# 2025 COMMUNITY HEALTH NEEDS ASSESSMENT

## Cass County, Indiana

Sponsored by

PARKVIEW LOGANSPORT HOSPITAL


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Prepared by
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# INTRODUCTION

# PROJECT OVERVIEW

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 — a follow-up to similar studies conducted in 2013, 2016, 2019 and 2022 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Parkview Logansport Hospital (formerly Logansport Memorial Hospital). Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment was conducted on behalf of Parkview Logansport Hospital by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

## Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

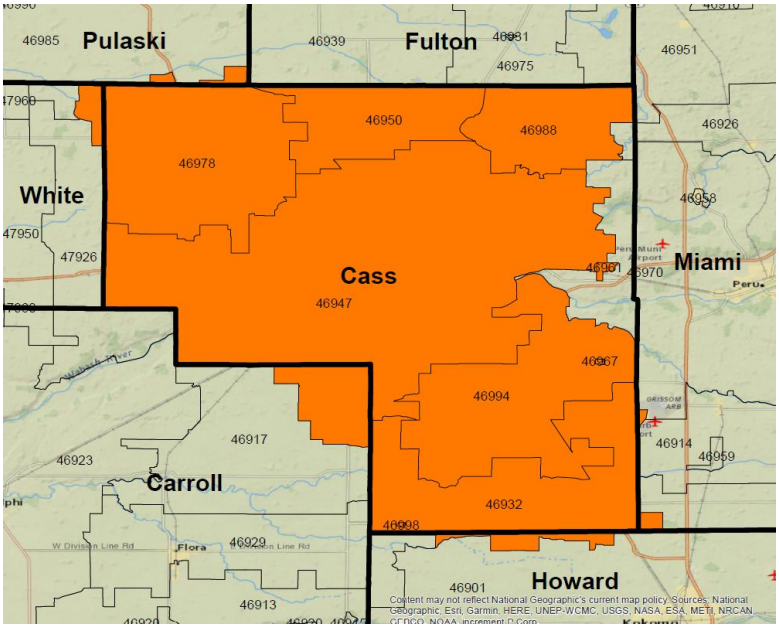
### PRC Community Health Survey

#### Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Parkview Logansport Hospital 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 “Cass County” in this report) is defined as each of the residential ZIP Codes comprising Cass County, Indiana, including 46932, 46947, 46950, 46961, 46967, 46978, 46988, 46994, and 46998. This community definition, determined based on the ZIP Codes of residence of recent patients of Parkview Logansport Hospital, is illustrated in the adjacent map.



## Sample Approach & Design

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

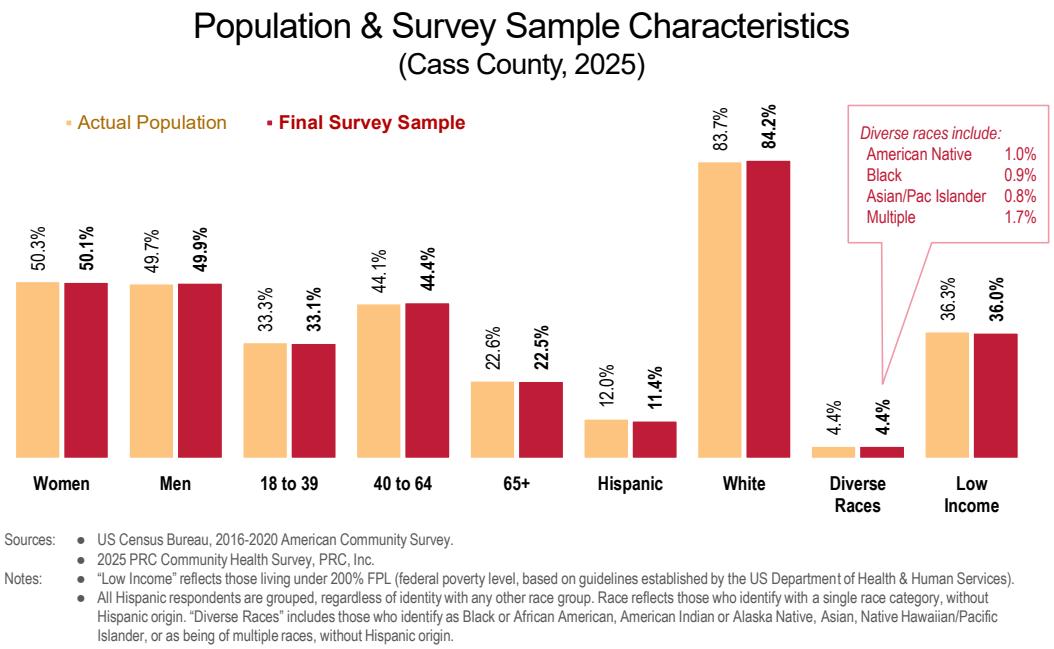
The sample design used for this effort consisted of a random sample of 400 individuals age 18 and older in Cass County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Cass County as a whole. All administration 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 400 respondents is ±4.9% at the 95 percent confidence level.

## 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.

The following chart outlines the characteristics of the Cass 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.
- 2025 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (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. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

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

## Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 64 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows. Note that while a public health representative was invited to participate, they did not respond.

| ONLINE KEY INFORMANT SURVEY PARTICIPATION | |
|---|---|
| KEY INFORMANT TYPE | NUMBER PARTICIPATING |
| Physicians | 4 |
| Other Health Providers | 23 |
| Social Services Providers | 13 |
| Other Community Leaders | 24 |

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.

- 4C Health
- Area Five
- BodyWorks
- Cass County Chamber of Commerce
- Cass County Commissioners
- Cass County Community Foundation
- Cass County Family Y
- Cass County Online
- Cass-Logansport Planning Department
- Caston School Corporation
- City of Logansport
- Emmaus Mission Center
- Guardian Angel Hospice
- Heart to Heart Hospice
- Indiana Area Health Education Centers Network
- Indiana Health Centers
- Lewis Cass Kings
- Logansport Community School Corp
- Logansport Fire Department Chief
- Logansport High School
- Logansport Parks and Recreation
- MPI Corporation
- Parkview Foundation (formerly Logansport Memorial Hospital Foundation)
- Parkview Logansport Hospital (formerly Logansport Memorial Hospital)
- Pioneer School Corporation
- Steinberger Construction
- The Vineyard
- Trinity Lutheran
- United Way of Cass County
- WoodBridge Health Campus
- WSAL Radio
- Youth Services Alliance

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 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

Note that secondary data reflect county-level data.

## Benchmark Data

### Trending

Similar surveys were administered in Cass County in 2013, 2016, 2019, and 2022 by PRC on behalf of Parkview Logansport Hospital (formerly Logansport Memorial Hospital). Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

### Indiana Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

### National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

### Healthy People 2030

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

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the 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 identifiable or might not be represented in numbers sufficient for independent analyses.

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

## Public Comment

Parkview Logansport Hospital made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Parkview Logansport Hospital 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. Parkview Logansport Hospital 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 nonprofit 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 | See Report Page |
|---|---|
| Part V Section B Line 3a<br>A definition of the community served by the hospital facility | 4 |
| Part V Section B Line 3b<br>Demographics of the community | 24 |
| Part V Section B Line 3c<br>Existing health care facilities and resources within the community that are available to respond to the health needs of the community | 111 |
| Part V Section B Line 3d<br>How data was obtained | 4 |
| Part V Section B Line 3e<br>The significant health needs of the community | 10 |
| Part V Section B Line 3f<br>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<br>The process for identifying and prioritizing community health needs and services to meet the community health needs | 11 |
| Part V Section B Line 3h<br>The process for consulting with persons representing the community's interests | 6 |
| Part V Section B Line 3i<br>The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | 115 |

# 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<br>○ Appointment Availability<br>○ Difficulty Finding a Physician<br>▪ Primary Care Physician Ratio<br>▪ Eye Exams<br>▪ Emergency Room Utilization<br>▪ Ratings of Local Health Care |
| CANCER | ▪ Leading Cause of Death<br>▪ Lung Cancer, Female Breast Cancer, and Colorectal Cancer Deaths<br>▪ Cancer Prevalence<br>▪ Cervical Cancer Screening |
| DIABETES | ▪ Diabetes Deaths<br>▪ Kidney Disease Deaths<br>▪ Key Informants: *Diabetes* ranked as a top concern. |
| DISABLING CONDITIONS | ▪ Alzheimer's Disease Deaths |
| HEART DISEASE & STROKE | ▪ Leading Cause of Death<br>▪ Heart Disease Deaths<br>▪ High Blood Pressure Prevalence<br>▪ High Blood Cholesterol Prevalence |
| INFANT HEALTH & FAMILY PLANNING | ▪ Infant Deaths<br>▪ Teen Births |
| INJURY & VIOLENCE | ▪ Unintentional Injury Deaths<br>▪ Intimate Partner Violence |
| MENTAL HEALTH | ▪ "Fair/Poor" Mental Health<br>▪ Diagnosed Depression<br>▪ Symptoms of Chronic Depression<br>▪ Stress<br>▪ Mental Health Provider Ratio<br>▪ Receiving Treatment for Mental Health<br>▪ Difficulty Obtaining Mental Health Services<br>▪ Key Informants: *Mental Health* ranked as a top concern. |

*— continued on the following page —*

| AREAS OF OPPORTUNITY (continued) | |
|---|---|
| NUTRITION, PHYSICAL ACTIVITY & WEIGHT | ▪ Leisure-Time Physical Activity<br>▪ Meeting Physical Activity Guidelines<br>▪ Children's Physical Activity<br>▪ Overweight & Obesity [Adults & Children]<br>▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern. |
| RESPIRATORY DISEASE | ▪ Lung Disease Deaths<br>▪ Asthma Prevalence [Adults]<br>▪ Chronic Obstructive Pulmonary Disease (COPD) Prevalence |
| SUBSTANCE USE | ▪ Alcohol-Induced Deaths<br>▪ Unintentional Drug-Induced Deaths<br>▪ Illicit Drug Use<br>▪ Key Informants: *Substance Use* ranked as a top concern |
| TOBACCO USE | ▪ Use of Vaping Products<br>▪ Key Informants: *Tobacco Use* ranked as a top concern |

## Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

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

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

Further, the **social determinants of health** are an important lens through which to understand and address all of these issues.

## Hospital Implementation Strategy

Parkview Logansport Hospital 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, Cass County results are shown in the larger, gray column.

The columns to the right of the Cass County column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Cass 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 2013 (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 | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| Linguistically Isolated Population (Percent) | **2.8** | 1.9 | 3.9 | | |
| Population in Poverty (Percent) | **12.7** | 12.2 | 12.4 | 8.0 | |
| Children in Poverty (Percent) | **14.7** | 15.7 | 16.3 | 8.0 | |
| No High School Diploma (Age 25+, Percent) | **14.2** | 9.8 | 10.6 | | |
| Unemployment Rate (Age 16+, Percent) | **3.7** | 3.4 | 4.0 | | |
| % Worry/Stress Over Rent/Mortgage in Past Year | **21.0** | | 45.8 | | 25.6 |
| % Unhealthy/Unsafe Housing Conditions | **8.6** | | 16.4 | | |
| Population With Low Food Access (Percent) | **6.3** | 28.7 | 22.2 | | |
| % Food Insecure | **19.8** | | 43.3 | | 17.3 |
| | | better | similar | worse | |

| OVERALL HEALTH | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| % "Fair/Poor" Overall Health | **24.4** | 20.3 | 15.7 | | 12.5 |
| | | better | similar | worse | |

| ACCESS TO HEALTH CARE | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| % [Age 18-64] Lack Health Insurance | **7.2** | 9.1 | 8.1 | 7.6 | 13.6 |
| % Difficulty Accessing Health Care in Past Year (Composite) | **35.4** | | 52.5 | | 28.3 |
| % Cost Prevented Physician Visit in Past Year | **7.5** | 10.4 | 21.6 | | 8.4 |
| % Cost Prevented Getting Prescription in Past Year | **9.9** | | 20.2 | | 9.7 |
| % Difficulty Getting Appointment in Past Year | **19.4** | | 33.4 | | 10.8 |
| % Inconvenient Hrs Prevented Dr Visit in Past Year | **10.5** | | 22.9 | | 7.5 |
| % Difficulty Finding Physician in Past Year | **13.1** | | 22.0 | | 8.0 |
| % Transportation Hindered Dr Visit in Past Year | **6.2** | | 18.3 | | 3.4 |
| % Language/Culture Prevented Care in Past Year | **0.9** | | 5.0 | | 0.7 |
| % Stretched Prescription to Save Cost in Past Year | **10.2** | | 19.4 | | 9.5 |
| % Difficulty Getting Child's Health Care in Past Year | **3.1** | | 11.1 | | 2.1 |
| Primary Care Doctors per 100,000 | **60.7** | 99.6 | 117.3 | | |
| % Have a Specific Source of Ongoing Care | **65.0** | | 69.9 | 84.0 | 68.7 |
| % Routine Checkup in Past Year | **82.2** | 79.8 | 65.3 | | 71.0 |
| % [Child 0-17] Routine Checkup in Past Year | **89.9** | | 77.5 | | 82.0 |
| % Two or More ER Visits in Past Year | **14.0** | | 15.6 | | 5.8 |

| ACCESS TO HEALTH CARE (continued) | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| % Eye Exam in Past 2 Years | **58.3** | | 55.5 | 61.1 | 66.9 |
| % Low Health Literacy | **15.4** | | 25.1 | | 21.6 |
| % Rate Local Health Care "Fair/Poor" | **18.4** | | 11.5 | | 14.4 |
| | | better | similar | worse | |

| CANCER | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| Cancer Deaths per 100,000 | **212.8** | 204.1 | 182.5 | 122.7 | 234.8 |
| Lung Cancer Deaths per 100,000 | **61.8** | 52.3 | 39.8 | 25.1 | |
| Female Breast Cancer Deaths per 100,000 | **31.1** | 26.4 | 25.1 | 15.3 | |
| Prostate Cancer Deaths per 100,000 | **15.9** | 20.3 | 20.1 | 16.9 | |
| Colorectal Cancer Deaths per 100,000 | **24.5** | 18.6 | 16.3 | 8.9 | |
| % Cancer | **12.8** | 12.1 | 7.4 | | |
| % [Women 50-74] Breast Cancer Screening | **77.7** | | 64.0 | 80.5 | 72.1 |
| % [Women 21-65] Cervical Cancer Screening | **66.6** | | 75.4 | 84.3 | 71.7 |
| % [Age 45-75] Colorectal Cancer Screening | **70.7** | | 71.5 | 74.4 | 61.9 |
| | | better | similar | worse | |

| DIABETES | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS vs. IN | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Diabetes Deaths per 100,000 | **53.2** | 36.5 | 30.5 | | 56.9 |
| % Diabetes/High Blood Sugar | **16.8** | 13.2 | 12.8 | | 14.4 |
| % Borderline/Pre-Diabetes | **9.5** | | 15.0 | | 6.9 |
| % [Non-Diabetics] Blood Sugar Tested in Past 3 Years | **48.6** | | 41.5 | | 53.9 |
| Kidney Disease Deaths per 100,000 | **19.7** | 21.4 | 16.4 | | 23.6 |
| | | better | similar | worse | |

| DISABLING CONDITIONS | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS vs. IN | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % 3+ Chronic Conditions | **41.4** | | 38.0 | | 43.9 |
| % Activity Limitations | **23.1** | | 27.5 | | 19.2 |
| % High-Impact Chronic Pain | **21.2** | | 19.6 | 6.4 | |
| Alzheimer's Disease Deaths per 100,000 | **45.2** | 32.9 | 35.8 | | 45.5 |
| % Caregiver to a Friend/Family Member | **25.4** | | 22.8 | | 24.6 |
| | | better | similar | worse | |

| HEART DISEASE & STROKE | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| Heart Disease Deaths per 100,000 | **306.8** | 224.0 | 209.5 | 127.4 | 229.0 |
| % Heart Disease | **10.4** | 7.7 | 10.3 | | 7.4 |
| Stroke Deaths per 100,000 | **53.2** | 50.6 | 49.3 | 33.4 | 47.3 |
| % Stroke | **4.0** | 3.8 | 5.4 | | 4.6 |
| % High Blood Pressure | **46.9** | 37.6 | 40.4 | 42.6 | 43.6 |
| % [HBP] Taking Action to Control High Blood Pressure | **87.3** | | | | 91.2 |
| % High Cholesterol | **38.1** | | 32.4 | | 29.5 |
| % [HBC] Taking Action to Control High Blood Cholesterol | **89.7** | | | | 91.2 |
| % 1+ Cardiovascular Risk Factor | **90.1** | | 87.8 | | 90.0 |
| | | better | similar | worse | |

| INFANT HEALTH & FAMILY PLANNING | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| Teen Births per 1,000 Females 15-19 | **31.1** | 19.0 | 15.5 | | |
| Low Birthweight (Percent of Births) | **8.0** | 8.3 | 8.4 | | |
| Infant Deaths per 1,000 Births | **8.7** | 7.1 | 5.7 | 5.0 | |
| | | better | similar | worse | |

| INJURY & VIOLENCE | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| Unintentional Injury Deaths per 100,000 | **80.7** | 74.1 | 67.8 | 43.2 | 49.8 |
| Motor Vehicle Crash Deaths per 100,000 | **12.4** | 14.1 | 13.3 | 10.1 | |
| % [Age 45+] Fell in the Past Year | **33.6** | | | | 33.6 |
| % Victim of Violent Crime in Past 5 Years | **1.3** | | 7.0 | | 1.5 |
| % Victim of Intimate Partner Violence | **15.4** | | 20.3 | | 9.3 |
| | | better | similar | worse | |

| MENTAL HEALTH | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| % "Fair/Poor" Mental Health | **21.6** | | 24.4 | | 7.8 |
| % Diagnosed Depression | **27.0** | 24.1 | 30.8 | | 14.6 |
| % Symptoms of Chronic Depression | **33.2** | | 46.7 | | 22.8 |
| % Typical Day Is "Extremely/Very" Stressful | **11.1** | | 21.1 | | 7.1 |
| Suicide Deaths per 100,000 | **15.4** | 16.1 | 14.5 | 12.8 | 20.5 |
| Mental Health Providers per 100,000 | **213.9** | 202.1 | 323.0 | | |
| % Receiving Mental Health Treatment | **19.5** | | 21.9 | | 13.2 |
| % Unable to Get Mental Health Services in Past Year | **8.0** | | 13.2 | | 4.0 |
| | | better | similar | worse | |

| NUTRITION, PHYSICAL ACTIVITY & WEIGHT | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| % "Very/Somewhat" Difficult to Buy Fresh Produce | **19.6** | | 30.0 | | 18.5 |
| % No Leisure-Time Physical Activity | **35.9** | 24.4 | 30.2 | 21.8 | 42.8 |
| % Meet Physical Activity Guidelines | **21.5** | 29.3 | 30.3 | 29.7 | 21.2 |
| % [Child 2-17] Physically Active 1+ Hours per Day | **46.4** | | 27.4 | | 62.2 |
| % Overweight (BMI 25+) | **74.9** | 71.2 | 63.3 | | 71.9 |
| % Obese (BMI 30+) | **43.2** | 37.8 | 33.9 | 36.0 | 31.4 |
| % [Child 5-17] Overweight (85th Percentile) | **53.4** | | 31.8 | | 32.0 |
| % [Child 5-17] Obese (95th Percentile) | **39.6** | | 19.5 | 15.5 | 16.4 |
| | | better | similar | worse | |

| ORAL HEALTH | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| % Have Dental Insurance | **80.2** | | 72.7 | 75.0 | 61.1 |
| % Dental Visit in Past Year | **63.4** | 63.1 | 56.5 | 45.0 | 60.4 |
| % [Child 2-17] Dental Visit in Past Year | **78.6** | | 77.8 | 45.0 | 70.7 |
| | | better | similar | worse | |

| RESPIRATORY DISEASE | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS vs. IN | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Lung Disease Deaths per 100,000 | **70.0** | 64.3 | 43.5 | | 76.1 |
| Pneumonia/Influenza Deaths per 100,000 | **16.5** | 13.0 | 14.3 | | 14.2 |
| % Asthma | **11.9** | 11.5 | 17.9 | | 6.0 |
| % [Child 0-17] Asthma | **4.9** | | 16.7 | | 5.0 |
| % COPD (Lung Disease) | **11.4** | 8.4 | 11.0 | | 7.2 |
| | | better | similar | worse | |

| SEXUAL HEALTH | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS vs. IN | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| HIV Prevalence per 100,000 | **126.4** | 223.0 | 386.6 | | |
| Chlamydia Incidence per 100,000 | **377.0** | 491.0 | 492.2 | | |
| Gonorrhea Incidence per 100,000 | **37.2** | 144.0 | 179.0 | | |
| | | better | similar | worse | |

| SUBSTANCE USE | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| Alcohol-Induced Deaths per 100,000 | **12.2** | 14.8 | 14.6 | | 7.9 |
| % Excessive Drinking | **8.7** | 16.0 | 34.3 | | 11.7 |
| Unintentional Drug-Induced Deaths per 100,000 | **24.0** | 31.3 | 26.6 | | 11.0 |
| % Used an Illicit Drug in Past Month | **2.3** | | 8.4 | | 0.6 |
| % Used a Prescription Opioid in Past Year | **18.6** | | 15.1 | | |
| % Ever Sought Help for Alcohol or Drug Problem | **4.7** | | 6.8 | | 3.4 |
| % Personally Impacted by Substance Use | **32.7** | | 45.4 | | 29.8 |
| | | better | similar | worse | |

| TOBACCO USE | Cass County | CASS COUNTY SERVICE AREA vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. IN | vs. US | vs. HP2030 | TREND |
| % Smoke Cigarettes | **14.4** | 14.5 | 23.9 | 6.1 | 15.1 |
| % Someone Smokes at Home | **15.1** | | 17.7 | | 17.0 |
| % Use Vaping Products | **8.7** | 8.5 | 18.5 | | 4.5 |
| % [Smokers] Have Quit Smoking 1+ Days in Past Year | **38.7** | 52.1 | 53.1 | 65.7 | 40.1 |
| | | better | similar | worse | |


# DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

# COMMUNITY CHARACTERISTICS

## Population Characteristics

### Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

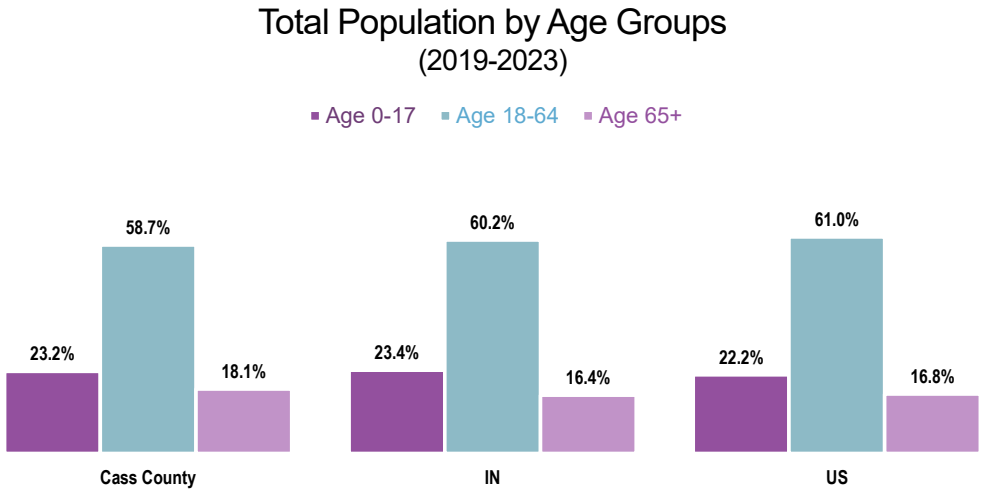
**Total Population**
(Estimated Population, 2019-2023)

| | TOTAL POPULATION | TOTAL LAND AREA (square miles) | POPULATION DENSITY (per square mile) |
|---|---|---|---|
| **Cass County** | **37,703** | **412.14** | **91** |
| IN | 6,811,752 | 35,825.11 | 190 |
| United States | 332,387,540 | 3,533,298.58 | 94 |

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

### 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.



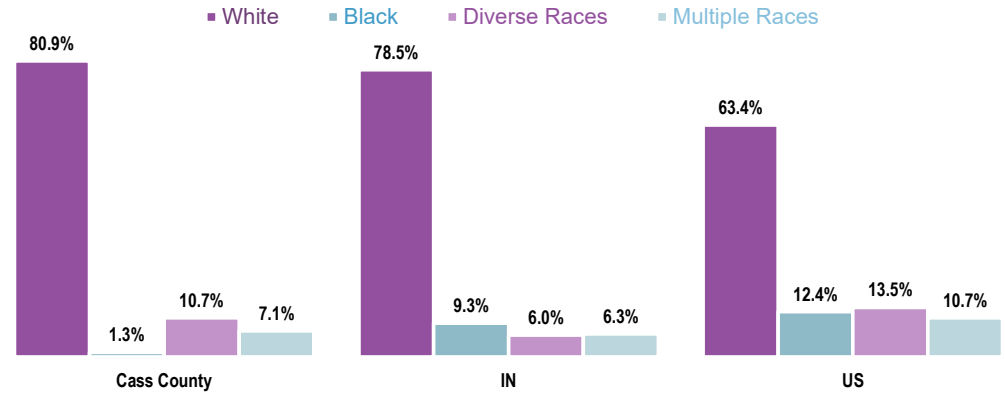

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

## Race & Ethnicity

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.

The following charts illustrate the racial and ethnic makeup of our community.

### Total Population by Race Alone
(2019-2023)

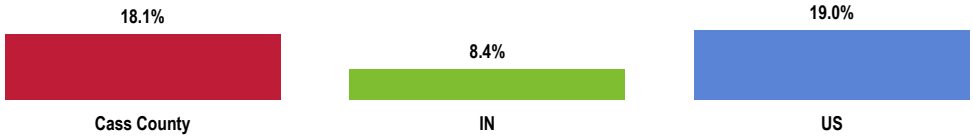



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

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

### Hispanic Population
(2019-2023)

The Hispanic population increased by 1,778 persons, or 36.3%, between 2010 and 2020.




Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

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

# 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.

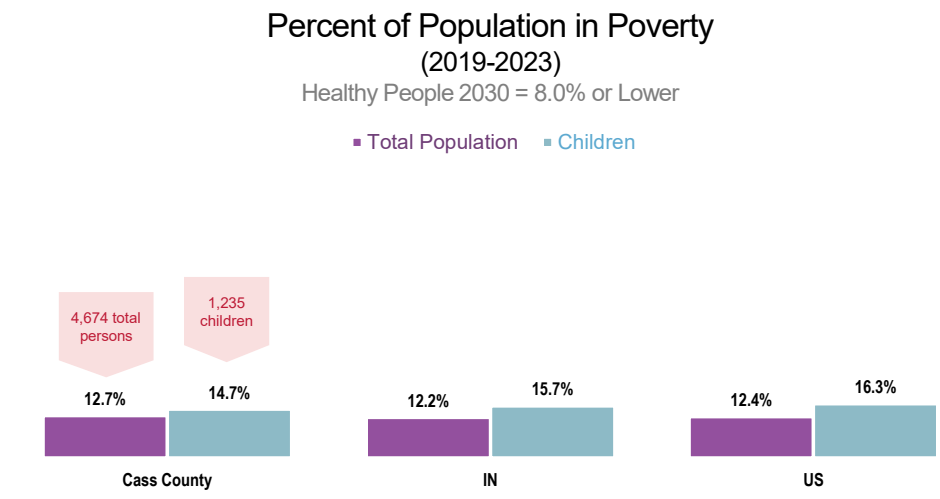
– Healthy People 2030 (https://health.gov/healthypeople)

## Income & Poverty

### 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 health status.

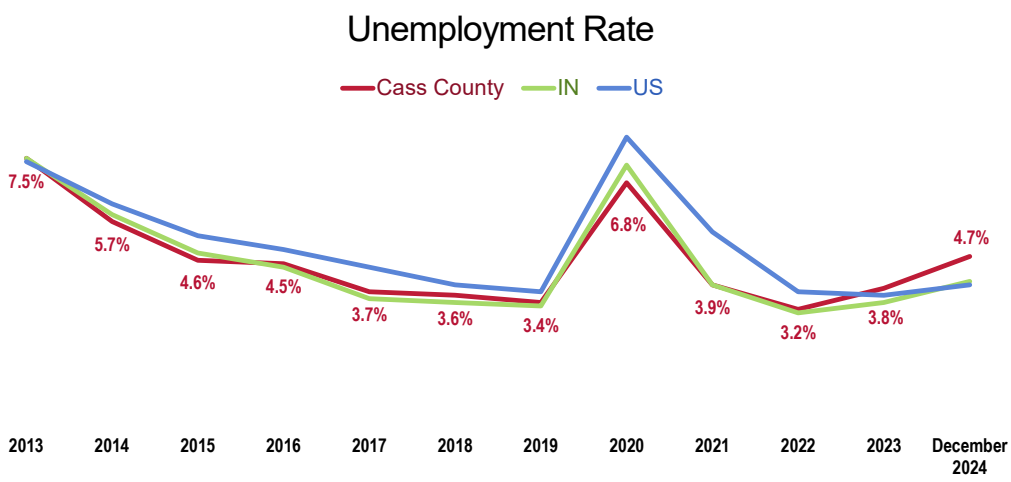
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.




Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

## Employment

Note the following trends in unemployment data derived from the US Department of Labor.

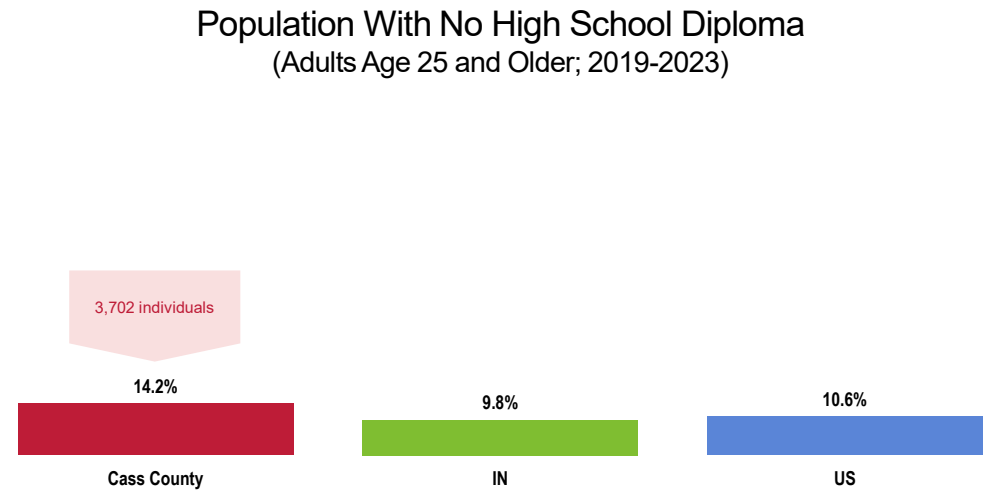



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

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

# Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

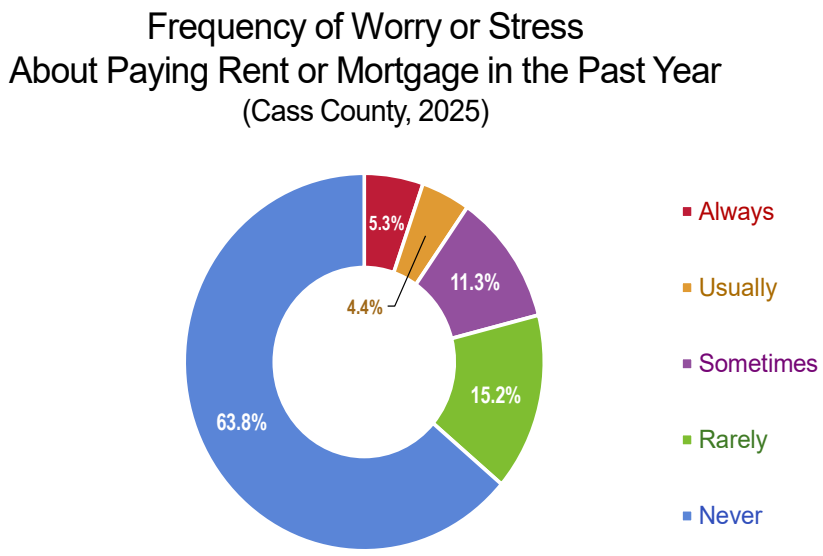



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

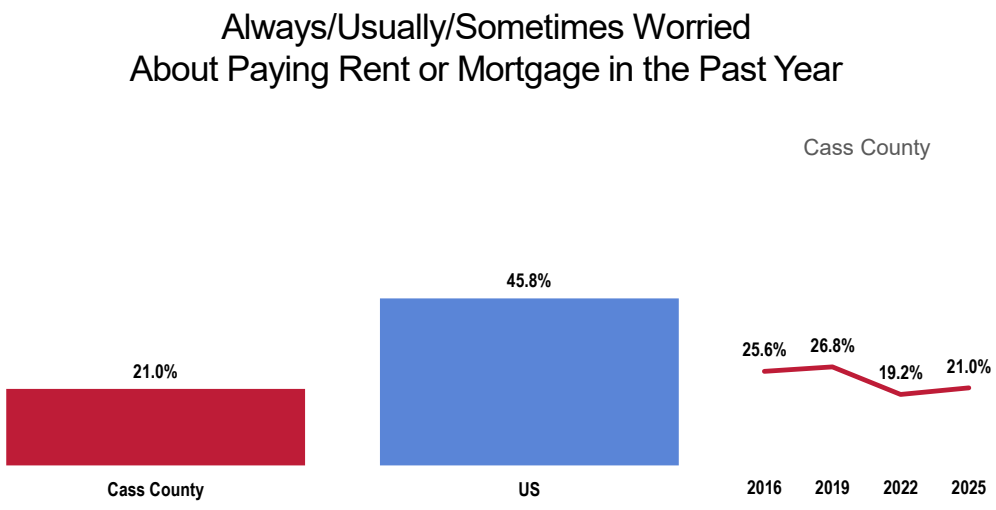
# Housing

## Housing Insecurity

**PRC SURVEY ► "In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"**



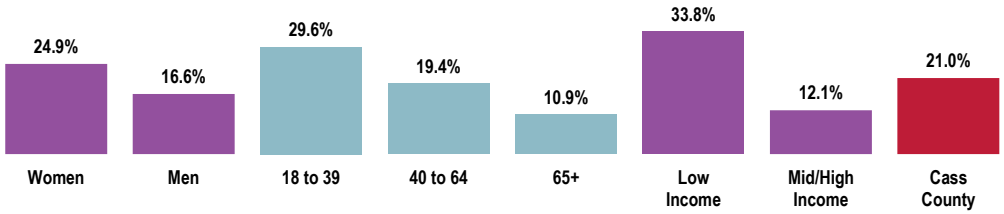

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.




Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

## Always/Usually/Sometimes Worried About Paying Rent or Mortgage in the Past Year
(Cass County, 2025)

Among homeowners 14.9%
Among renters 35.0%




Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: • Asked of all respondents.

### INCOME & RACE/ETHNICITY

**INCOME ►** Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

**RACE & ETHNICITY ►** While the survey data are representative of the full racial and ethnic makeup of the population, samples were not of sufficient size for independent analysis by race and/or ethnicity.

## Unhealthy or Unsafe Housing

**PRC SURVEY ► "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?"**

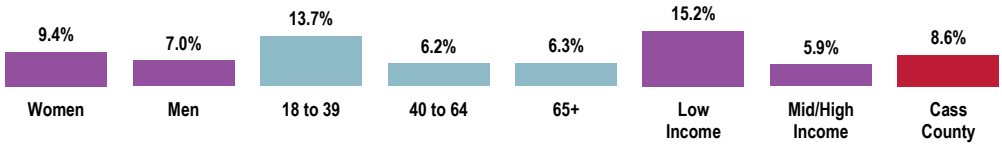
### Unhealthy or Unsafe Housing Conditions in the Past Year


Sources:
- 2025 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.

### Unhealthy or Unsafe Housing Conditions in the Past Year
(Cass County, 2025)

| | |
|---|---|
| Among homeowners | 7.5% |
| Among renters | 8.8% |




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]

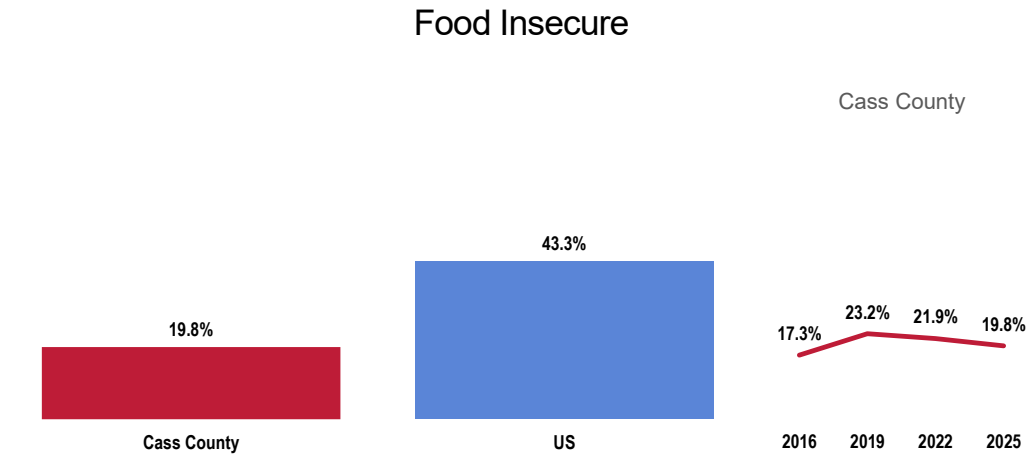
Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

## Food Insecurity

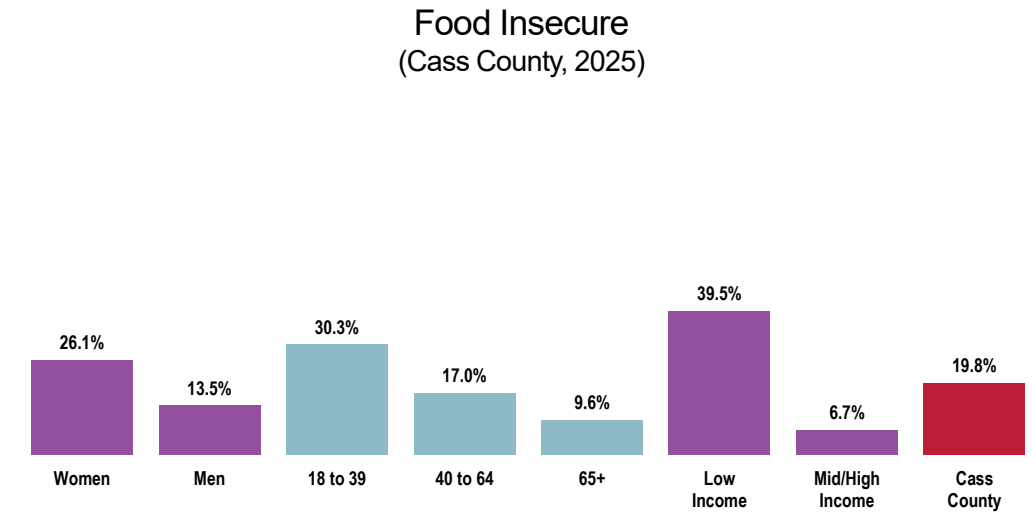
**PRC SURVEY ► "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.**

- '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.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.




Sources: ● 2025 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.




Sources: ● 2025 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

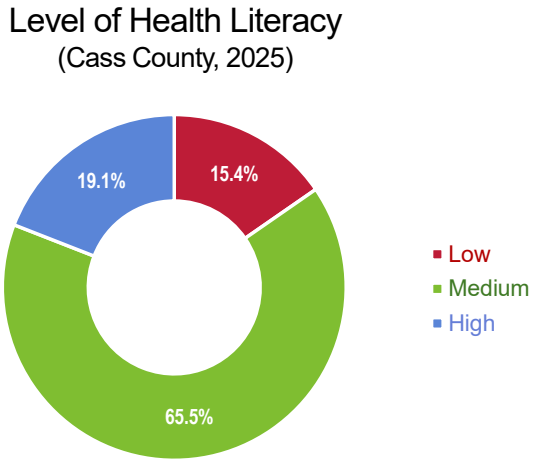
Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

**PRC SURVEY ► "The next questions are about any type of health care information you may receive. You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor's office, in clinics, and many other places. How often is health information written in a way that is easy for you to understand?"**

**PRC SURVEY ► "People who might help you read health information include family members, friends, caregivers, doctors, nurses, or other health professionals. How often do you need to have someone help you read health information?"**

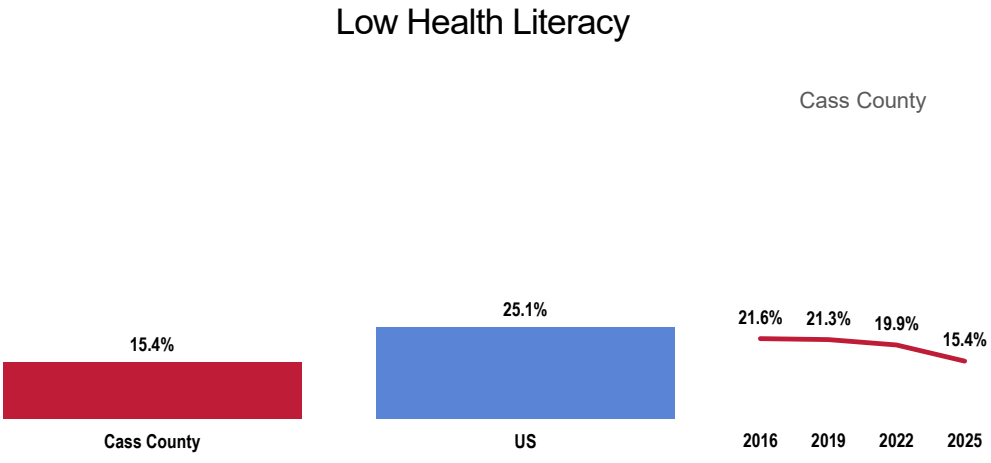
**PRC SURVEY ► "How often is health information spoken in a way that is easy for you to understand?"**

**PRC SURVEY ► "Health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and health care. In general, how confident are you in your ability to fill out health forms yourself?"**




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 313]

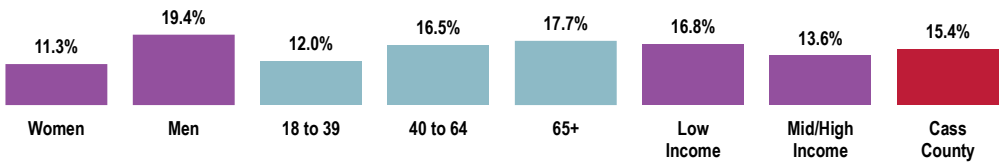
Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 313]
- 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
(Cass County, 2025)

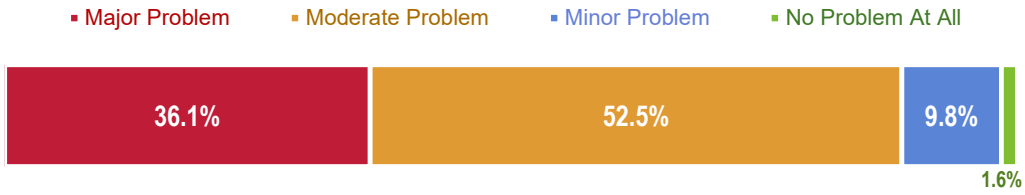



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: ● Asked of all respondents.
● Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

## Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health* as a problem in the community:

### Perceptions of Social Determinants of Health as a Problem in the Community
(Key Informants; Cass County, 2025)




Sources: ● 2025 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:

### Housing

> Major housing and transportation issues in our county with many immigrants. – Health Care Provider
>
> There is a major lack of affordable housing, people not working, people are homeless. Our community doesn't have a large population of people with a degree and therefore not a lot of high paying jobs for those who do have a degree to want to stay here or come back after college. Therefore, the majority of the people cannot afford basic needs. – Community Leader
>
> Lack of affordable housing, reliable transportation and affordable healthy food. – Health Care Provider
>
> Many people are unable to afford housing, medicine, food, and utilities. Making them have to choose which will be paid for. – Health Care Provider
>
> We do not have enough housing that can be rented! Many don't have the ability to buy a home and then the homes that are available are either overpriced, not taken care of, etc. There are just not enough options. Income, well not enough higher paying jobs available. Environment, not enough options for youth and a families to do in the area. They travel outside of Logansport to go do things. Discrimination, many people who talk or act negatively around people who do not look like them or think like them. Problems with racism and LGBTQ+ population. – Social Services Provider

## Income/Poverty

> Lower income, high rental rates, lack of low-income housing, lack of good paying jobs. – Social Services Provider
>
> We have many low income/poverty families in Cass County. – Community Leader
>
> We have many patients with zero to minimal income who cannot afford housing, have no education and/or use drugs. – Health Care Provider

## Language Barrier

> Language barriers, economic deficits. – Community Leader
>
> I believe the problem is the different languages that we have in the community. Some people are here and get what they need and some don't. A lot struggle for what they have. You can see how some people appreciate what they have, while others don't care what so ever. Discrimination is everywhere. You can't fix everything. – Community Leader
>
> The ever-changing landscape of Logansport makes serving her families difficult. As a cultural melting pot there are a variety of influences in the lives of her people that become barriers to healthcare. Sometimes it is inability to communicate, inability to understand access, inability to pay for services. So many things that are perceived as barriers. – Health Care Provider

## Access to Care/Services

> Limited access to social services. – Health Care Provider
>
> Lack of resources in the community to support the need for social determinants of health needed. Specifically, transportation is a large need in the community. We have one county transport service and one taxi service that is running part of the time. The ability to get patients to appointments is restricted due to this. The lack of healthy food resources for those in need is a growing concern. Food provided by the food banks is not always healthy and does not support healthy foods to manage chronic conditions such as diabetes or heart failure. – Health Care Provider

## Incidence/Prevalence

> The world in general makes Healthcare an obstacle for most. – Community Leader
>
> I base this on observation as I drive through Logansport and working with kids through Kiwanis, Reading Railroad, etc. LCSC has over 60% use of free and reduced lunches. I have heard from CC Development Corp. that housing is an issue. – Community Leader

## Transportation

> Transportation. – Health Care Provider
>
> Transportation is a huge issue in this county and most likely in Indiana. Not many resources for transportation alternatives other than taxis. – Health Care Provider

## Awareness/Education

> Long-established mindset, education levels, income levels, language barriers. – Physician

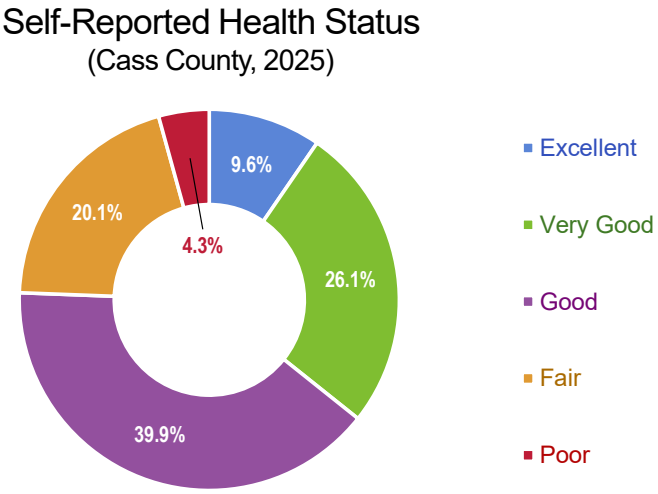
## Cultural/Personal Beliefs

> Maslow's hierarchy of needs where Physiological needs like food, water, and shelter have to come first. Too many people in our community can't move on from that. – Community Leader

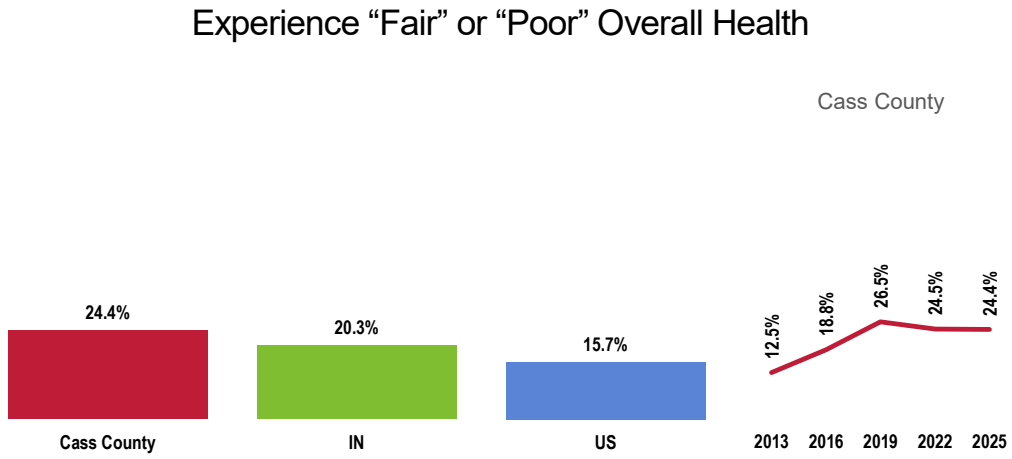
# HEALTH STATUS

## Overall Health

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

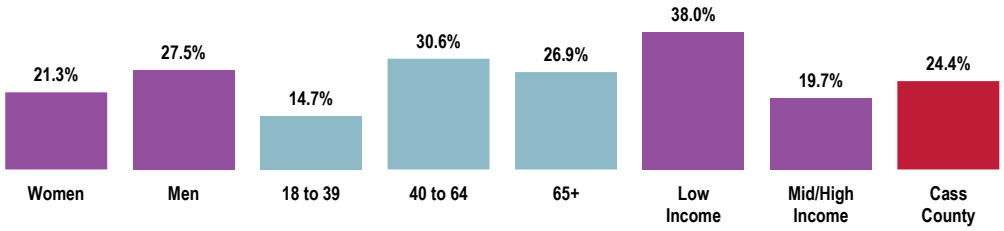



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.




