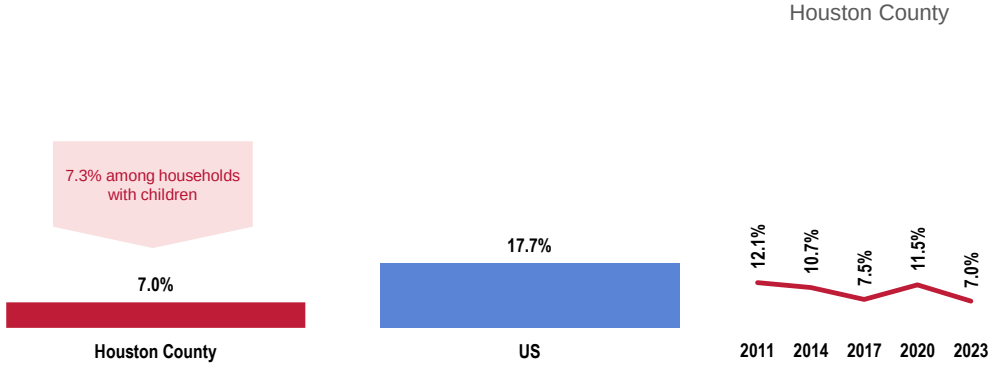
Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

Environmental Tobacco Smoke

Among all surveyed households in Houston County, 7.0% report that someone has smoked cigarettes in their home an average of four or more times per week over the past month.

BENCHMARK ▶ Much lower than found nationally.

Member of Household Smokes at Home



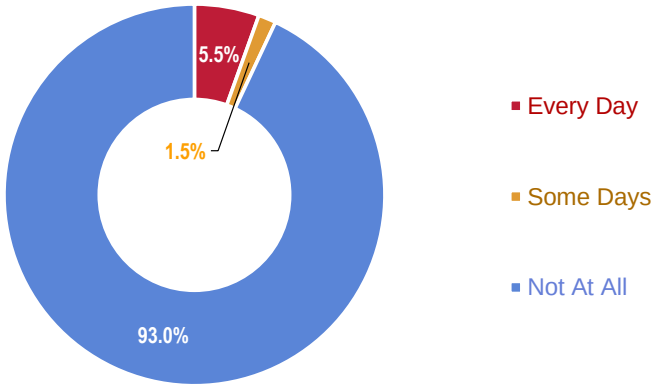
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

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.

Use of Vaping Products

Most Houston County adults do not use electronic vaping products.

Use of Vaping Products
(Houston County, 2023)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 36]

Notes:
- Asked of all respondents.

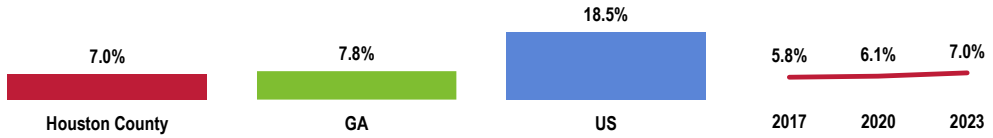
However, 7.0% currently use electronic vaping products either regularly (every day) or occasionally (on some days).

BENCHMARK ► Much lower than the US percentage.

DISPARITY ► More often reported among younger adults (age 18 to 39).

Currently Use Vaping Products
(Every Day or on Some Days)

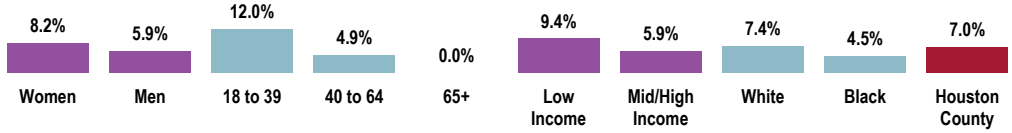
Houston County



Sources:
- 2023 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): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Currently Use Vaping Products
(Houston County, 2023)

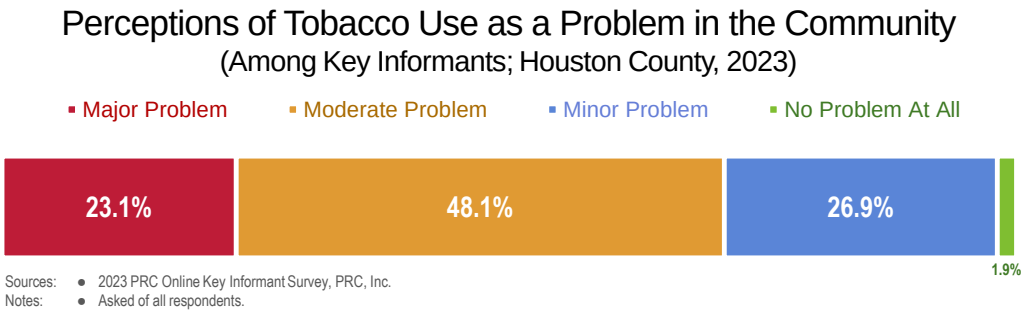


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 36]

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

Key informants taking part in an online survey most often characterized *Tobacco Use* as a "moderate problem" in the community.



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

Co-Occurrences

> Tobacco use continues to be a major contributor to lung cancer rates in our community. – Community/Business Leader
>
> Increased number of residents with COPD and lung cancer. – Community/Business Leader
>
> Because of its link to cancer. – Community/Business Leader
>
> So many people with COPD. – Community/Business Leader

Easily Accessible

> It is easily accessible. – Community/Business Leader
>
> It is offered at every retail outlet, and it contributes to a host of medical conditions, both acute and chronic in nature. – Other Health Provider
>
> Easily accessible. – Other Health Provider
>
> Use of vaping products. This is becoming increasingly a problem as relates to accessibility by teens, etc. – Other Health Provider

Impact on Quality of Life

> We can still make a huge impact on health by getting people to reduce or quit. – Other Health Provider
>
> It causes significant health problems. It is often used by those who cannot afford to spend money on tobacco, or who do not have health insurance. – Community/Business Leader

Addiction

> It has no physical value and is the most addictive of all outside substances. – Community/Business Leader

Incidence/Prevalence

> By conjecture, there are more smokers per capita than other areas of the country. Overall exasperation of existing conditions, such as COPD, etc. – Other Health Provider

Teen/Young Adult Usage

> Young people are smoking and vaping to help with anxiety, but they don't realize that tobacco and smoking substances just create more problems. – Social Services 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.

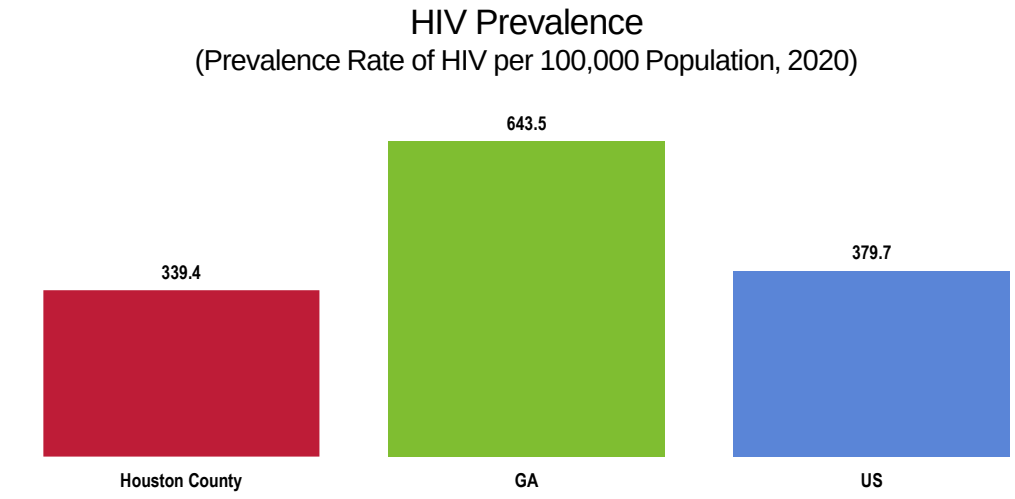
– Healthy People 2030 (https://health.gov/healthypeople)

HIV

In 2020, there was a prevalence of 339.4 HIV cases per 100,000 population in Houston County.

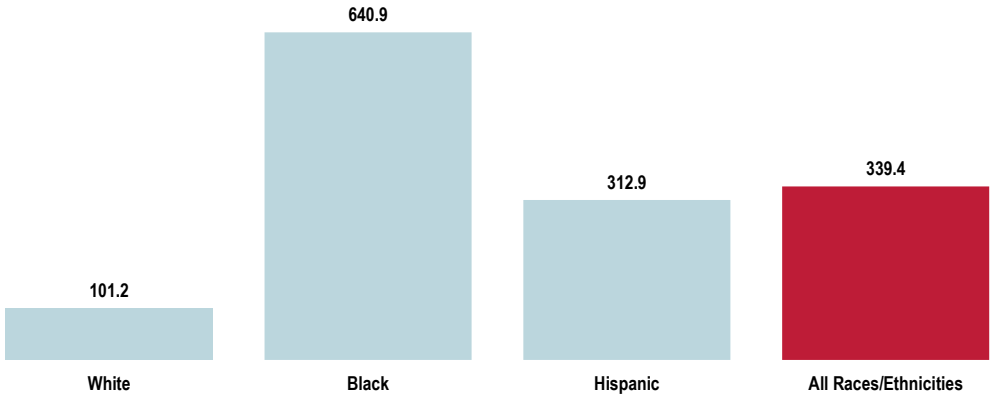
BENCHMARK ► Considerably lower than the statewide rate.

DISPARITY ► Dramatically higher among Black residents.



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 April 2023 via SparkMap (sparkmap.org).

HIV Prevalence by Race/Ethnicity
(Rate per 100,000 Population; Houston County, 2020)



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 April 2023 via SparkMap (sparkmap.org).

Notes:
- Race categories reflect individuals without Hispanic origin.

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

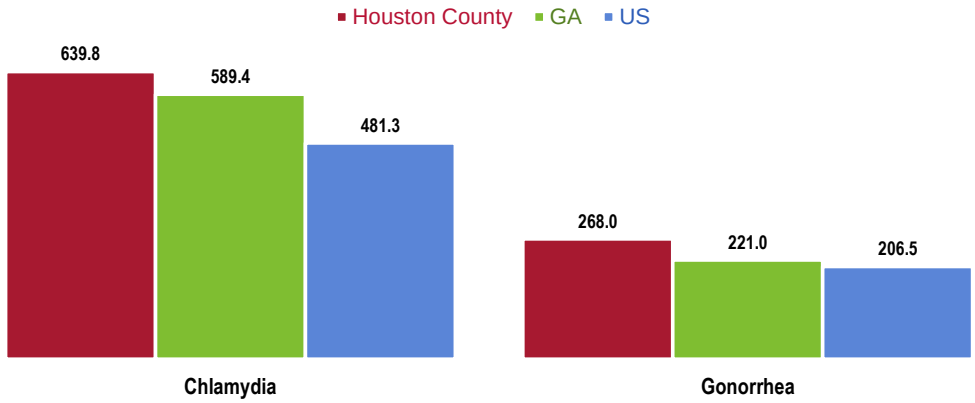
In 2020, the chlamydia incidence rate in Houston County was 639.8 cases per 100,000 population.

BENCHMARK ► Worse than found nationally.

The Houston County gonorrhea incidence rate in 2020 was 268.0 cases per 100,000 population.

BENCHMARK ► Worse than found statewide and nationally.

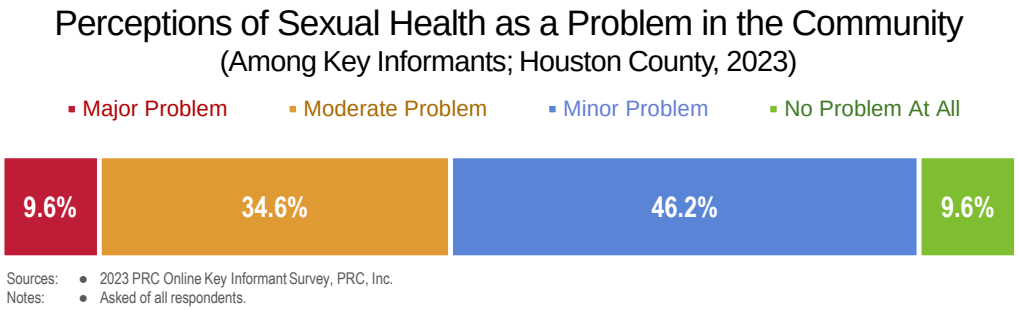
Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2020)



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 April 2023 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

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



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

Lack of Sex Education in Schools

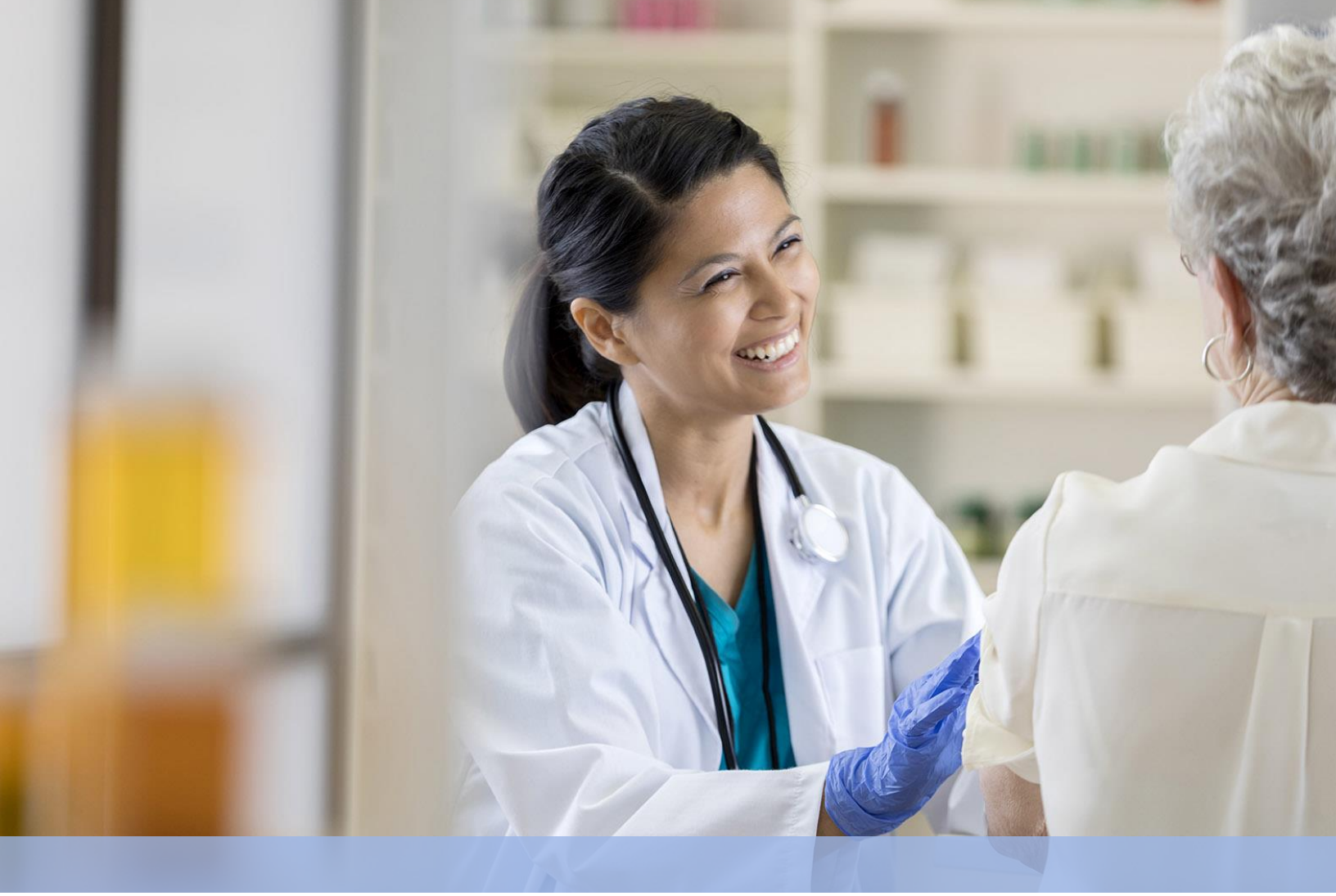
> Because the schools do not want to talk about it. They just want to teach abstinence. Teen pregnancy is an issue, along with STIs. – Other Health Provider

Incidence/Prevalence

> High rates of HIV and other STDs are still being monitored and remain prevalent in our community. According to the Georgia Department of Public Health's OASIS System, Houston County had approximately 1,639 STD cases reported in 2021. – Community/Business Leader

Multiple Factors

> Unprotected sex, drugs, and lack of education. – Community/Business Leader



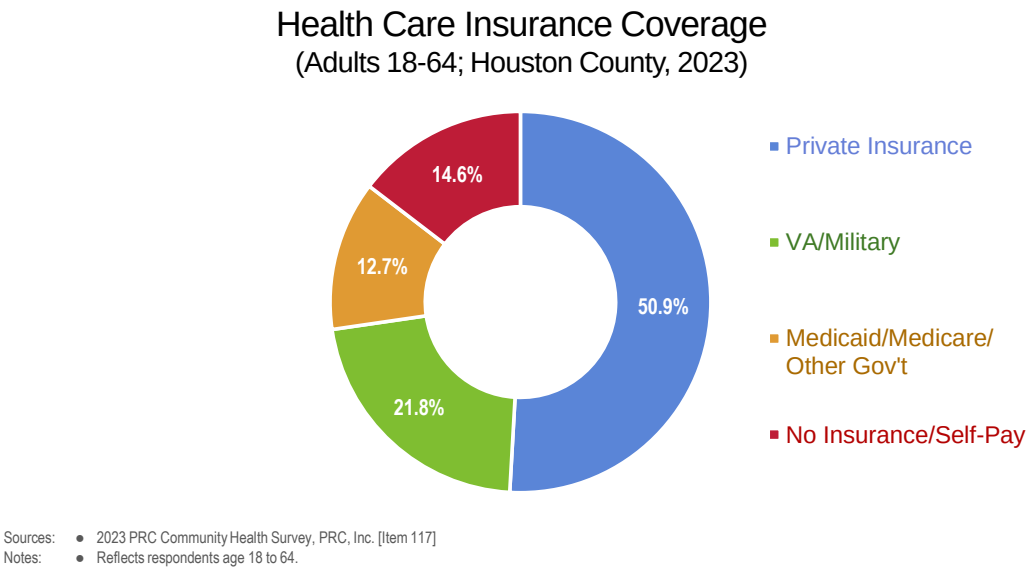
ACCESS TO HEALTH CARE

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 50.9% of Houston County adults age 18 to 64 report having health care coverage through private insurance. Another 21.8% report coverage through military benefits, while 12.7% are covered through other government-sponsored programs (e.g., Medicaid, Medicare).



