Putnam County

Community Health Assessment Report 2021

Release Date: May 12, 2022

PUTNAM COUNTY HEALTH DEPARTMENT

PREVENT • PROMOTE • PROTECT

Table of Contents

Appendices

Addendum

Executive Summary

The Putnam County Health Department has been, and continues to be, the lead agency for conducting a health assessment of the community. The Partners for a Healthy Putnam County (Partners) is the group of organizations that are working toward the vision of "promoting active and healthy lifestyles to enhance the quality of life in Putnam County". Members of the group include representatives from a variety of agencies, organizations, and businesses, as well as interested members of the community. A list of partners can be found in Appendix A of this document. The Partners are provided with annual reports, either in a meeting or through email of the progress toward meeting the goals of the current Community Health Improvement Plan (CHIP). The partners may meet as needed to plan and update the Community Health Assessment and any other data related to the health of the community. Committees meet more often to implement the strategies written in CHIP.

In mid-2021, the Partners for a Healthy Putnam County met to review progress toward the CHIP, review available data and discuss conducting another community health assessment in Putnam County. The MAPP process was presented to the Partners and it was determined that the MAPP process will be used again to ensure that all the necessary data is obtained to have a comprehensive assessment. See Page 4 for the full MAPP process. To review the full Community Health Assessment Report, visit https://putnamhealth.com/resources/community-health-assessments/

Process and Partnership

The Partners for a Healthy Putnam County conducted the majority of a MAPP process in 2019. However, the reports were never finalized or released to partners and the public because the COVID-19 pandemic began before that was done. The Putnam County Health Department (PCHD), leading the process, was then immersed in the pandemic response until 2021. Internally PCHD staff began discussions in the spring of 2021 on how to proceed and if any of the 2019 assessments could be utilized.

Solicitations for contributions were requested of hospitals in June. And on July 14, 2021, the Partners for a Healthy Putnam County were mobilized and recruited via email to participate in an in-person meeting on August 5, 2021 at the Putnam County Office of Public Safety. A presentation of previous findings was shared and planning for a new assessment began. At this meeting volunteers were requested to be on a steering committee. The steering committee guided the survey question selection primarily via email and video/phone chat. In-person meetings were very limited due to COVID-19 spikes.

Each assessment in the MAPP process is outlined below and a timeline for completion provided.

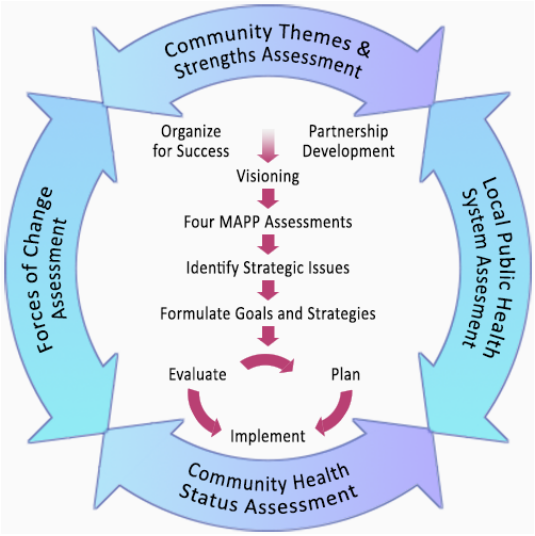
Methodology

Mobilizing for Action through Planning & Partnership (MAPP) Process Overview

The Partners for a Healthy Putnam County utilized the NACCHO's Strategic Planning tool Mobilizing for Action through Planning and Partnerships (MAPP) process to complete community health improvement planning. The MAPP framework includes six phases which are listed below: 1. Organizing for success and partnership development 2. Visioning 3. The four assessments 4. Identifying strategic issues 5. Formulate goals and strategies 6. Action cycle

The MAPP process includes four assessments: local public health system, forces of change, community themes and strengths, and the community health assessment. These four assessments were used by Healthy Putnam County to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1 illustrates how each of the four assessments contributes to the MAPP process.

Figure 1. The MAPP Model



Local Public Health System Assessment

The Local Public Health System Assessment (LPHSA) was held in-person on November 7, 2019 at Pathways Counseling Center. At that time a "Gallery Walk" was used to identify resources already available in the community that addresses each of the *10 Essential Public Health Services.* Participants in the LPHSA were then assigned to small groups based on expertise and asked to discuss and score at least three of the *10 Essential Services*. Due to the COVID-19 pandemic, work on the Community Health Assessment was not completely finished in 2020 as originally planned.