Sources: ● 2025 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): 2023 Indiana data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

## Experience “Fair” or “Poor” Overall Health
(Cass County, 2025)




Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

# Mental Health

## ABOUT MENTAL HEALTH & MENTAL DISORDERS

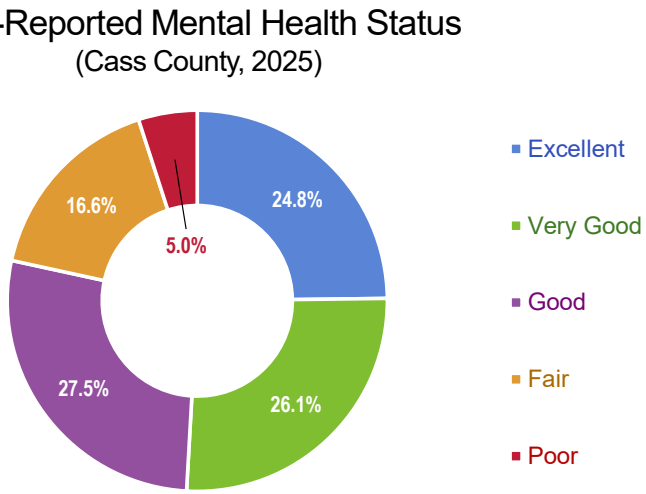
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

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

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

## Mental Health Status

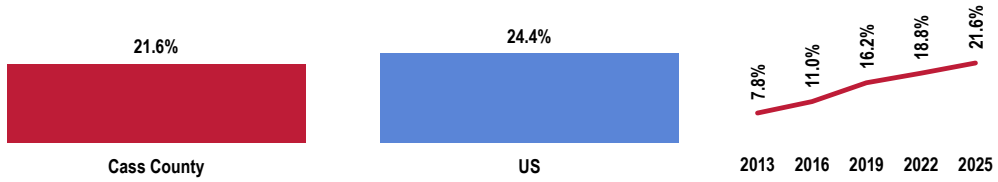
**PRC SURVEY ► "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"**




Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

## Experience “Fair” or “Poor” Mental Health

Cass County




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

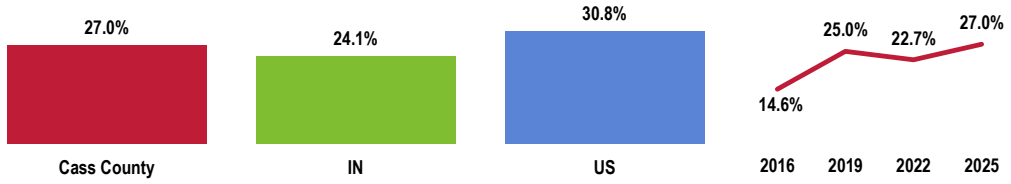
# Depression

## Diagnosed Depression

**PRC SURVEY ► “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”**

## Have Been Diagnosed With a Depressive Disorder

Cass County



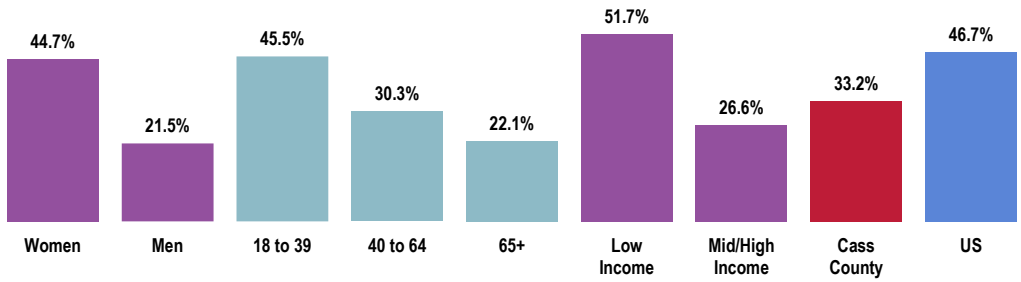

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

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

## Symptoms of Chronic Depression

**PRC SURVEY ► "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"**

### Have Experienced Symptoms of Chronic Depression
(Cass County, 2025)



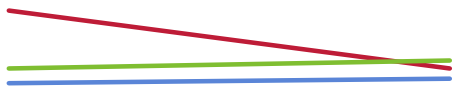

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

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.

## Suicide

The following chart outlines the most current mortality rates attributed to suicide in our population.

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



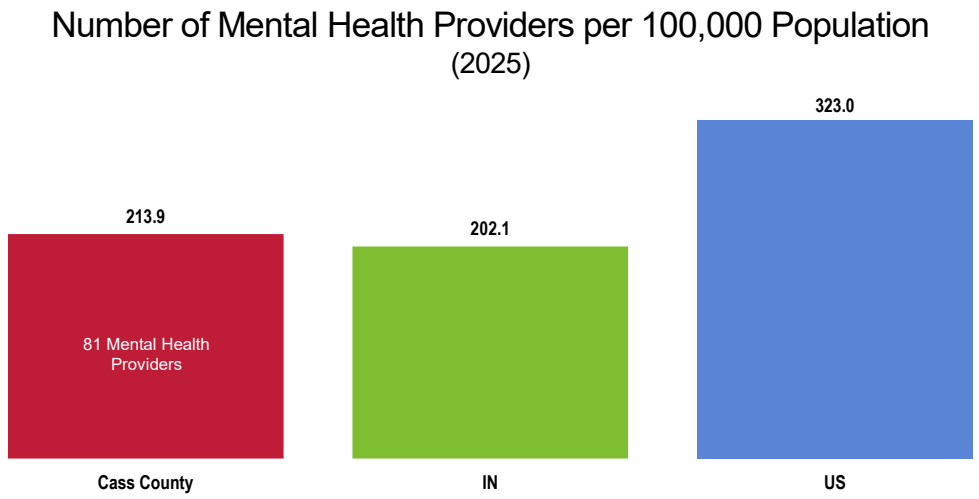
| | 2014-2018 | 2019-2023 |
|---|---|---|
| Cass County | 20.5 | 15.4 |
| IN | 15.4 | 16.1 |
| US | 14.1 | 14.5 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

## Mental Health Treatment

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

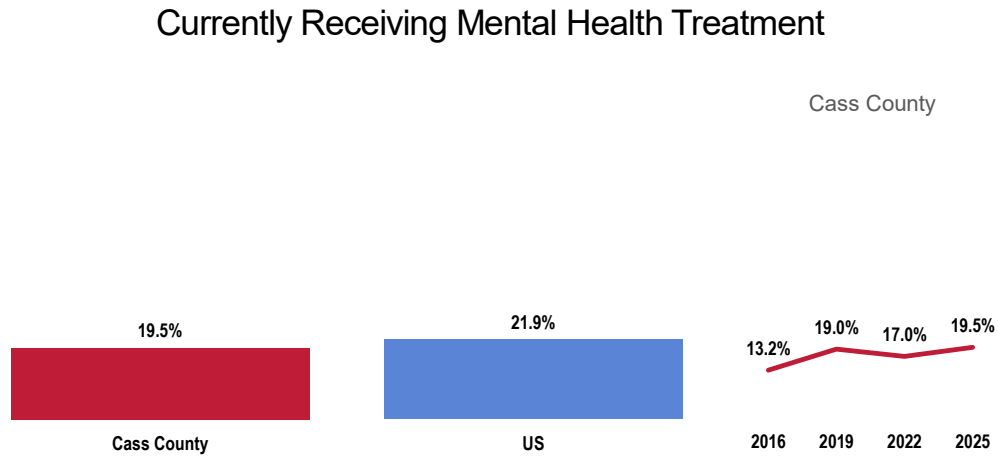
The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents.




Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 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.

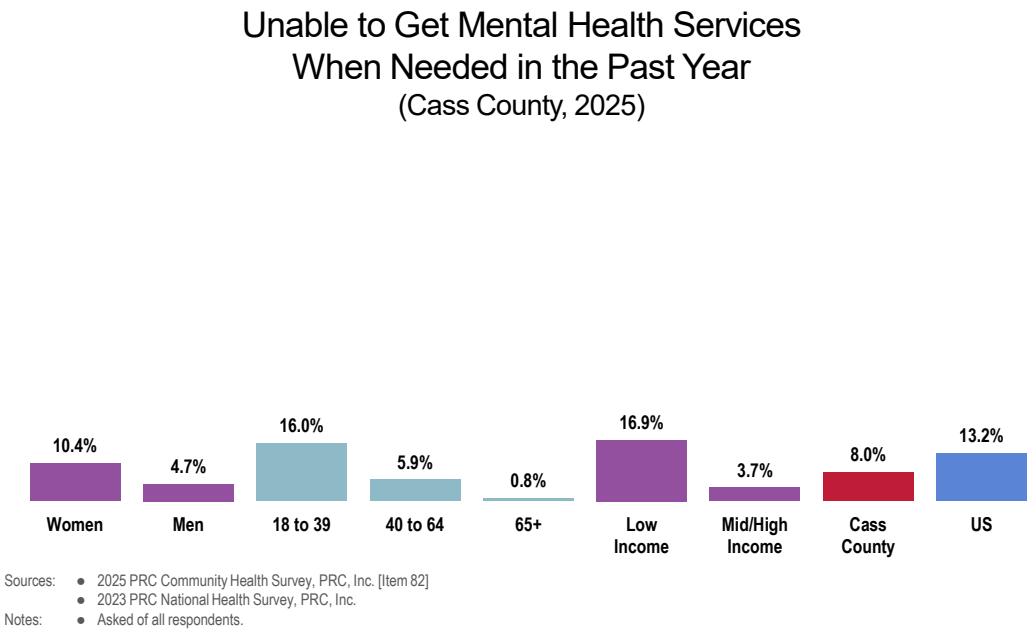
**PRC SURVEY ► "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"**




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

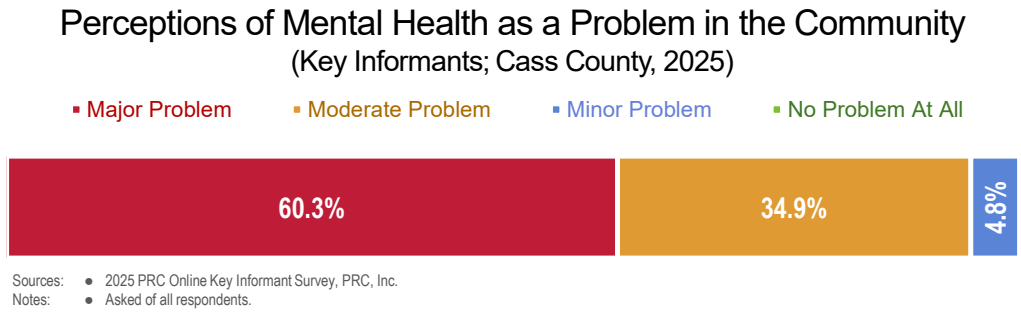
Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

**PRC SURVEY ► "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"**




## Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:




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

### Access to Care/Services

> Lack of access and follow up. Lack of attention in acute situations as well. Too few mental health therapists. The state hospital for mental health is nearly impossible to get placement with. The Mobile Crisis Team through 4C is less than ideal. – Health Care Provider
>
> Access to care. – Community Leader
>
> Lack of mental health care access. – Health Care Provider
>
> Access to mental health care. – Health Care Provider
>
> Cost and access to mental health services in a timely manner. – Health Care Provider
>
> Accessibility and stigma remain major obstacles to people who are facing mental health issues in our community. Even those in crisis who do not meet the requirements for placement may have to wait weeks to see a mental health specialist. Many go undiagnosed and untreated because they can not be seen or because they do not know how to access services. – Health Care Provider
>
> Access to care. – Physician

A number of those who transfer out of the Emergency Room were there for mental health. I feel we have a high prevalence based on our population. There is not a lot of resources locally. Our one mental health resource, 4C, has now moved to Miami County. – Health Care Provider

Lack of options for care, medication management, and counseling. – Health Care Provider

There are long wait times for someone with commercial insurance. There are no options for a school-based therapist in schools anymore either. Parents don't want to take their kids into the offices or other places. – Social Services Provider

There is no access to care, and for the facilities and providers that do exist, it takes months to get patients in to be seen. – Health Care Provider

Accessing services and continuing with the services once they get them. – Community Leader

Access to options. Having a supportive and attentive mental health facility in Cass County. Lack of providers. – Social Services Provider

Services in Cass County and cultural barriers. – Social Services Provider

### Lack of Providers

Availability of mental health professionals. – Community Leader

Mental health needs are growing substantially. Unfortunately, the number of quality mental health service providers have not. – Health Care Provider

4C Health experiences the problem of not having enough therapists and counselors and also has been working on addressing issues with employee on turnover. More multilingual service providers and immigrant providers are needed to relate to the service area population. More school services for adolescents are also needed. The amount of time it takes to get an appointment is also an issue. Increased support for the criminal justice system for providing assistance to offenders. We have several organizations working to address mental health in our community but we struggle with collaboration. This is not unique to just the mental health field. – Social Services Provider

Not enough providers for the need in Cass County. Insurance reimbursement rates are too low and make it difficult for facilities to hire enough licensed providers to meet the needs of the community. Referrals are high; waiting lists are high and people are waiting too long and or going without services needed. – Health Care Provider

There are not enough behavioral health providers here. No one to prescribe antipsychotics. – Health Care Provider

### Incidence/Prevalence

Our mental health issues are increasing significantly. – Health Care Provider

It is evident that mental health issues exist in our community at a pretty high rate. – Community Leader

Increased amount of suicide rates. – Health Care Provider

Particularly in the pre-adolescent and adolescent population, I see a high degree of anxiety and depression. – Physician

### Diagnosis/Treatment

Getting the appropriate services individuals need to detect and treat mental illness. Costs of treatment and placement, and paperwork surrounding identification of mental illness. – Social Services Provider

Getting the right treatment they need and then being placed back in the community to get on with their lives. I believe there is no place around here to work with people and try to make their lives better. Always have to go out of town for a problem. – Community Leader

In my limited exposure to people I know diagnosis is often made too quickly and many have been over medicated. Once they have sought a second opinion and time has been taken to truly analyze their condition and proper medication has been prescribed their issues have vastly improved. In several instances it was determined that they were over medicated. Just seems that locally many times the diagnosis was rushed. – Community Leader

### Suicide Prevention

I don't know if it is considered outside of mental health, but the suicide rates are alarming. We need more resources for those who are suicidal. We also need support for after the fact. Access to support groups for people. – Social Services Provider

Suicide is happening too frequently in Cass County, especially among our youth. Whenever I go to the doctor, someone asks me about my mood and my current state of depression. I wonder if people that don't go to the doctor's office regularly are not getting asked those questions? – Community Leader

Suicide prevention. There is beginning to be more education but still not enough. – Health Care Provider

### Follow-Up/Support

> People with severe mental health issues are often a danger to themselves and the community at large. Contributes significantly to homelessness. – Community Leader
>
> Not enough support groups. – Community Leader
>
> Lack of resources for follow up support after a mental health crisis. – Health Care Provider

### Awareness/Education

> Knowing where to go or having accessible contacts. Many times, we have people with mental health issues, and we do not have direct contacts to be able to seek help. – Social Services Provider
>
> Some are not sure where to turn to, while others don't seek the help they need. Many complain that the services located here don't help them, such as 4C Health. – Community Leader

### Denial/Stigma

> The stigma associated with mental health, suicide ideation, etc. – Community Leader
>
> As much as we've made progress, I still think there's a lot of stigma. I also think that in some populations, it can be more difficult for them to accept that they need professional help. I have also seen people report that it takes a long time for them to get into a professional. – Social Services Provider

### Access for Medicare/Medicaid Patients

> Access to mental health therapists and counselors for children and people not serviced by Medicaid. As a school counselor, parents who work and have insurance are left with absolutely no choices for their child's mental health issues. 4C and Bowen Center have skills trainers in schools that I can sign kids up for who have Medicaid, but families with insurance cannot use the 4C and Bowen Center services. There is no help for them unless they pay out of pocket for places they must drive out of county to or be put on a waiting list for online mental health treatment. This is extremely scary for my students who are in crisis. I appreciate that 4C has a walk-in clinic in our county but it still doesn't meet the needs of all. We also need access in schools for actual therapists. I have been working with 4C to encourage them to send a therapist to schools so our single parents who struggle to make ends meet don't have to take the day off from their low-income jobs to transport to treatment. – Social Services Provider

### Co-Occurrences

> Mental Health and substance abuse issues are related to no mental health care. – Physician

### Teens/Young Adults

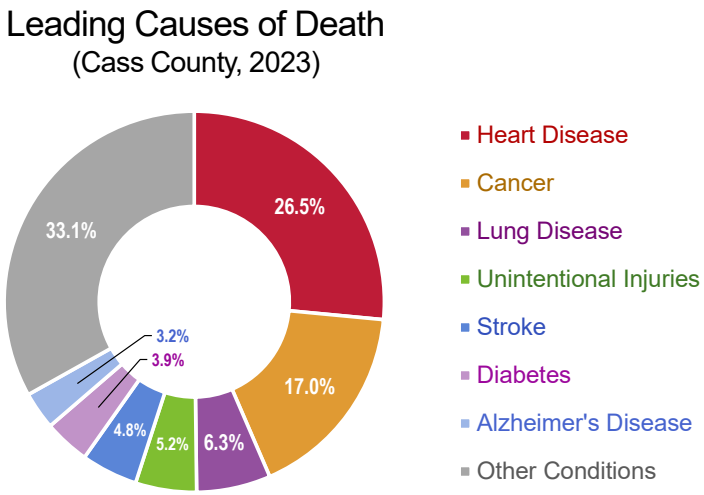
> Teen mental health. – Health Care Provider

# DEATH, DISEASE & CHRONIC CONDITIONS

## Leading Causes of Death

### Distribution of Deaths by Cause

The following outlines leading causes of death in the community.




Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

Notes: ● Lung disease includes deaths classified as chronic lower respiratory disease.

## Death Rates for Selected Causes

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

Here, 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.

The following chart outlines annual average death rates per 100,000 population for selected causes of death.

### Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

| | Cass County | IN | US | Healthy People 2030 |
|---|---|---|---|---|
| **Heart Disease** | 306.8 | 224.0 | 209.5 | 127.4* |
| **Cancers (Malignant Neoplasms)** | 212.8 | 204.1 | 182.5 | 122.7 |
| **Unintentional Injuries** | 80.7 | 74.1 | 67.8 | 43.2 |
| **Lung Disease (Chronic Lower Respiratory Disease)** | 70.0 | 64.3 | 43.5 | — |
| **Stroke (Cerebrovascular Disease)** | 53.2 | 50.6 | 49.3 | 33.4 |
| **Diabetes** | 53.2 | 36.5 | 30.5 | — |
| **Alzheimer's Disease** | 45.2 | 32.9 | 35.8 | — |
| **Unintentional Drug-Induced Deaths [2019-2023]** | 24.0 | 31.3 | 26.6 | — |
| **Kidney Disease [2019-2023]** | 19.7 | 21.4 | 16.4 | — |
| **Pneumonia/Influenza [2019-2023]** | 16.5 | 13.0 | 14.3 | — |
| **Suicide [2019-2023]** | 15.4 | 16.1 | 14.5 | 12.8 |
| **Motor Vehicle Deaths** | 12.4 | 14.1 | 13.3 | 10.1 |
| **Alcohol-Induced Deaths [2019-2023]** | 12.2 | 14.8 | 14.6 | — |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.
- 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.

# Cardiovascular Disease

## ABOUT HEART DISEASE & STROKE

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

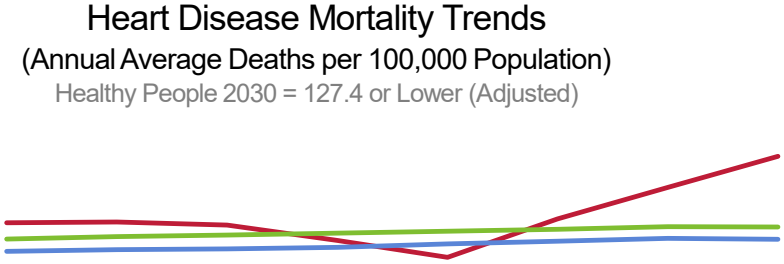
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they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

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

## Heart Disease & Stroke Deaths

The following charts outline mortality rates for heart disease and for stroke in our community.

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




| | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2018-2020 | 2019-2021 | 2020-2022 | 2021-2023 |
|---|---|---|---|---|---|---|---|---|
| Cass County | 229.0 | 230.0 | 226.5 | 208.5 | 188.5 | 233.5 | 270.2 | 306.8 |
| IN | 209.9 | 212.6 | 214.7 | 216.7 | 219.3 | 221.4 | 224.4 | 224.0 |
| US | 195.5 | 197.5 | 198.6 | 200.0 | 204.2 | 207.3 | 210.7 | 209.5 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.
- 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.

## Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

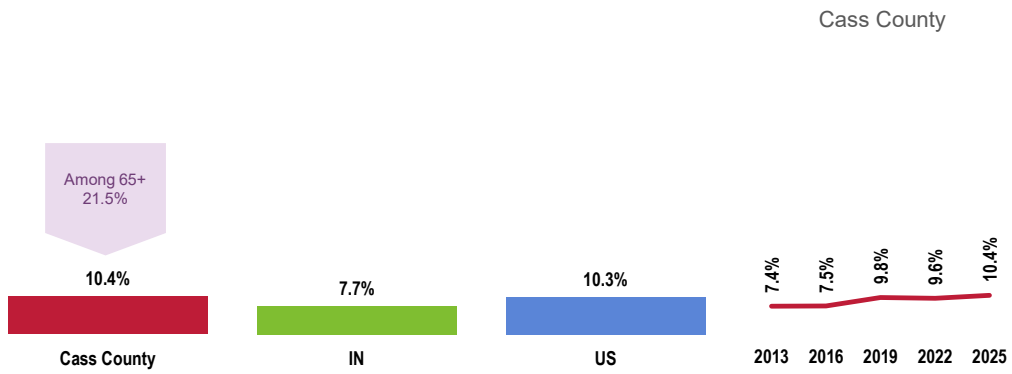
| | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2018-2020 | 2019-2021 | 2020-2022 | 2021-2023 |
|---|---|---|---|---|---|---|---|---|
| Cass County | 47.3 | 54.4 | 50.9 | 58.1 | 50.4 | 51.4 | 47.1 | 53.2 |
| IN | 45.9 | 45.9 | 46.7 | 48.1 | 48.7 | 49.8 | 50.1 | 50.6 |
| US | 43.1 | 44.2 | 44.7 | 45.3 | 46.5 | 47.8 | 49.1 | 49.3 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

## Prevalence of Heart Disease & Stroke

**PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"**

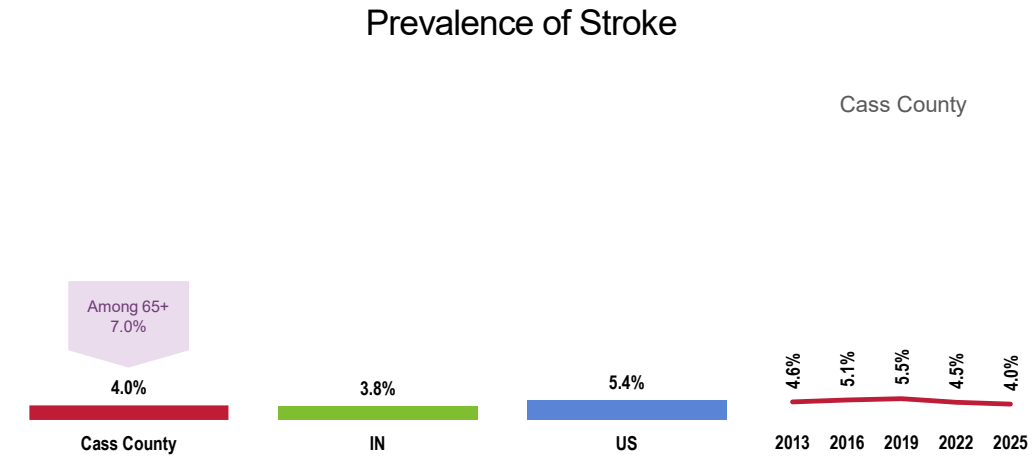
### Prevalence of Heart Disease




Sources:
- 2025 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): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

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

**PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"**




Sources:
- 2025 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): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

## Cardiovascular Risk Factors

### Blood Pressure & Cholesterol

**PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"**

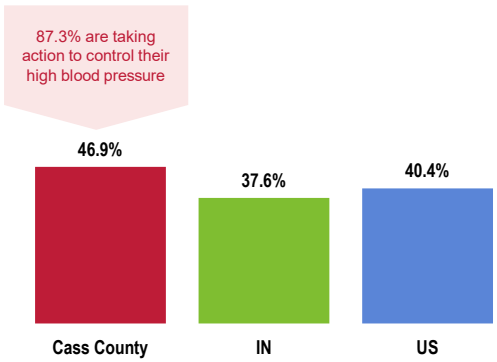
**PRC SURVEY ► "Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"**

**PRC SURVEY ► "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"**

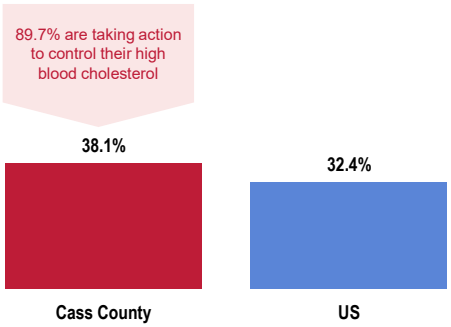
**PRC SURVEY ► "Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"**

## Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower




## Prevalence of High Blood Cholesterol

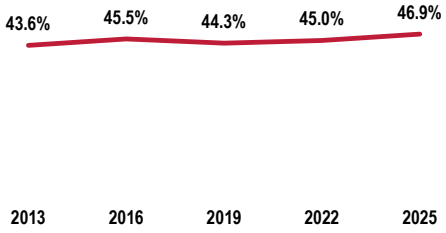



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30, 303-304]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

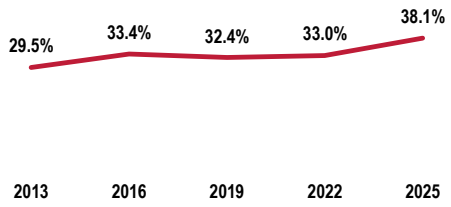
Notes:
- Asked of all respondents.

## Prevalence of High Blood Pressure (Cass County)

Healthy People 2030 = 42.6% or Lower




## Prevalence of High Blood Cholesterol (Cass County)




Sources:
- 2025 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:

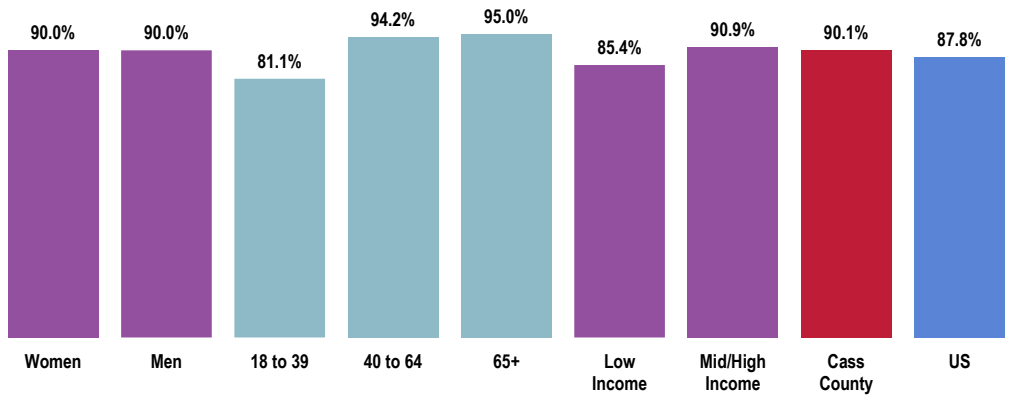
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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.