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 117]
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, 14.6% report having no insurance coverage for health care expenses.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Significantly higher than reported in 2020.

DISPARITY ► Especially high among lower-income residents.

Lack of Health Care Insurance Coverage

(Adults 18-64)

Healthy People 2030 = 7.6% or Lower

Houston County

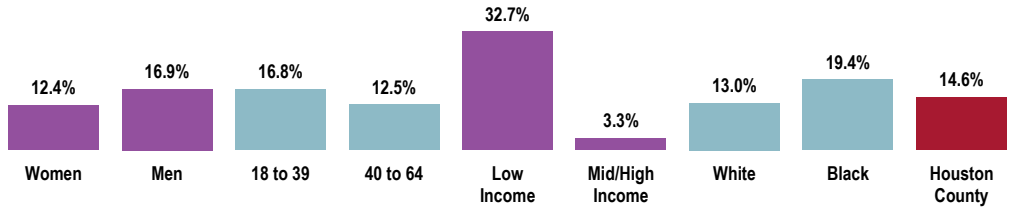
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage

(Adults 18-64; Houston County, 2023)

Healthy People 2030 = 7.6% or Lower



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …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)

Difficulties Accessing Services

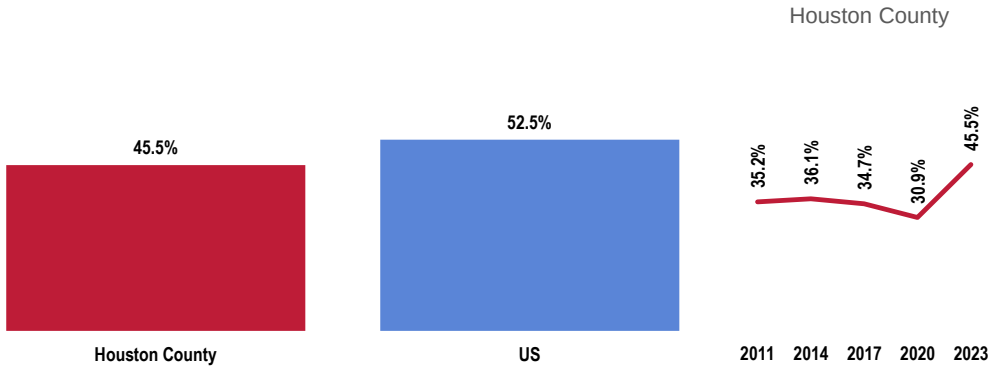
This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

A total of 45.5% of Houston County adults report some type of difficulty or delay in obtaining health care services in the past year.

TREND ► Represents a significant increase from previous surveys.

DISPARITY ► More often reported among women and adults younger than 65 (note the negative correlation with age).

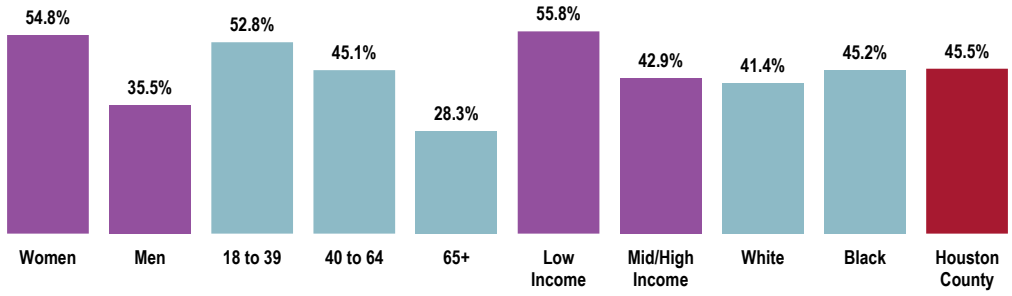
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Houston County, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Barriers to Health Care Access

Of the tested barriers, appointment availability impacted the greatest share of Houston County adults.

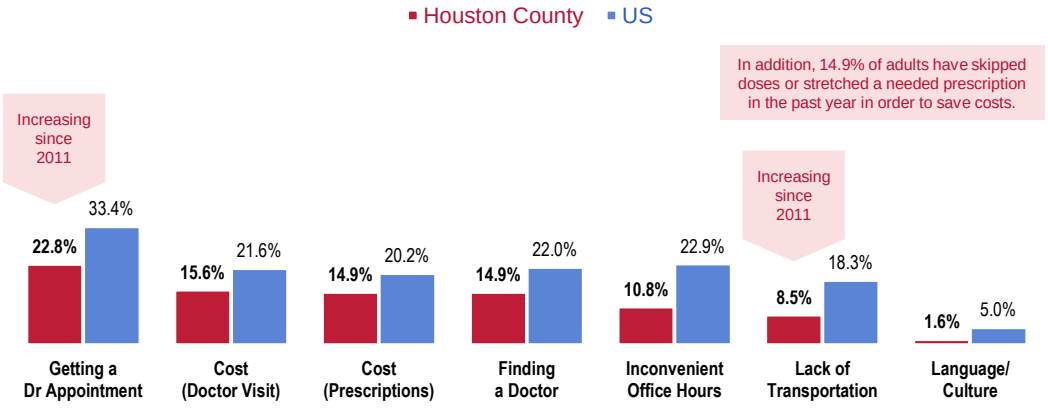
To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

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

BENCHMARK ► Six of the seven barriers were found to have less of an impact locally than nationally: **appointment availability**, **cost of a physician visit**, **difficulty finding a physician**, **inconvenient office hours**, **lack of transportation**, and **language/culture**.

TREND ► Since 2011, mentions of **appointment availability** and **lack of transportation** as barriers have increased significantly.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Items 6-13]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

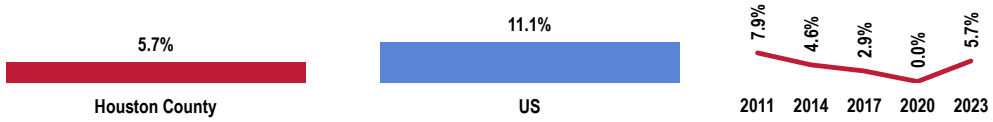
Accessing Health Care for Children

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 5.7% 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.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

Houston County

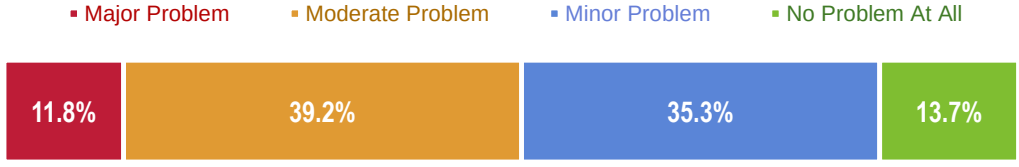


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

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
(Among Key Informants; Houston County, 2023)



Sources: ● 2023 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/Services

> Addressing mental health issues with the difficulty in getting these services in the field. HMC addresses them when the patients get there. – Community/Business Leader
>
> It is difficult to get an appointment with a primary care physician. – Physician

Specialty Care

> Specialty care for uninsured and low-income residents. Not able to be seen due to the cost of referral fees and not having access to physicians who will see them. – Community/Business Leader

Affordable Care/Services

> Costs, access, quality of services. – Community/Business Leader

Awareness/Education

> There are many points of access, but people don't always know what is available to them or know if they are eligible for various services. Transportation is also a big barrier. – Other Health Provider

Transportation

> Affordable and timely transportation. – 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.

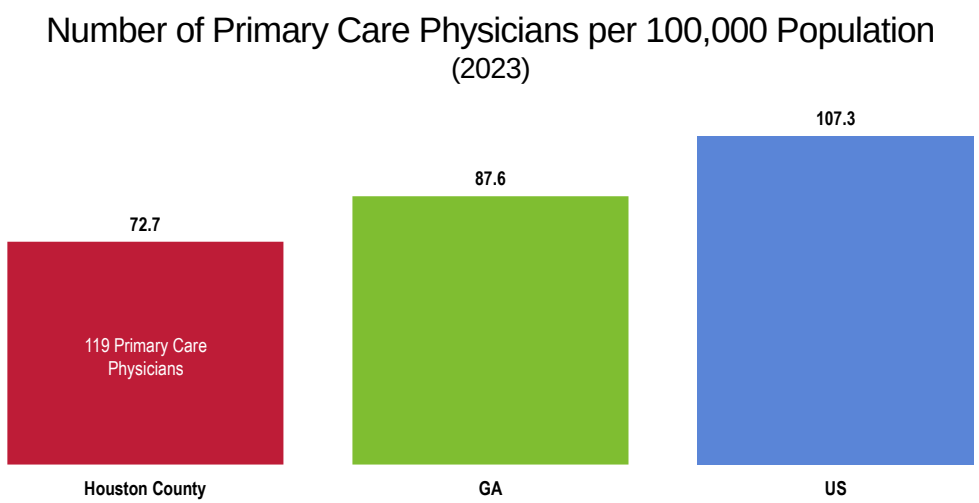
– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

In 2023, there were 119 primary care physicians in Houston County, translating to a rate of 72.7 primary care physicians per 100,000 population.

BENCHMARK ► Lower than state and national rates.



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 April 2023 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.

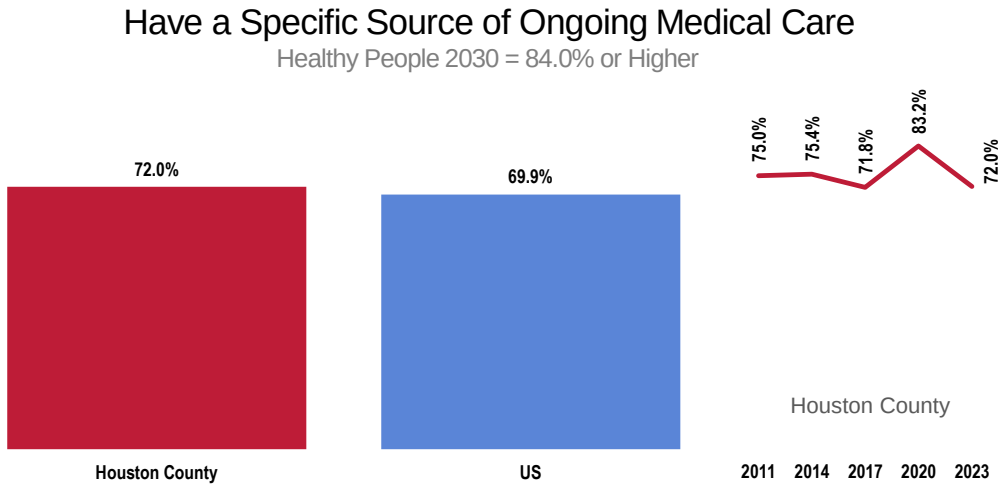
Specific Source of Ongoing Care

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

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

A total of 72.0% of Houston County adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 118]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Utilization of Primary Care Services

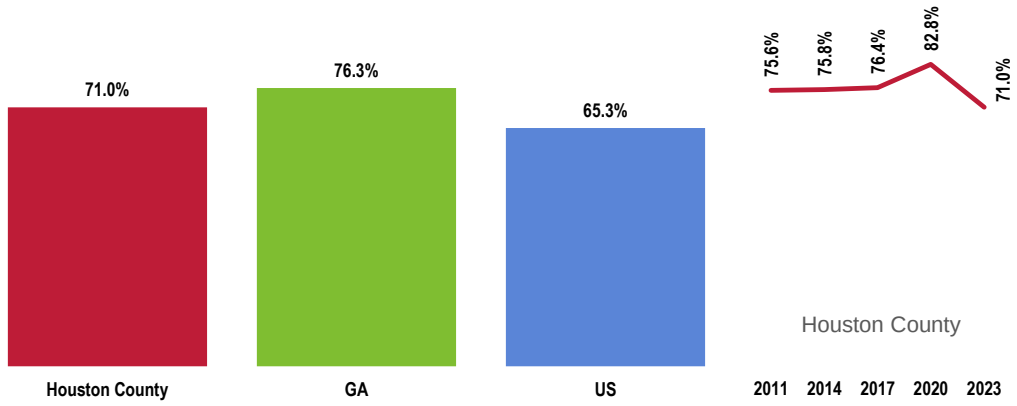
Adults

7 in 10 adults (71.0%) visited a physician for a routine checkup in the past year.

TREND ► Lower than recorded in 2020.

DISPARITY ► Those less likely to have received a checkup are adults younger than 65 (note the correlation with age) and White respondents.

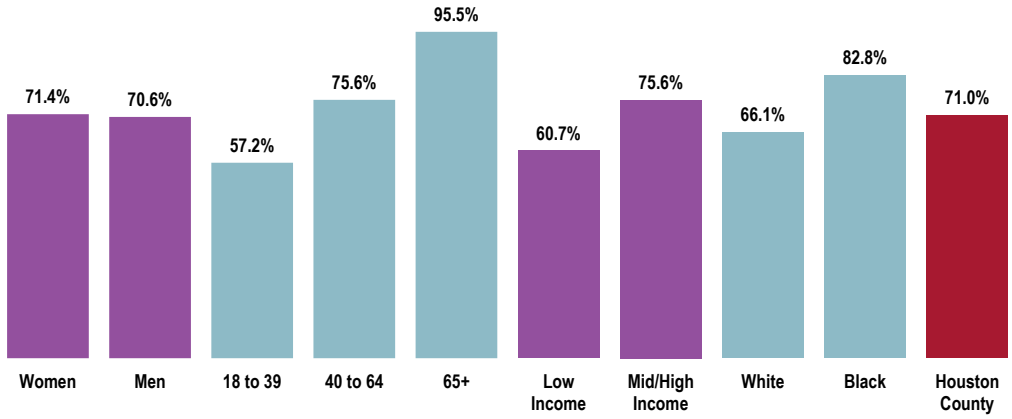
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2023 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): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(Houston County, 2023)



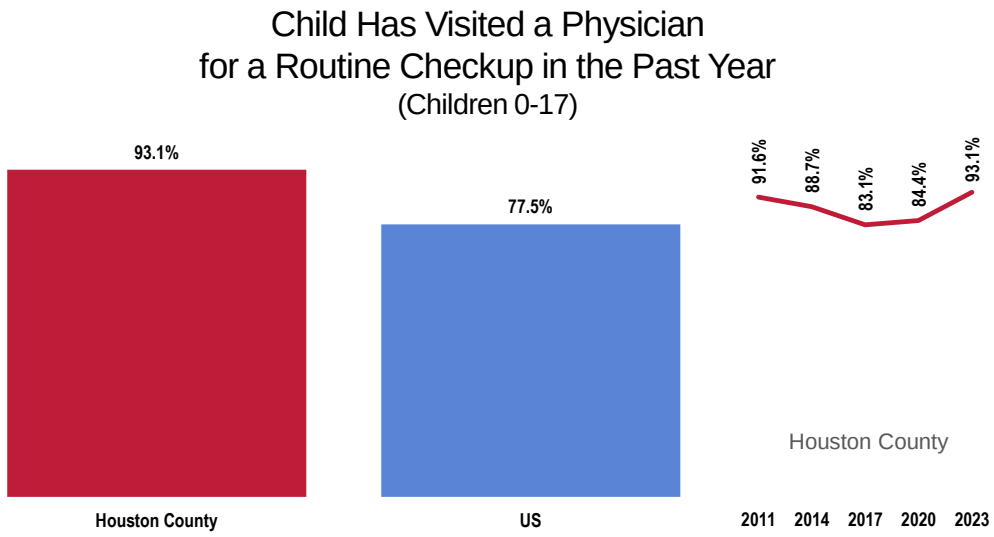
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 16]

Notes:
- Asked of all respondents.