In mid-2021, partners were asked to review the 2019 LPHSA and answer a series of questions via Survey Monkey to decipher the extent they felt the scores from 2019 reflected the current functioning of the public health system for each Essential Service. They were also asked to provide input regarding their thoughts of how the public health system in Putnam County is, or isn't, addressing the model standards related to the Essential Services.

Table 1 below provides a summary of the performance scores (an average of the scores given for each of the model standards in the respective Essential Service) for each of the *10 Essential Public Health Services* in 2019. The 2013 and 2016 Performance Scores are also provided for reference. Table 1 shows improvement in 7 of the 10 Essential Services, with the greatest improvement from 2016 to 2019 in Essential Service 3: Educate and Empower, and Essential Service 8: Assure Workforce. There are a few areas in which there was a decline in the performance scores that may need to be addressed. The greatest decrease was in Essential Service 4: Mobilize Partnerships.

Table 1: Performance Scores and Priority Rating

Essential Service	Performance Score 2019*	Performance Score 2016*	Performance Score 2013 *
ES1: Monitor Health Status	88.9%	80.6%	61.1%
ES2: Diagnose and Investigate	97.2%	89.6%	95.8%
ES3: Educate and Empower	97.2%	72.2%	66.7%
ES4: Mobilize Partnerships	62.5%	89.6%	64.6%
ES5: Develop Policies and Plans	81.3%	85.4%	68.8%
ES6: Enforce Laws	82.8%	73.3%	55.3%
ES7: Link to Health Services	84.4%	81.3%	56.3%
ES8: Assure Workforce	87.9%	54.7%	36.6%
ES9: Evaluate Services	98.3%	83.3%	77.1%
ES10: Research and Innovation	25.7%	38.9%	37.5%
Overall Score (Average)	80.6%	74.9%	62.0%

*Average score for all Model Standards associated with each Essential Service

In the 2021 assessment, most essential services maintained their 2019 level of performance.

Positive progress includes:

- Monitoring mental health status and identifying problems has improved (ES1)
- Stronger in diagnosing and identifying health problems with partners because of the pandemic (ES2)
- Increase in electronic communication by health dept. and partners (ES3)
- Partnerships strengthened among community agencies dealing with the pandemic (ES4)
- Use of online trainings, virtual meetings, and social media increased significantly (ES8)

Needed improvements to the system include:

- Community directory did not happen, which was a goal from last assessment (ES4)
- Better implementation of policies and plans to support community health efforts, mainly recruitment of people to work in health field (ES5)
- Difficult to enforce laws when community doesn't follow them, such as isolation and quarantine (ES6)
- Training staff members in community resources to build awareness of the options available in all service areas (ES7)
- More local trainings, especially leadership trainings (ES8)
- Improve collaboration with institutions of higher education. Having a trade school or 2 year college would help entice a population growth in the county (ES10)

The entire Local Public Health System Assessment report can be found on the Putnam County Health Department website at www.putnamhealth.com.

Forces of Change Assessment

The Forces of Change Assessment is designed to help determine what is occurring or might occur that affects the health of the community or the local public health system. Participants in the assessment were asked to identify specific threats or opportunities that are generated by these occurrences. Trends (patterns over time), factors (discrete elements such as a rural setting or population demographics) and events (one-time occurrences such as a natural disaster) are considered when reviewing the results of the Community Health Assessment as a whole and in determining priorities for the Community Health Improvement Plan.

Methodology

The participants that contributed to the Forces of Change Assessment included the members of the Partners for a Healthy Putnam County and staff and leadership of the Putnam County Health Department. This year there were two options for members to participate in the survey. They could either fill out a

survey monkey via a link that was emailed out on February 14, 2022, or attend a virtual meeting held on February 23, 2022. The virtual meeting was led by Sherri Recker, Director of Nursing at the Putnam County Health Department.

The Forces of Change Brainstorming Worksheet was emailed to all participants to prepare them for either completing the survey monkey or to attend the virtual meeting. The 6 categories in which feedback was requested, both positive and negative, were the following:

1. Social
2. Economic
3. Political
4. Technological
5. Environmental
6. Health

The following information was included in the brainstorming worksheet sent to participants.

How to Identify Forces of Change

Think about forces of change – outside of your control – that affect the local public health system or community.

1. What has occurred recently that may affect our local public health system or community?
2. What may occur in the future?
3. Are there any trends occurring that will have an impact? Describe the trends.
4. What forces are occurring locally? Regionally? Statewide? Nationally? Globally?
5. What characteristics of our county may pose an opportunity or threat?
6. What may occur or has occurred that may pose a barrier to achieving a shared vision?

Be sure to consider health equity and disparities. Are there populations in our county that may have factors that affect their health? Identify those populations in your answers.

Also, consider whether forces identified were unearthed in other community/agency discussions.