The following chart reflects the percentage of adults in Cass County who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

### Exhibit One or More Cardiovascular Risks or Behaviors
(Cass County, 2025)

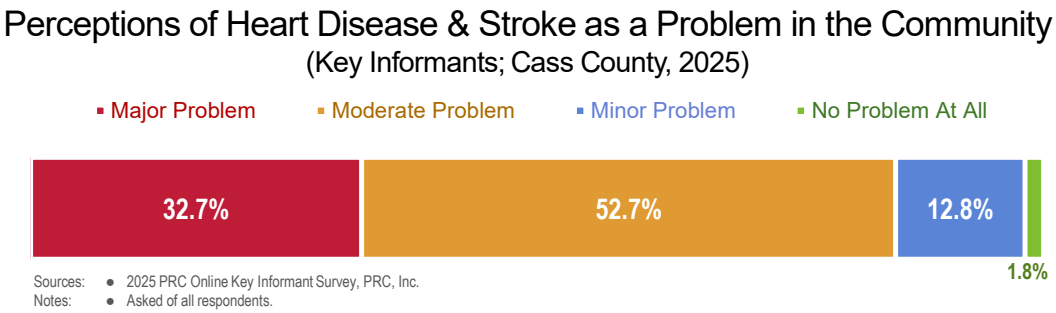



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

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.

## Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:




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

### Incidence/Prevalence

> I can think of five people I knew who have died in Cass County of a heart attack in the last few years. – Social Services Provider
>
> These are, to some extent, preventable issues, yet they are high on the list of causes of death in our community. – Social Services Provider
>
> It seems many in our community suffer from heart disease, and I know many who have had a stroke. – Social Services Provider
>
> High number of people have these conditions. – Community Leader

### Lifestyle

> Unhealthy lifestyles. No preventative screening is available locally. – Health Care Provider
>
> Just the lifestyle most Americans have in general. – Community Leader
>
> Diet, exercise, and heredity factors of those in the area add to this. – Community Leader
>
> Diets and smoking. – Health Care Provider

### Access to Specialty Care

> Limited access to cardiology care. – Health Care Provider
>
> Personally have heart issues and had to seek appropriate care outside of Logansport for proper diagnosis and treatment. – Community Leader

### Awareness/Education

> Education on the importance of good health habits. Accountability for compliance. Education level of patients with disease. – Health Care Provider
>
> Lack of disease education and understanding for community. High incidence of heart disease including hypertension and cardiovascular disease. – Health Care Provider

### Preventative Care

> Poor preventative care and non-compliance. Increased risk factors such as high BMI and smoking. – Health Care Provider

### Tobacco Use

> Tobacco use. – Community Leader

# Cancer

## ABOUT CANCER

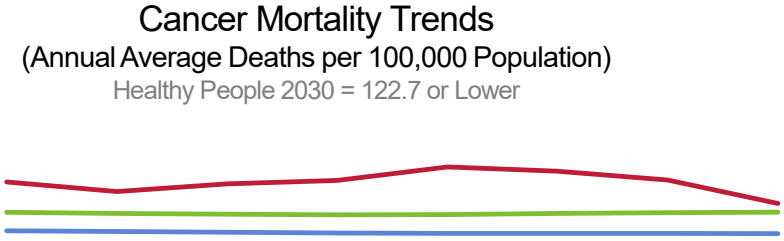
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are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

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

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

## Cancer Deaths

The following chart illustrates cancer mortality (all types).




| | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2018-2020 | 2019-2021 | 2020-2022 | 2021-2023 |
|---|---|---|---|---|---|---|---|---|
| Cass County | 234.3 | 224.7 | 232.7 | 235.8 | 249.5 | 245.1 | 236.5 | 212.8 |
| IN | 203.8 | 202.8 | 201.9 | 201.4 | 201.5 | 202.9 | 203.6 | 204.1 |
| US | 185.4 | 184.8 | 184.1 | 183.3 | 182.9 | 182.6 | 182.6 | 182.5 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Lung cancer is by far the leading cause of cancer deaths.

## Cancer Death Rates by Site
(2019-2023 Annual Average Deaths per 100,000 Population)

| | Cass County | IN | US | HP2030 |
|---|---|---|---|---|
| ALL CANCERS | 212.8 | 204.1 | 182.5 | 122.7 |
| Lung Cancer | 61.8 | 52.3 | 39.8 | 25.1 |
| Female Breast Cancer | 31.1 | 26.4 | 25.1 | 15.3 |
| Colorectal Cancer | 24.5 | 18.6 | 16.3 | 8.9 |
| Prostate Cancer | 15.9 | 20.3 | 20.1 | 16.9 |

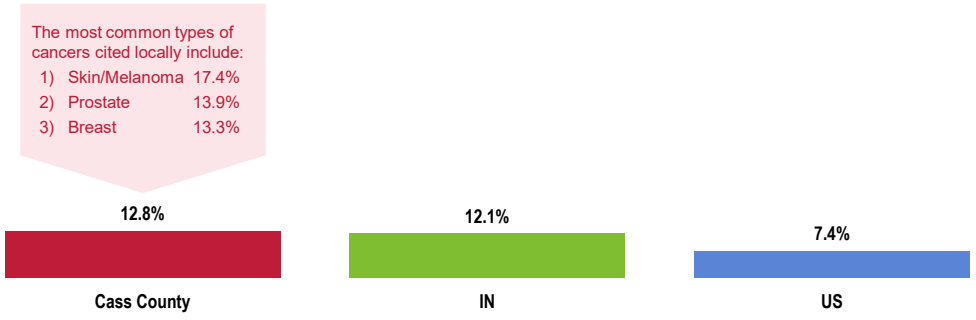
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

## Prevalence of Cancer

**PRC SURVEY ► "Have you ever suffered from or been diagnosed with cancer?"**

**PRC SURVEY ► "Which type of cancer were you diagnosed with?"** (If more than one past diagnosis, respondent was asked about the most recent.)

### Prevalence of Cancer




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

# Cancer Screenings

## 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 45 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.

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

### Breast Cancer Screening

**PRC SURVEY ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"**

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

### Cervical Cancer Screening

**PRC SURVEY ► "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"**

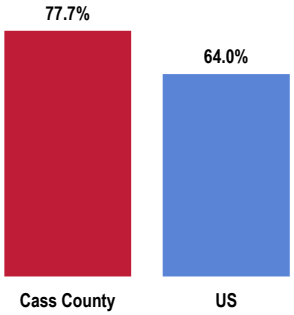
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

### Colorectal Cancer Screening

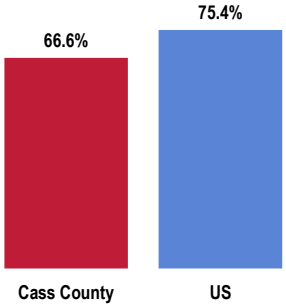
**PRC SURVEY ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"**

"Appropriate colorectal cancer screening" includes a fecal occult blood test among adults age 45 to 75 within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

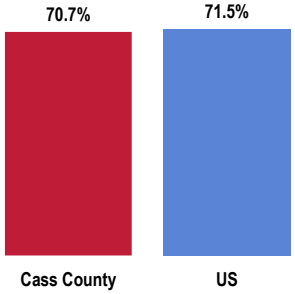
Breast Cancer Screening
(Women 50-74)
Healthy People 2030 = 80.5% or Higher




Cervical Cancer Screening
(Women 21-65)
Healthy People 2030 = 84.3% or Higher



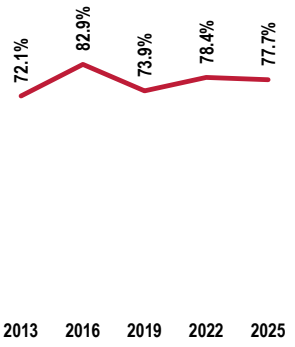

Colorectal Cancer Screening
(All Adults 45-75)
Healthy People 2030 = 74.4% or Higher



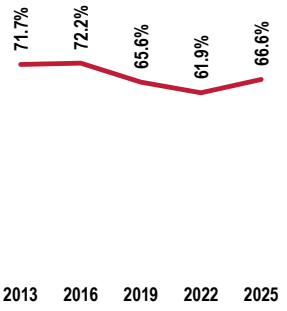

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that national data for colorectal cancer screening reflect adults ages 50 to 75.

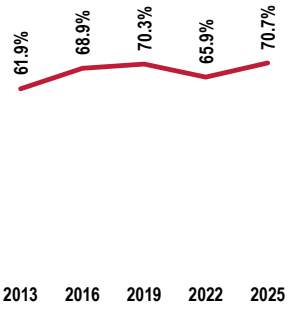
Breast Cancer Screening
(Women 50-74)
Healthy People 2030 = 80.5% or Higher




Cervical Cancer Screening
(Women 21-65)
Healthy People 2030 = 84.3% or Higher




Colorectal Cancer Screening
(All Adults 45-75)
Healthy People 2030 = 74.4% or Higher

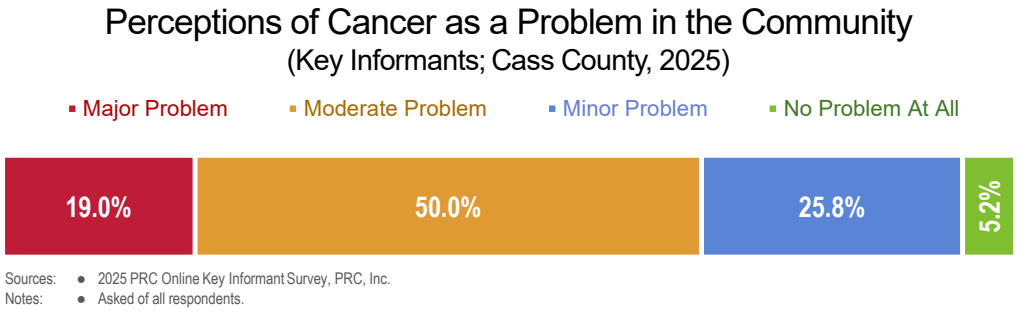



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

## Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:




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

### Incidence/Prevalence

> High incidence of cancer diagnoses. – Health Care Provider
>
> I have known numerous people who have had cancer in Cass County. – Social Services Provider
>
> It has in the past been one of the leading causes of death within our community. It also seems that it's becoming more common for younger people to get cancer. – Social Services Provider
>
> It seems cancer is a major health problem as so many people seem to be afflicted with it. – Social Services Provider
>
> We have a high cancer rate in Cass County. Smoking is a major factor, I believe. – Community Leader
>
> Cass County has one of the highest rates of cancer per capita in the state. – Health Care Provider
>
> The number of people diagnosed is high. – Community Leader
>
> Number of residents diagnosed. – Community Leader
>
> Seems to be an elevated number of people who have cancer in our community. – Community Leader

### Environmental Contributors

> Environmental factors such as factories in the area causing pollution. Additionally, there is a concern for cancer due to the unhealthy lifestyles of most of our patients. – Health Care Provider

### Lack of Resources

> I am not sure what resources are available for someone with cancer. – Social Services Provider

# Respiratory Disease

## ABOUT RESPIRATORY DISEASE

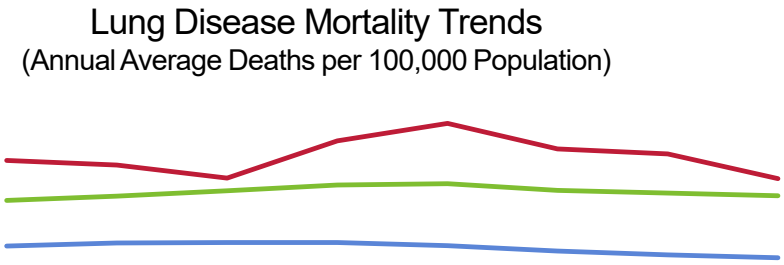
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million 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)

## Respiratory Disease Deaths

### Lung Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the charts that follow.



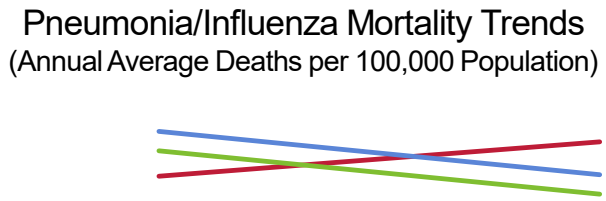

| | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2018-2020 | 2019-2021 | 2020-2022 | 2021-2023 |
|---|---|---|---|---|---|---|---|---|
| Cass County | 76.1 | 74.6 | 70.2 | 82.7 | 88.5 | 79.9 | 78.3 | 70.0 |
| IN | 62.7 | 64.2 | 66.0 | 67.9 | 68.3 | 66.1 | 65.2 | 64.3 |
| US | 47.4 | 48.4 | 48.6 | 48.6 | 47.6 | 45.7 | 44.5 | 43.5 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

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.

### Pneumonia/Influenza Deaths

Pneumonia and influenza mortality is illustrated here.




| | 2014-2018 | 2019-2023 |
|---|---|---|
| Cass County | 14.2 | 16.5 |
| IN | 15.9 | 13.0 |
| US | 17.2 | 14.3 |

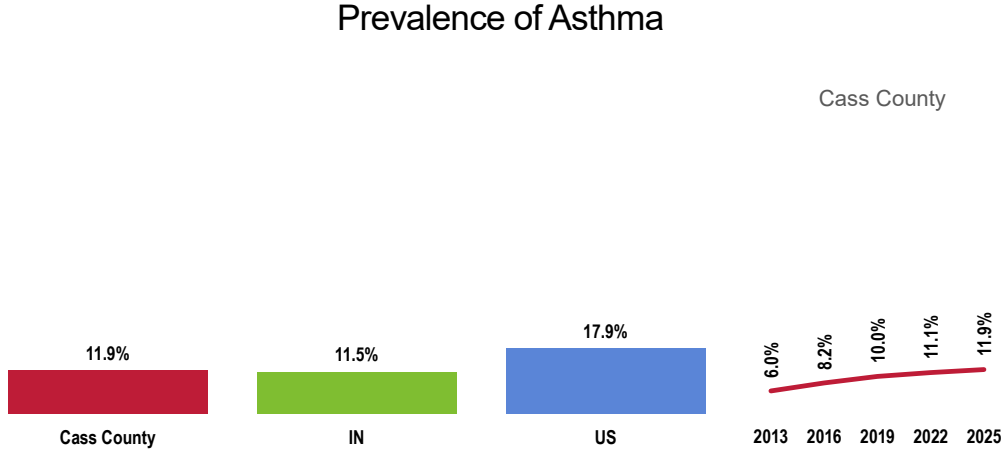
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

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.

## Prevalence of Respiratory Disease

### Asthma

**PRC SURVEY ► "Do you currently have asthma?"**



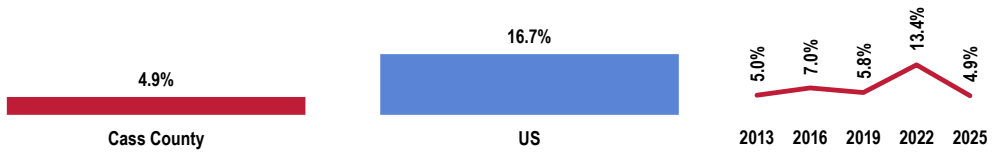

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

**PRC SURVEY** ► [Among parents of children age 0-17] **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

## Prevalence of Asthma in Children
(Children 0-17)

Cass County




Sources:
- 2025 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)

**PRC SURVEY** ► **"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"**

## Prevalence of
## Chronic Obstructive Pulmonary Disease (COPD)

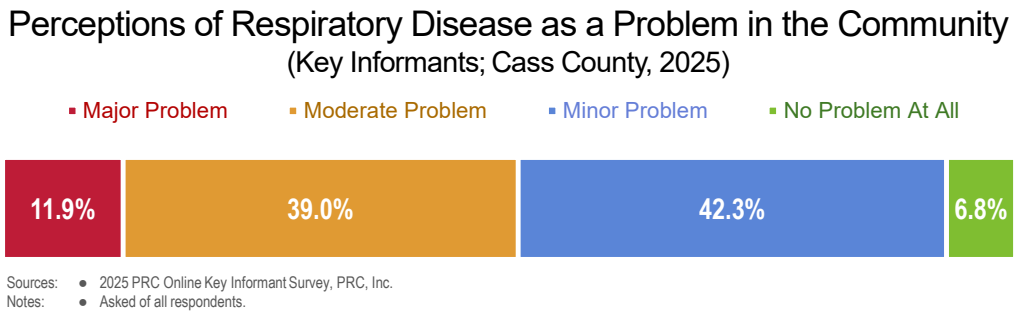
Cass County


Sources:
- 2025 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): 2023 Indiana 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

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:




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

### Tobacco Use

> Tobacco use. – Community Leader
>
> High smoking rate causing high rates of COPD and emphysema. – Health Care Provider

### Tuberculosis

> Public health involvement with TB is behind. Tyson is not screening their people appropriately or helping to prevent TB. This is also included with COVID 19 previously. Smoking is very popular. Many of our population work in factories that require a respirator. – Health Care Provider
>
> Tuberculosis is a major public health concern due to the elevated number of cases. – Health Care Provider

### Diagnosis/Treatment

> Personal experience was I was given several tests locally and was told the results indicated I was healthy and there were no issues. In spite of this, I struggled and had to seek additional medical assistance on my own to determine my issues. – Community Leader

### Impact on Quality of Life

> My uncle passed away this past week. He was diabetic, doing well, and then got sick. In three weeks he was gone. His lungs filled up, he couldn't walk, was on oxygen, and then was gone. – Community Leader

### Incidence/Prevalence

> A Lot of respiratory diseases this winter. Pneumonia started as early as August in the school systems which is very unusual. – Health Care Provider

# Injury & Violence

## ABOUT INJURY & VIOLENCE

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

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

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

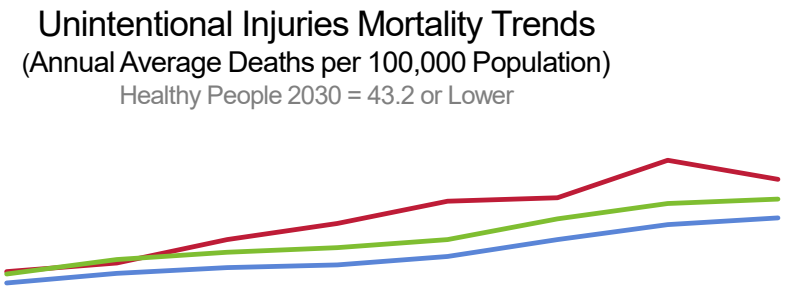
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

## Unintentional Injury

### Unintentional Injury Deaths

The following chart outlines mortality rates for unintentional injury in the area.




| | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2018-2020 | 2019-2021 | 2020-2022 | 2021-2023 |
|---|---|---|---|---|---|---|---|---|
| Cass County | 49.8 | 52.7 | 60.6 | 66.0 | 73.4 | 74.6 | 87.1 | 80.7 |
| IN | 49.0 | 53.9 | 56.3 | 57.9 | 60.6 | 67.5 | 72.6 | 74.1 |
| US | 46.0 | 49.2 | 51.1 | 52.0 | 54.9 | 60.5 | 65.6 | 67.8 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

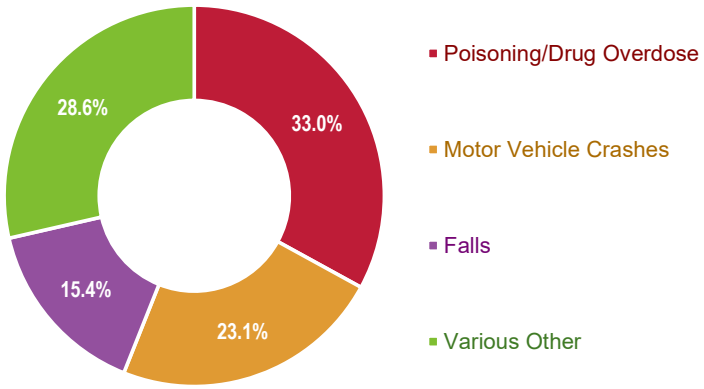
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

## Leading Causes of Unintentional Injury Deaths

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

The following outlines leading causes of accidental death in the area.

### Leading Causes of Unintentional Injury Deaths
(Cass County, 2021-2023)



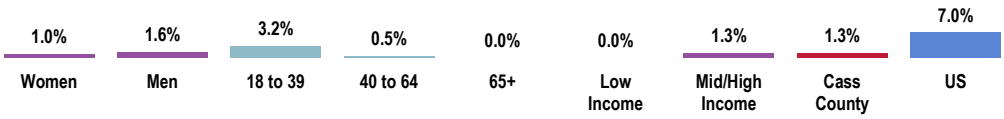

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

# Intentional Injury (Violence)

## Violent Crime Experience

**PRC SURVEY ► "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"**

### Victim of a Violent Crime in the Past Five Years
(Cass County, 2025)

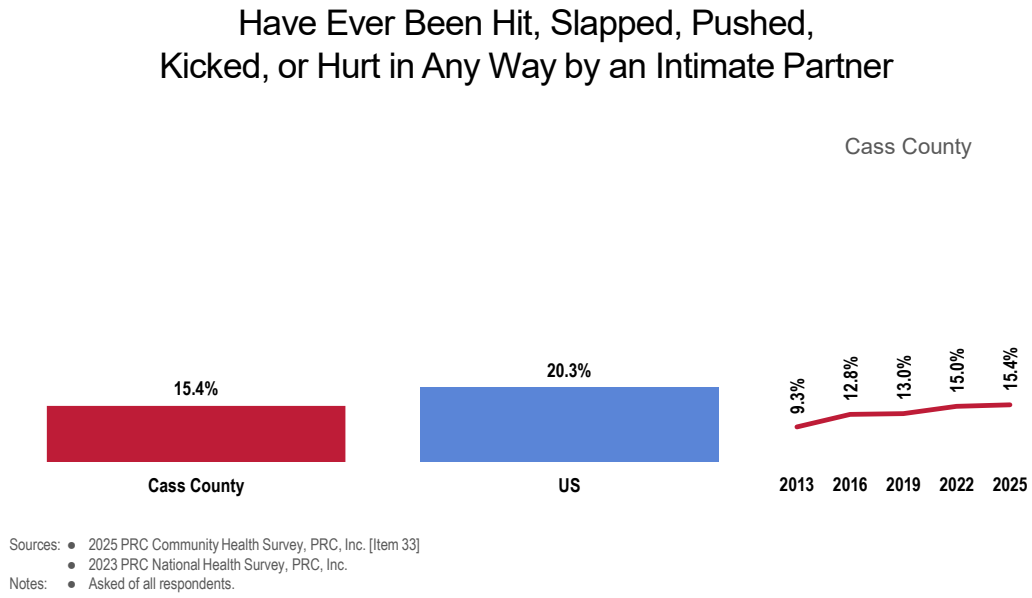



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

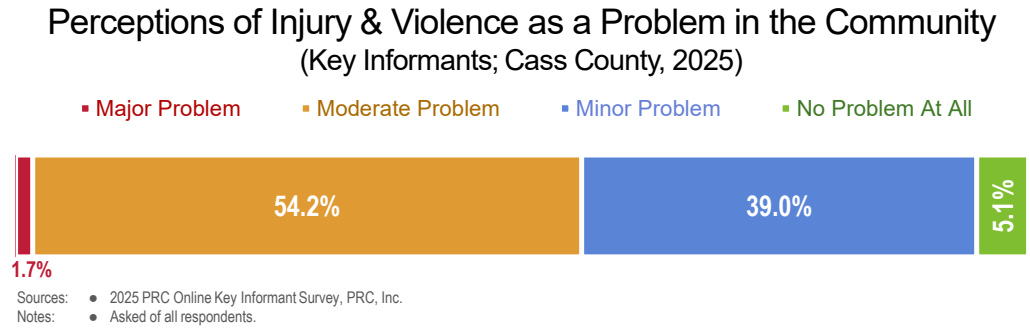
### Intimate Partner Violence

**PRC SURVEY ▶ "The next question is about violence in relationships with an intimate partner. 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. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**




## Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:




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

### Incidence/Prevalence

> Very gun friendly community and there is lack of education and knowledge on gun safety. Suicide is high in my opinion with the youth which I consider to be injury and violence. Also, there is lack of safety with ATV and off road vehicles. Also, no helmet law with motorcycles. – Health Care Provider

# Diabetes

## ABOUT DIABETES

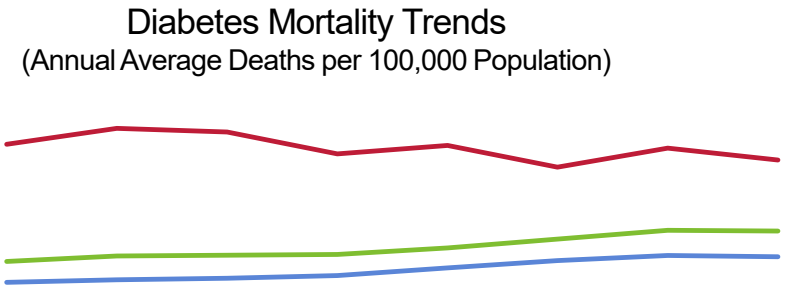
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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

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

## Diabetes Deaths

Diabetes mortality for the area is shown in the following chart.




| | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2018-2020 | 2019-2021 | 2020-2022 | 2021-2023 |
|---|---|---|---|---|---|---|---|---|
| Cass County | 56.9 | 60.6 | 59.7 | 54.6 | 56.6 | 51.5 | 56.0 | 53.2 |
| IN | 29.4 | 30.7 | 30.9 | 31.0 | 32.6 | 34.6 | 36.7 | 36.5 |
| US | 24.5 | 25.1 | 25.5 | 26.1 | 27.9 | 29.6 | 30.8 | 30.5 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

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.