Children

Among surveyed parents, 93.1% report that their child has had a routine checkup in the past year.

BENCHMARK ▶ Better than the national percentage.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

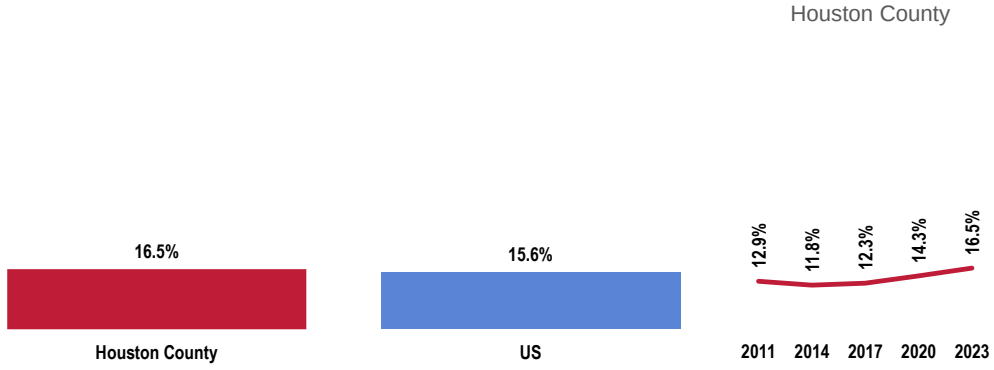
Notes:
- Asked of all respondents with children age 0 to 17 in the household.

EMERGENCY ROOM UTILIZATION

A total of 16.5% of Houston County adults have gone to a hospital emergency room more than once in the past year about their own health.

DISPARITY ► More often reported among adults age 40+ and lower-income residents.

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



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 19]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(Houston County, 2023)

Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 19]
Notes: ● Asked of all respondents.

ADVANCE DIRECTIVES

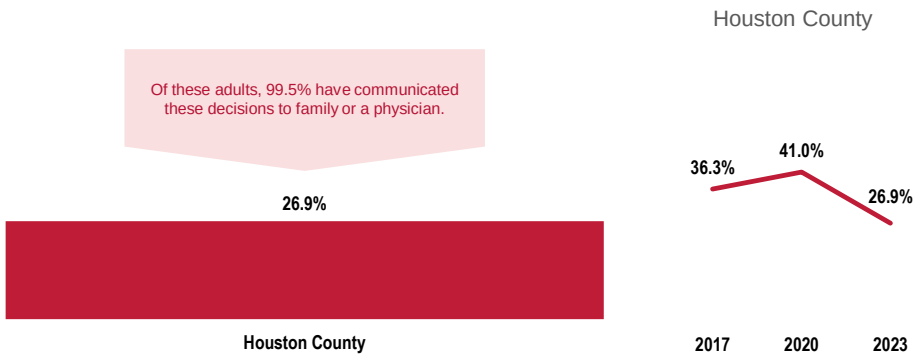
An advance directive document is a set of directions given about the medical health care a person wants if he/she ever loses the ability to make those decisions. Formal advance directives include living wills and health care powers of attorney.

A total of 26.9% of Houston County adults have completed advance directive documents.

TREND ► Denotes a significant decrease from previous surveys.

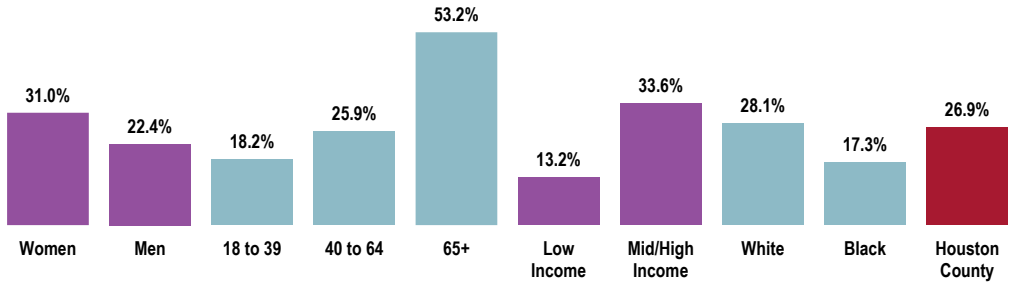
DISPARITY ► As might be expected, adults age 65+ are much more likely to report having advance directives, along with higher-income respondents.

Have Completed Advance Directive Documents



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Items 308-309]
Notes: ● Asked of all respondents.
● An advance directive is a set of directions given about the medical health care a person wants if he/she ever loses the ability to make those decisions. Formal advance directives include living wills and health care powers of attorney.

Have Completed Advance Directive Documents
(Houston County, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.
● An Advance Directive is a set of directions given about the medical health care a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Health Care Powers of Attorney.

ORAL HEALTH

ABOUT ORAL HEALTH

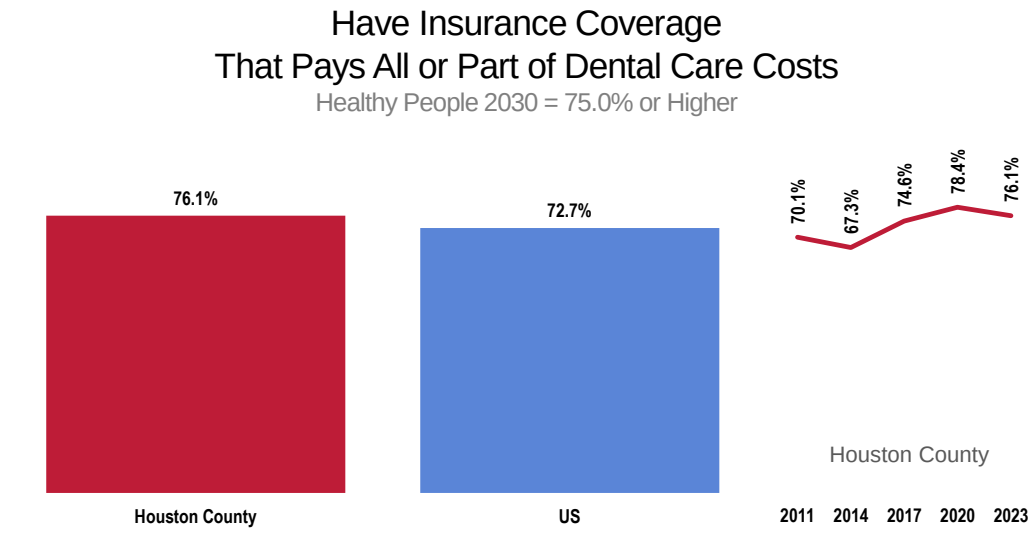
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems 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 Insurance

Over three-fourths (76.1%) of Houston County adults have dental insurance that covers all or part of their dental care costs.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 18]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Dental Care

Adults

A total of 64.3% of Houston County adults have visited a dentist or dental clinic (for any reason) in the past year.

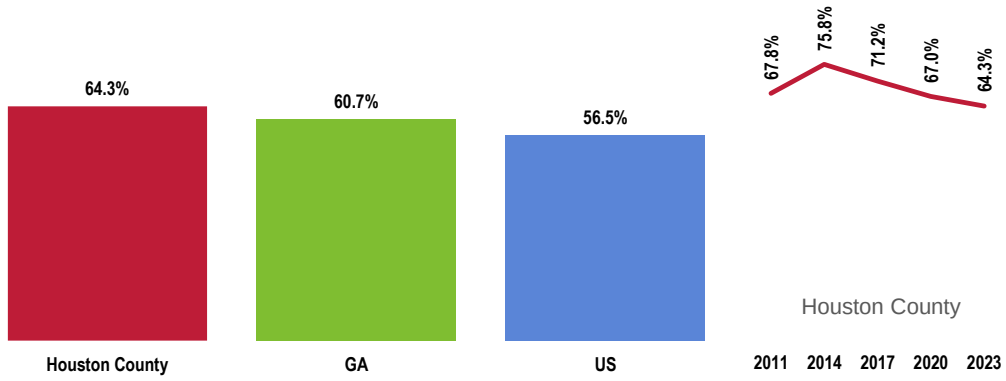
BENCHMARK ► Better than the US percentage. Satisfies the Healthy People 2030 objective.

TREND ► Similar to baseline findings, but declining since 2014.

DISPARITY ► Adults age 18 to 39 and lower-income adults are less likely to report having visited a dentist.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



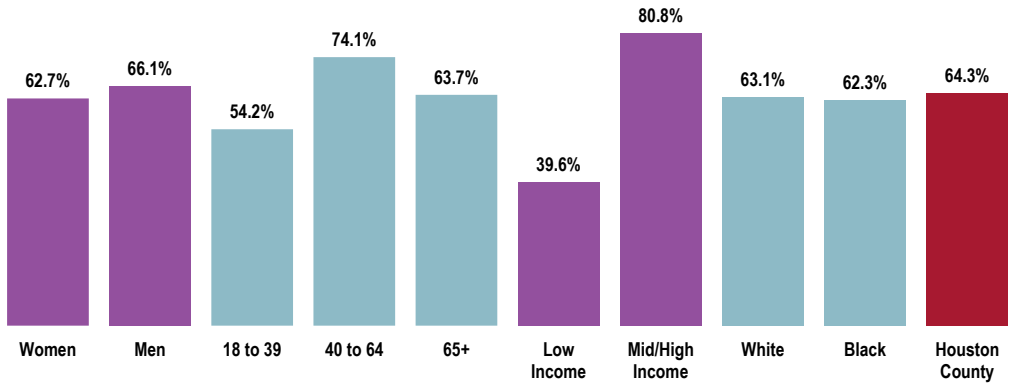
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 Georgia data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Houston County, 2023)

Healthy People 2030 = 45.0% or Higher



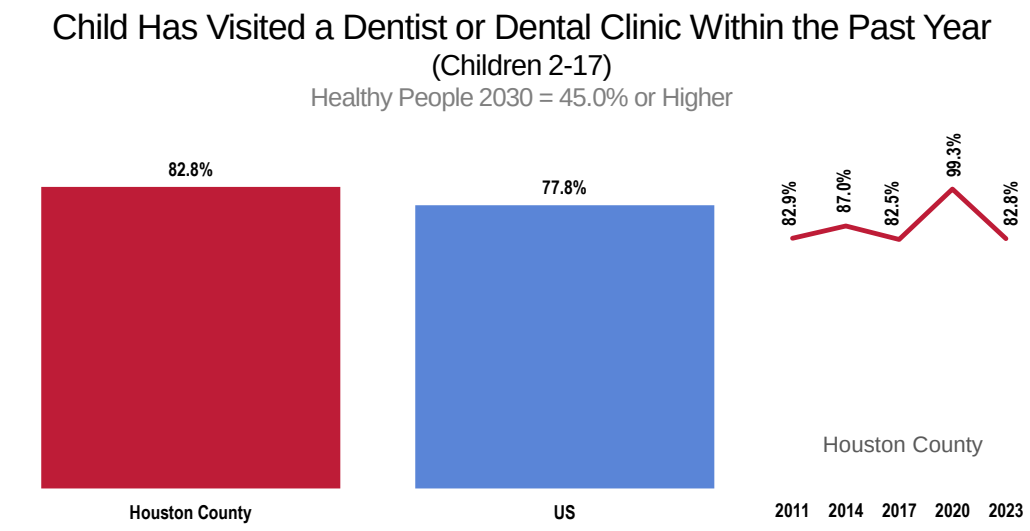
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 17]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Children

A total of 82.8% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

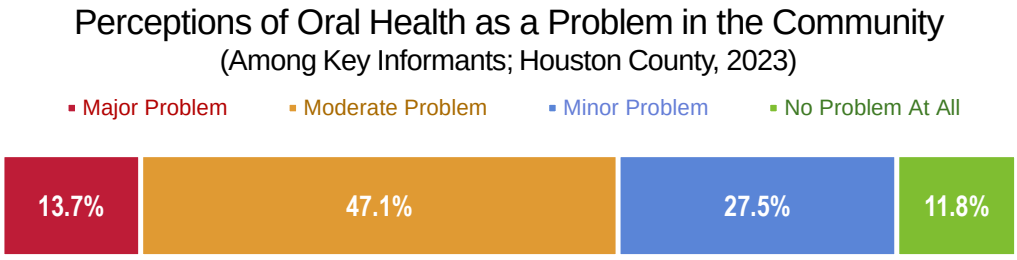


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 93]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.



Sources:
- 2023 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

> Uninsured, low-income, and seniors who do not have dental insurance or access to the area dental programs, or dentists can only get an extraction. Not proper dental oral care. – Community/Business Leader

> Oral health care access is extremely limited for those without dental insurance, and even those who have insurance often cannot afford the non-covered expenses. While dentists are plentiful, dentists who accept Medicaid or offer discounts for uninsured are extremely limited. Oral health impacts whole body health, including predisposition to cardiac disease. Poor oral health is a known contributor to learning challenges, weight management, poor mental health, and increased cardiac risk. – Community/Business Leader
>
> People don't have dental insurance and cannot afford to go to the dentist. – Other Health Provider

Awareness/Education

> People don't understand the importance of oral health and how the lack of proper oral health can cause other health issues. – Community/Business Leader
>
> Although we have dentists in the area, a lot of people in the community are not aware that oral health plays a part in other health problems. There is a long wait list for appointments for pediatric dentistry. – Social Services Provider

Access to Care/Services

> We operate a non-profit dental clinic; we are bombarded with calls and have a waitlist, though we have been able to reduce the wait time since the pandemic. Many people, including adults and children, cannot afford to pay for a regular dental visit; many of those we see are in pain. We receive calls from far away, though we've had to limit access to people in 4 counties (Houston, Peach, Crawford, and Taylor). – Social Services Provider

Prevention/Screenings

> Lack of access to preventative services. Folks without dental insurance cannot get preventative care due to the costs. Adults can get teeth extracted if a slot is available. – Community/Business Leader

VISION CARE

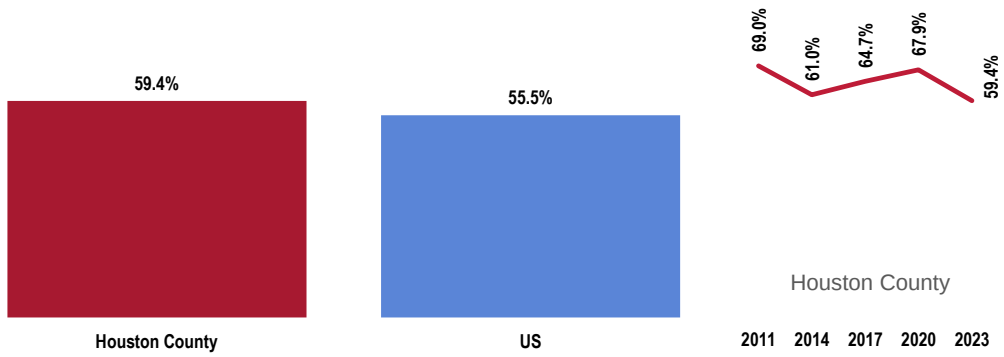
A total of 59.4% of Houston County residents had an eye exam in the past two years during which their pupils were dilated.

TREND ► Marks a significant decrease over time.