1. Did discussions during other meetings with partners bring to light any other trends, factors, or events that you feel may affect the public health system or community?

Participants were also asked that once a force of change was recognized, to identify threats that force could pose to our community and what opportunities could be created from this force. We collected all input from the survey monkey and from the brainstorming session via Microsoft Teams virtual meeting and compiled it into a matrix which can be viewed in the full Forces of Change report.

Assessment Results

The Forces of Change Assessment provided an overview of key trends, events, or factors, identified by participants, as current or potential influences on the overall health of the Putnam County community.

The common trends that were identified for Putnam County include:

Social/Health

- Workforce
- Health Education
- Mental Health

Economic/Political

- Health Equity
- Health Care Policy
- Health Education

Environmental/Technological

- Health Information and Communication Technology
- Program Education
- Health Education

The entire Forces of Change report can be found on the Putnam County Health Department website at www.putnamhealth.com.

Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment is a combination of focus group discussions and a survey from a variety of groups in the community and key informants. The purpose of the Community Themes and Strengths Assessment is to determine what is important to the community and how the quality of life in the community is perceived. This assessment is also a way to discover possible resources for addressing some of the community's needs.

The focus group questions were chosen and finalized by the Partners for a Healthy Putnam County steering committee in the summer to fall of 2021. To obtain a good picture of the health of the community from the viewpoint of our residents, nine focus group discussions were conducted with a number of different groups. The following participated in the focus group meetings: senior citizens, Head Start parents, school guidance counselors, P.A.R.T.Y. youth, police chiefs, business and social agency leaders, ministers, and at-risk youth parents. The focus groups were held between October 2021 through February 2022. There was a total of 63 participants.

Throughout the focus group process, several themes were identified by most or all the groups. Those themes include:

- Mental Health
- Substance Use and Abuse
- Access to resources in the community (Awareness)
- Lack of supportive services
- Isolation

A key informant survey was also completed as part of the Community Themes and Strengths Assessment. The survey was created by The Center for Marketing and Opinion Research (CMOR) in partnership with Putnam County Health Department. The survey was finalized in January 2022. The survey was provided to healthcare providers, mental health providers, and representatives of area businesses via an email with a survey link on February 2, 2022. Key informants had three weeks to complete the survey. These individuals were asked to respond to a series of questions relating to health issues in Putnam County. A total of 19 individuals completed the survey. Some of the questions were more specific, relating to the results of the community survey that had been completed. This was done to gather a better understanding of the role of the key informants in helping to address health issues.

Similar themes as those found in the focus groups were also identified by the county's key informants. Some of the top health issues were:

- Substance abuse and addiction issues
- Healthy living and obesity
- Mental Health
- COVID-19 related issues

The key informants were also asked to provide suggestions for ways to address some of the issues. More education on the various concerns was a common recommendation provided by those surveyed. The key 19 informants also acknowledged barriers, such as transportation, awareness of what is available, cost, personal unwillingness to seek care/Social norms.

Focus groups and key informants were also asked to identify assets or resources that are available to them in Putnam County. Participants mentioned that people coming together in the community, church related activities, community involvement and volunteers in the community, food banks, and social clubs as a few examples of what is healthy in our community. When asked about resources in our community, participants mentioned places such as the Council on Aging, Health Department, Pathways, Thrift Store, JFS, guidance counselor at school, friends, and family among others.

More information regarding the Community Themes and Strengths Assessment can be found on the Putnam County Health Department website at www.putnamhealth.com.

Community Health Status Assessment

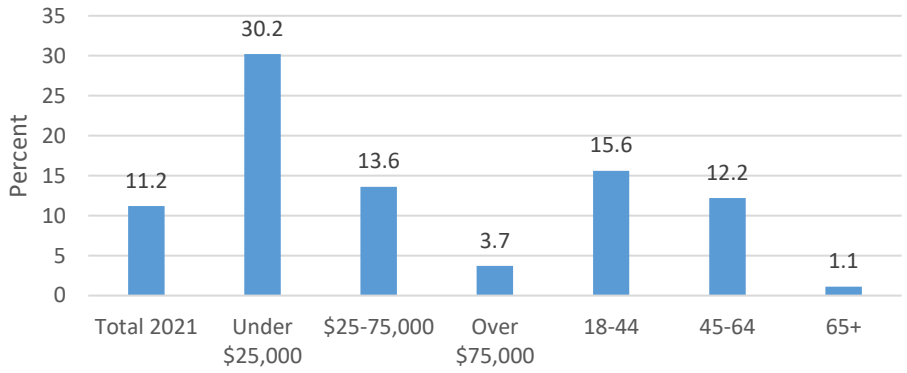
The Community Health Status Assessment was conducted in Fall 2021. It was determined that there was a need for updated primary data, therefore, the Partners contracted with an outside organization, the Center for Marketing and Opinion Research (CMOR) to conduct a community health survey in Putnam County. The CHA Steering Committee, a small workgroup of partners, met virtually throughout late summer 2021 to determine questions and methodology to be used for the survey. Preliminary results from the survey were presented to the workgroup for review and comment. Suggestions and requests for additional information were made to CMOR. A final report was presented at a public meeting on May 12, 2022. Members of the Partners for a Healthy Putnam County, stakeholders and community members were invited to attend. The complete Community Health Assessment report includes the demographic