## Prevalence of Diabetes

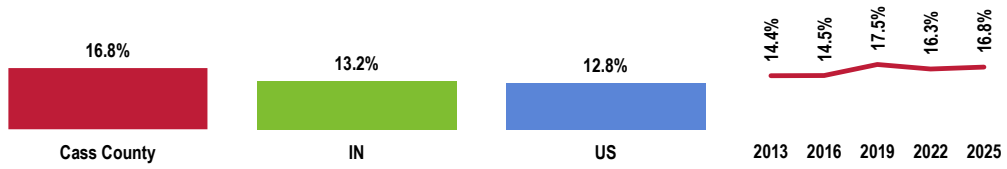
**PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"**

**PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"**

**PRC SURVEY ►** [Non-diabetics] **"Have you had a test for high blood sugar or diabetes within the past three years?"**

## Prevalence of Diabetes

Another 9.5% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

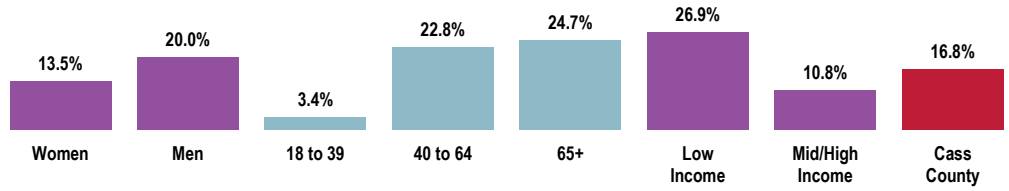



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

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

## Prevalence of Diabetes
(Cass County, 2025)

Note that among adults who have not been diagnosed with diabetes, 48.6% report having had their blood sugar level tested within the past three years.



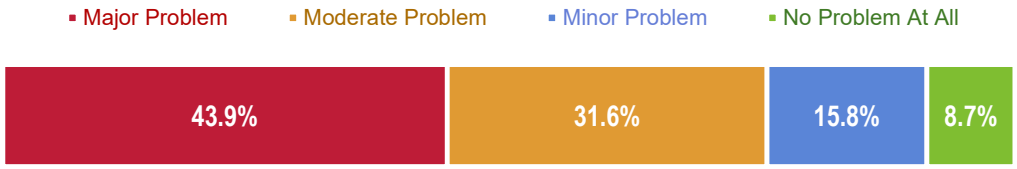

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 106, 302]

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

## Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

### Perceptions of Diabetes as a Problem in the Community
(Key Informants; Cass County, 2025)




Sources:
- 2025 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

> Dietary education and availability. – Physician
>
> While there are many opportunities for people to be educated, they do not take full advantage of the education. – Community Leader
>
> Lack of knowledge about diabetes and a lack of local specialists. – Community Leader
>
> Lack of understanding of disease process and management. – Health Care Provider
>
> Access to knowledge concerning diet and other health issues related to diabetes. – Social Services Provider
>
> Education on the disease and compliance with medication and nutrition. – Health Care Provider
>
> Dietary education, following recommendations, lack of exercise, and cost of medications. – Health Care Provider

### Access to Specialty Care

> No endocrinologists in the community, no support groups, and not many healthy options at restaurants. – Community Leader
>
> No endocrinologists in close proximity currently accepting patients. – Health Care Provider
>
> Little to no access to endocrinology care, and the cost of medications as many have no insurance. – Physician
>
> Access to an endocrinologist. – Physician

### Access to Affordable Healthy Food

> I think the biggest challenge for our community with diabetes is access to healthier options and resources, as well as the cost of medications. – Health Care Provider
>
> Depending on where people live and their transportation means, some may not have regular access to quality, healthy foods. This in turn makes it harder for some members of our community to prevent diabetes and/or to lessen the risks of having it. I think there's a lack of education on nutrition, because there's so much different information out there. – Social Services Provider
>
> Access to better nutrition that isn't expensive. – Health Care Provider

### Disease Management

> Medication compliance and prevention. – Health Care Provider
>
> Weight management and access to healthy food items are limited. – Community Leader
>
> Poor compliance with diet choices, weight management, and medication regimens. – Health Care Provider

### Diagnosis/Treatment

> Knowledge of the diagnosis, noncompliance, and cost of medication. – Health Care Provider
>
> There are many undiagnosed individuals with diabetes, and many do not control their diabetes. – Health Care Provider

### Nutrition

> Good nutrition, exercise, and access to healthcare. – Community Leader
>
> Quality options, selections, and education of food and nutritional resources. – Community Leader

### Youth/Adolescents

> Students at school have different levels of need with diabetics. Often turns to home environment. Many students access the nurses' office. – Social Services Provider

### Affordable Medications/Supplies

> Access to affordable medications. – Health Care Provider

# Disabling Conditions

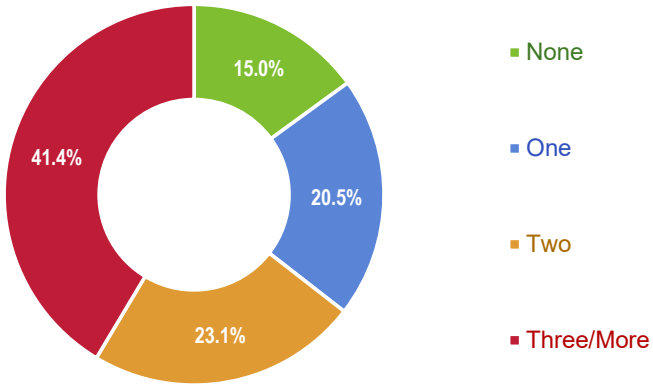
## Multiple Chronic Conditions

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

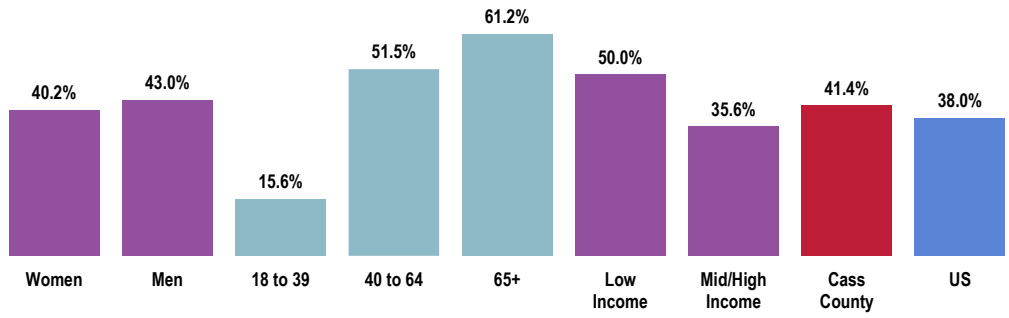
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

### Number of Chronic Conditions
(Cass County, 2025)




Sources: 2025 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.

### Have Three or More Chronic Conditions
(Cass County, 2025)




Sources: 2025 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.

## Activity Limitations

### ABOUT DISABILITY & HEALTH

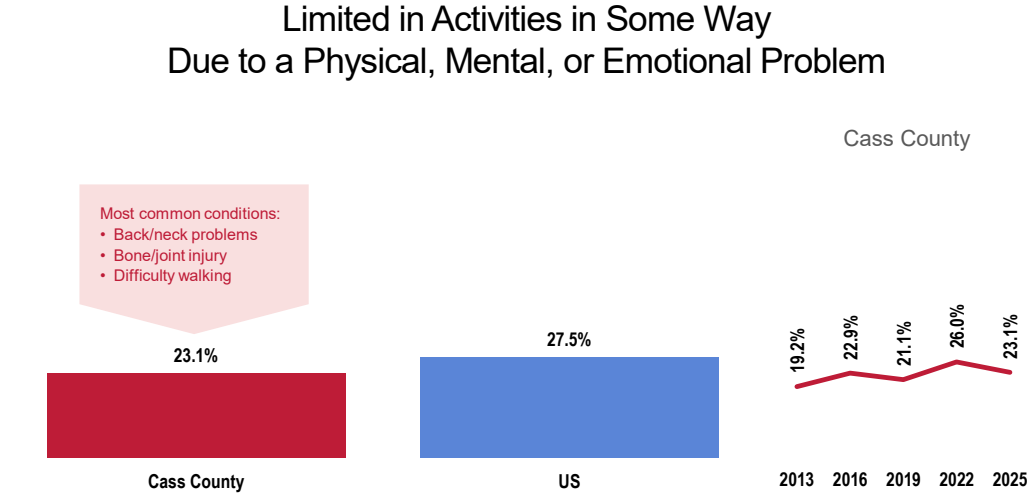
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

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)

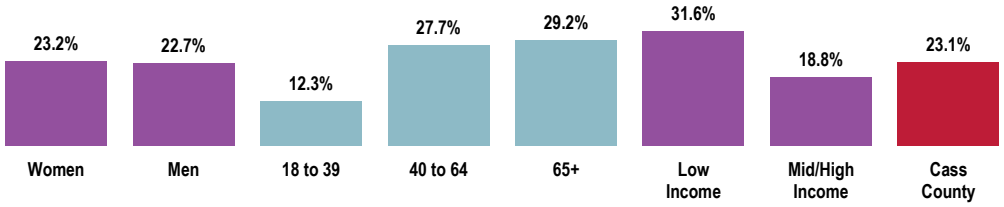
**PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"**

**PRC SURVEY ►** [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**




Sources: ● 2025 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
(Cass County, 2025)

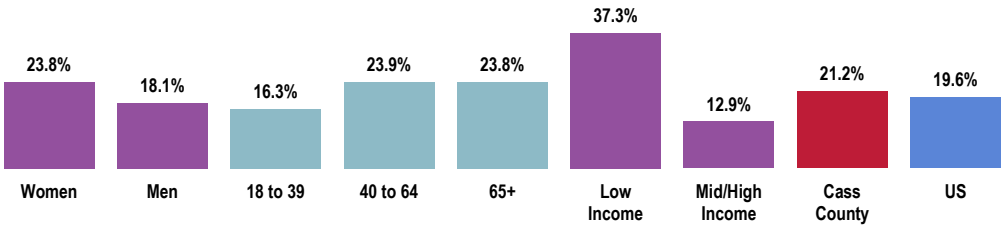



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

## High-Impact Chronic Pain

**PRC SURVEY ► "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?"** (Reported here among those responding "most days" or "every day.")

## Experience High-Impact Chronic Pain
(Cass County, 2025)
Healthy People 2030 = 6.4% or Lower




Sources: ● 2025 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.

# Alzheimer's Disease

## ABOUT DEMENTIA

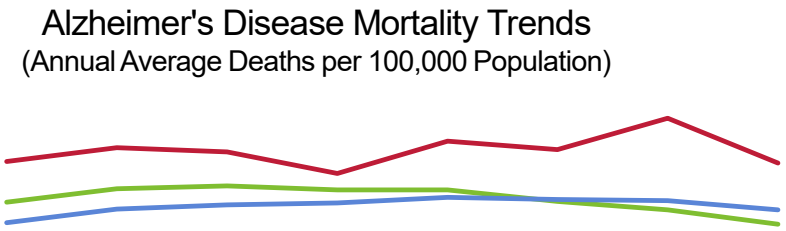
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

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)

## Alzheimer's Disease Deaths

Alzheimer's disease mortality is outlined in the following chart.




| | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2018-2020 | 2019-2021 | 2020-2022 | 2021-2023 |
|---|---|---|---|---|---|---|---|---|
| Cass County | 45.5 | 48.3 | 47.4 | 43.1 | 49.6 | 47.9 | 54.2 | 45.2 |
| IN | 37.3 | 40.0 | 40.6 | 39.8 | 39.8 | 37.5 | 35.8 | 32.9 |
| US | 33.2 | 35.9 | 36.8 | 37.2 | 38.3 | 37.9 | 37.6 | 35.8 |

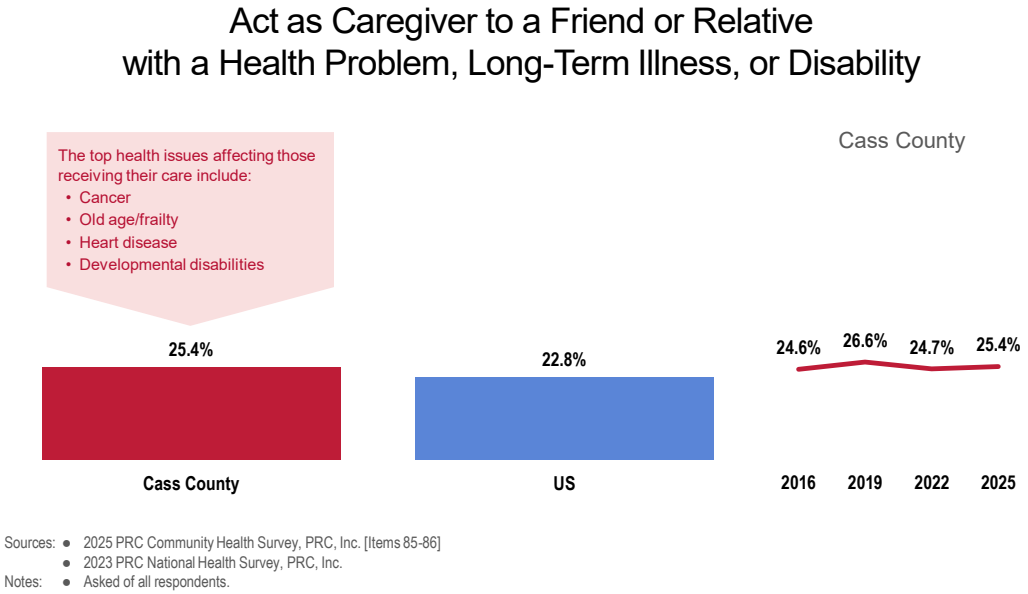
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

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.

## Caregiving

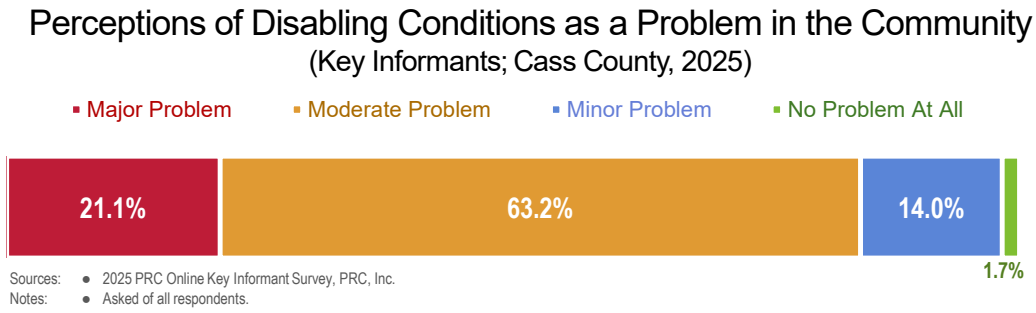
**PRC SURVEY ▶ "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"**

**PRC SURVEY ▶** [Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**




## Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:




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

### Incidence/Prevalence

> I am aware of numerous students and adults who suffer from chronic pain and dementia. – Social Services Provider
>
> Dementia and Alzheimer's rates are increasing. Also, an uptick in chronic pain. – Health Care Provider
>
> High number of people have these conditions. – Community Leader

### Access to Affordable Healthy Food

> The rural/agricultural population and socioeconomic demographic leave healthy foods out of financial reach and/or nutritional information about what sugars and carbohydrates can do to health conditions when not well balanced. – Health Care Provider

### Protective Equipment

> Many partake in activities that can cause harm by not wearing protective equipment, for example, no hearing protection when going to a gun range. Chronic pain due to not taking care of our bodies when we are younger, like using proper lifting mechanics. – Health Care Provider

### Disease Management

> People don't take care of themselves, or they don't have available medical care. – Community Leader

### Nutrition

> Most of this is due to diet and lack of exercise, which leads to degenerative conditions. – Community Leader

# BIRTHS

## 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.

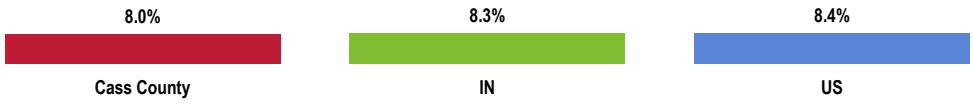
– Healthy People 2030 (https://health.gov/healthypeople)

# 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.

Low-Weight Births
(Percent of Live Births, 2017-2023)

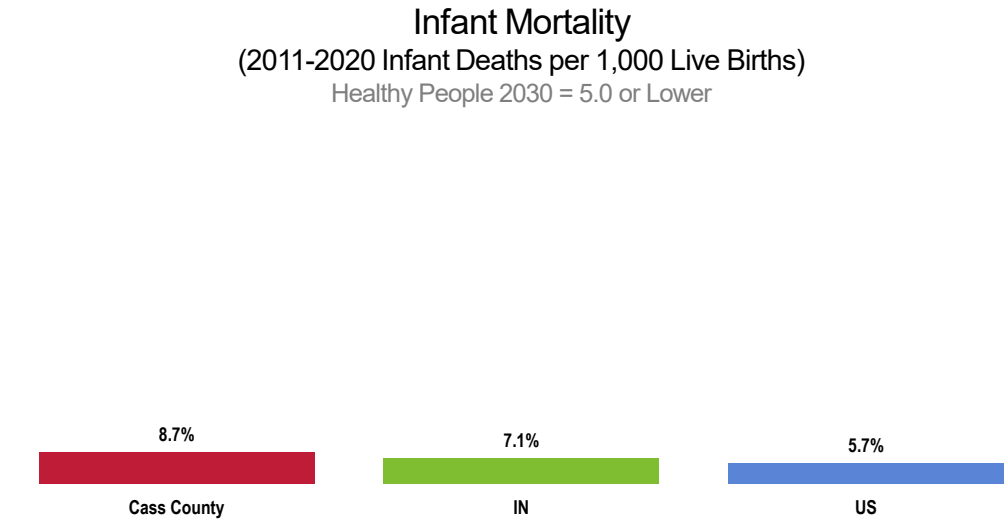



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

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 1 year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health.




Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted June 2025.
- 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:
- This indicator reports 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.

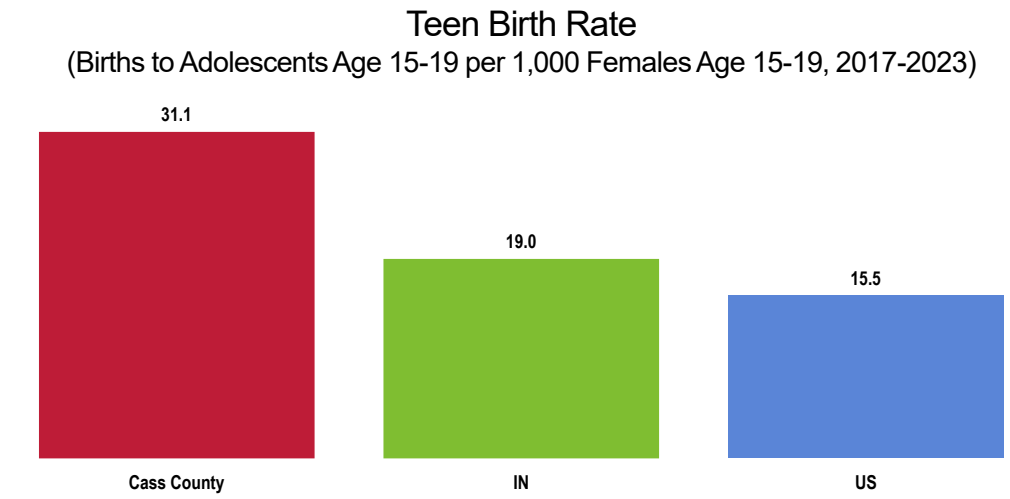
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

## Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

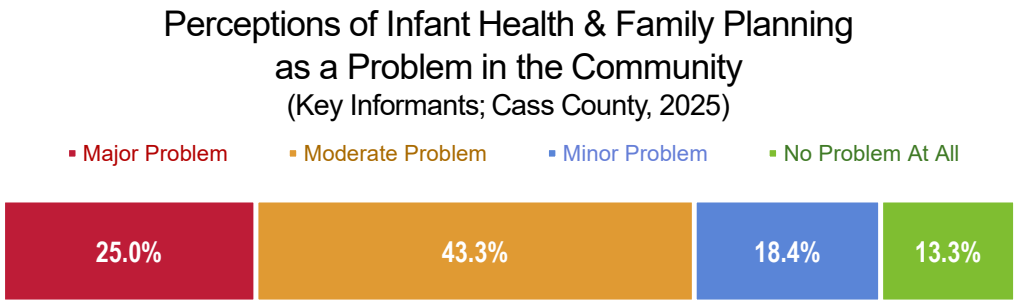
The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.




Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 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.

## Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:




Sources: ● 2025 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

> Clinic/hospital access is limited to one location in the county. – Community Leader
>
> My own experience with my children has been 35 years ago, so I am no longer involved in this aspect of pre-natal, and infant care. But it seems like services available to our population are not always accessible here in Cass County. I appreciate that the hospital has pediatricians that can address infant care, but access to family planning, including birth control has been reduced by the State of Indiana. – Community Leader
>
> Obstetric care is limited in some surrounding counties which causes an influx here. No available clinics locally to help with family planning. Most have to go out of county. – Health Care Provider
>
> Social and economic status of mothers and cultural differences. – Health Care Provider

> Correlated with social determinants of health, prenatal care is lacking. – Physician

### Infant Mortality

> Our community is continuing to work to address our high rate of infant mortality. – Social Services Provider
>
> Our infant mortality rate for our county is one of the highest in the state. We also have a great deal of babies that are born on Medicaid, and the cost to deliver a baby is astronomical. – Community Leader
>
> I base that on Indiana statistics on infant birth/death rates, not Cass County specifically. I also think teen pregnancy is a big problem in society in general. I see it as a CASA in Tippecanoe County. – Community Leader

### Lack of Prenatal Care

> I don't believe many are using our facilities to seek pre and post natal care. Some might be because they don't have the money. Others, I think, are due to a lack of knowledge about the importance of it. – Community Leader
>
> As a pediatrician, I see many newborns born to low income families with poor prenatal care. I also see a large population of new immigrants with spotty prenatal care, particularly those who are Haitian-Creole and Hispanic. – Physician

### Awareness/Education

> Many mothers do not get prenatal care because of lack of education. – Community Leader
>
> Lack of education, access to healthcare, delayed prenatal care, and limited financial resources. – Health Care Provider

### Language Challenges

> I am on the front lines trying to provide care. Half of our population speaks no English and has no money for medications. Some can't even get to appointments, and resources have been exhausted. – Physician

# 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.

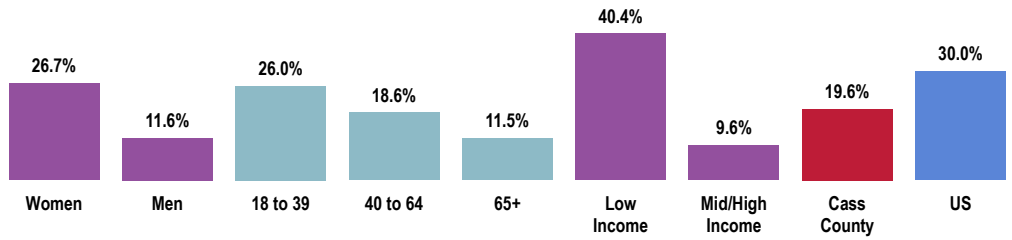
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

## Access to Fresh Produce

**PRC SURVEY ► "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?"**

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(Cass County, 2025)

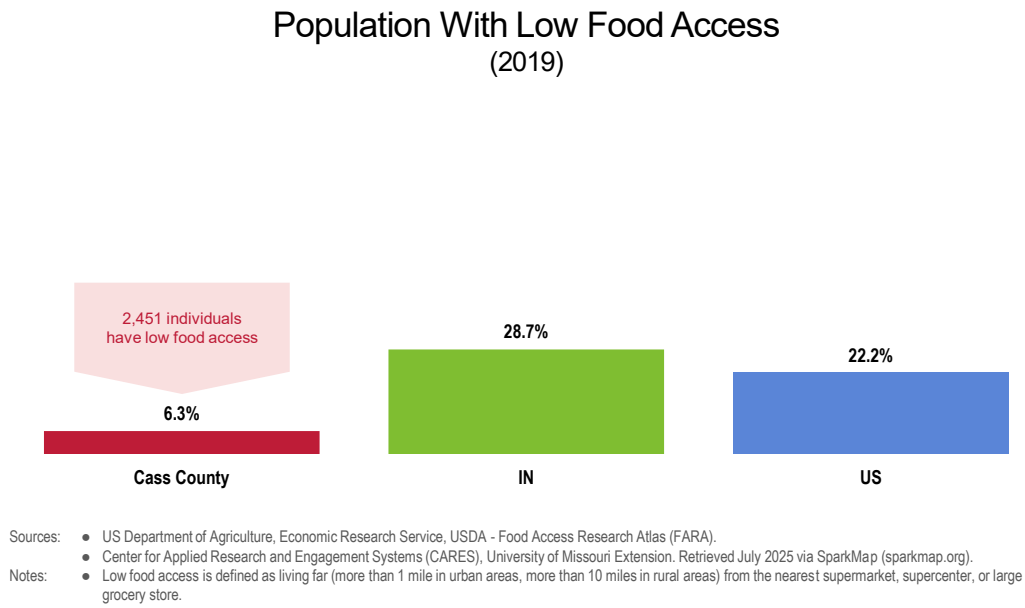



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

## Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data.




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 July 2025 via SparkMap (sparkmap.org).