DISPARITY ► Adults younger than 65 and White residents are less likely to report having received an eye exam.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

Healthy People 2030 = 61.1% or Higher



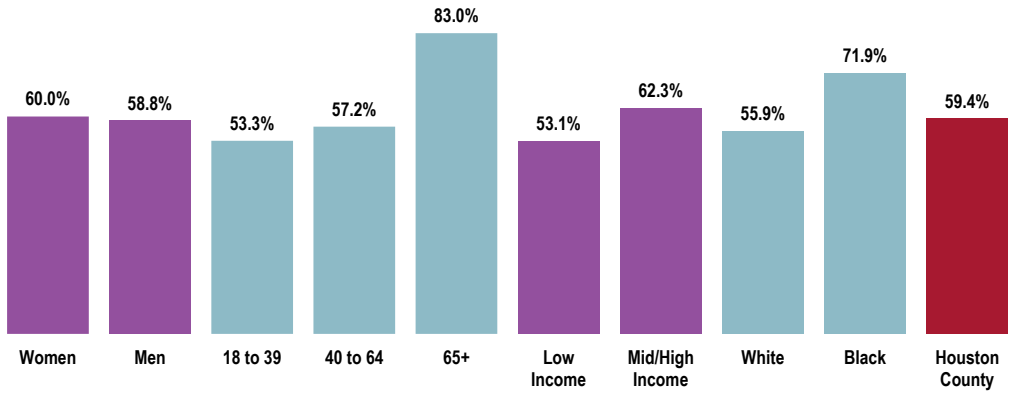
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 302]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Houston County, 2023)

Healthy People 2030 = 61.1% or Higher



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 302]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

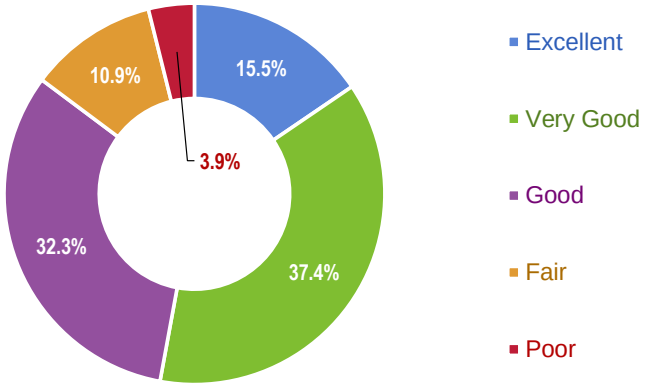
Notes:
- Asked of all respondents.

LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

More than half of Houston County adults rate the overall health care services available in their community as "excellent" or "very good."

Rating of Overall Health Care Services Available in the Community
(Houston County, 2023)

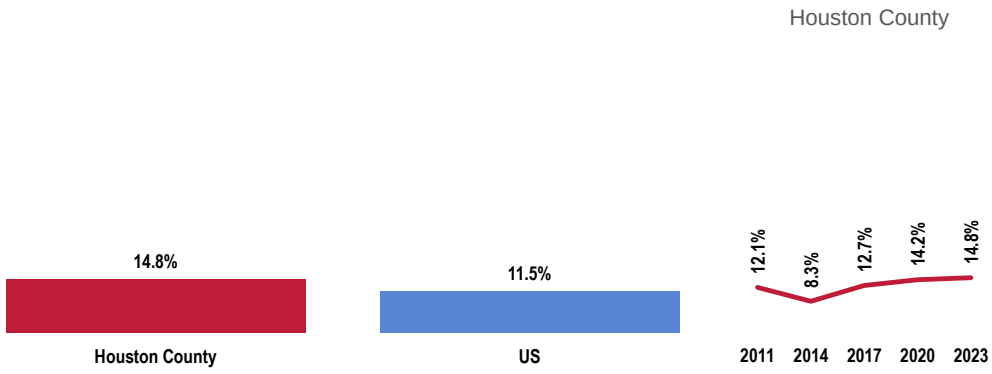


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

However, 14.8% of residents characterize local health care services as "fair" or "poor."

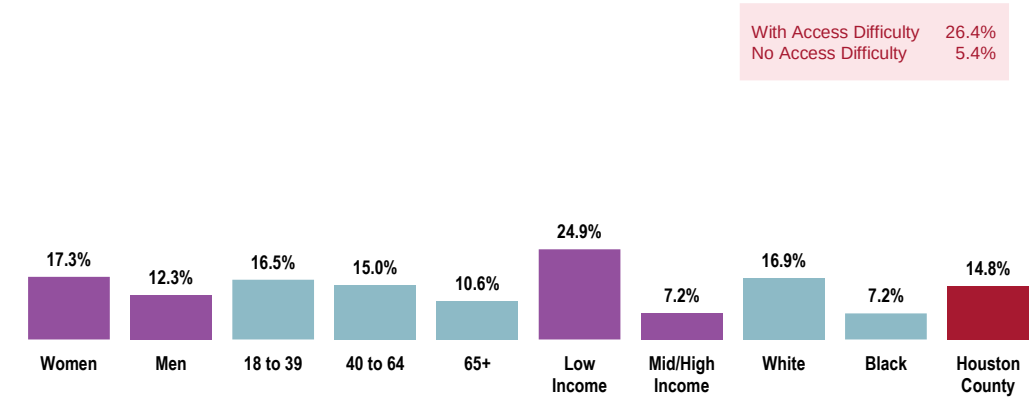
DISPARITY ► Lower-income adults, White residents, and those who have difficulty accessing services are more likely to give low ratings of local services.

Perceive Local Health Care Services as "Fair/Poor"



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Local Health Care Services as “Fair/Poor”
(Houston County, 2023)

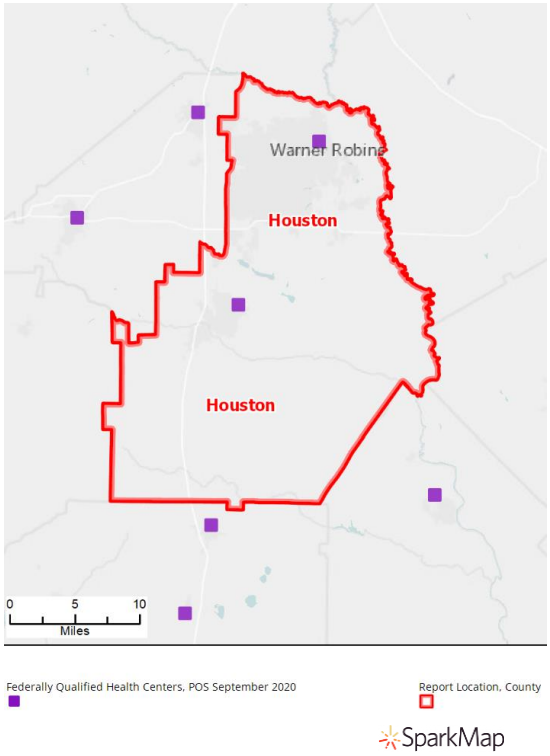


Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within Houston County as of September 2020.



Resources Available to Address 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

- Churches
- Community Home Investment Program
- First Choice Primary Care
- Government
- Houston County Health Department
- Houston County Volunteer Medical Clinic
- Houston Healthcare
- Houston Medical Center
- Pavilion Family Medicine Center
- Private Charities
- Rehoboth Dental Clinic
- Volunteer Clinic

Cancer

- Atrium Health Navicent Peyton Cancer Center
- Cancer Center
- Cancercare.org
- Central Georgia Cancer Care
- Health Department
- Houston Medical Center
- Macon
- Piedmont Healthcare
- United in Pink

Diabetes

- Atrium Health Navicent
- Beverly Knight Olson Children's Hospital
- Dental Offices
- Doctor's Offices
- Dollar Tree
- Educare
- Employee Wellness Programs
- Family Planning
- First Choice Primary Care
- GoodRx
- Health Department
- Hospitals
- Houston County Family Promise
- Houston County Health Department
- Houston County Volunteer Medical Clinic
- Houston Healthcare
- Houston Healthcare - Warner Robins
- Houston Medical Center
- Jones Center
- Medicare/Medicaid
- Pain Clinics
- Pavilion Family Medicine Center
- Pharmaceutical Companies
- Population Health
- Prescription Assistance Program
- Referral Programs
- School System
- Senior Centers

Disabling Conditions

- Adult Day Care Facilities
- Atrium Health Navicent
- Cancer Center
- Disability Funds
- Doctor's Offices
- First Choice Primary Care
- Georgia Health Department
- Goodwill Industries
- Heart of Georgia Hospice
- Houston Healthcare
- Houston Medical Center
- Long-Term Care Facilities
- National Alliance on Mental Illness
- Pain Management Center
- Physical Therapy
- Summer Hill Alzheimer's Unit
- The Canopy
- The Lodge
- Visiting Angels

Heart Disease & Stroke

- American Heart Association
- Atrium Health Navicent
- Churches
- Doctor's Offices

- Educare
- Fitness Centers/Gyms
- Georgia Health Department
- Health and Wellness Programs
- Health Department
- Healthy Houston
- HHI
- Houston County Health Department
- Houston Healthcare
- Houston Medical Center
- Parks and Recreation
- Piedmont Healthcare
- School System
- Volunteer Clinic
- Weight Loss Programs

Infant Health & Family Planning

- Atrium Health Navicent
- Caring Solutions
- Churches
- Georgia Health Department
- Houston Healthcare
- Piedmont Healthcare
- School System

Injury & Violence

- Atrium Health Navicent
- Faith-Based Community
- Houston County Fire Department
- Houston County Police Department
- Houston Healthcare
- Law Enforcement
- Piedmont Healthcare
- School System

Mental Health

- Atrium Health Navicent
- Celebrate Recovery
- Churches
- Crisis Line
- Doctor's Offices
- Door of Hope Counseling Ministry
- Family Counseling
- Flint River
- Georgia Health Department
- Guiding Light
- Health Department
- Houston County Health Department
- Houston Healthcare
- Houston Healthcare - One West
- Houston Medical Center
- Mental Health Services
- Middle Flint Behavioral Health Center
- National Alliance on Mental Illness
- Phoenix Behavioral Health
- Phoenix Center
- Piedmont Behavioral Health
- Private Health Care Facilities
- River Edge
- Salvation Army
- Veterans' Administration
- Virtual Counseling Services

Nutrition, Physical Activity, & Weight

- Atrium Health Navicent
- Bariatric and Metabolic Institute
- Carnivore Nutrition
- Churches
- Cooking Classes
- Doctor's Offices
- Educare
- Farmers' Markets
- Fitness Centers/Gyms
- Georgia Health Department
- Health and Wellness Programs
- Healthy Houston
- Houston County Health Department
- Houston Healthcare
- JDCE
- Parks and Recreation
- Phoenix Center
- Piedmont Healthcare
- School System
- Weight Loss Programs

Oral Health

- Central Georgia Technical College
- Dental Offices
- Hospitals
- Houston County Health Department
- Medicare/Medicaid
- Middle Georgia Tech
- North Central Health District
- Rehoboth Dental Clinic
- Rehoboth Life Care Ministries
- School System
- Volunteer Clinic

Respiratory Diseases

- Atrium Health Navicent
- Georgia Health Department
- Houston Healthcare
- Piedmont Healthcare

Sexual Health

- Atrium Health Navicent
- Churches
- Georgia Health Department
- Health Department
- Houston County Health Department
- Houston Healthcare
- Piedmont Healthcare

Social Determinants of Health

- Churches
- Community Action Agency
- Department of Family and Children’s Services
- Georgia Health Department
- Girls and Boys Club
- Health Department
- Housing Authority
- Houston County Board of Education
- Houston County School System
- Houston County Volunteer Medical Clinic
- Houston Healthcare
- Medicare/Medicaid
- Parks and Recreation
- Robins Air Force Base
- United Way of Central Georgia
- Warner Robins Transit
- Work Source Georgia

Substance Use

- Alcoholics Anonymous/Narcotics Anonymous
- Abba House
- Churches
- Cornick Inpatient Rehab
- Doctor's Offices
- Health Qwest
- Houston Healthcare - One West
- Houston Medical Center
- iHOPE Inc.
- Law Enforcement
- Middle Flint Behavioral Health Center
- Phoenix Center
- River Edge
- Substance Abuse Rehab Center

Tobacco Use

- Atrium Health Navicent
- Churches
- Doctor's Offices
- Educare
- Georgia Health Department
- Houston Healthcare
- Piedmont Healthcare
- Quit Line

APPENDICES

PHASE ONE: INFRASTRUCTURE FOR A SUCCESSFUL COMMUNITY BENEFIT PROGRAM

Houston Healthcare Commitment

Under the leadership of the Houston Healthcare System and Houston Hospitals Boards, Houston Healthcare strives to carry out its mission of providing patient-focused, high quality, cost-effective care while improving the health of the people whom we serve. Houston Healthcare operates Houston Healthcare-Warner Robins, a 237-bed facility, Houston Healthcare-Perry a 45-bed facility, Houston Heart Institute, outpatient urgent care centers and various other services.

The commitment to our communities is demonstrated by the Houston Healthcare Executive Team and Boards as they establish financial and manpower resources to meet community needs as well as their involvement in establishing an ongoing Community Benefit Program. The staff follows the example of Leadership in demonstrating concern for the community in the areas of modifiable risk factors, chronic disease management services and care designed to meet the needs of vulnerable populations. Throughout the Houston Healthcare Community Benefit efforts is the focus on ease of access to care as well as matching resources to specific needs.

A successful community benefit plan must include the key components of (1) Assessment, (2) Planning, (3) Implementation and (4) Evaluation**.** The Houston Healthcare plan follows these key components that are interrelated as well as ongoing.

Mission

The mission of Houston Healthcare is: “To improve the healthcare of the communities we serve by providing patient-focused, high-quality, cost effective services while promoting health and wellness.” Our Community Benefit program compliments this mission statement stressing the importance of addressing identified health care needs in our communities, providing easy access to needed health care services, as well as focusing on our most vulnerable populations.

The Program Core Principles

The following principles drive the Houston Healthcare community benefit plan.

- Address identified health care needs in our communities
- Provide ease of access to needed healthcare services
- Identify specific needs of the most vulnerable population and create services to address those needs
- Build a seamless continuum of care

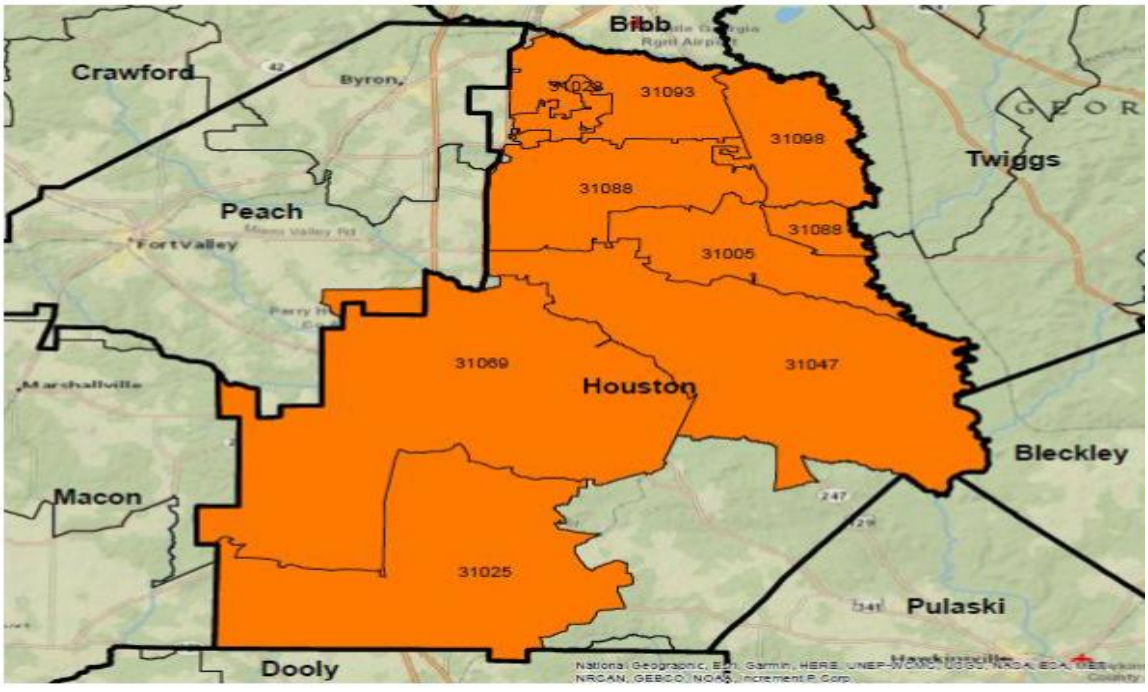
- Emphasize prevention and lifestyle modification to prevent chronic disease
- Use a collaborative approach to address health related community needs
- Provide financial assistance for the uninsured of limited means
- Communicate charity care and financial assistance policies
- Assist patients to qualify for financial assistance
- Ensure fair and transparent billing and collection practices
- Provide an annual Report to the Community on the full range of services, programs and support from Houston Healthcare

Definition of the Community

The study area for the survey effort is Houston County, Georgia. The community definition, determined based on the ZIP Codes of residence of recent patients of Houston Healthcare. The community definition was determined because more than 70 percent of Houston Healthcare patients originate from Houston County. Below describes the zip code and the cities.