information of Putnam County, a breakdown of health issues of the population, related health disparities among the population, and identified populations with an inequitable share of poorer health outcomes. The report also includes information regarding contributing factors for health issues and a section regarding the social determinants of health. The following is a snapshot of some of the findings from the Community Health Assessment survey that was conducted. The entire report can be found on the Putnam County Health Department website at www.putnamhealth.com.

Mental Health

- Nearly half, 48.0%, of residents had at least one day in the past 30 days that their mental health was not good. One-sixth, 16.3%, indicated that their mental health was not good 11 or more days in the past 30.
    - Groups of residents more likely to have 11 or more bad mental health days in the past 30 days include: obese residents, those ages 18 to 44, residents with a high school diploma or less education, those with an annual income under $50,000 (especially those with an annual income under $25,000), non-white residents, those who are single or divorced, and unemployed residents.

Figure 2. Putnam County Adults Feeling Sad or Hopeless for 2 or more week in a row



- More than one in ten residents, 11.2%, had felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities in the past 12 months.
    - Groups of respondents more likely to have felt sad or hopeless for two weeks or more in a row include females, residents ages 18 to 44, those with some college or less education, non-white residents, those who are single or divorced, residents who work part-time or are unemployed, those with an annual income under $25,000, residents who live alone, and obese residents.
- More than one-quarter of residents reported that they or an immediate family member had been diagnosed by a medical professional with anxiety or emotional problems.
- Nearly a third, 31.8%, feel lonely or isolated from others occasionally or more often.

- Groups of respondents more likely to often or some of the time feel lonely or isolated include residents ages 18 to 44, non-white residents, those who are not married, unemployed residents, those with an annual income under $50,000 (especially those with an annual income under $25,000), residents who live alone, and obese residents.

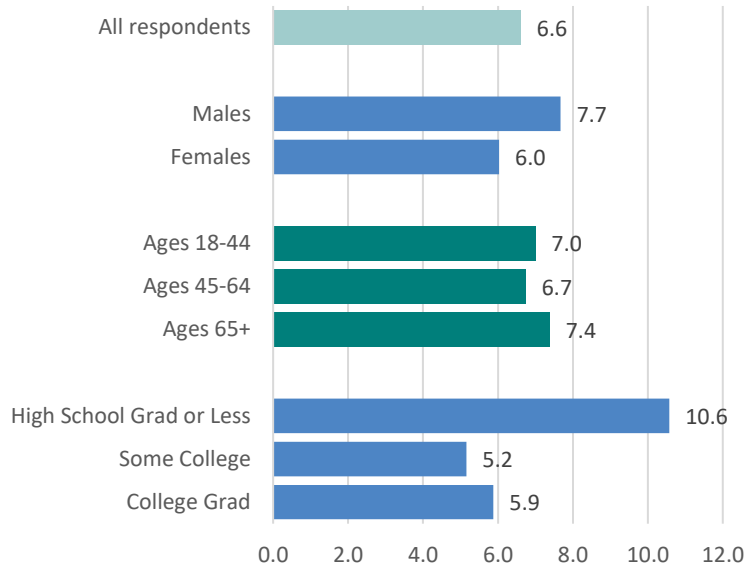
- Only a small percentage of residents, 2.2%, seriously considered suicide in the past year. Groups of respondents more likely to have seriously considered suicide include respondents with children in the home, and those ages 18 to 44.

Lifestyles/Healthy Behaviors

Alcohol and Substance Use

- Nearly two-thirds of residents, 63.2%, reported drinking alcoholic beverages such as beer, wine, malt beverages or liquor at least some days. The average number of alcoholic beverages a week was 6.61.
  - Groups of residents with significantly higher averages include males (7.7), residents ages 65 and over (7.4) and those with a high school diploma or less education (10.6).
  - Groups of residents more likely to drink alcoholic beverages include males, residents ages 18 to 44, those with some college or less education, residents with an annual income of $50,000 or less, those who are divorced, employed residents, and those with children in the home.