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

# Physical Activity

### ABOUT PHYSICAL ACTIVITY

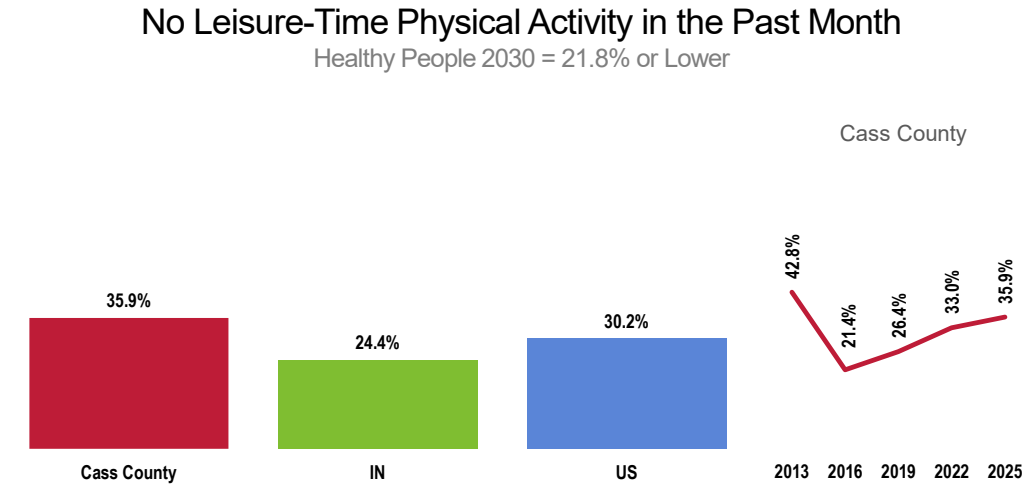
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity,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

**PRC SURVEY ► "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"**




Sources:
- 2025 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): 2023 Indiana 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 Physical Activity Recommendations

### ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

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

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

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

To measure physical activity frequency, duration and intensity, respondents were asked:

**PRC SURVEY ► "During the past month, what type of physical activity or exercise did you spend the most time doing?"**

**PRC SURVEY ► "And during the past month, how many times per week or per month did you take part in this activity?"**

**PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"**

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

**PRC SURVEY ► "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."**

## Meets Physical Activity Recommendations

(Cass County, 2025)

Healthy People 2030 = 29.7% or Higher


Sources:
- 2025 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): 2023 Indiana 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.

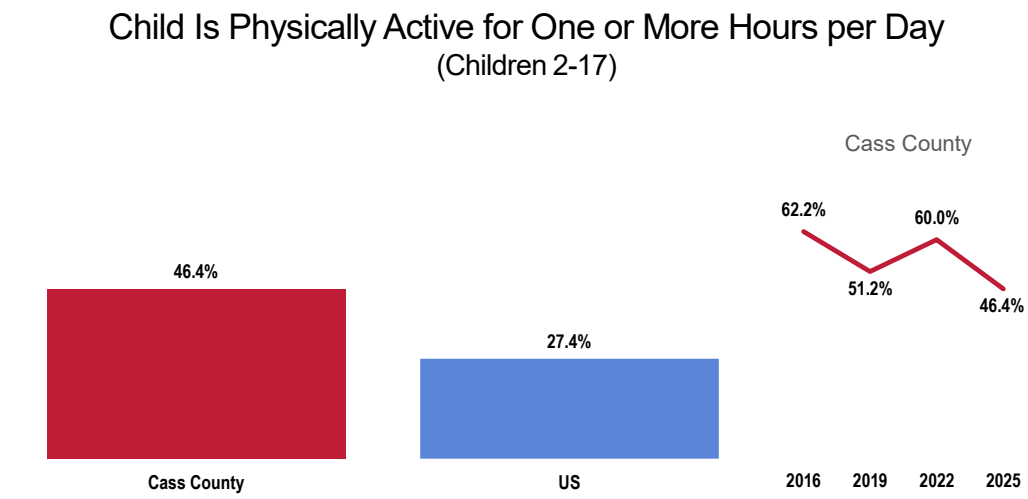
## Children's Physical Activity

### 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

**PRC SURVEY** ► [Among parents of children age 2-17] **"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"**




Sources:
- 2025 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.

# 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 |

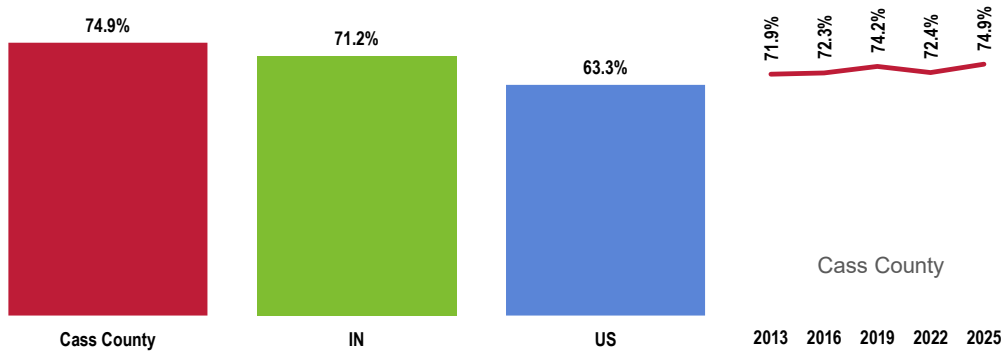
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

**PRC SURVEY ► "About how much do you weigh without shoes?"**

**PRC SURVEY ► "About how tall are you without shoes?"**

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

## Prevalence of Total Overweight (Overweight and Obese)

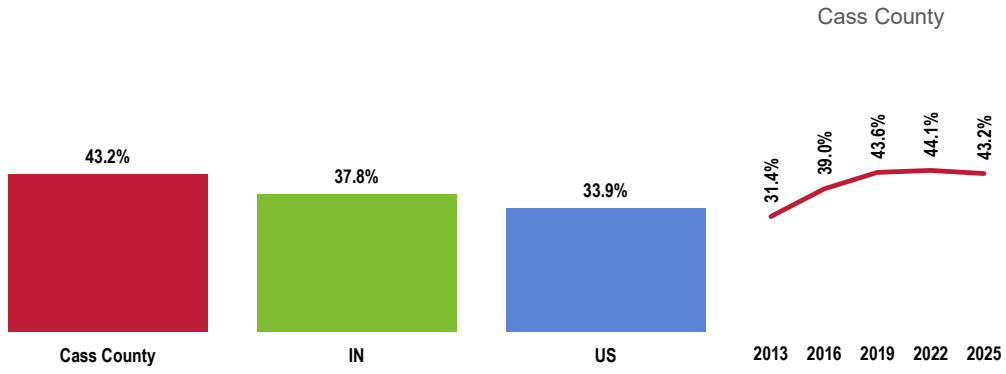



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
- 2023 PRC National Health Survey, 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.

## Prevalence of Obesity

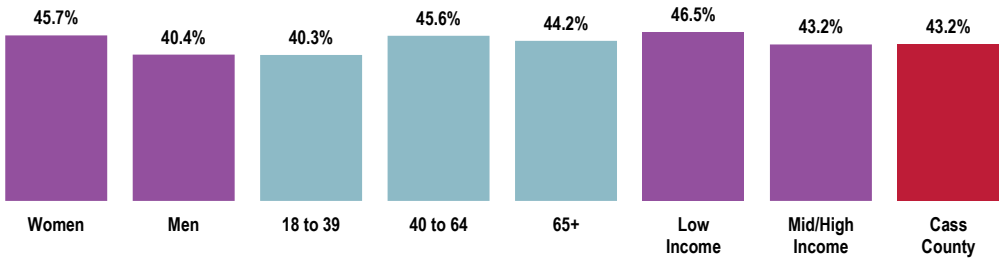
Healthy People 2030 = 36.0% or Lower




Sources:
- 2025 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): 2023 Indiana 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
(Cass County, 2025)
Healthy People 2030 = 36.0% or Lower




Sources:
- 2025 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.

## Children's Weight Status

### ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

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

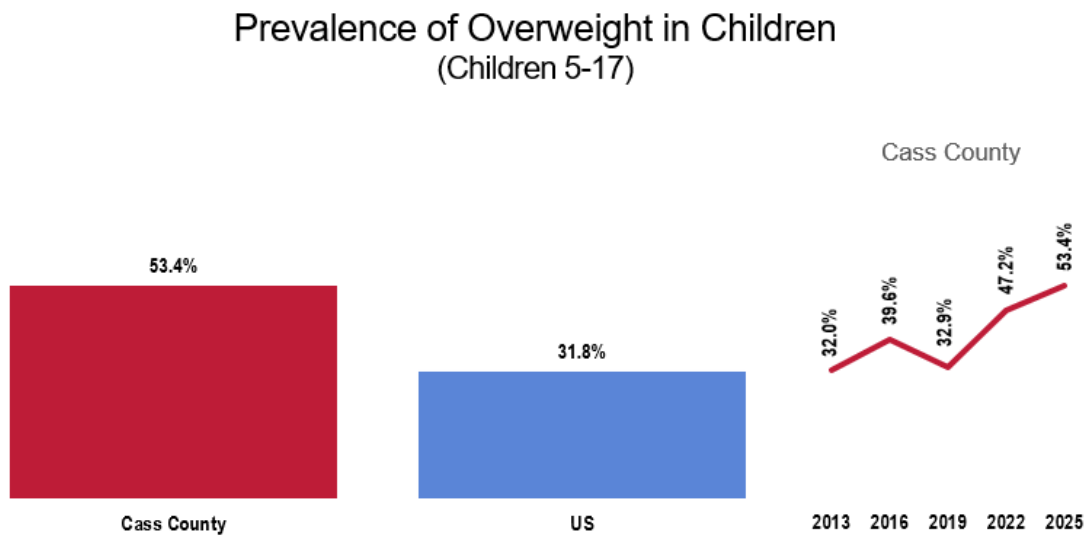
- Underweight <5$^{th}$ percentile
- Healthy Weight ≥5$^{th}$ and <85$^{th}$ percentile
- Overweight ≥85$^{th}$ and <95$^{th}$ percentile
- Obese ≥95$^{th}$ percentile

– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

**PRC SURVEY** ▶ [Among parents of children age 5-17] **"How much does this child weigh without shoes?"**

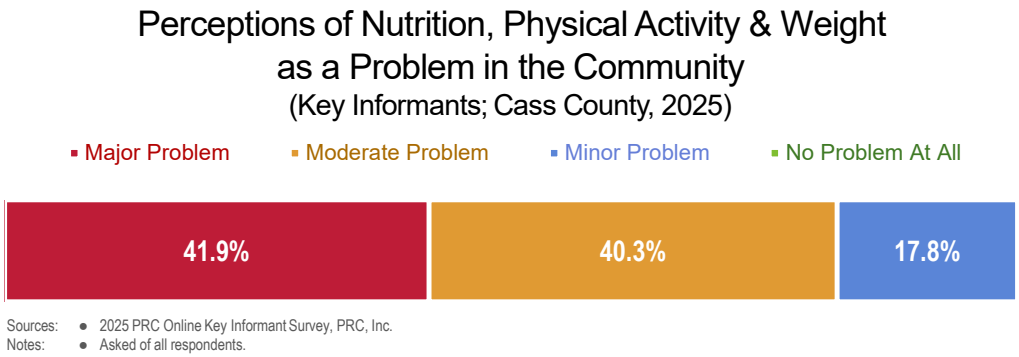
**PRC SURVEY** ▶ [Among parents of children age 5-17] **"About how tall is this child?"**




Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 5-17 at home.
● Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

## Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:




Sources: ● 2025 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 Affordable Healthy Food

> Too much junk food available, fast food restaurants that mainly serve cheap food without fruit, vegetables, & high quality proteins. People not taking advantage of the facilities and programs that the community offers at schools, churches, parks, and Cass County Family Y. – Community Leader
>
> It costs too much to eat the right foods. People are lazy and don’t get out of the house. Eat junk food, play on their phones. When I was a kid, no phone, no computer, just a bicycle and friends. We played in the hot sun and cold winters. Always had a great time. – Community Leader
>
> Minimal affordable options to promote healthy nutrition, physical activity, and weight loss. – Health Care Provider
>
> Socio-economic factor in being able to not only obtain (more expensive) healthy foods, but also when people have financial strain, they tend to not focus on their own healthcare needs for being proactive or preventative. There may not be enough incentive for people to improve wellness. For example, most employers have incentives for lower insurance rates when goals are met and certain metrics for better health are maintained. Medicaid nor Medicare do that as far as I am aware. Less healthy foods are less expensive...it's too easy to gain weight, have Type II diabetes and other health issues on the typical Western diet. – Health Care Provider
>
> Low access to healthy foods, prepared healthy foods, affordable groceries. Low physical activity by residents, trails not utilized, not perceived as safe. Primarily a focus on unhealthy restaurants, fast food. Not enough support for those trying to change this landscape. – Community Leader
>
> Cost of healthy food options and lack of areas to exercise for low or no cost. – Health Care Provider
>
> Sources of and education on healthy food options. Education of low-cost exercise options and benefits of such among all demographics of our community. – Community Leader

## Lifestyle

> In our community, we have bike and walking trails, sports opportunities, and pools that families can access. I feel families don't access these choices and instead choose to allow their children to play video games or apps on their phones instead. Educating parents on the need for good nutrition and physical activity for themselves and their children is a great need. – Social Services Provider
>
> Can be intimidating to start and/or change habits and overwhelming to sift through the various approaches to both nutrition and exercise. – Social Services Provider
>
> Culture deems that you have to work 40 plus hours a week, take care of your family, home etc. Where does that leave time to include fitness? It's culture more than anything when a meal at McD's is less than getting a cup of fresh fruit or vegetables. – Health Care Provider
>
> There are not a lot of activities to promote healthy lifestyles in the Logansport area. There are trails, but many people have deemed those unsafe. A lot of fast food but not healthy food stores. – Health Care Provider
>
> Altering long-established mindsets. – Physician

## Access to Recreational Facilities

> Cost and access to facilities. – Social Services Provider
>
> Access to physical activity. – Health Care Provider
>
> Limited community access to workout facilities. – Community Leader
>
> Poor availability and utilization of indoor and outdoor resources. – Physician

## Awareness/Education

> Lack of knowledge and ability to get the help people need. For those of low income, food is a barrier because the food that is donated or given to people usually isn't very healthy. It's more to sustain hunger than it is a healthy option. – Community Leader
>
> Getting people to understand that they need to take care of themselves before they have major health issues. – Community Leader

## Youth/Adolescents

> Assistance for teens who need support in increasing physical activity and education on nutrition. – Health Care Provider

## Income/Poverty

> Social and economic status of the population. Accountability to programs. – Health Care Provider

## Obesity

> A lot of obese children. – Health Care Provider

# Substance Use

## ABOUT DRUG & ALCOHOL USE

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

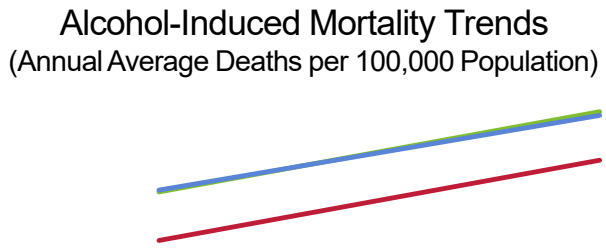
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

## Alcohol

### Alcohol-Induced Deaths

The following chart outlines alcohol-induced mortality in the area.




| | 2014-2018 | 2019-2023 |
|---|---|---|
| Cass County | 7.9 | 12.2 |
| IN | 10.5 | 14.8 |
| US | 10.6 | 14.6 |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

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.

## Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

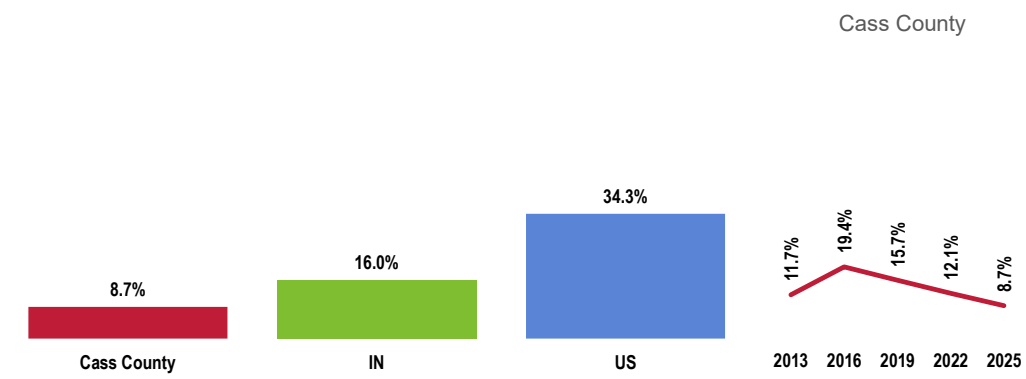
- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

**PRC SURVEY ► "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"**

**PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"**

**PRC SURVEY ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5** (if male)**/4** (if female) **or more drinks on an occasion?"**

### Engage in Excessive Drinking



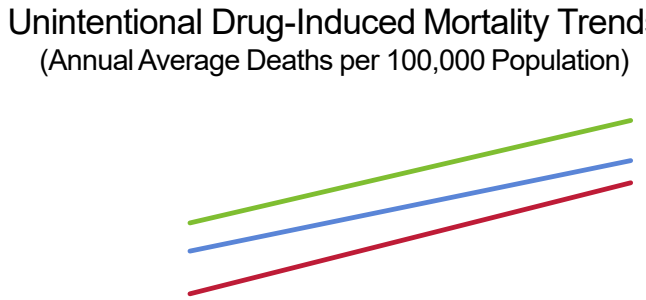

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
- 2023 PRC National Health Survey, 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.

# Drugs

## Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local mortality for unintentional drug-induced deaths.




| | 2014-2018 | 2019-2023 |
|---|---|---|
| Cass County | 11.0 | 24.0 |
| IN | 19.3 | 31.3 |
| US | 16.0 | 26.6 |

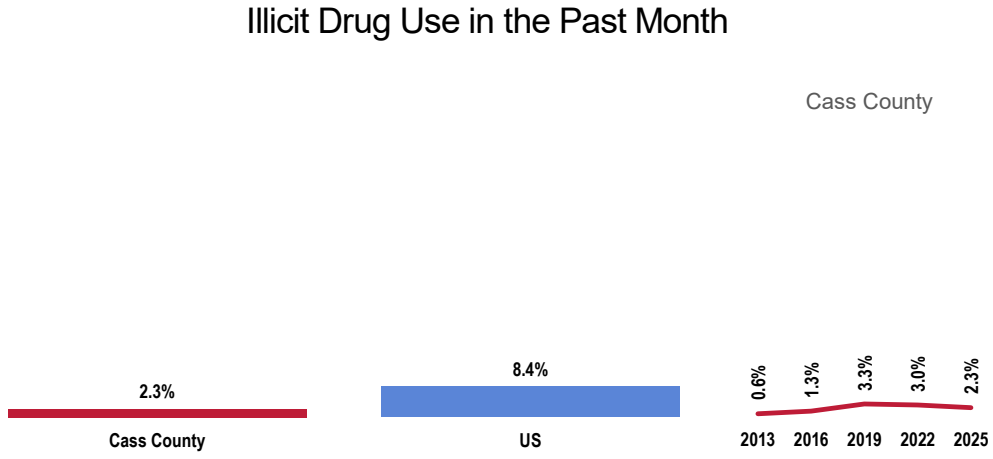
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2025.

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.

## Illicit Drug Use

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.

**PRC SURVEY ► "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"**




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

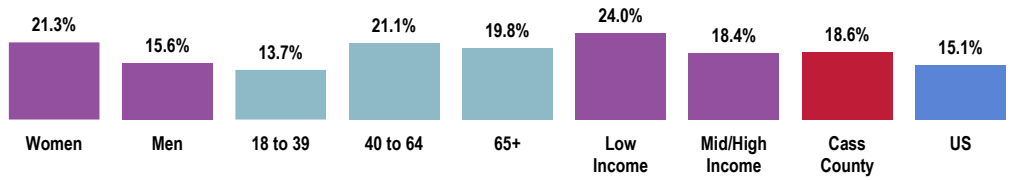
Notes:
- Asked of all respondents.

## 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.

**PRC SURVEY ► "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"**

### Used a Prescription Opioid in the Past Year
(Cass County, 2025)



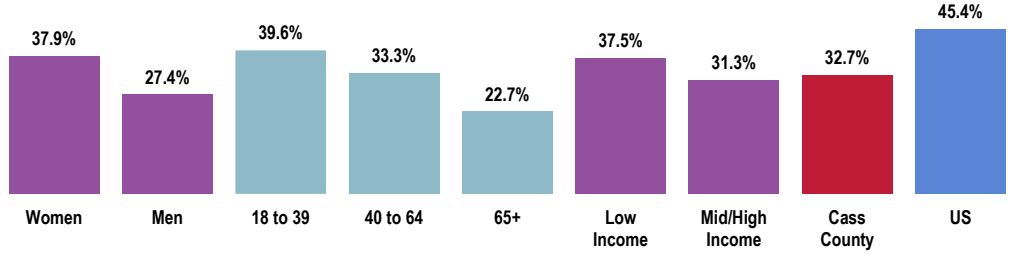

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

## Personal Impact From Substance Use

**PRC SURVEY ► "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"**

### Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(Cass County, 2025)

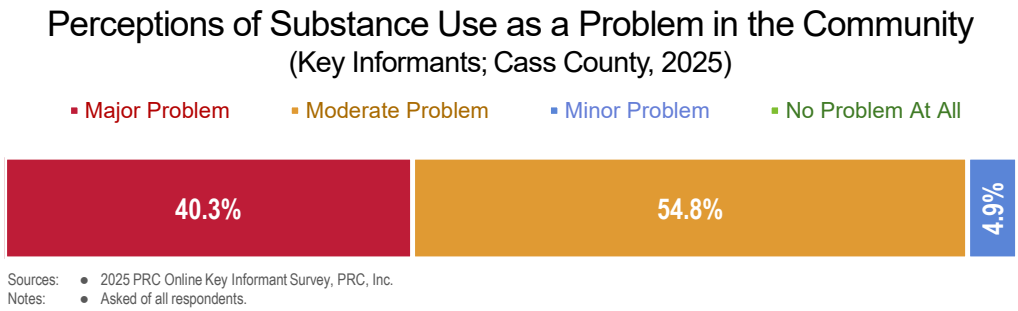



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," or "a little."

## Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:




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

### Access to Care/Services

> Number of programs and options. – Community Leader
>
> Lack of availability of care and stigma around substance abuse users due to fear of legal consequences. – Community Leader
>
> Financial constraints (lack of insurance and cost), stigma (perceived lack of need and fear of judgement), lack of awareness about treatment options, limited access to care (transportation issues). – Social Services Provider
>
> There is no place in Cass County that will treat someone with substance abuse issues. You have to leave Cass County to get that kind of treatment. AFTER you've received treatment, there is now a half-way house for men, but there isn't anything for women. Just reading the police reports will demonstrate the number of people that have methamphetamine addictions, and the jail is the only place I am aware of that can help a person detox. God-awful! – Community Leader
>
> Local substance abuse treatment facilities. – Health Care Provider
>
> Money. Not enough facilities to treat people with substance abuse. No one cares. – Community Leader
>
> Lack of treatment facilities and their affordability. – Community Leader
>
> Lack of facilities to treat substance abuse. – Social Services Provider
>
> Mental health treatment for people of all income levels is the greatest barrier. – Social Services Provider

### Lack of Providers

> The amount of accessible providers. Not addressing known mental health issues at a young age. – Health Care Provider
>
> Availability of providers and cost for patients without insurance. – Physician
>
> Too few providers that specialize in substance abuse in Cass County. Some employers "point" their employees for attending appointments and do not inform them that they may apply for intermittent FMLA to accommodate meeting their needs as well as the needs of the employers. – Health Care Provider

### Denial/Stigma

> Stigma, cost of treatment, and lack of treatment options. – Social Services Provider
>
> Social stigma and lack of community support. – Health Care Provider

### Easy Access

> A lot of illegal drugs are coming into Cass County. – Health Care Provider
>
> Many substances are common place for adults to use and are accessible to teens. Alcohol, vapes, and weed. – Social Services Provider

### Alcohol Use

> Alcohol use. – Health Care Provider
>
> Alcohol use is also another major health issue in our community. Students tell me about their exposure to alcohol at very young ages. – Social Services Provider

### Drug Use

> Drug use. The gentleman who was found in the river a few weeks ago had one of the highest meth levels recorded in the State of Indiana. – Community Leader

### Awareness/Education

> Lack of awareness of existing programs. – Community Leader

### Diagnosis/Treatment

> Identifying and motivating affected individuals. – Physician

### Incidence/Prevalence

> I listed it as a major problem due to the amount of the issues I hear. Not sure what the barriers are. – Community Leader

## Tobacco Use

### ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

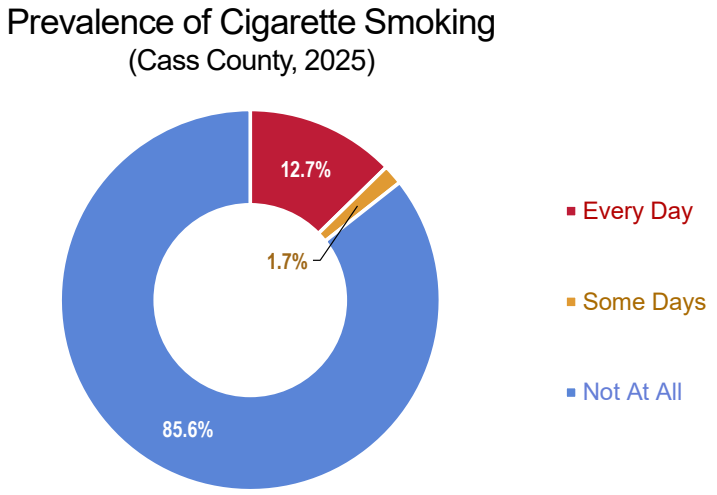
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

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

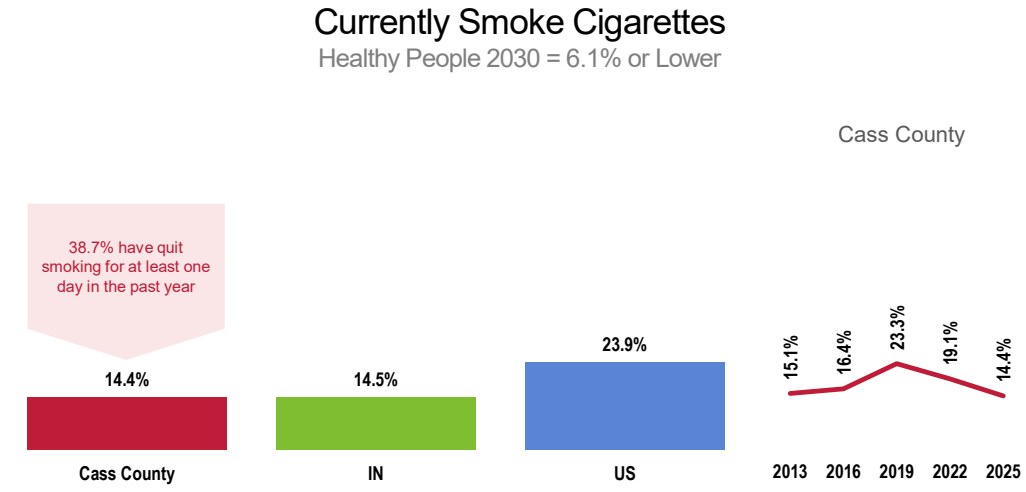
## Cigarette Smoking

**PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"**
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")

**PRC SURVEY ►** [Among smokers] **"During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?"**




Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.