HOUSTON County, GA Covers 11 ZIP Codes

ZIP Code	City
ZIP Code 31005	BONAIRE
ZIP Code 31013	CLINCHFIELD
ZIP Code 31025	ELKO
ZIP Code 31028	CENTERVILLE
ZIP Code 31047	KATHLEEN



ZIP Code 31069	PERRY
ZIP Code 31088	WARNER ROBINS
ZIP Code 31093	WARNER ROBINS
ZIP Code 31095	WARNER ROBINS
ZIP Code 31098	WARNER ROBINS
ZIP Code 31099	WARNER ROBINS

Houston Healthcare also provides services to other counties surrounding Houston County. Peach County has the second highest utilization rates following Houston County. Other counties considered as our secondary market area include: Bleckley, Crawford, Dooly, Macon, Pulaski, Taylor, Twiggs, Baldwin and Bibb.

Review of Infrastructure

Community outreach activities are recognized by Houston Healthcare as a method to reach our mission "To improve the healthcare of the communities we serve." To provide successful and effective community outreach requires a strong infrastructure. The following were identified as strengths in providing our community benefit program:

- Houston Healthcare established an ongoing community outreach program over twenty-five years ago.
- The community outreach program has been successful in demonstrating improved health outcomes as well as receiving numerous recognitions or awards for outstanding community programs.
- Houston Healthcare identified organizations, coalitions and boards who share our mission and works in a collaborative manner to synergize outcomes.
- Tracking of objectives is accomplished by utilizing the CBISA on-line system. This allows us an efficient method to account for community benefit efforts.
- Trainings on the community benefit program were provided for various departments and for those serving as reporters.
- A Community Work Group has been established.
- Reporters for Community Benefit are identified and have received training on what to "count" as activities that support the objectives of community benefit.
- Leadership supports and participants in Community Benefit activities.
- Community Benefit policies as well as Financial Assistance policies are in-place and are reviewed annually.
- Communication with the community is established and includes informational flyers, media, phone line for questions and registration for classes or events, a monthly calendar, a quarterly publication "HouseCalls" as well as the Houston Healthcare website and Social Media. In addition, the information is shared at coalition meetings as well as sent to community partners.

Community Health Needs Assessment

A Community Health Needs Assessment (CHNA) is the first step in providing an effective community benefit program. Professional Research Consultants (PRC) conducts the Community Health Needs Assessment every three years to assist is determining the needs of Houston County residents. PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments.

PRC provided a Community Health Needs Assessment in 2011, 2014, 2017 and 2020. The most recent assessment was completed in August 2023. Having PRC complete the last 12 years of CHNA information gives Houston Healthcare beneficial trending data. The assessment included both quantitative and qualitative sources. PRC also conducted an online "Key Informant Survey". In addition, PRC conducted a phone line survey which consisted of a random sample of 200 individuals age 18 and older. The assessment provides a comparison to benchmark data at state and national levels and includes Healthy People 2030 goals. In addition to this assessment, information was gathered by local discussion groups from participants at community events and meetings. Information from other community organization assessments was also reviewed.

**The CHNA was shared with the Community Benefit Work Group. In addition, a summary was presented to several community groups such as Warner Robins Regional Leadership, and with community collaboratives such as the Central Georgia Perinatal Coalition. The goal in sharing the CHNA was to obtain feedback from local community persons, as well as to raise awareness of the needs identified. The assessment was also added to the Houston Healthcare website and is available for groups or persons who have an interest in viewing the information.

PHASE TWO:
PLANNING AND ESTABLISHING PRIORITIES

Methods utilized to establish priorities

- Community Health Needs Assessment
- Key Informants online survey
- Phone Survey of 200 Community Residents
- Healthy People 2030
- The Community Benefit Work Group
- Community Group and Coalition Discussions
- Review of other Community Assessments
- Review of areas targeted by Community Partners
- Discussions of priorities by Executive Leadership and Hospital Board Members

Establishing Priorities for the Community Benefit Plan

The Community Health Needs Assessment serves as a major resource for setting the priority areas. Contributing to the planning is the discussion with other community partners on community needs. Feedback from several coalitions was applied to develop target issue recognition for specific populations. Resources were reviewed to prevent duplication of services and to ensure identified needs were met.

Identifying Priorities

The community served by Houston Healthcare has multiple health needs.
In setting the priorities for the implementation plan the following were considered:

- Magnitude of the problem or number of people impacted by the problem
- Severity of the problem or the risk of morbidity and mortality associated with the problem
- Historical trend
- Alignment of the problem with the organizations strengths and priorities
- Impact of the problem on vulnerable populations
- Importance of the problem to the community
- Existing resources to address the problem
- Feasibility of change
- Consequences of not addressing this problem

Process and methods utilized to determine priorities for the Community Benefit Plan: The process utilized for establishing priorities included ranking as well as discussion with internal departments and external organizations. Below is a summary of information reviewed and discussed.

1-Community Health Needs Assessment- A Community Health Needs Assessment was completed in June 2023. This was a major source of information to review in setting priorities. The following were identified through the CHNA as "Areas of Opportunity".

Focus Area	Health Concern of Opportunity related to Specific Focus Area *Ranked as a top concern of Key Informants
Modifiable Risk Factors	***Healthy Weight**- Overweight/Obese prevalence, Access to Recreation/Fitness Facilities, Low Food Access (Food Deserts)/Food Insecurity, Fruit and Vegetable Consumption, Meeting Physical Activity Guidelines **Substance Abuse-** Unintentional Drug Induced Deaths, Help for drug and alcohol issues **Pneumonia/Influenza Deaths-** Flu vaccine for 65+ **Sexually Transmitted Diseases-** gonorrhea and chlamydia incidence
Access to Health Services	**Access to physicians-** Number or ratio of primary care physicians **Access Barriers**- Appointment Availability and Lack of Transportation **Eye Exams** **Access to Mental Health Providers Ratio** **Use of Advance Directive Documents**
Chronic Disease Management	**Cancer-** Cancer Death Rates – leading cause of death, lung, prostate, breast, and colorectal cancer deaths as well as prostate cancer incidence ***Heart Disease and Stroke**- leading causes of death, high blood cholesterol prevalence, overall cardiovascular risk increase ***Diabetes-** diabetes prevalence, blood sugar testing (non-diabetics) **Chronic Kidney Disease-** kidney disease deaths **Respiratory Diseases-** CLRD/ COPD/ Adult Asthma **Alzheimer's Disease Death**
Vulnerable Population	**Maternal/Child Health**-Infant Deaths, Teen Births ***Mental Health-** Incidence of Diagnosed Depression, Suicide Deaths, Symptoms of Chronic Depression, Treatment for Mental Health, Number Reporting "Fair/Poor" Mental Health

2-Key Informant Focus Group- As a part of the on-line key informant survey, participants were asked what they individually perceive as the top health priorities for the community. The informants included persons from Public Health, District Public Health, Physicians, City Officials, local Universities, Board of Education, along with representatives from numerous community organizations. A summary of collected responses and concerns is listed below:

Focus Area	Health Concerns- Top 15 concerns are numbered
Modifiable Risk Factors	#4-Substance Abuse #2-Nutrition, physical activity and weight #8-Tobacco Use #12-Injury and Violence #14-Sexual Health #10-Oral health
Access to Care	#11-Access to health -related services
Chronic Disease Management	#3- Diabetes #1- Mental Health #5-Heart Disease and Stroke #9-Cancer #6- Disabling Conditions #13- Respiratory Disease
Vulnerable Population	#15 Infant and Child health/Family Planning #1- Mental Health #7- Social Determinants of Health

3-Houston County Volunteer Medical Clinic- The Houston County Volunteer Medical clinic is a free clinic for Houston County residents who are 200% of the poverty level, are uninsured, but have a job. Their Director and Board members were asked to share their top diagnosis, health concerns for this population.

Focus Area	**Health Concern- Top perceived health problems**
Modifiable Risk Factors	Obesity Tobacco
Access To Care	All pts. are uninsured, 200% of poverty level, funds for clinic, nurses, physicians to assist with clinic
Chronic Disease- Top Diagnosis Note: clinic serves ages 18-64	Hypertension Hyperlipidemia Diabetes Chronic Kidney Disease
Vulnerable Population	Behavioral Health, stress management

4- North Central Health District – Community Health Assessment 2022
Houston County is one of 13 counties which fall under the Department of Public Health-North Central Health District. Below are the health priorities for the North Central Health District to use in developing their Community Health Improvement Plan.

Focus Area	**Health Concern- Top perceived health problems**
Modifiable Risk Factors	Nutrition, Food Access, Obesity, Physical Activity (4th)
Access to Care	Access to quality healthcare and preventive services (1st)
Chronic Disease	Chronic Disease- Cardiovascular Disease, Cancer and Diabetes (2nd)
Vulnerable Population	Health Inequalities (3rd), Mental Health (5th), Maternal, Infant and Child Health (8th)

Other top concerns include: Infectious disease like HIV, Covid and Immunizations (6th), Environmental Health (7th), Injury, Motor Vehicle Injury and Falls (9th), Substance and Tobacco Use and Prevention (10th)

5- Coalition Discussion several coalitions were asked for their input in prioritizing needs. Summary below:

Perinatal Coalition- The Perinatal Coalition is led by Houston Healthcare with the goal of providing optimal prenatal care and services for all women. Priorities discussed by this coalition included: (1) Rate of low birth weight newborns, (2), Access to Care for lower

income women (3) Additional education and assistance for women with a higher risk pregnancy (4) STD's (5) Increasing the number of women who breastfeed (6) Overweight and obese women of childbearing age (7) Mental health access (8) Newborn/Infant Safety

Family Connections-Coalition is made up of service providers for children and organizations concerned with children and families. Their priorities include 1) Improving the nutrition and healthy weight of kids, 2) Successful kids who graduate from high school on time 3) Additional assistance, mentoring for kids who have been involved with the court system 4) Support and resources to assist kids in making good choices

Faith Community Nurses-Coalition of health care workers who volunteer in their churches providing health education, screening and linking to health-related services. The issues identified as priority focus areas included: (1) Transitional Care (2) Management of Chronic disease (3) preventing illness/modifiable risk factors, (4) Support/training for caregivers, (5) End of life care (6) Resources for health care (7) Community resources

6. Review of other community surveys or assessments examples include:

- 2021-Georgia Kid's Count Data
- Georgia Department of Public Health – North Central Health District- Health Status Report
- North Central Health District –Community Health Assessment 2022-Community Health Improvement Plan (CHIP)
- 2022 March of Dimes – Premature Birth Rate for Georgia
- 2023 County Health Rankings and Roadmaps- Robert Wood Johnson Foundation/ University of Wisconsin Health Institute
- Healthy People 2030
- Senior Care Surveys- 2020-2023
- Community Education 2020-2023 Surveys

6- Review of areas targeted by other community partners. The last method of establishing priorities was to review areas of need targeted by other organizations. Included in the review is the partnership role of Houston Healthcare in working with these organizations. Due to the length of information in this review a detail summary is in appendix-2.

The Review Included:

- **Children and Youth-** Family Connections Coalition, Houston County Schools, Rainbow House, Houston Hot Shots, Houston County Health Department, CASA, Houston County Safe Kids Coalition, Houston County Extension Service
- **Socio-Economic Needs-** Middle Georgia Tech, Perry Volunteer Outreach, Local churches & Faith Based Organizations, Middle Georgia Community Action Agency, Housing Authority Partnership

- **Access to Care-** Houston County Volunteer Medical Clinic, The Vine Clinic, Community Health Works, Rehoboth Life Care Ministries Dental Clinic, First Choice Primary Care, Houston Healthcare Physician Residency Program/ Pavilion Family Medicine, United Way/United in Pink
- **Behavioral Health and Substance Abuse-** Middle Flint Behavior Health, Suicide Prevention Coalition, District Public Health, Robins Air Force Base-Family Services, Middle Georgia Rescue Mission, HHC Emergency Room and Mental Health Department.

- **Emergency Preparedness, community infections, or epidemics-** District Public Health, Houston County Health Department, Houston Healthcare Emergency Medical Services

- **Persons with disabilities or persons unable to live alone-** Carter Institute- Care Net Coalition, Houston County Aging Coalition, Area Agency on Aging

- **Adequate Health Workforce-** Central Georgia Technical College, Middle Georgia Tech College, Macon State College, Mercer University AHEC- Area Health Education Center- Georgia Southern, Philadelphia College of Osteopathic Medicine, Middle Georgia College, University of Georgia, Georgia Southwestern University

Areas of need identified that are addressed by other community agencies

Behavioral Health and Substance Abuse- Houston Healthcare has in-patient behavioral health services on 1-West and provides social workers in the ED and other areas as needed. Houston Healthcare also employs psychiatrists. Houston Healthcare assist with other agencies in addressing the behavioral health, and substance abuse needs in the community, however, agencies such as Middle Flint Behavioral Health, Middle Georgia Rescue Mission, Suicide Prevention Coalition and others lead the community long-term care efforts.

Sexually Transmitted Diseases- Treatment and prevention education is led by Houston County Health Department along with District Public Health.

Transportation to Health Care Services- Transportation to services is provided by private companies, as well as some churches providing assistance, along with LogistiCare available for Medicaid recipients. Perry Volunteer Outreach assists some patients with transportation. In addition, the American Cancer Society has a transportation service for persons diagnosed with cancer. The “Population Health” initiative at Houston Healthcare provides taxi vouchers to at risk patients for health related appointments and a MedVan staffed by Houston Healthcare EMS for non-emergent discharge transportation.

Accident Prevention/Safety- Houston County Safe Kids leads the efforts on child safety for issues such as infant/child and adult car seat safety, medication safety, fire and water safety and CPR and AED use. Houston Healthcare and the Area Agency on Aging provides A Matter of Balance/fall prevention classes. #HoustonHealthy provides free community Hands-Only CPR demonstrations. AARP provides Driving Safety Classes for adults.

Finalizing the Priority Areas for 2024- 2026

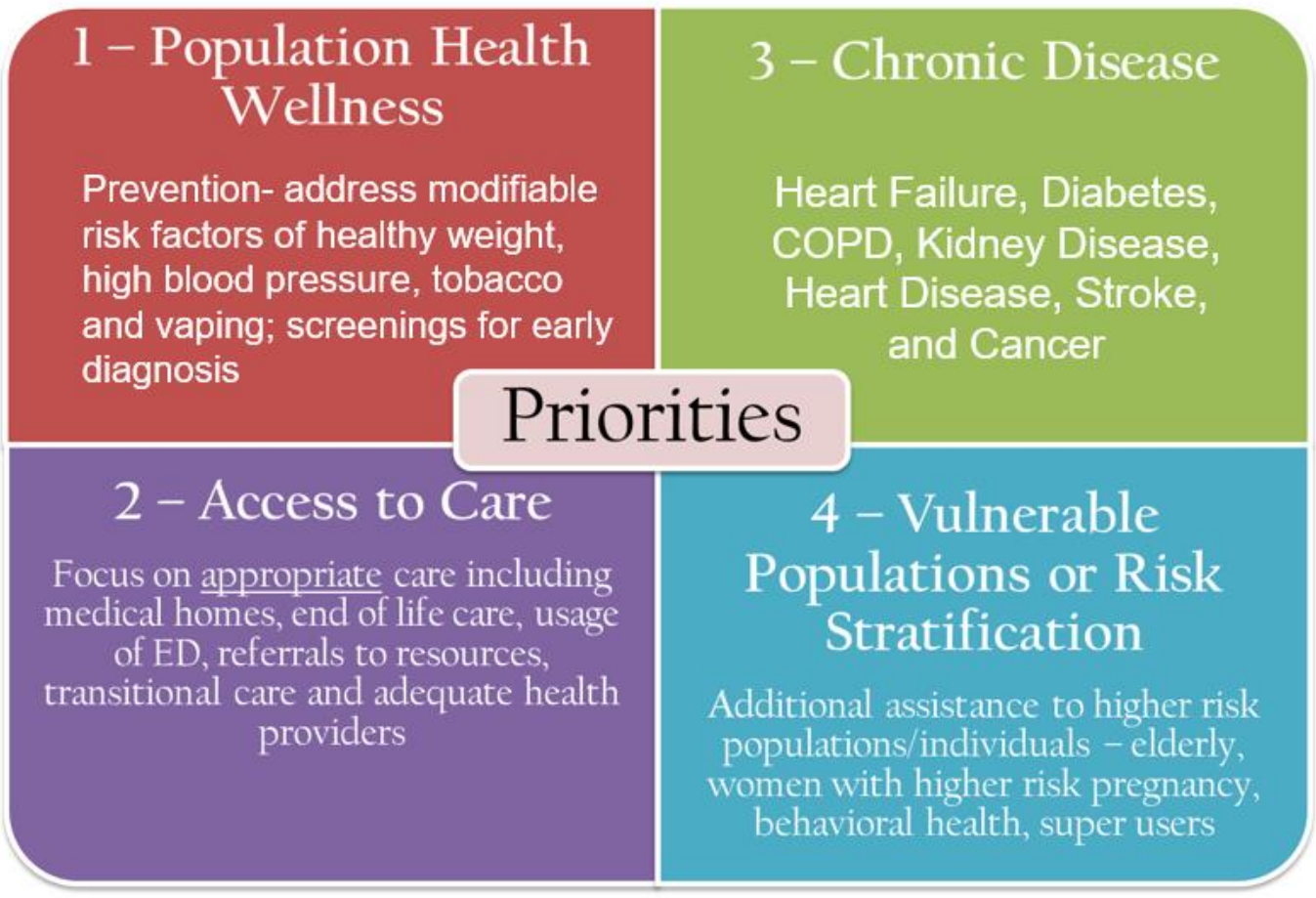
This information was presented to Executive Leadership for review and discussion on September 11, 2023. The information was presented to the Hospital Board and final priority approval on November 15, 2023. Below are the final priorities for the implementation plan.