Figure 3. Average Number of Drinks per Week

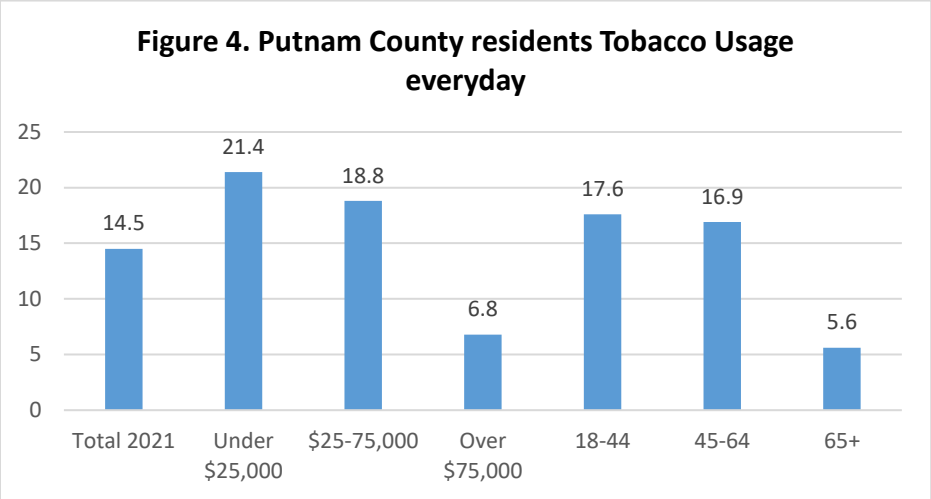


- More than one in ten, 11.6% reported driving after drinking any alcoholic beverages.
- 7.4% of Putnam County residents reported anyone in the household used marijuana during the last 6 months
- Half, 49.5%, of residents reported being aware of any drug and alcohol addiction treatment options available in their community.

Tobacco Use

- Nearly one fifth, 19.3%, of residents indicated they currently smoke cigarettes, cigars, chewing tobacco or use other tobacco. ***Every day users*** amounted to 14.5% of all residents. The remaining proportion of tobacco users indicated they smoke cigarettes or use tobacco less frequently or only

some days, amounting to 4.8% of all residents. Groups of residents more likely to smoke or use tobacco include males, residents ages 18 to 44, those with some college or less education, divorced or single residents, those who are employed part-time or unemployed, and residents with an annual income under $50,000.



- More than a third of residents, 36.6%, have smoked 100 or more cigarettes in their lifetime. Groups of respondents more likely to have smoked 100 or more cigarettes in their lifetime include residents without children in the home, males, those with a high school diploma or less education, divorced or single residents, those with an annual income under $25,000, and residents who live alone.

Healthy Eating

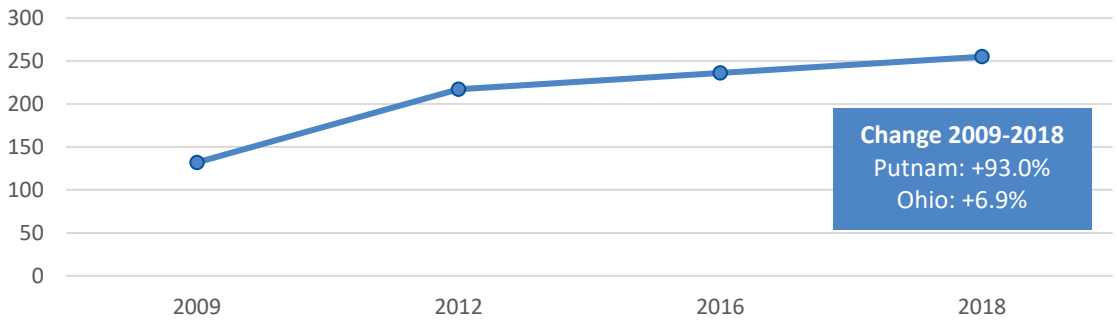
- A quarter of residents, 24.6%, eat fresh fruits or vegetables 2 or more times a day.
- Nearly a quarter of residents, 21.1%, reported having difficulty getting fresh fruits and vegetables in their neighborhood, with 2.3% saying it was very difficult and 18.8% saying it was somewhat difficult.
- More than a third of residents, 39.6%, drink soda or other unhealthy drinks at least once a day.

Social Determinants of Health

- The educational attainment for adults ages 18 to 24, in Putnam County the percentage of the population with a high school degree or higher is slightly lower in the county (83%) than in the state (87%).
- The unemployment rate for Putnam County was slightly lower that Ohio (5.6% vs 8.1%).
- The percentage of the population in poverty in Putnam County is nearly half of what it is for the state (7.6% compared to 14.0%).
- When looking just at children under the age of 18 in poverty, the percentage is significantly lower than the state (11%, 19.9%).