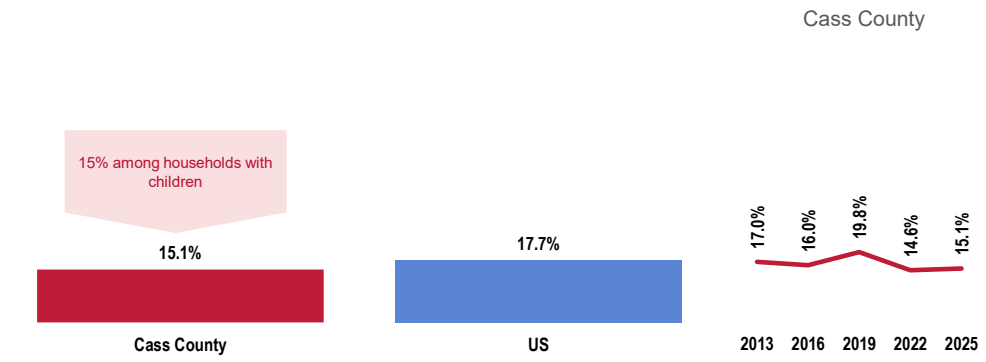

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 34, 305]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.
● 2023 PRC National Health Survey, 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.

## Environmental Tobacco Smoke

**PRC SURVEY ► "In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"**

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

### Member of Household Smokes at Home




Sources:
- 2025 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.

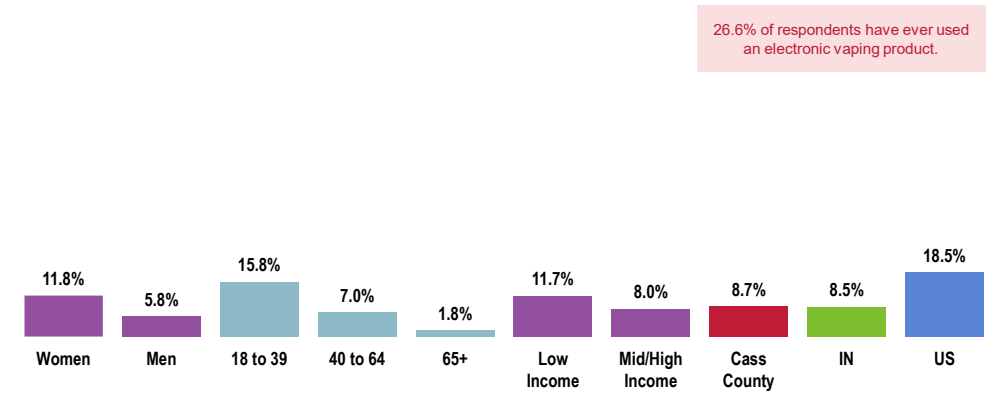
## Use of Vaping Products

**PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"**

("Currently Use Vaping Products" includes use "every day" or on "some days.")

**PRC SURVEY ► "Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"**

### Currently Use Vaping Products
(Cass County, 2025)

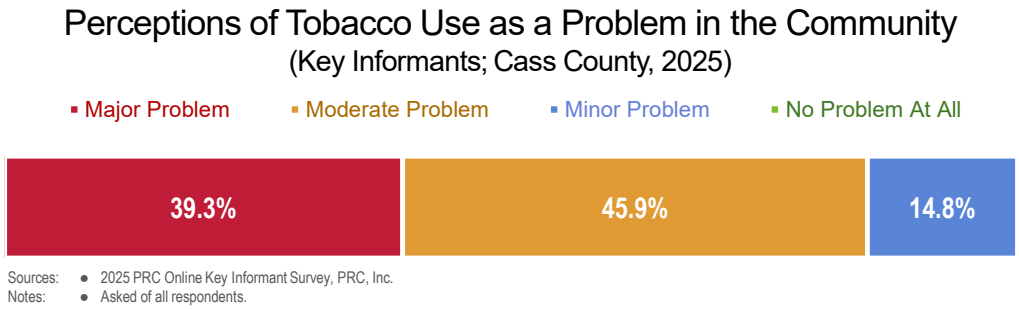



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 36, 306]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Indiana data.

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

## Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:




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

### Tobacco Use

> Too many people smoke. – Community Leader
>
> We have many smokers and even pregnant women who smoke. Many infants and small children are exposed to second and third-hand smoke. – Health Care Provider
>
> High smoking rate in Indiana by county. – Health Care Provider
>
> Maybe I'm wrong. But until it is totally wiped out, tobacco use is something that we should keep addressing for the health of all of our families. I'm totally supportive of raising the cigarette tax in Indiana, but I think more money needs to be spent on smoking prevention and cessation. – Community Leader
>
> Many people are smoking cigarettes, marijuana, or vaping. – Health Care Provider
>
> The number of smoke shops per capita. – Community Leader
>
> I am a school counselor at an elementary school. I hear from my students how many of their parents continue to use tobacco-related products. Also, the fact our community can support the number of businesses that sell these products is disgusting. I feel if businesses are going to be allowed to sell these products, they should be charged extra to help cover the cost of extra counselors in our schools to deal with the aftermath.
> – Social Services Provider

### E-Cigarettes

> Vaping is out of control. – Community Leader
>
> Vapes are marketed toward our youth. – Social Services Provider
>
> Our students are starting to vape and use tobacco at younger ages each year. – Health Care Provider
>
> Too many people think that vaping tobacco is not as dangerous as smoking it and it has become an epidemic. People vape tobacco/thc so casually, they will do it inside businesses or organizations. They are even doing it in the schools. Youth are then exposed to this and have a low perception of harm. – Social Services Provider
>
> Vaping is widely recognized as a problem in schools among teens. – Community Leader

### Impact on Quality of Life

> Smoking increases the risk of respiratory disease. Adults smoking in homes increase the risk of respiratory problems for the dependents within the household. – Health Care Provider
>
> Smoking continues to cause and aggravate existing health problems. – Social Services Provider

### Low Education Levels

> Our community is made up of 85% of people with a high school education and 15% of people with a bachelor's degree or higher. These education levels correspond with people who tend to use more tobacco products.
> – Social Services Provider

### Youth

> Many youth are exposed to tobacco use, and most exposure is in their line of work, which is mostly factory work.
> – Health Care 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).

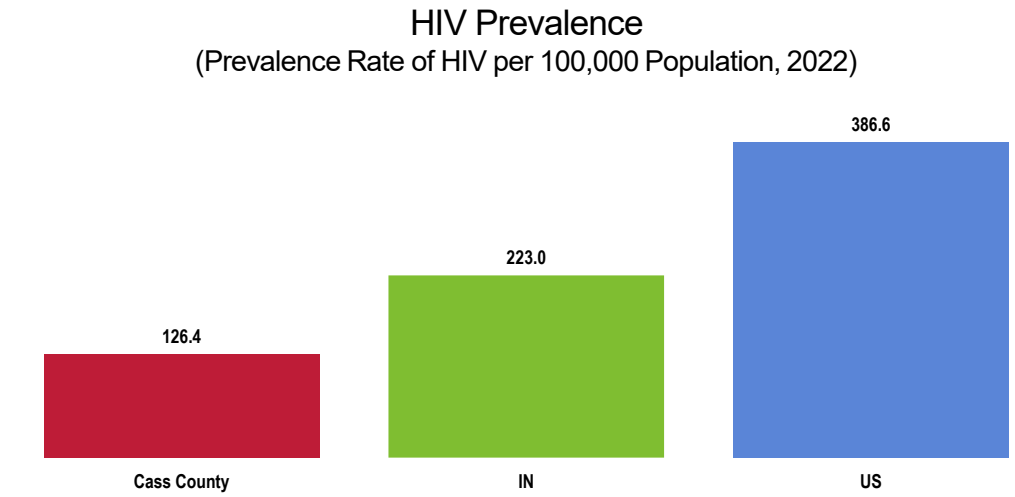
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.




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 July 2025 via SparkMap (sparkmap.org).

## Sexually Transmitted Infections (STIs)

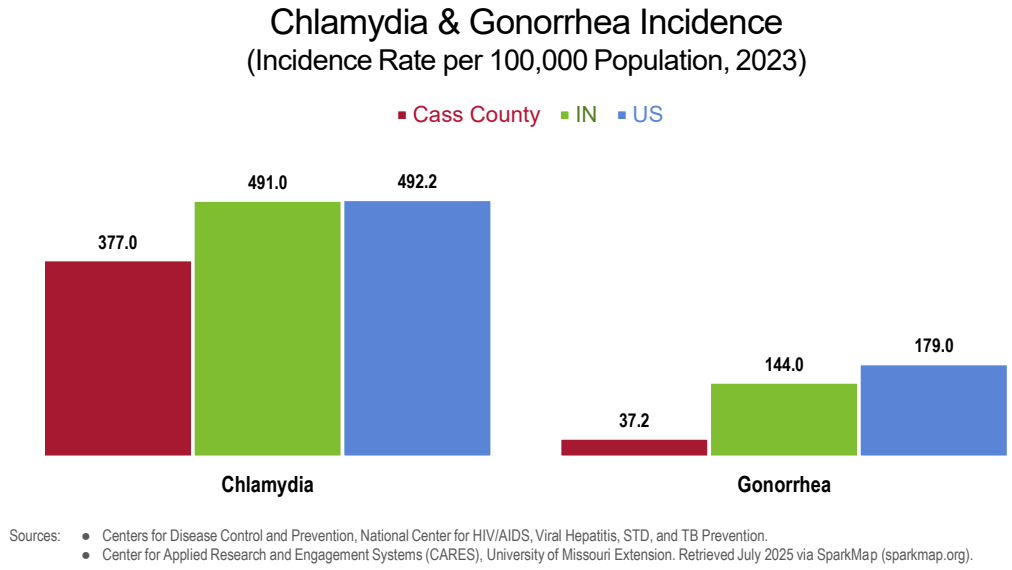
### Chlamydia

Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

### Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

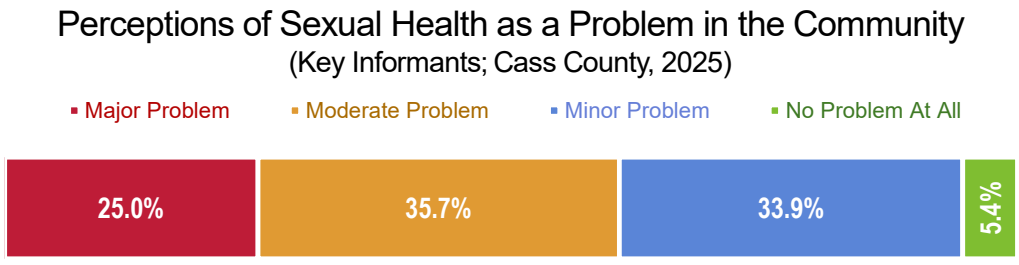
The following chart outlines local incidence for these STIs.




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 July 2025 via SparkMap (sparkmap.org).

## Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:




Sources: 2025 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:

### Sexually Transmitted Infections

> Cass County has a very high rate of STDs. – Health Care Provider
>
> I hear from LMH, and employees of LMH that Cass County has one of the highest rates of STD's and HIV. This is mainly due to lack of education that they have on safe sex practices, and personal hygiene.
> – Community Leader
>
> We have lots of STIs. – Health Care Provider

> Increase in STDs reported monthly. – Health Care Provider
>
> I just think it is a problem. Don't have any specific knowledge. – Community Leader

### Cultural/Personal Beliefs

> With the influx of new people to our community, it has become a problem. Their culture is much different, and there is a lack of knowledge. – Community Leader
>
> Cultural norms and social and economic status. – Health Care Provider

### Awareness/Education

> There is an uptick in STDs. I don't think this is addressed nearly enough in health classes. – Health Care Provider

### Language Challenges

> We have many patients returning for recurrent STIs. There is a language barrier that prevents some patients from understanding the seriousness and correct treatment options. – Health Care Provider

### Unprotected Sex

> I think this has gotten better, however, I believe many teenagers have unprotected sex. – Social Services Provider

# ACCESS TO HEALTH CARE

## ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

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

## 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.

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

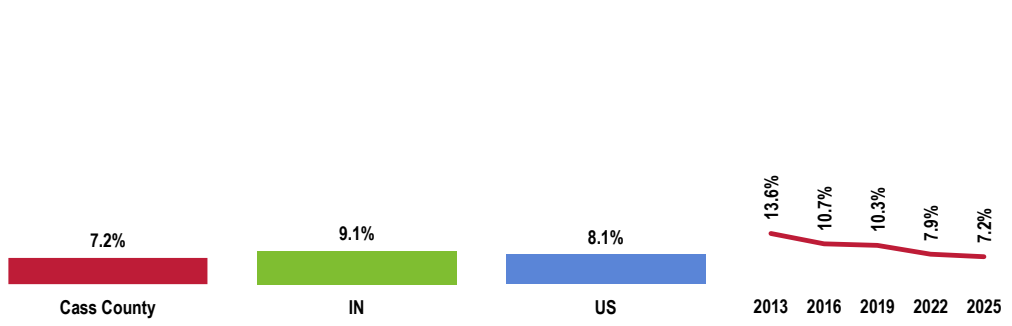
**PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"**

**PRC SURVEY ► "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"**

### Lack of Health Care Insurance Coverage

(Adults 18-64)

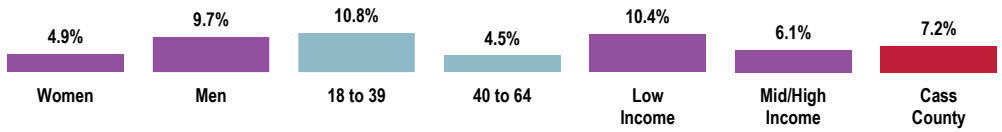
Healthy People 2030 = 7.6% or Lower




Sources:
- 2025 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): 2023 Indiana 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; Cass County, 2025)
Healthy People 2030 = 7.6% or Lower




Sources:
- 2025 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

## Barriers to Health Care Access

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

**PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"**

**PRC SURVEY ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"**

**PRC SURVEY ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"**

**PRC SURVEY ► "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"**

**PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"**

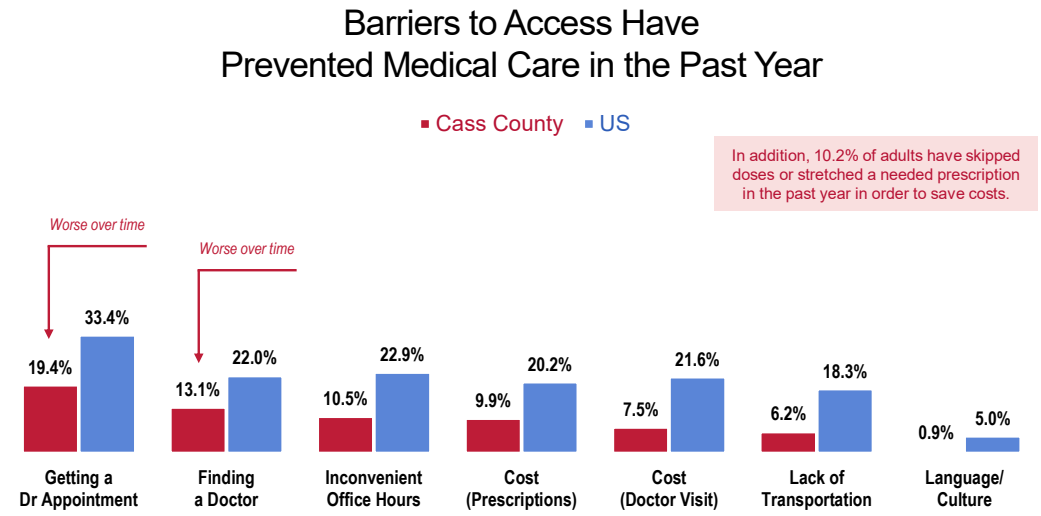
**PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"**

**PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"**

Also:

**PRC SURVEY ► "Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"**

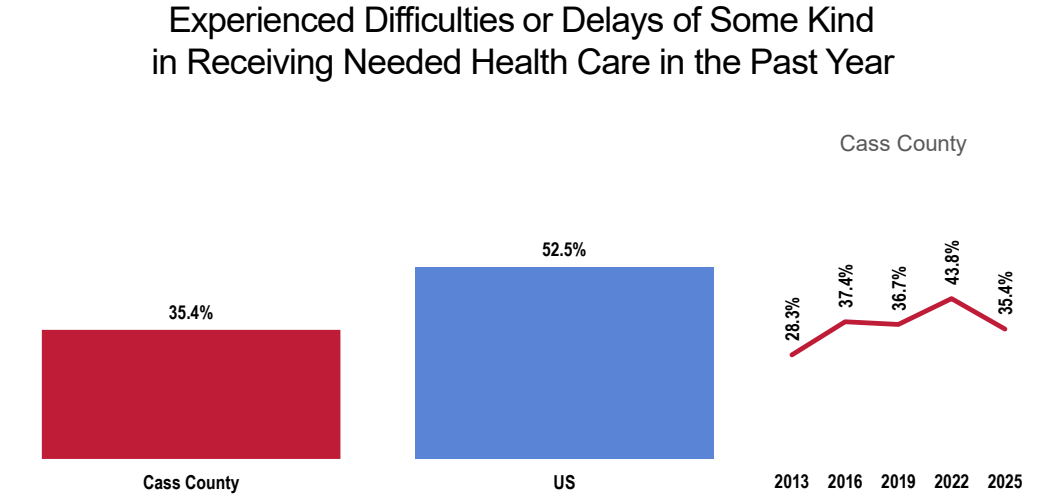
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

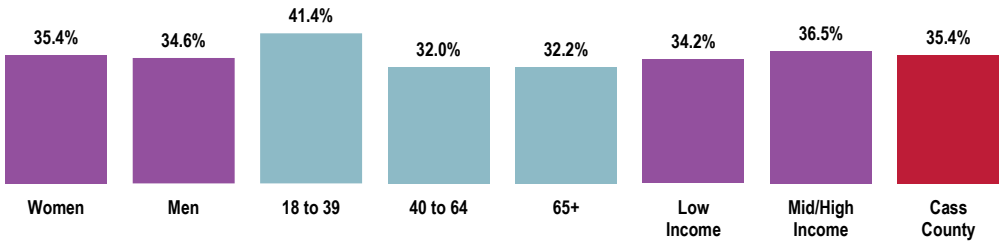
The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers), again regardless of whether they needed or sought care.




Sources:
- 2025 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
(Cass County, 2025)




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]

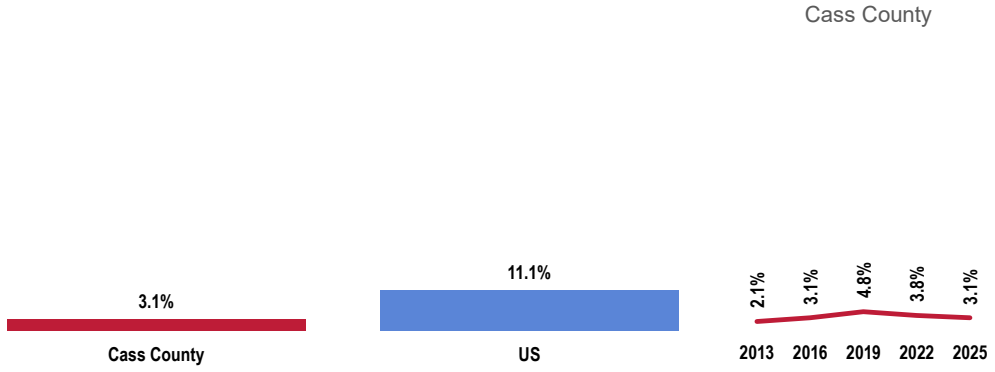
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

## 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.

**PRC SURVEY** ▶ [Among parents of children age 0-17] **"Was there a time in the past 12 months when you needed medical care for this child but could not get it?"**

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

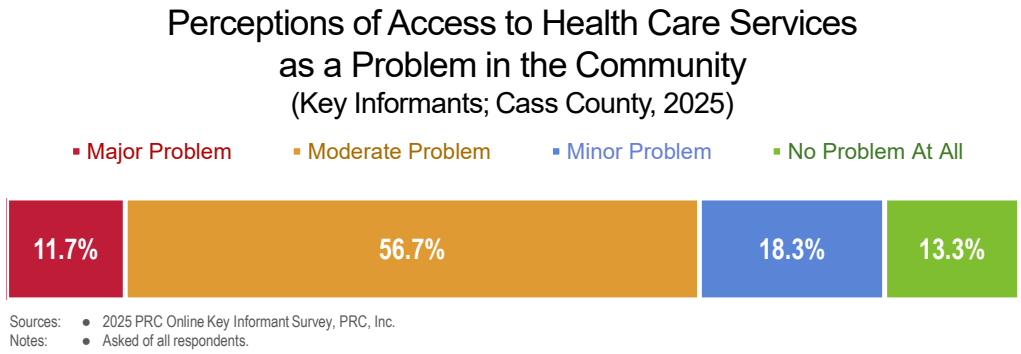



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

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

## Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:




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

### Language Challenges

> We have a large Haitian-Creole population and limited resources to communicate with them. – Health Care Provider
>
> Growing diversity in our community creates barriers in communication and access to health care. The growing number of languages spoken is challenging in providing translation services and it's difficult to keep up with having publications translated for these community members. Many rely on public transit, and it can be inconsistent and unreliable. – Social Services Provider
>
> Language and transportation barriers. – Physician

### Lack of Providers

> It's difficult to call a provider's office and get in quickly. It's also difficult to call a provider's office and talk to someone. Many times you have to leave a message and hope you receive a call back. This lack of being able to get in to see a provider quickly causes people to go to the emergency room or urgent care because that's the only choice. – Community Leader
>
> Lack of providers for all service lines. No options at all for some specialties like endocrinology and psychiatry, and that leaves primary care and others to do specialty work amidst horrific patient loads. – Physician

### Access to Care/Services

> Limited availability of primary care appointments causes unnecessary utilization of the Emergency Room. – Health Care Provider
>
> Wait times to get an appointment are four to six weeks, including follow-ups. This allows issues to progress untreated and worsen, or it causes more issues. – Community Leader

### Transportation

> Transportation. – Health Care Provider

### Local Hospital

> Sale of our hospital to Parkview. – Community Leader

# 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.

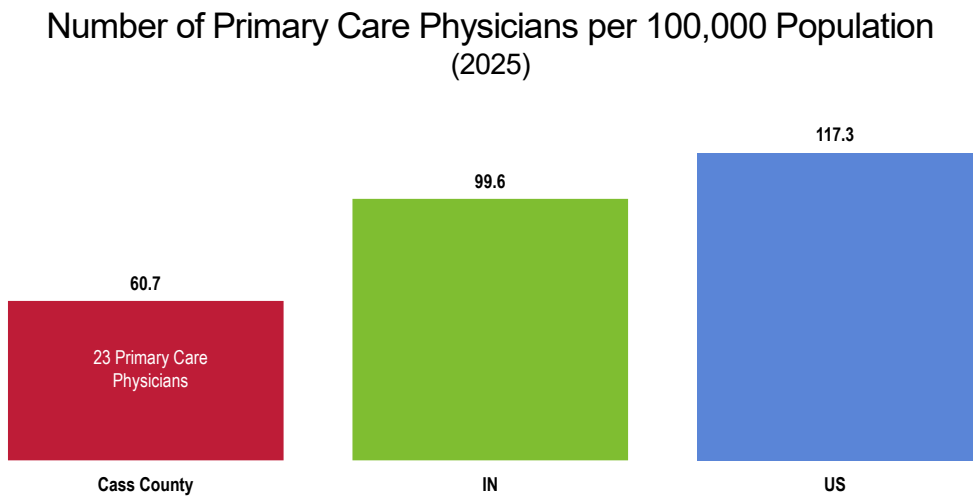
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– 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.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

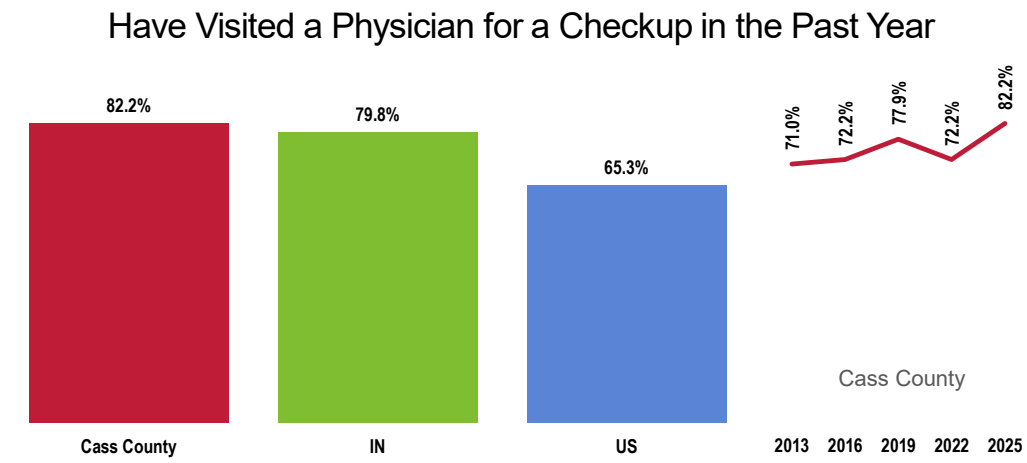



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2025 via SparkMap (sparkmap.org).