Four Priorities Established for 2024 - 2026

Priority	Goals	Strategies
Promote Population Health and Wellness	**Improve Modifiable Risk factors** by focusing on promotion of healthy weights, decreasing tobacco/vaping usage, and controlling blood pressure, blood sugar and lipids through lifestyle changes	1) **Provide health screenings** for early identification of risk factors for poor health with referrals to health-related services 2) **Provide education and skills** to modify the risk and decrease illness 3) **Partner** with other community organizations who have this same goal. 4)**Promote** healthy lifestyle, disease prevention and management initiatives with community wide participation and support of #HoustonHealthy

Improve Access to Appropriate Health Care and Service	**Improve the ease of access to health care** by addressing possible barriers.	1) **Educate on resources**-Provide information on resources available for persons who are uninsured or lower income as well as how to navigate the health care system 2)**Advocate for sufficient numbers and quality health providers** Serve as a clinical site for institutions providing training for health care professionals 3) **Provide financial assistance** as needed for individuals with lower incomes 4) **Support and collaborate** with existing organizations providing health and care services to indigent and vulnerable populations. 5) **Provide transitional care assistance-** Inpatient educators, health screenings, classes, events, collaboration groups and other will assist with linking to appropriate care and resources 6) **Establish** a tracking system to follow persons throughout all HHC systems and services; Ensure medical home and use of available resources are utilized
Chronic Disease Management	**Improve individual's management of chronic diseases.** Provide disease management programs to equip individuals with a chronic disease with self-management skills needed to decrease complications, decrease medical cost and improve their quality of life.	1) **Educate**-Provide evidence-based chronic disease management programs; 2) **Collaborate** with physicians, health department and others in providing a process to support and link to resources; 3) **Provide Individualized care** management for those struggling with control of a chronic disease; 4) **Partner** with organizations such as the American Diabetes Association and American Heart Association in meeting national standards for excellence in care of persons with a chronic disease.
Vulnerable Populations	**Provide Additional Assistance to Vulnerable Populations** Improve the health of populations at higher risk for poor health,	1) **Collaborate** with other organizations serving these populations such as the Health Department, Family Connections, Food

	specifically targeting older adults, women with a higher risk pregnancy, individuals with behavioral health challenges and those noted to have frequent hospital visits due to behavioral or other underlying causes.	Pantries, Perinatal Coalition and Senior Adult Centers; 2) **Provide individual care management**; to those at risk 3) **Provide education, referrals, monitoring and support** as needed. 4) **Provide training and support to Caregivers** **5) Develop new programs or services-** research additional programs or services to address the needs of those with behavioral health challenges and those noted to have frequent hospital visits due to behavioral or other underlying causes.



PHASE THREE: IMPLEMENTATION PLAN

- Three Year Implementation Plan -January 1, 2024- December 31, 2026
- Annual Year Work Plan 2024/2025/2026

Phase Three – Implementation Plan Narrative

Writing/ finalizing the Houston Healthcare Community Benefit 3 Year Plan

Houston Healthcare includes Houston Healthcare- Warner Robins and Houston Healthcare- Perry. Both facilities are in Houston County and serve the same populations. Residents can and often do utilize both facilities along with the other resources provided through Houston Healthcare. Because the service area is the same population, the needs and the plan to address them are the same.

Houston Healthcare will utilize various methods to reach the goals set in the implementation plan. Healthy People 2030 information states "Educational and community-based programs and strategies will play a key role in improving the health of the community."

Community settings such as churches, lower income housing projects, and worksites increase the access to populations with health disparities. Barriers such as low literacy rates, non-traditional work hours, and limited education contribute to a decreased understanding of addressing health challenges early and setting healthy lifestyles as a priority to prevent illness.

Houston Healthcare has explored and is continuing to seek methods to reach all populations within the service area but especially those with the greatest need. This is accomplished by taking needed health information out into the communities we serve.

Community partnerships provide a vehicle to broaden the outreach as well as to provide feedback on methods to reach vulnerable populations. This includes providing screening and education through avenues such as churches, soup kitchens/food pantries, workplace/industry sites, public libraries and the Houston County Board of Education. Houston Healthcare also partners with the Houston County Health Department, local housing authority, free or lower cost medical clinics, senior centers and others to impact the health of our community.

Description of Plan

Every three years a Community Health Needs Assessment is completed and a three-year implementation plan is created. The three-year plan addresses the needs identified in the Community Health Needs Assessment. The implementation plan includes the four priority areas of

(1) Improve Modifiable Risk Factors

(2) Improve Ease of Access to Appropriate Health Care,
(3) Improve individual's Management of Chronic Disease, and
(4) Additional Assistance for Vulnerable Populations.

Each year a detailed annual work plan is developed to measure the progress of reaching the goals and address the priorities described in the three -year plan. Anticipated impact or outcomes are reviewed each year. The three-year plan will be evaluated by utilizing a score card.

This narrative will address each of the four priority areas and will include:

Priority Area

A- An overview of the health priority

B- The Goal and Strategies

C- The Score Card- objective, baseline, and strategies (Complete Score Card is in appendix 3)

Priority Area 1 – Improve Modifiable Risk Factors

Overview: Major Risk Factor- Overweight or obesity

The Nutrition and weight status information included in Healthy People 2030 reflect strong science supporting the health benefits of maintaining a healthy body weight through a balanced diet and exercise. The information also emphasizes that efforts to change diet and weight should address individual behaviors, as well as policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Our community adults as well as children will face chronic obesity-related health problems like heart disease, high blood pressure, diabetes, cancer, and asthma if the present trends continue.

The Community Health Needs Assessment defined overweight as BMI of 25.0 to 29.0 and obesity as BMI over 30.

Baseline

- 78.5% are overweight, 45.8% of these adults are obese.
- **21.5% of Houston County adults are at a healthy weight.**

Goal: Increase the number of adults at a healthy weight to at least 23.5% by December 2026

Strategy: The strategy will include promotion of the Healthy People 2030 recommendations to "Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, lean meats and other protein sources and water as a beverage of choice. Limit the intake of saturated and *Trans* fats, added sugars, sodium, and alcohol." The strategy also includes programs specifically designed to promote healthy weights such as the Healthy Living for Life Class, Nutrition Education/Cooking Classes along with exercise classes.

Health screenings will be provided at worksites, churches and other community sites will include BMI measurements. The local school system is targeting youth promotion of healthy weight and Houston Healthcare is providing cooking schools and education at Lindsay Transitional Center. Cooking demos are also being offered at indigent care health facilities and senior programs.

The City of Perry provides free indoor space for exercise which is staffed and promoted by Houston Healthcare. The EduCare department has an on-site exercise area for classes at the Houston Health Pavilion that target seniors, working population and families. Several classes are offered to meet participants at their movement level including chair yoga, balance class, tai chi, strength, aerobic and resistance classes.

The #HoustonHealthy initiative was started at the end of 2020 to encourage healthy habits and promote wellness with hospital employees and in the community. This initiative will continue to partner with individuals, groups, leaders, schools, businesses and organizations to support encouraging healthy options available to the people in Houston County.

Overview: Major Risk Factor Tobacco

A major goal of Healthy People 2030 is prevention and cessation of tobacco usage. The report shares "Tobacco use remains the leading cause of premature and preventable death in our nation, responsible for 443,000 deaths each year. Tobacco use causes cancer, heart disease, lung disease as well as premature birth and low birth weight infants." In Houston County, the leading causes of death include cardiovascular disease and cancer, with tobacco as a major contributor to these diseases.

Baseline

- The rate of tobacco usage is highest among residents age 40 to 64 (14.7%)
- Lower income residents had higher rates of tobacco usage at 19.4%.
- **12.3% of persons living in Houston County smoke tobacco and 7% of residents use vaping products with most use reported among younger adults age 18-39 (under 18 was not assessed).**

Goal: Decrease the usage of tobacco use to 10% and vaping to 5% by Dec. 2026

Strategy: Addressing this health issue requires multiple methods and partnerships. While it is recognized tobacco cessation is difficult, it is possible. Houston Healthcare refers to the Georgia Quit Line which offers individual assistance through a phone line. The Quit Line utilizes trained counselors, is free, anonymous, and is easily assessable. This resource will be shared at community outreach events.

In addition, each hospitalized patient and/or class/health fair participant who states they are a tobacco user will receive tobacco cessation information along with information on the Georgia Quit Line. Additional education will also be provided regarding the harms of vaping to both young and old. Community Partners include Houston County Public Health assisting with tobacco cessation education, providing resources for the Houston County Public School system to include dangers of vaping resources to adolescents, and The American Cancer Society assisting with the annual Great American Smoke Out.

Score Card Priority Area 1- Improve Modifiable Risk Factors

Community Need Identified/Baseline	Overall Goal/ Measurable Scorecard 3-year goal-CHNA-2026	Objectives/ Anticipated Impact
Leading causes of death is cancer and cardiovascular disease both are impacted by modifiable risk factors of nutrition, exercise and tobacco use. **A-<u>Healthy Weight</u>**- 21.5% of community are at a healthy weight (BMI- 18.5 to 24.9)	Improve risk factors associated with the development of cancer and chronic disease **A-2- increase the number of adults at a healthy weight (BMI 18.5-24.9) to at least 23.5%**	Provide weekly educational programs to increase knowledge and skills to improve modifiable risk factors and over- all health. **A-1**-At least 50% of the participants in the Healthy Living Class will demonstrate a weight loss and report one positive healthy lifestyle change. **A-2**- Provide at least four Worksite Wellness screenings, to include BMI consultation. **A-3**- Participate in community events that promote healthy weight, healthy eating and physical activity **A-4**- Provide cooking classes and demonstrations that promote cost effective healthy food choices to prepare at home
B-<u>Tobacco</u> 2011 CHNA- Tobacco Use- 18.6% 2014 CHNA- Tobacco Use- 12.7% 2017- CHNA- Tobacco Use- 13.9% 2017- CHNA-Tobacco Use- lower income residents- 22.7% 2020- CHNA- 11.1% tobacco use residents (17.8% low-income) 17.9% use vaping products 2023-CHNA 12.3% tobacco use (19.4% low- income) 7% use vaping products	**B- decrease the usage of tobacco to 10%** **Decrease number of residents who vape to 5%**	**B-1**- Present tobacco/vaping educational materials and info. at both hospitals during Great American Smokeout. **B-2**-Tobacco cessation education including the "Georgia Tobacco Quit line" will be provided to at least four worksites or community organizations serving lower income population. **B-3** Provide/participate in community outreach activities that teach dangers of vaping especially to school age children **B-4** All EduCare programs to include smoking cessation education and referrals documented in monthly report

Priority Area 2- Improve Ease of Access to Healthcare

Overview: The ease of access to healthcare services is important in the achievement of a healthy life. The Healthy People 2030 review includes "Access to health care means the timely use of personal health services to achieve the best health outcomes".
Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. Barriers to services include:

- Lack of availability which is impacted by the number of health workers
- Limited financial ability to pay for services
- Lack of insurance coverage
- Lack of knowledge of resources for health services

These barriers to accessing health services lead to:

- Unmet health needs
- Delays in receiving appropriate care
- Inability to get preventive services
- Hospitalizations that could have been prevented

Baseline
The Community Health Needs Assessment information included:

- 14.6 % lack healthcare insurance coverage with 32.7% of lower income persons have no insurance coverage.
- 14.9% skipped prescription doses to save cost on medications
- 16.5% of Houston County adults have gone to a hospital emergency room more than once in the past year.
- The number of primary care physicians is 72.7 per 100,000 population which is less than the state (87.6) and national (107.3) average.
- 26.9% have completed an advance directive document
- 72% of residents have a specific source of ongoing medical care (which means 28% do not have a PCP)

Goal: **Improve the ease of access to appropriate health care services.**

Increase the number of Houston County residents who have a medical home or ongoing source of healthcare to at least 80%.

Strategy: Houston Healthcare is addressing this critical issue in multiple ways including: (1) Providing support for local technical schools, and colleges for training additional health care workers. (2) Providing a physician's residency program, as well as serving as a clinical site for students going into a health care profession (3) Assisting and supporting the free Volunteer Medical Clinic and operating Pavilion Family Medicine which serves uninsured, lower income residents (4) Providing a phone referral service to link community persons to needed services or medication assistance and encourage establishing a medical home. (5) Health fairs and community screenings include information on qualifying for financial assistance and obtaining a medical home (6) Partnerships with groups such as United Way and others to provide assistance in obtaining specific health services. (7) Houston Healthcare has added Care Managers to assist in-patients and ED patients to better navigate the health care system. (8) Houston Healthcare is also providing Med Stops for urgent care in three locations for easier access. (9) Policies and processes are in place to provide financial assistance.

Goal: **Decrease the number of persons who frequently utilize the ED for health care to 12%**

Assist members of the community to find a medical home for non-emergent health needs

Strategy: Referral Services offer information for any person needing information for a medical home based on insurance type, no insurance or low or no income. All health screenings, health fairs, community events and classes will provide information and need for a medical home. Partnership with agencies providing funding to assist with services related to health services, mammograms, prenatal care and other screenings provided as needed and made available.

Goal: **Decrease the number of persons who do not take medications as prescribed to < 10%**

Provide information to members of the community on sources for lower cost prescriptions or prescription assistance

Strategy: Many resources are available to the community to assist in medication cost. Organizations that offer services include- Middle Georgia Community Action Agency, Good Rx and many discount medications offered at local pharmacies. All information will be made available at all health screenings, health fairs, classes and are available through Referral Services, Care Management and in-patient services.

Score Card- Priority Area 2- Improve Ease of Access To Health Care

Community need identified/Baseline	Overall Goal Measurable Scorecard 3- year goal- CHNA- 2026	Objectives/ Anticipated Impact
The ease of access to healthcare services impact personal health, delays appropriate care, leads to increased health care cost, hospitalizations and ED visits. **A-Medical Homes** 2014- CHNA- 73.9% report ongoing source of health care 2017 CHNA- 71.8% report ongoing source of health care 2020 CHNA- 83.2% report ongoing source of health care 2023 CHNA- 72% report ongoing source of health care **B-Appropriate Usage of Health Services** CHNA-2023 16.5% of residents have utilized the ED more than once in a year(31.8% low income)	Improve the health of individuals by improving the ease of access to care. **A-Increase the number of Houston County residents who have a medical home or ongoing source of healthcare to at least 80%.** B-**Decrease the number of persons who frequently utilized the ED for health care to 12%**	**A-1** increase in the number of persons who call Referral Services to obtain information on establishing a Medical Home by 3% compared to request in 2023. **A-2** Community screenings will include documentation on participants screening form of their medical home. If no medical home participant will be linked to Referral Services. **A-3** At least 4 health fairs with screenings will be provided in low income areas. Each event will promote medical homes, resources for persons who are uninsured, and financial assistance available. **B-**Patient Care Services, EduCare, Marketing, 1 West, Population Health and EMS will explore efforts to increase appropriate usage of the ED
C- Medications 2014 CHNA- 15.1% of residents skipped Rx doses to save cost. 2017 CHNA-11.9% of residents skipped Rx doses to save cost. 2020 CHNA- 9.5% of residents skipped Rx doses to save cost 2023 CHNA-14.9% skip RX to save cost	**C- Decrease the number of persons who do not take their medications appropriately to less than 10%**	**C-1** Referral services will refer community persons to resources for lower cost prescriptions **C-2** Information on prescription assistance will be provided at all health fairs/screenings **C-3** Patients attending Chronic Disease Education will receive information on lower cost medications and be provided medication organizers.