- 20% of Putnam County residents are 65 years of age or older. This is higher percentage than Ohio and the U.S (17%, 16%).
- Nearly one in ten residents, 8.6%, reported they are responsible for providing regular care or assistance for an elderly parent or loved one.

Figure 6. Number of Grandparents Raising Grandchildren - Putnam



- The change in percentage of children living with their grandparents in Putnam County is more than 10 times the increase for the state.

Personal Health Status

- 82% of Putnam County Residents reported their health as excellent/good.
- 8% of Putnam County Residents reported being unable to get needed services in the past year
    - Most frequently not able to get needed prescriptions (43%), see a specialist (17%), and surgery (17%)
    - Most common barriers include service not available in the area, high cost of the service, and uninsured
- Over a fifth of respondents, 21.6%, reported that poor physical or mental health kept them from doing their usual activities such as self-care, work, or recreation in the past 30 days.
    - Of these respondents, 44%, were kept from their usual activities because of their physical health, 21% due to their mental health and 35% because of both their physical and mental health.
    - Groups of respondents more likely to have been kept from usual activities in the past 30 days because of poor physical or mental health include obese residents, females, those ages 18 to 44, those with an annual income under $50,000, residents who are single or divorced, and those who are employed part-time or unemployed.

Figure 5. Personal Health Rating

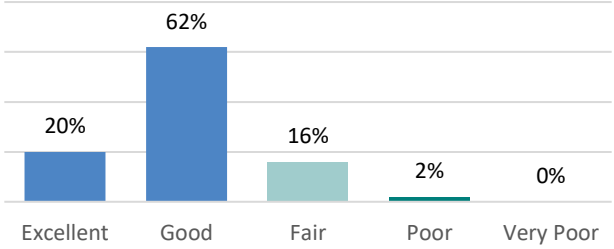


Table 2. Putnam County Trend Summary		Putnam County CHA 2016	Putnam County CHA 2021
Health Status	Average days that **physical** health was not good in past month	3	3.5
	Average days that **mental** health was not good in past month	4.1	4.8
Health Care Coverage, Access, and Utilization	Uninsured	5%	2%
	Visited a doctor for a routine checkup in the past year	63.0%	77.5%
	Adults who have visited the dentist in the past year	80.0%	73.2%
Health Lifestyle/Behaviors	Overweight (Self-reported)	36.0%	33.4%
	Obese (Self-reported)	38.0%	44.3%
	Current drinker (everyday/someday)	74.0%	63.2%
	Smoked 100 or more cigarettes in life	33.0%	36.6%
	Adults who used marijuana in the past 6 months	3.0%	7.4%
Quality of Life	Limited in some way because of physical, mental, or emotional problem	18.0%	21.0%
Mental Health	Ever seriously considered suicide in the past year	3.0%	2.2%
	Two or more weeks in a row felt sad or hopeless	9.0%	11.2%
Preventive Medicine	Annual flu vaccine	55.0%	44.7%
	Blood Cholesterol Check	88.0%	88.0%
	Had a mammogram (age 40 and older)	77.0%	68.6%
	PSA test for prostate cancer	47.0%	40.1%
	Colonoscopy	64.0%	52.3%

Conclusions

Putnam County has many positive social indicators which influence access to healthcare such as a high percentage of people with insurance and a primary care provider, and a high percentage of people reporting access to prenatal care contributing to the low infant mortality rate.

Access seems influenced by the rural location of the county impacting the availability of specialist and hospital based services. Residents travel 20-30 miles to the nearest hospital and 100-150 miles to a large metropolitan care center. For those with transportation difficulties, these barriers make access very difficult even with insurance for coverage.

The lack of dental providers and mental health professionals is particularly pronounced in Putnam County. The ratio for the number of dentists per population is 2.3 times higher in Putnam County that it is for the state as a whole, and the mental health provider ratio is 5 times higher in Putnam County.

Residents and key informants list mental health, substance use and abuse, access to resources in the community (awareness), and healthy behaviors as top concerns in the county. Data from the community survey would support these opinions. Of the supportive services in the county, people report being unaware of the availability. Lifestyle choices contributing to obesity and excessive alcohol consumption are also areas for improvement leading to a decrease in chronic disease. Addressing these concerns would contribute to the vision of Putnam County being a healthy, equitable place to live.