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.

## Utilization of Primary Care Services

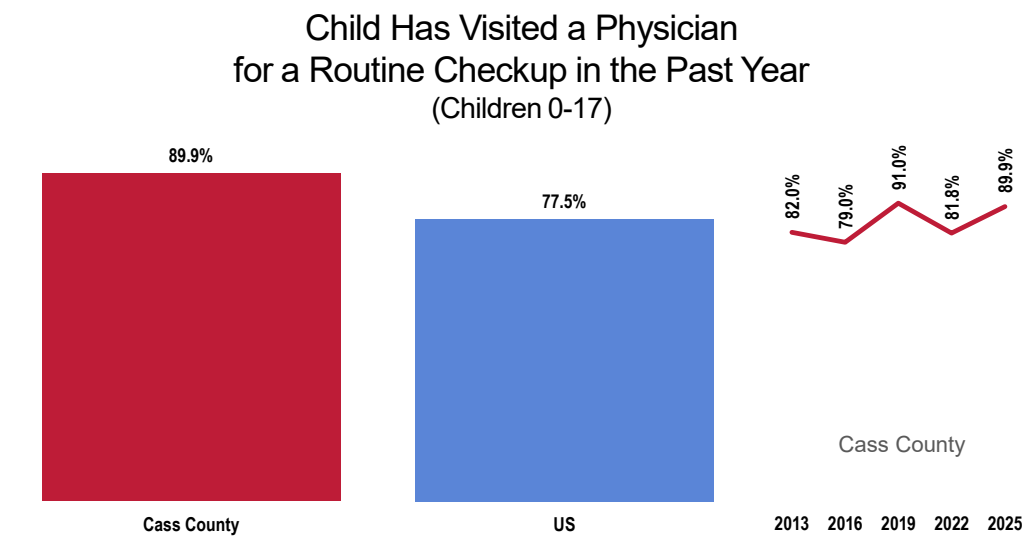
**PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"**




Sources:
- 2025 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): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

**PRC SURVEY ► [Among parents of children age 0-17] "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**




Sources:
- 2025 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.

# Oral Health

## ABOUT ORAL HEALTH

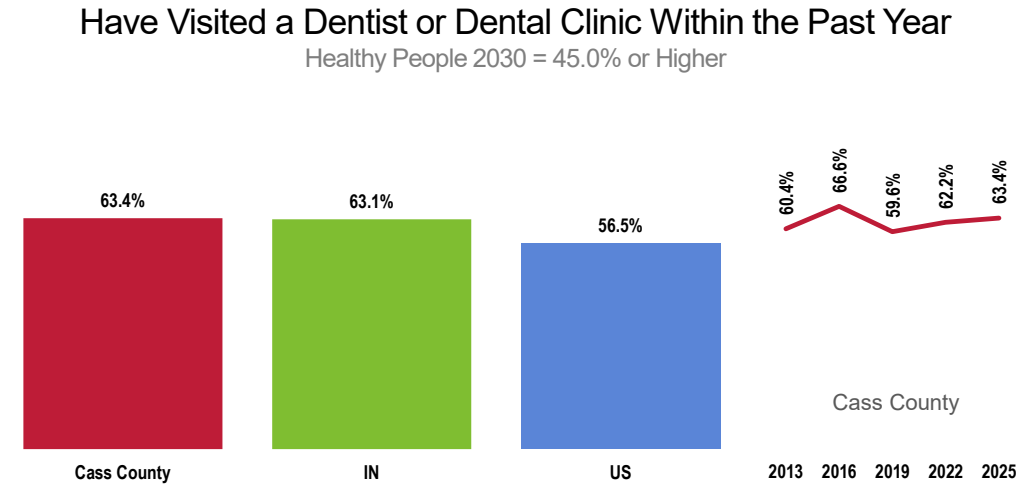
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems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

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

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

## Dental Care

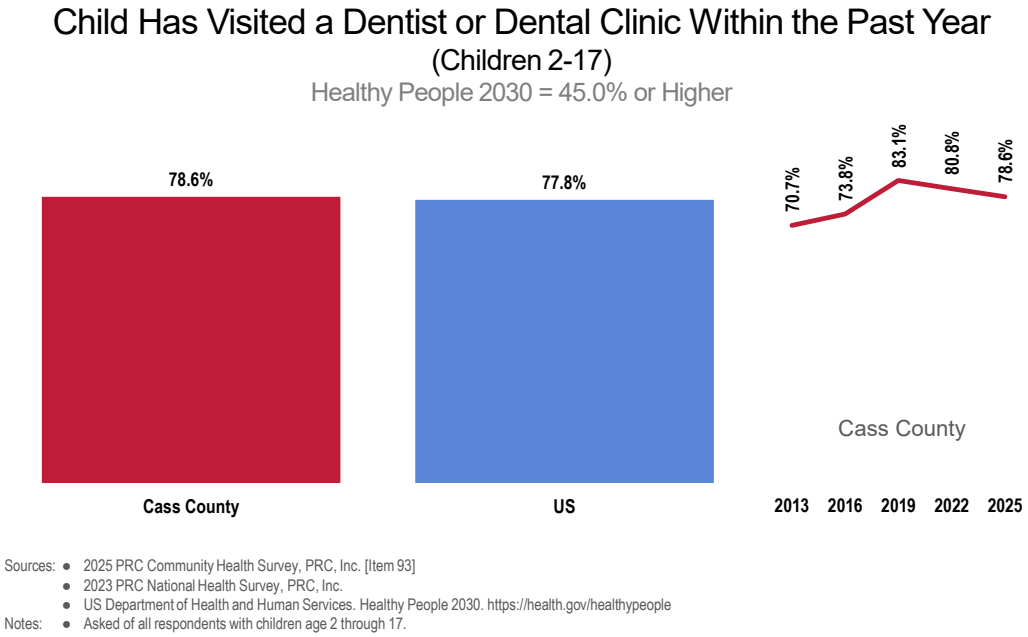
**PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"**




Sources:
- 2025 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): 2023 Indiana data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

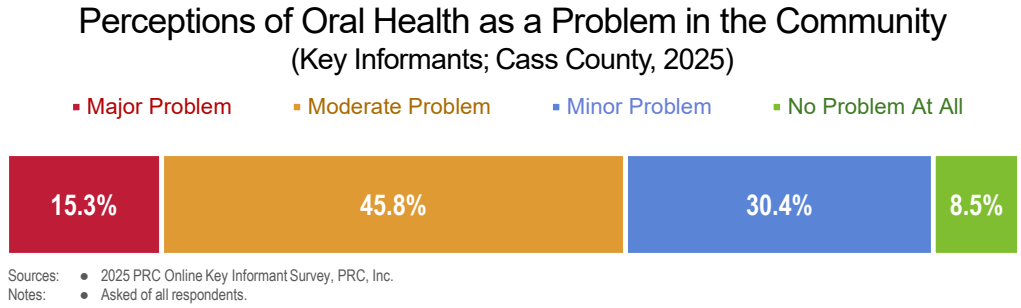
Notes:
- Asked of all respondents.

**PRC SURVEY** ▶ [Among parents of children age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**




## Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:




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

### Access to Care

> There are not many dentists who take Medicaid. – Health Care Provider
>
> Students who do not have dental insurance, and their teeth need attention. – Health Care Provider
>
> Poor access to dental hygiene if you do not have insurance. Use of the Emergency Department for dental problems. – Health Care Provider

### Incidence/Prevalence

> I see the numbers through my wife since she is a dental hygienist. – Community Leader
>
> The amount of people walking around with terrible oral hygiene and the number of kids in the schools with bad dental care is shocking. It can be observed first-hand out in public and at the local schools. – Community Leader

### Affordable Care/Services

> Often times, families do not have access due to the cost of dentists and/or dental insurance.
> – Social Services Provider

### Income/Poverty

> I think it's probably an issue within low-income families. That is low on the priority list when comparing it to housing, food, and medicine. I don't know this for a fact, just my opinion. – Community Leader

### Tobacco Use

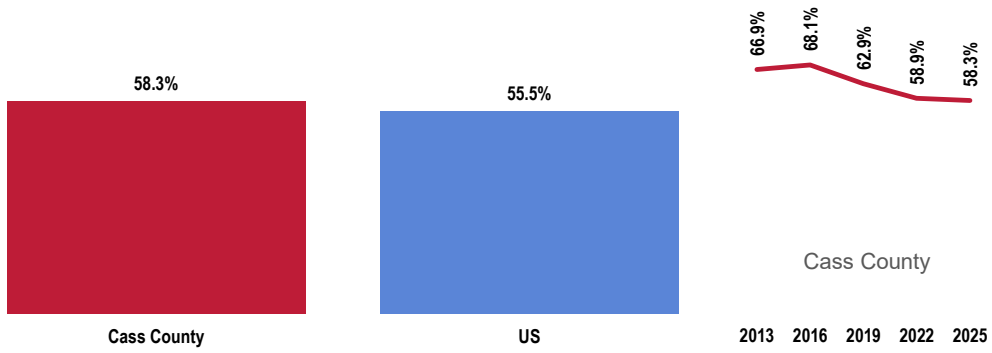
> Heavy smoking and tobacco use. Youth are using ZYN pouches. We've seen many with dental pain and cavities in the Emergency Room. – Health Care Provider

# VISION CARE

**PRC SURVEY ► "When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light."**

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

Healthy People 2030 = 61.1% or Higher



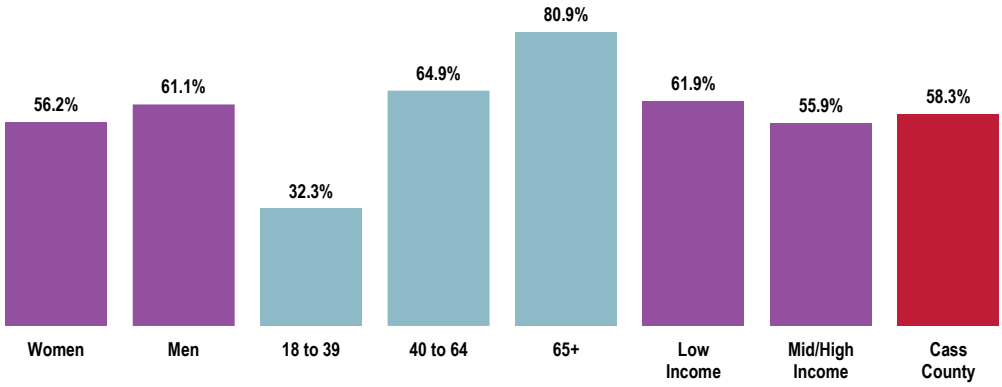

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 301]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

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

(Cass County, 2025)

Healthy People 2030 = 61.1% or Higher



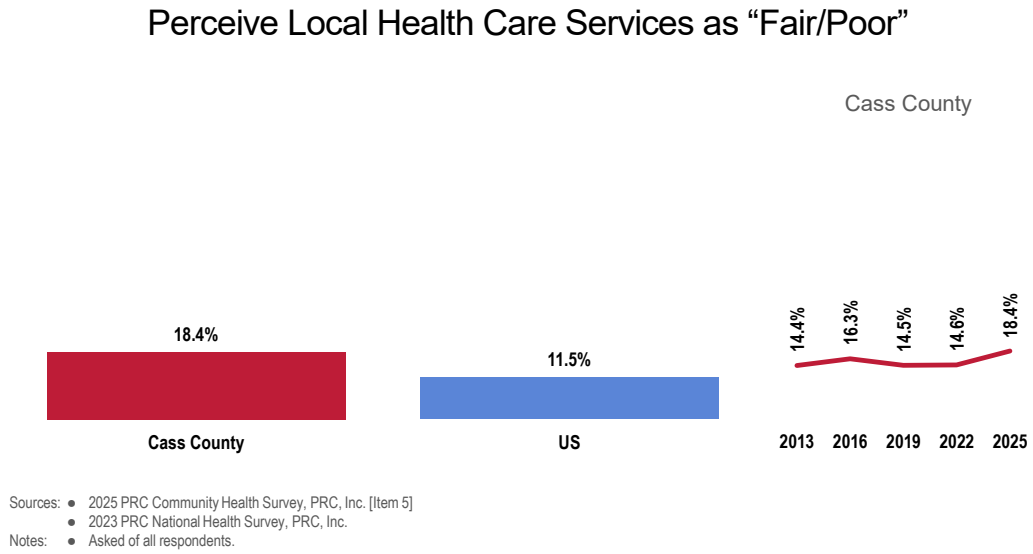

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 301]

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.

# LOCAL RESOURCES

## Perceptions of Local Health Care Services

**PRC SURVEY ► "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"**




Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

# 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

- 4C Health
- 4C Mental Health
- Area Office on Aging
- Doctors' Offices
- Indiana Health Center
- Logansport Memorial Hospital

### Cancer

- Cancer Center
- Cass County Health Department
- Doctors' Offices
- Health Departments
- Hospitals
- Logansport Memorial Hospital
- YMCA

### Diabetes

- Area 5
- Cass County Farmer's Market
- Cass County Health Department
- Doctors' Offices
- Empower Eatery
- Funds for Supplies
- Health Care Facilities
- Health Clinics
- Health Departments
- Hospitals
- Indiana Health Center
- Logansport Community School Corporation
- Logansport Memorial Hospital
- Programs Outside the Local Hospitals
- Purdue Extension
- School Systems
- United Way
- YMCA

### Disabling Conditions

- Anytime Fitness
- Area 5
- Doctors' Offices
- Health Clinics
- Health Departments
- Logansport Memorial Hospital
- North Central Orthopedics
- Parks and Recreation
- Peak Community
- Residential Facilities
- YMCA

### Heart Disease & Stroke

- Area 5
- Ascension St. Vincent
- Cass County Health Department
- Doctors' Offices
- Indiana Health Center
- Logansport Memorial Hospital
- Parks and Recreation
- Purdue Extension
- Smoking Cessation Classes
- United Way
- YMCA

### Infant Health & Family Planning

- Area 5
- Cass County Division of Family Resources
- Cass County Health Department
- Churches
- Fast Paced Health Urgent Care
- Health Clinics
- Health Departments
- Indiana Health Center
- Logansport Memorial Hospital
- Purdue Extension
- School Systems
- Women, Infants and Children

### Injury & Violence

- School Systems

### Mental Health

- 4C Health
- 4C Mental Health
- AA/NA
- Area 5
- Bowen Center
- Bringing Hope Counseling
- Bungalo Bar
- Cass County Health Department
- Cass County Law Enforcement
- Churches
- Clear Skies Counseling Services
- Counselors
- Doctors' Offices
- Emergency Response Team
- Ford County
- Friends Counseling
- Hospitals
- Indiana Health Center
- Law Enforcement
- Liquor Store
- Logansport Memorial Hospital
- Logansport Police Department
- Logansport State Hospital
- Mental Health America
- Peak Community
- RCH Virtual Clinic
- Recovery Cafe
- School Systems
- Snyder Counseling Services
- Stand Up Cass County
- Suicide Prevention Task Force
- Thrive Works Counseling and Child Therapy
- Youth Services Alliance

### Nutrition, Physical Activity & Weight

- Area 5
- Bodyworks Studio
- Cass County Division of Family Resources
- Cass County Farmer's Market
- Cass County Health Department
- Churches
- Cynthia Bricknell
- Emmaus Mission Center
- Empower Nutrition and Yoga Studio
- Empower Wellness
- Fitness Centers/Gyms
- Food Banks/Pantries
- Logansport Community School Corporation
- Logansport Memorial Hospital
- Parks and Recreation
- Planet Fitness
- Purdue Extension
- School Systems
- Workout Anytime
- YMCA

### Oral Health

- Dental Offices
- Free Resources for Those Without Insurance
- Salvation Army
- Special Olympics

### Respiratory Diseases

- Health Departments
- Indiana Health Center
- Logansport Memorial Hospital

### Sexual Health

- Area 5
- Cass County Health Department
- Express Medical Center
- Health Departments
- Indiana Health Center
- Logansport Memorial Hospital
- School Systems
- Women, Infants and Children

### Social Determinants of Health

- 4C Health
- Area 5
- Bike Distribution
- Cass Area Transit
- Cass County Business Development Corporation
- Cass County Health Department
- Cass County Transportation Van
- Cass County Trustees
- Community Doulas
- Doctors' Offices
- Emmaus Mission Center
- Felix's Pantry
- Food Banks/Pantries
- Habitat for Humanity
- Housing Authority

Indiana Health Center
Logansport Memorial Hospital
Medicare/Medicaid
Mission
Non-Emergency Medical Transport
Salvation Army
Stand Up Cass County
Taxi
United Way
Veterans Affairs
Work One
YMCA
Youth Services Alliance

### Substance Use

4C Health
4C Mental Health
4th Dimension
AA/NA
Area 5
Bowen Center
Cass County Health Department
Cass County Law Enforcement
Celebrate Recovery
Churches
Counselors
Doctors' Offices
Hospitals
Logansport Memorial Hospital
Logansport Police Department
Recovery Cafe
Recovery Navigators
School Systems
Snyder Counseling Services
Stand Up Cass County
The Father's House
Women at the Well

### Tobacco Use

1-800-Quit-Now
4C Health
Bowen Center
Cass County Health Department
Doctors' Offices
Health Departments
Logansport Community School Corporation
Logansport Memorial Hospital
School Systems
Smoking Cessation Classes
Stand Up Cass County
Tobacco Free Task Force

# APPENDIX

# EVALUATION OF PAST ACTIVITIES

## Community Benefit

Over the past three years, Logansport Memorial Hospital has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $11,201,533 million in community benefit, excluding uncompensated Medicare.
- More than $1.8 million in charity care and other financial assistance programs.

Our work also reflects a focus on community health improvement, as described below.

## Addressing Significant Health Needs

Logansport Memorial Hospital conducted its last CHNA in 2022 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that Logansport Memorial would focus on developing and/or supporting strategies and initiatives to improve:

- Mental Health
- Nutrition, Physical Activity, and Weight
- Substance Abuse
- Access to Health Care Services
- Infant Health and Mortality

Strategies for addressing these needs were outlined in Logansport Memorial Hospital's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Logansport Memorial Hospital to address these significant health needs in our community.

# Evaluation of Impact

| Priority Area: Mental Health | |
|---|---|
| **Community Health Need** | Improve mental, emotional, and behavioral well-being |
| **Goal(s)** | • Strengthen partnerships to deliver mental health and substance use services more effectively in the community. |
| **Strategy 1: LMH will implement OB maternal bundle focused on mental health** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Expectant mothers seeking maternal care in Cass and surrounding counties. |
| **Partnering Organization(s)** | Internal: Family Birth Center, Women's Health Center Providers<br>External: Doulas, Family Nurse Partnership of Indiana |
| **Results/Impact** | • Established OB bundles and education promoting positive maternal outcomes for patients and families in collaboration with local partners. |
| **Strategy 2: Create a locally based EAP program to ensure timely follow-up and create follow-through between employer and employee.** | |
| **Strategy Was Implemented?** | No |
| **Strategy 3: Develop a mobile app for service access (tied to information sharing).** | |
| **Strategy Was Implemented?** | Utilization of FindHelp.org promoted to identified population. |
| **Target Population(s)** | Individuals in need of mental health services |
| **Partnering Organization(s)** | Internal: Primary Care providers, Emergency Department providers<br>External: Mental Health services |
| **Results/Impact** | • Unable to identify usage |
| **Strategy 4: Promote 988 as mental health hotline.** | |
| **Strategy Was Implemented?** | No |
| **Strategy 5: Develop programming to identify and address family issues earlier.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Individuals struggling with family issues affecting mental health. |
| **Partnering Organization(s)** | Internal: All providers across the organization<br>External: |
| **Results/Impact** | • Increased screening opportunities to identify family issues earlier.<br>• Initiated screening for Social Determinants of Health. |
| **Strategy 6: Convene quarterly implementation team meetings.** | |
| **Strategy Was Implemented?** | No |

| Priority Area: Nutritional, Physical Activity, and Weight | |
|---|---|
| **Community Health Need** | To empower and engage participations in living healthy lifestyles, using education to demonstrate how those choices and behaviors lead to an improved quality of life. |
| **Goal(s)** | • Provide and support inclusive, accessible, and diverse health and wellness opportunities. |
| **Strategy 1: Develop initiatives to promote student participation in sports. (Participation has declined over the years due to issues related to family support, transportation and costs.)** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Students |
| **Partnering Organization(s)** | Internal: Providers, Clinics<br>External: Schools |
| **Results/Impact** | • Offered no or low cost sports physicals in local schools. |
| **Strategy 2: Reduce screen time initiatives.** | |
| **Strategy Was Implemented?** | No |
| **Strategy 3: Provide community health events at no cost.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Members of Cass County and surrounding counties |
| **Partnering Organization(s)** | Internal: Clinicians, Educators and Nutritional Services<br>External: State Dept of Health, Multiple vendors across the region attending the events |
| **Results/Impact** | • Community Health Resource Fair in 2023 and 2024<br>• Participated in the Immunization Coalition events<br>• Participated in the Senior Expo |
| **Strategy 4: Partner with the Cass County Family YMCA and the Logansport Parks department to promote physical activities.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Residents of Cass County and surrounding area |
| **Partnering Organization(s)** | Internal: LMH<br>External: Parks Department, YMCA |
| **Results/Impact** | • Continued support and maintenance on Sports Park.<br>• Continued promotion and maintenance on the River Bluff Trail system. |

| Strategy 5: Create promotional material in English and Spanish. | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All residents |
| **Partnering Organization(s)** | Internal: LMH<br>External: Cass County Health Department, 4C Health, Indiana Health Centers |
| **Results/Impact** | • Created the following materials: Diabetic Educational Materials, Disease Prevention Literature, Infection Prevention Materials, Healthcare Access Materials, Healthcare Financial Assistance Materials |
| **Strategy 6: Convene quarterly implementation team meetings.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All ages within the Cass County area |
| **Partnering Organization(s)** | Internal: LMH<br>External: Cass County Health Department |
| **Results/Impact** | • Meetings established to promote collaboration among health partners. |

| Priority Area: Substance Abuse | |
|---|---|
| **Community Health Need** | To reduce the incidence of illicit drug use. |
| **Goal(s)** | • Provide opportunity for early intervention services for individuals with substance use disorders. |
| **Strategy 1: Develop "Before Second Chance" Policy Program – go through program to keep job assistance for employers to create this opportunity.** | |
| **Strategy Was Implemented?** | No |
| **Strategy 2: Support Medication Assisted Treatment (MAT) for substance use.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Individuals struggling with substance abuse |
| **Partnering Organization(s)** | Internal: LMH<br>External: 4C, other mental health services |
| **Results/Impact** | • Referral patterns established |
| **Strategy 3: Convene quarterly implementation team meetings.** | |
| **Strategy Was Implemented?** | No |

| Priority Area: Access to Health Care Services | |
|---|---|
| **Community Health Need** | To increase access to health care services. |
| **Goal(s)** | • Provide increased and varied access to healthcare services that are designed to meet the needs of the community served by LMH. |
| **Strategy 1: Create a hub for information sharing to be used by general public, social service providers and consumers.** | |
| **Strategy Was Implemented?** | No |
| **Strategy 2: Conduct regular social service provider meeting.** | |
| **Strategy Was Implemented?** | No |
| **Strategy 3: Expand and promote digital platforms i.e. telehealth services, remote patient monitoring, etc.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Individuals with transportation difficulties |
| **Partnering Organization(s)** | Internal: LMH<br>External: |
| **Results/Impact** | • Individuals with transportation difficulties were able to be scheduled/seen via telehealth services for appointments as needed. |
| **Strategy 4: Develop in-home programming to include remote patient monitoring and para-medicine.** | |
| **Strategy Was Implemented?** | No |
| **Strategy 5: Promote direct healthcare services contracts with employers.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Local Employers |
| **Partnering Organization(s)** | Internal: LMH-Workplace Wellness/Occupational Health<br>External: Dilling, LMU, Grissom RAFB |
| **Results/Impact** | • Contracts established |
| **Strategy 6: Convene quarterly implementation team meetings.** | |
| **Strategy Was Implemented?** | No |

| Priority Area: Infant Health and Mortality | |
|---|---|
| **Community Health Need** | To empower and engage participants in living healthy lifestyles, using education to demonstrate how those choices and behaviors lead to an improved quality of life. |
| **Goal(s)** | • Reduce the rates of fetal infant mortality (>than 20 weeks) and child mortality (under 18 years) in Cass County. |
| **Strategy 1: Activate Community Action Team commissioned by the Indiana Department of Health.** | |
| **Strategy Was Implemented?** | No, but will potentially be launched in 2026. Full time Fetal Infant Mortality Grant employee hired. |
| **Partnering Organization(s)** | Internal: OB and Pediatric Departments<br>External: Cass County Health Department |
| **Strategy 2: Provide Safe Sleep Education** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Low income, poverty level families including parents, grandparents and guardians. |
| **Partnering Organization(s)** | Internal: Obstetrics providers, Pediatric providers, Emergency department<br>External: Doulas, Family Nurse Partnership, Healthy Families, CC Health Department Cass and surrounding County DSC , Police and Sheriff's department, Fire Department |
| **Results/Impact** | • Began to offer an Infant Safety Class and Safe Sleep education upon admission and prior to discharge. Families in need are given a sleep sack, pack N play and car seat with education.<br>• Decreased the risk of mortality as a result of co-sleeping. |
| **Strategy 3: Deliver Family Health Education classes.** | |
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Pregnant Women, breast-feeding or plan to breast feed, expecting parents, new parents, grandparents, guardians. |
| **Partnering Organization(s)** | Internal: Pediatric Department, Women's Health Center<br>External: Doulas, Family Nurse Partnership, WIC, Healthy Families |
| **Results/Impact** | • Offer Infant Safety, Child Birth and Lactation classes along with Safe Sleep. Began including education on proper mixing of formula prior to discharge. |