		C-4 Medication Management will be provided to senior groups, classes, and community events stressing the importance of medication compliance and maintaining a current medication list (Know Your Meds cards)

Priority Area 3- Improve Individual's Management of Chronic Diseases

Overview: Chronic diseases are the leading cause of death and disability in the United States. Heart disease, cancer, and stroke alone cause more than 50 percent of all deaths each year. Chronic diseases include (but are not limited to): arthritis, diabetes, kidney disease, asthma, cancer, congestive heart failure/heart disease/stroke and chronic obstructive pulmonary disease (COPD)

Baseline

- Almost half of all deaths in Houston County are from cancer or cardiovascular disease (heart disease and stroke)
- 20% of the population has diabetes/ 7.2% pre-diabetes
- 17.8% of the adult population has COPD/asthma
- Stroke rate is 38.2 deaths per 100,000

Goal: **Decrease the number of residents who have diabetes to 15%**
Decrease the number of residents who have pre-diabetes to 6%
Decrease rate of deaths from strokes to 35 per 100,000
Reduce the death rate from heart disease to 175 per 100,000
Decrease hypertension rate to 40%

Provide Chronic Disease Management to equip persons with skills needed to control their condition in such a way that decreases complications, and improves their quality of life.

Strategy: The first strategy is to prevent chronic disease. These efforts are listed in our first and second priority areas which include addressing risk factors, early identification through screenings and improving the access to appropriate health services. These play a key role in addressing chronic illness.

Once a person has a chronic illness our strategy becomes; (1) to provide chronic disease management programs that empower and encourage the patient to be an active participant in their care. Provide evidenced based chronic disease management programs which include: Diabetes Management- nationally recognized program from American Diabetes Association, Arthritis Management- Walk with Ease from Arthritis Association, as well as Heart Failure, Cholesterol and Hypertension Management both based on chronic disease management models. (2) Provide a smooth transitional care process to provide hospitalized patients with education and skills to manage their illness. Transitional Care

is a priority for Houston Healthcare and includes appropriate discharge planning and referrals. This is accomplished and tracked though in-patient education services and Care Management. (3) Provide education to prevent complications that can arise with the progression of an uncontrolled chronic disease.

Score Card Priority Area 3- Chronic Disease Management

Community need identified/Baseline	Overall Goal Measurable Scorecard 3-year goal- CHNA- 2026	Objectives/ Anticipated Impact
A- Diabetes 2011- CHNA- 14% Houston County Residents are diagnosed with diabetes 2014- CHNA- 11.7% Houston County Residents diagnosed with diabetes (6.7% with pre-diabetes) 2017- CHNA- 18.3% of Houston County residents diagnosed with diabetes. (4.2% with pre-diabetes) 2020-CHNA- 17.3% of Houston County residents diagnosed with diabetes (10.3% with pre-diabetes) 2023 CHNA- 20% with diabetes (7.2%with pre-diabetes)	-Decrease diabetes related complications and improve quality of life of patients living with diabetes **-Decrease the number of residents who have diabetes to 15%** **Decrease the number of residents who have pre-diabetes to 6%**	**A-1**-Maintain National Recognition for Diabetes Management Program through annual audit (due Sept 2025) **A-2**-Decrease ED visits and hospitalizations to <20% for participants in Diabetes Management program (3 month tracking) **A-3**- Decrease the 30- day readmission rate for patients receiving in-patient diabetes education to less than 20%. **A-4-** The Diabetes Advisory Board will include at least one patient with diabetes who has experienced a hospitalization **A-5**- At least 50% of pts. Referred will be scheduled. **A-6** Start at least 2 National Diabetes Prevention Program Cohorts with 50% of participants completing full year program **A-7** NDDP to maintain CDC full recognition status (due Nov 2026)

B- Hypertension/Cholesterol Management – 2014- CHNA- 38.3%- residents have high blood pressure 2017- CHNA- 43.5%- residents have high blood pressure 2020 CHNA-51.3% residents have high blood pressure, 40.8% have high cholesterol 2023 CHNA- 43.3% residents have high blood pressure, 45.6% residents have high cholesterol **Stroke rate is 38.2 deaths per 100,000** **Rate heart disease deaths per 100,00** 2011- CHNA- 182.7 2014 CHNA--179.6 2017- CHNA- 181.3 2020-CHNA- 203.2 2023 CHNA- 214.0	**B-**Decrease complications of hypertension **Decrease rate of deaths from strokes to 35 per 100,000** **Reduce the death rate from heart disease to 175 per 100,000**	**B-1-**Decrease ED visits & hospitalizations by at least 50% for participants in Hypertension Management program (3 month F/U tracking) **B-2-** At least 75% of hypertension/cholesterol management class will list at least one lifestyle change **B-3-** 100% of persons with abnormal BP/cholesterol screening will receive education and referral as needed to additional follow up health care.
C-Heart Failure Diseases of the heart account for the number one cause of death in Houston County	**C-**Improve the ability of persons with heart failure to manage this condition, and improve their quality of life	**C-1-**80% of class participants will report increase in knowledge and skills to management heart failure **C-2-**Readmissions from Heart Failure will decrease to <15% (in-patient 1 month tracking, class 3 month tracking) **C-3-** Meet as a work group to improve the care of persons with heart failure.
D-CPR 14.9% report receiving CPR training in last year	D-Improve outcomes for those with an out-of-hospital cardiac event **Increase number trained in CPR to 60% (3-year scorecard)**	**D-** Multi-department effort to provide hands-only CPR training at 10 or more community events

Priority Area 4- Assist Vulnerable Populations-

Improve the health of populations at higher risk for poor health specifically targeting women with higher risk pregnancies as well as older adults, persons with behavioral health challenges, and hospital/ED frequent users

Overview: Low Birth Weight Infants

Preterm/ low birth weight is the leading cause of newborn death in the United States. Low birth weight babies, (newborns weighing less than 5 pounds 8 ounces) at birth are much more prone to illness and neonatal death than are babies of normal weight. Risk factors for low birth weight are continuing to be studied, however, known risk factors include women who are uninsured and lower income, tobacco usage and lack of prenatal care as well as pre-existing medical conditions.

Baseline:

- 9% low birth weight
- 19.1% no prenatal care in the first trimester
- 10 infant death rate per 1,000 births (infant defined as birth to 1 yr. old)

Goal: Increase the number of women having a healthy newborn by addressing the risk factors for newborn low birth weights and preterm births.

Decrease low birth rate to 8% in Houston County
Decrease infant death rate to 6 per 1000 births (infant defined as birth to 1 year old)

Strategy: The strategy is to target women with a higher risk pregnancy due to socio-economic risk or a medical risk. Activities will include (1) Partnering with other organizations providing pregnancy related services through the Perinatal Coalition. (2) Providing a Hispanic interpreter/care manager for uninsured and non-English speaking pregnant women (3) work with the local health department as well as local physicians to ensure all women have access to prenatal care (4) Providing a Nurse Care Manager for pregnant women with a medical condition (5) Providing a Nurse Educator to meet with pregnant teens in schools as requested. (6) Partner with agencies providing safety interventions for infants (DPH, Safe Kids, Family Connections, etc).

Overview: Senior Adults 65+

Older adults are among the fastest growing age group accounting for 12.5% of residents in Houston County. 65.4% of older adults will manage more than one chronic condition. Managing one chronic condition is challenging, however, with each additional disease, control becomes more difficult often involving more medications, and the need for increased monitoring, additional health services and education.

Another risk among older adults is accidental falls. Falls are the second leading cause of death due to unintentional injury among older adults. According to the Healthy People 2030 Report, “Behaviors such as participation in physical activity, self-management of chronic diseases, or use of preventive health services can improve health outcomes.” In our work with older adults the desire to maintain independence was identified as a major goal among this population. To support the older population to maintain their

independence requires additional assistance in health education, monitoring, chronic disease management and opportunities to improve physical strength, balance and fitness.

Baseline:

- 65.4% of adults over age 65 are managing three or more chronic conditions
- 97.7% of adults over age 65 exhibit one or more cardiovascular risk behaviors including smoking, no physical activity, hypertension, high cholesterol and/or are overweight
- 27% of 65+ year old's report "fair" or "poor" overall health
- 12% of adults over age 65 meet physical activity recommendations each week
- 53.1 per 100,000 of unintentional injury deaths among 65+ is related to falls

Goal: Improve the health, function, and quality of life of older adults.

Reduce senior "3 or more" chronic conditions to 90%
Decrease rate of unintentional injury deaths related to falls to 15%
Increase seniors meeting physical activity recommendations to 20%.

Strategy: (1) Provide free exercise program for older adults in collaboration with other community organization's such as the Warner Robins Recreation Department, local care homes, senior centers and the Perry Recreation Department. (2) Provide health education programs which include health screenings, education at convenient locations, and referrals as needed to physician's care and other resources. (3) Partner with other local organizations that are providing services for older adults by providing health related information as well as information on resources. Priorities for these health information programs includes: tools for medication management and the importance of being engaged and taking responsibility for personal health, prevention of falls, and chronic illness related information. (5) Ensure opportunities for caregiver training are available in order to establish support for older adults.

Overview: Mental Health

For the first time on the Houston County Community Needs Health Assessment, mental health was at the top of problem health topics from key informants with 50% listing as a major problem and 42.3% as a moderate problem. Following the Covid-19 epidemic, mental health has gained public attention in relation to prevalence and determining options for addressing increasing concerns. Estimates suggest that only half of all people with mental health disorders receive the treatment they need. With mental health and physical health being so closely related, it is imperative that this concern be addressed in order to attain all other health concern goals discussed in this workplan.

Baseline:

- 30% diagnosed with depression, 43.2% experience symptoms of chronic depression
- 17.9 per 100,000 suicide deaths
- 21.2 receiving mental health treatment
- 71.5 mental health providers per 100,000 of population (117 including psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health)

Goal: Improve the mental health/well-being of the community.

Reduce those who experience chronic depression symptoms to 38%
Reduce suicide deaths to 12 per 100,000
To increase metal health organizations and mental health providers/partners to 81 per 100,000

Strategy: (1)Ensure a mental health educational component be included in all chronic disease education and classes (2) Provide a mental health self-assessment guide with community resources available at all health fairs/screenings (3) Offer mental health talks to senior groups, churches, businesses, organizations through speakers bureau (4)Make referrals to Department of Public Health Mental Health Clinic, Emergency Room Services, 1 West, and Middle Flint Behavioral Health as needed (5) Promote the Suicide Prevention and Crisis Line

Score Card- Priority Area 4-Additional Assistance for Vulnerable Populations

Community need identified/Baseline	Overall Goal Measurable Scorecard 3-year goal- CHNA- 2025	Objectives/Anticipated Impact
A-Pregnant Women and Newborns 2014- CHNA- 8.9% Low birth weight 2017-CHNA- 8.5%- Low birth weight 2020 CHNA-8.8% low birth weight 2014- CHNA-8.9 infant death rate per 1,000 births 2017-CHNA- 7 infant deaths per 1,000 births 2020 CHNA- 7.8 infant deaths per 1,000 births	**A-1 Decrease the low birth weight to 8% (<2500g or 5lbs 8oz)** **A-2- Decrease infant death rate to 6 per 1,000 births**	Provide education and services for assistance to vulnerable populations to decrease the deliveries with low birth weight among women identified with a **higher risk pregnancy.** **A-1-** Class Survey will show 90% can list: -Risk factors for pre-term birth -Symptoms of pre-term labor -Importance of 39 weeks gestational -Benefits of breastfeeding **A-1** L+D records to show decreased low birth weight/pre-term delivery rates **A-2** Class survey will show 90% can list: -car seat safety starting at discharge from the hospital -back to sleep to prevent SIDS

2023 CHNA- 10 infant deaths/1,000 9% low birth weight		-co-sleeping risks -not to shake the baby/ways to comfort -aware of community resources available for infant safety
B- Older Adults 97.7% of adults over age 65 have one or more cardiovascular risk behaviors 65.4% of senior adults are managing 3 or more chronic conditions 53.1/100,000 of senior unintentional injury deaths is related to falls 12% of 65+residents meet physical activity recommendations (light-mod activity 150 min/week or 75 min vigorous activity/week)	**B- 1 Reduce Seniors "1 or more" risk to 90%** **B2- Reduce Seniors "3 or more" chronic conditions to 60%** **B-2 Decrease rate of unintentional injury deaths related to falls to 45/ 100,000** **B-3 25% of seniors will meet activity recommendations**	**B-1-** Health and safety educational programs will be provided each month at facilities serving older adults. **B-1-**Provide Stroke Prevention/Heart Protection Program -Monthly screenings will be provided each month at facilities serving older adults. -RN providing the BP screening will also provide education on controlling BP and signs and symptoms of stroke, heart disease and medication management -RN will make referrals to physicians as needed **B2& 3-**Participants in the Senior Adult exercise programs: -80% surveyed will continue or increase their exercise plan as a result of programs offered -80% surveyed will report making safety changes -80% surveyed will report improved balance

C- Mental Health 30% diagnosed with depression, 43.2% experience symptoms of chronic depression 17.9 per 100,000 suicide deaths 21.2% receiving mental health treatment 71.5% mental health providers per 100,000 (117 actual)	**C-1 Reduce those who experience chronic depression symptoms to 38%** **C-2 Reduce suicide deaths to 12 per 100,000** **C-3 Increase mental health organizations and mental health providers/partners to 81 per 100,000**	**C-1** Ensure a mental health educational component be included in all chronic disease education and classes **C-1&2** Provide a mental health self-assessment guide with community resources available at all health fairs/screenings **C-1&**2Offer mental health talks to senior groups, churches, businesses, organizations through speakers bureau **C-2** Promote the Suicide Prevention and Crisis Line at classes, screenings and community speaking events **C-3** Make referrals to Department of Public Health Mental Health Clinic, Emergency Room Services, 1 West, Population Health and Middle Flint Behavioral Health as needed. Participant in Coalition groups with same goals**.**

SCORECARD AND OUTCOMES FOR 2020-2022

Legend: **(Overall Scorecard Goals)** **Goal Met** **Goal Not Met** **(Actual Impact Goals)** **Goal Met** **Neutral Reporting** **Goal Not Met**

Please note-department closed to assist in Covid efforts from March 2020 –Aug 2020 and re-opened with restrictions from Aug 2020- March 2022

Improved Modifiable Risk Factors

Overall Goal: Decrease deaths and improve health in the community. Baseline: The leading cause of death is cardiovascular disease at 23.7% and cancer 18.1% both impacted by modifiable lifestyle factors of nutrition, exercise and tobacco.