Next Steps

The completion of the four MAPP assessments answers important questions regarding the health of Putnam County:

- The Local Public Health System Assessment answered: What system weaknesses must be improved? What system strengths can be used? What system performance opportunities are there?
- The Forces of Change Assessment answered: What forces affect how to take action?
- The Community Themes and Strengths Assessment answered: Why do health conditions exist? What assets are available in the community? What is the quality of life in the community?
- The Community Health Status Assessment answered: What health conditions exist in the community?
- There was a lack of social vulnerability Index (SVI) examined in the Putnam County CHA. PCHD will further investigate inequities in the factors that contribute to health challenges and create a Healthy Equity Report.

Underlying themes related to the completed assessments were identified and shared with the Partners for a Healthy Putnam County and with the community. Three to five strategic priorities will be determined and a Community Health Improvement Plan (CHIP) will be developed. The CHIP will include innovative, strategic activities to guide health improvement programs and policies for the next three years.

Appendix A. Acknowledgements- Participating Partners

Putnam County Health Department

Kim Rieman, Health Commissioner*

Sherri Recker*

Joan Kline*

Angela Recker

Bridget Fischer

Allison Rosebrock

Trilogy

Steve Apple (The Meadows of Leipsic)

Jim Sherry (The Meadows of Ottawa)

Kris Schroeder (The Meadows of Kalida)

Mercy Health**

Beth Keehn*

Tyler Smith

Putnam County Job and Family Services

Suzy Wischmeyer

Putnam County Council on Aging

Jodi Warnecke*

Pathways Counseling Center

Donna Konst

Law Enforcement

Sheriff Brian Siefker

Chief Arnie Hardy (Continental)

Chief Jim Gulker (Kalida)

Chief Rich Knowlton (Ottawa)

Chief Rob Searfoss (Glandorf)

Putnam County Family and Children First**

Beth Tobe

Putnam County Community Improvement Corp.

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Putnam County YMCA

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Mercy Health-PC Ambulatory Care

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Leipsic Community Center

Kristen Pickens

Putnam County Educational Service Center

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Gary Herman

Community Members

Lita Siefker

Lisa Langhals

Alcohol, Drug and Mental Health Services Board**

Jennifer Horstman*

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Ottawa Senior Citizens Association

Sue Barnhart

Crime Victim Services

Tammy Baumunk

HHWP Community Action

Erin Rodabaugh-Gallegos*

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Jeff Utz*

Schools

Linda Knowlton (Ottawa-Glandorf)

Audrey Beining (Ottawa Elementary)

Jackie Fields (Ottawa Elementary)

Michelle Leach (Ottoville School)

Blanchard Valley Health System **

BJ Pasztor

Ohio Department of Health

Sonrisa Sehlmeyer (Northwest Regional representative)

*Community Health Status Assessment Planning Committee
**Provided funding for the Community Health Status Assessment