Community need identified/Baseline	Overall Goal/ Measurable Scorecard 3-year goal	Objectives/ Anticipated Impact	Activities/Strategies Staff/Partnerships	2022 Annual Actual Impact
Leading causes of death include cancer at 18.1% and cardiovascular disease at 23.7% both are impacted by modifiable risk factors of nutrition, exercise and tobacco cessation. **A-Healthy Weight-** 18.3% of community are at a healthy weight (BMI- 18.5 to 24.9)	Improve lifestyle factors associated with the development of chronic disease **A-Increase the number of adults at a healthy weight (BMI 18.5-24.9) to at least 20%(3- year scorecard)** **CHNA 2023- 21.5% of adults have a healthy weight (BMI 18.5-24.9)**	Provide weekly educational programs to increase knowledge and skills to improve modifiable risk factors and over- all health. **A-1**-At least 50% of the participants in the Healthy Living Class will demonstrate a weight loss and report one positive healthy lifestyle change. **A-2**- Provide at least four Worksite Wellness screenings, to include BMI consultation. **A-3** Participate in community events that promote healthy weight, healthy eating and exercise	**A-1-Healthy Living For Life** provided each week with topics aimed to improve health. Weekly weigh in/tracking of weight loss. **ALL** **-Increase physician and hospital staff awareness** to refer to Healthy Living and other exercise or cooking classes. **Chronicle articles, physician visits, Marketing** **A-2-Worksite and community screenings will include** BMI with individual consultation. **Community Health Educator** **A-3- Partner with Ex. Center, RAFB, Family Connections to increase the awareness of nutrition, exercise & healthy wt. among families- ALL**	**A1-Healthy Living For Life surveys indicate 83% of participants have a goal to modify a risk factor** **A1- 215 total attended-46 class participants (Apr-Dec) with 21 participating in optional weekly weigh-in with 62% of showing a weight loss of 35.6 lbs collectively**** **A1- 20 PCP referrals to HL4L class** **A2- Total-930 participants receiving BMI screenings:** **-5 Community Events- 152 screened, 114 abnormal BMI** **-13 Workplace Events – 303 screened, 238 with abnormal BMI** **- 29 Senior Events-475 screened,275 abnormal BMI** **A3- Community/Workplace Exercise Classes total 1436 participants** **A3-Cooking schools-151 participants**

				A3-10 other community education events- 446+ served
B-<u>Tobacco</u> 11.1% Houston County residents use tobacco 31.7% over 45 year old's smoke tobacco 17.9% under 60 year old's use vaping products 17.8% of lower income residents are current smokers	**B-Decrease the usage of tobacco to 10% and vaping to 16%** **(3- year Scorecard)** **CHNA 2023- 12.3% smoke cigarettes** **CHNA 2023 -7% use vaping products**	**B-1**-Educational displays will be posted at Houston Healthcare Warner Robins & Perry Hospital on Great American Smoke out Day in Nov. **B-2-** Tobacco cessation education including the Georgia tobacco quit line will be provided to at least four worksites or community organizations serving lower income population. **B-3-**Respiratory Therapy Departments at Perry and Houston Medical Center will provide education along with tobacco cessation information to at least 500 in-patient using tobacco. **B-4-** All EduCare Classes to provide nicotine cessation referrals to participants	**B-1- Participation in Great Am. Smoke Out will include displays and educational information at both hospitals as well as at least two other sites. Community Health Educator** **B-2-Provide tobacco cessation education at four community or worksites. Community Health Educator** **B-3-Tobacco cessation information packets will be given to any in-pt. who reports using tobacco and given to any person requesting this education. Referral Coordinator** **B-4 Provide nicotine cessation education to all class participants and document in monthly report ALL Educators**	**B-1-Great American Smoke Out Event to include vaping 2 sites with 32 total participants **** **B-2- Sites receiving tobacco/vaping Education 2 worksite / 5 low income**** **B-3 46 packets distributed to in-patients who presently smoked -smoking cessation education provided to 2369 patients by respiratory department** **B-4 59 class participants referred to GA quit line**

Improve Ease of Access To Appropriate Health Care

Overall Goal: Improve health of individuals by improving the ease of access to care. The ease of access to healthcare services will impact personal health, delays appropriate care, health care cost, hospitalizations and ER visits.

Community need identified/Baseline	Overall Goal/ Measurable Scorecard 3- year goal	Objectives/ Anticipated Impact	Activities/Strategies Staff/Partnerships	2022 Annual Actual Impact
The ease of access to healthcare services impact personal health, delays appropriate care, leads to increased	Improve the health of individuals by improving the ease of access to care.	**A-1** increase in the number of persons who call Referral Services to obtain information on establishing a Medical Home by 3%	**A-1-3 Referral Service phone line-** - options provided for obtaining primary care provider- **Referral Services Coordinator**	**A-1 Referral Services monthly referral year end reports (2019 Baseline- 271)** **388- 4.3% increase from baseline**

health care cost, hospitalizations and ED visits. **A-Medical Homes** or ongoing source of health care. 83.2% of Houston County residents have a specific source of ongoing health care. **B-Appropriate Usage of Health Services** 14.3% of residents have utilized the ED more than once in a year **C- Medications** 9.5% skipped prescription doses to save cost.	**Increase the number of residents who have a medical home or ongoing source of healthcare to at least 85%. (3- year score card)** **CHNA 2023- 72% have a specific source of ongoing care** **-Decrease the number of persons who frequently utilize the ED for health care to 12%** **CHNA 2023-16.5% have had two or more visits to ER** Provide information to lower income persons on sources for prescription assistance. **Decrease the number of persons who do not take medications as prescribed to less than 7.5%** **CHNA 2023- 14.9% cost prevented getting prescription medications and 14.9% stretched prescription to save cost**	**A-2** Community health screenings will include documentation on the participants screening form of their medical home; if the participant does not have a medical home there will be documentation of linking to Referral Services. **A-3** At least 12 health fairs with screenings will be provided in low income areas. Each event will promote medical homes, resources for persons who are uninsured, and financial assistance available. **B-** Patient Care Services, EduCare, Marketing, Population Health along with EMS will explore efforts to increase appropriate usage of the ED **C-1**-Referral Services will refer community persons to resources to obtain lower cost prescriptions. **C-2**- Information on prescription assistance will be provided at all health fairs/screenings **C-3-**Patients attending Chronic Disease classes will receive information on lower cost medications. **C-4-** Medication management stressing the importance of medication compliance and	**A-2, & 3-Health Screenings will promote medical homes- Community Health Educator** **A-3-** Research and write grant & assist community persons in accessing health services such as cancer screenings, or prenatal care. **Manger/Director/Referral Services Coordinator** **B**- Develop additional assistance for identified persons utilizing the ED frequently for health care. **ALL** **C-1-Referral Service phone line- Referral Service Coordinator** **C-2- Community health screening form Community Health Educator** **C-3- Chronic Disease classes CHF/DM Chronic Disease Educator** **C- 4- Provide Medication Management classes and**	**A-2&3- 11 Health fairs offered in low income areas. 119 PCP referrals for no medical home and/or resources for assistance.** **A-1,2&3 276 Uninsured referrals to Pavilion Family Med, Volunteer Medical Clinic and/or First Choice Primary Healthcare** **A-3 Mammogram grant served 132 patients** **B- 472 In-pt education patients referred to classes for Hypertension, CHF and DM, partnership with EMS and Population Health services suspended at this time** **C-1&2- 98 received Rx medication assistance information from referral services, in-pt services and health fair screening events** **C-3&4- Information on lower cost Rx medications provided to 19 patients in CHF classes and – 323 DSME patients** **C-4 "Know Your Meds" Cards provided at all Senior Exercise and Program Events**

		importance of having a current medication list.	**distribute "Know Your Med Cards" ALL**	

Decrease hospitalizations and readmissions by Improving Individual's Management of Chronic Disease

Community need identified/Baseline	Goal/ Measurable Scorecard 3-year goal	Objectives/ Anticipated Impact	Activities/Strategies Staff/Partnerships	2022 Annual Actual Impact
A- Diabetes 17.3 of Houston County residents have diabetes. 10.3% of Houston County residents have been diagnosed with pre-diabetes 22.1% age adjusted mortality. Persons with diabetes have increased risk of stroke, heart disease, blindness and amputations.	-Decrease diabetes related complications and improve quality of life of patients living with diabetes **-Decrease the number of residents who have diabetes to 15%** **CHNA 2023- 20% have diabetes/high blood sugar** **-Decrease the number of residents who have pre-diabetes to 8%** **CHNA 2023- 7.2% have pre-diabetes**	**A-1**-Maintain National Recognition for Diabetes Management Program through annual audit (due 2021) **A-2**-Decrease ED visits and hospitalizations by at least 50% for participants in Diabetes Management program **A-3**- Decrease the 30- day readmission rate for patients receiving in-patient diabetes education to less than 20%. **A-4**- The Diabetes Advisory Board will include at least one patient with diabetes who has experienced a hospitalization **A-5**- At least 50% of pts. referred will be scheduled. **A-6** Start at least 4 NDPP Cohorts with 60% participants completing 1 yr. program **A-7** NDDP keep CDC full recognition status (due 2026)	**A-1**-Diabetes Self-Management Education including 4 sessions and 1 year follow up **Chronic Disease Educators** Provide Community Wide Diabetes Awareness Day, Diabetes Update for Healthcare Providers, Support Group **ALL** **A-2 &3&5**-Provide initial diabetes education in the hospital and track the number referred patients to the outpatient diabetes program **In.pt educator** **A-4** Annual report of progression towards goals for all diabetes related education to HHC and community stakeholders **Chronic Disease Educator** **A-5**- Referral Phone call to all persons referred to schedule, if the pt. does not attend efforts to schedule will be made. Physicians will receive information on pt. referred who do not attend. **Referral Services**	**A-1-Diabetes Self-Management Education program awarded re-recognition Sept 14, 2021** **A-2-Admissions for pts. completing 1 year DSME program show 0 ED visit and 0 readmission out of 45 that completed follow-up program** **A-3 In patient education tracking shows 400 patients seen with 11 or 3% readmitted and 78 referred to DSME class following discharge** **A-4-Diabetes Advisory Board minutes and sign-in sheet Completed- June 27, 2022** **A-5- 329 Referrals from PCP for DSME with 31 refusing education, 89 scheduled (27%)** **A-5 198 letters sent to physicians and patients who were referred but did not attend DSME.** **A-6 2 new cohorts started- 1 cohort completed with a 68% retention rate for full 1 year**

			A-6- Provide referrals to Diabetes Prevention Program Cohorts at all community screenings and events **Community Nurse Educator**	**and 100% risk reduction at 12 months(A1c WNL)** **A-7 full recognition obtained till 2026**
B- Heart Disease/Stroke Risk Factors- Hypertension/Cholesterol Management 51.3% of Houston County residents have high blood pressure which is higher than the Healthy People 2020 target (26.9% or lower). 40.8% of residents have high cholesterol Age adjusted mortality for stroke is 41.7 per 100,000 Age-adjusted mortality for heart disease is 203.2 per 100,000 **C-Heart Failure** Diseases of the heart account for the number one cause of death in Houston County	**B-Decrease heart/stroke related risks and disease** **Decrease rate of deaths from strokes to 40 per 100,000 (3-year score card goal)** **CHNA 2023- 38.2 stroke deaths per 100,000** **B-2-Reduce the death rate from heart disease to 175 per 100,000 (3- year scorecard)** **CHNA 2023- heart disease 214 deaths per 100,000** **Decrease hypertension rate to 50% (3-year scorecard)** **CHNA 2023- 43.3% have high blood pressure** **C-Improve the ability of persons with heart failure to manage this condition, and improve their quality of life**	**B-1**-Decrease ED visits & hospitalizations by at least 50% for participants in Hypertension Management program **B-2**- At least 75% of hypertension management/cholesterol class will list at least one lifestyle change to improve **B-3**- 100% of persons with abnormal BP screening will receive education and referral as needed to additional follow up health care. **C-1**-80% of class participants will report increase in knowledge and skills to management heart failure **C-2**-Readmissions from Heart Failure will decrease to 18%. **C-3-** Meet as a work group to improve the care of persons with heart failure.	**B-1&2--Hypertension Management class**, class evaluations– verify ED/hospital admissions in Meditech **Community Nurse Educator** **B-3- Community and worksite screenings** All persons with an abnormal BP/cholesterol screening will receive education and referral to a medical home to further assess BP and any needed treatment**. Community nurse educator** **C-1&2--Help for the Heart Classes** **C- 2&3 Provide initial heart failure education in the hospital and refer patients to the outpatient program.** **-**Follow up phone calls to assess patient understanding of transitional care, and hospital experience. **In-pt/chronic educators** -Track in-pt CHF education and heart failure program participants readmission related to heart failure **In-pt/chronic educators**	**B-1-Survey and Follow up showed 15 hypertension class participants, 0 admission within 90 days of class** **B-2- 100% class participants list one lifestyle change to improve hypertension** **B-3- All participants with elevated BP given education by nurse** **110 received referral to class for high BP with 69 referred to PCP for f/u care** **C-1-.100% of CHF surveys reflect increased knowledge of skills to manage heart failure** **C-2-Admissions for patients receiving class education with F/U calls and chart reviews show 0 admissions after 90 days for 19 who attended CHF class** **C-2 In patient education tracking shows 173 patients seen with 13 or 8% readmitted**

				C-3 42 In-patient referrals to heart failure class after discharge

Assistance to Vulnerable Populations

Overall Goal: Improve the health of populations at higher risk for poor health specifically targeting women with a higher risk pregnancy and their newborns and older adults.

Community need identified/Baseline	Goal/ Measurable Scorecard 3-year goal	Objectives/ Anticipated Impact	Activities/Strategies Staff/Partnerships	2022 Annual Actual Impact
Populations such as older adults, pregnant women and newborns are at a higher risk for health complications **A-Pregnant Women and Newborns** Low birth weight and pre-term newborns are at greater risk for illness, infections and other complications. 8.8% of Houston County and 9.9% of Georgia births were low –weight compared to 8.2% for the US. Infant mortality rates -7.8 infant deaths per 1,000 live births in Houston County compared to 7.2 for Georgia and 5.7 for the US	**A-1-3 Decrease the low birth weight to 8% per 2023 CHNA (3-year score card goal) low birth weight defined as <2500g or 5lbs 8oz regardless of gestational age** **CHNA 2023- 9% low birth weight** **A-4-Decrease infant death rate to 6 per 1,000 births**	**A-1** Education and services to provide additional assistance to vulnerable populations to decrease the deliveries with low birth weight to <8% among women identified with a **higher risk pregnancy** (EduCare tracking) **A-2-** Class Survey will show 90% can list: -Risk factors for pre-term birth -Symptoms of pre-term labor -Importance of 39 weeks gestational -Benefits of breastfeeding L+D end of year records to show decreased low birth weight deliveries/ PTD **A-3-** Follow-up for Gestational Diabetes Class show normal for gestational age weight without complications	**A-1-Provide Care Management for women identified with a higher risk pregnancy due to medical risk or socio-economic risk. Chronic Disease Educator** **A-1- Lead Perinatal Coalition- Coalition meets to ensure optimal resources and services for pregnant women. Pregnancy Related Educator** **A-2-Childbirth/ Breastfeeding class Pregnancy Related Educator** **A-3- Gestational Diabetes Education Chronic Disease Educator**	**A-1 Care Management provided to 13 gestational diabetic patients** those followed had a 25% **Low birth wt. (8 delivered- 1 LBW/1 PTD May-Dec)** **A-1-Perinatal Coalition meetings cancelled**** **A-2 Class Surveys indicate 92% recognize signs of Pre-term labor 100% recognize health benefits of breastfeeding to mom and baby** **Low birth wt. 8.5% for all HHC deliveries/ 6.5% PTD for all HHC deliveries** **A-3 F/U records indicate 13% PTD for those that attended gestational diabetes classes.** A-4- **Class survey/ Safe Kids tracking show 95% recognize safety concerns and accident**

	per 2023 CHNA (infant death defined as any cause of death from birth to 1 year) **CHNA 2023- 10 infant deaths per 1,000 births**	**A-4** Class survey will show 90% can list: -car seat safety starting at discharge from hospital -back to sleep prevents SIDS -not to shake baby/ ways to comfort baby -aware of community resources for infant safety	**A-4 Baby Care Boot Camp Pregnancy Related Educator, Safe Kids/DPH**	**prevention for infants and newborns**
B- Older Adults 93.1% of adults over 60 have one or more cardiovascular risk (HTN, High Cholesterol, Smoking, Physical Inactivity, Overweight/Obesity) 22.4% of unintentional injury deaths is related to falls (CHNA 2020 49.4 deaths per 100,000) 20.4% of adults over age 60 meet physical activity recommendations of 150 minutes per week and strength building activity at least twice a week	**B-1 Reduce Seniors "1 or more" risk to 90% (3- year score card goal)** **CHNA 2023- 97.7% of senior adults age 65+ have 1 or more cardiovascular risk or behavior** **B-2 Decrease rate of unintentional injury deaths related to falls** **CHNA 2023- 53.1 deaths related to falls per 100,000** **B-2- 25% of seniors will meet physical activity recommendations (3-year scorecard goal)** **CHNA 2023- 12% of senior adults age 65+ meet physical activity recommendations**	**B**- Health and safety educational programs will be provided each month at facilities serving older adults. **B-1**-Stroke Prevention/Heart Protection Program -Monthly screenings will be provided each month at facilities serving older adults. -BP screening will also provide education on controlling BP and S&S of stroke, heart disease and medication management -RN will make referrals to PCP/resources as needed **B-2&3** Participants in the Senior Adult exercise programs: -80% surveyed will continue or increase their exercise plan as a result of programs offered -80% surveyed will report making safety changes -80% surveyed will report improved balance	**B-1- Senior Health Education Sessions ALL** **B-1-Senior Care Blood Pressure Screenings- Community Health Educator** **B-2&3 -Senior Exercise, Matter of Balance, Walk with Ease, Tai Chi** **Community Health Educator, Health Fitness Instructor**	**B-1 Senior Health Education provided to 241 participants (Mar-Nov)** **B-1 Senior Blood Pressures-** 31 screening events- 736 served, 498 with abnormal BP,126 referred to HTN Class **B-2 Pavilion and Rozar Park Senior Exercise 7050 (271 individual) participants** **-A Matter of Balance 152 (29 individual) participants** **-Tai Chi 268 (94 individual) participants** **-Chair Yoga 314 (124 individual) participants** **94% report continue exercise plan** **100% report making safety changes** **56% report improved balance/ concern about falling does not interfere with normal activities**