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

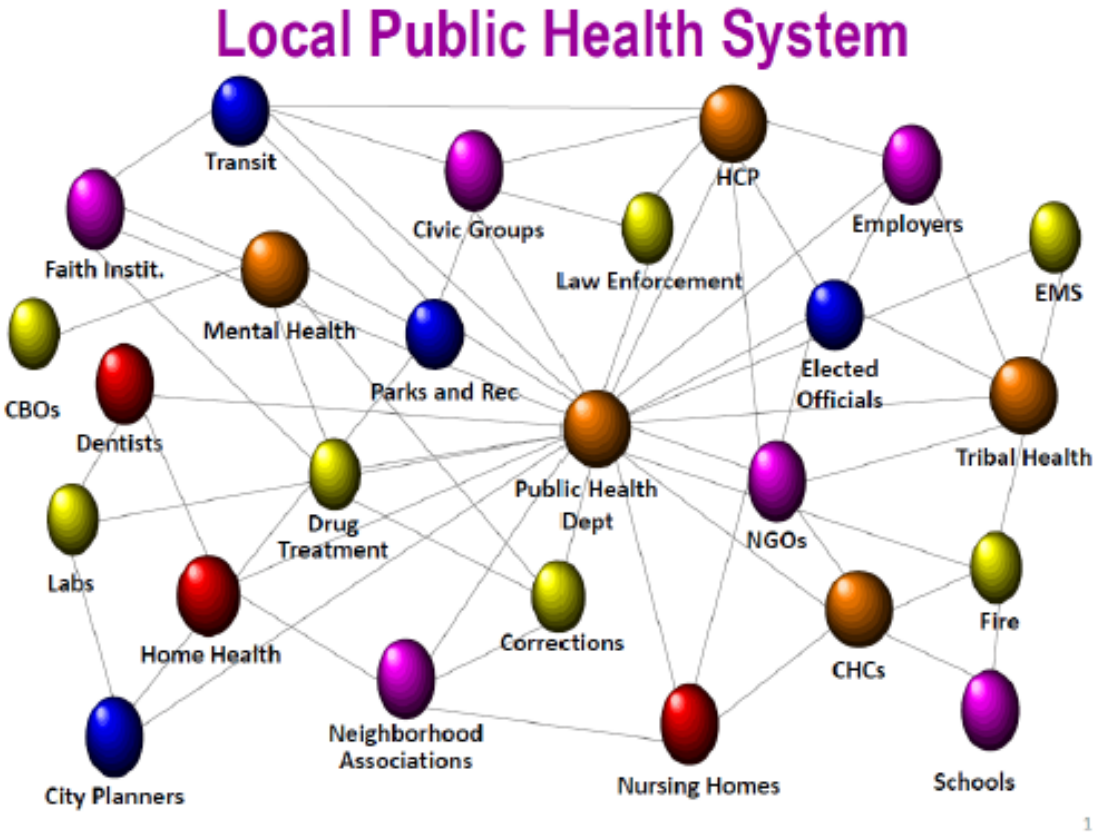
Putnam County, Ohio

November, 2019
Updated:
December, 2021

Introduction

In November 2019 the Putnam County Health Department, along with members from the Partners for a Healthy Putnam County, participated in the Local Public Health System Assessment (LPHSA). The LPHSA helps to answer questions such as, "What are the components, activities, competencies and capacities of our public health system?" and "How well are the *10 Essential Public Health Services* provided?" The local public health system is made up of many different entities within a community such as healthcare providers, EMS, mental health organizations and the health department. Other organizations that are not commonly viewed as being part of public health, including law enforcement, civic groups, schools, faith organizations, elected officials, and more, are just as important and play a vital role in protecting and promoting the health of the community. The LPHSA allows us to look at the entire public health system, and not just those of the local health department, with a critical eye to determine if improvement is needed.

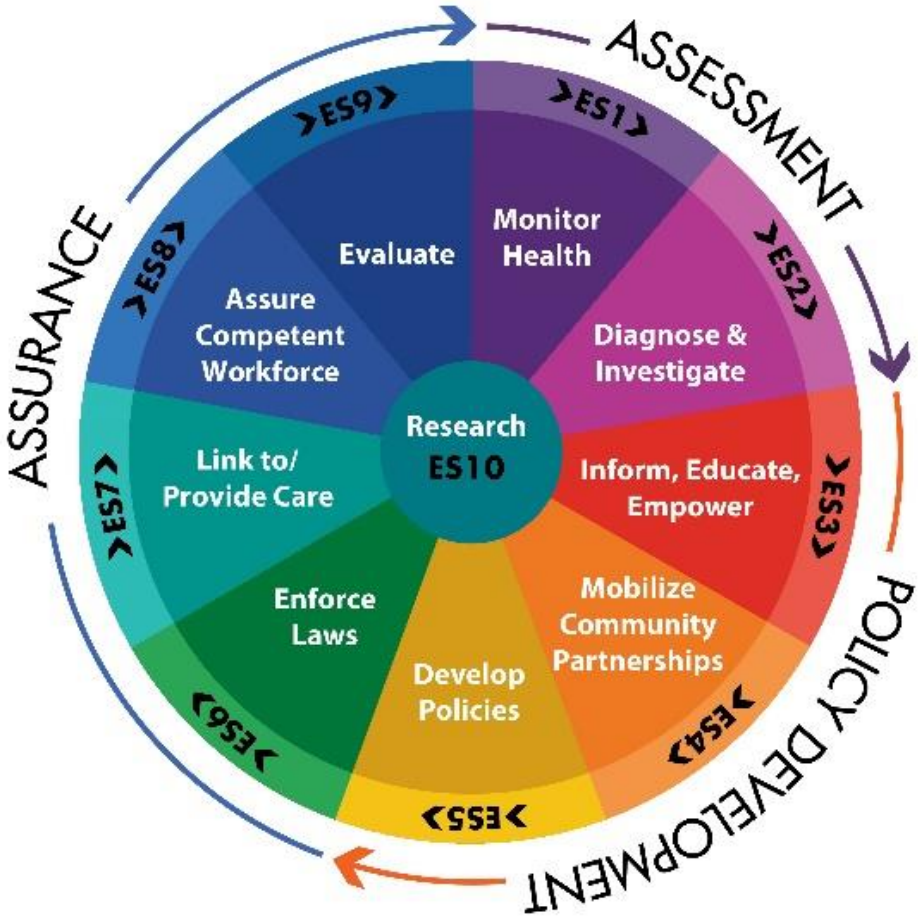
Please note: The 2021 update of the LPHSA is included in this report. The update was conducted through survey due to the COVID-19 pandemic and concerns about meeting in person and requiring a day-long event. More information about the update can be found in the Process section of this report.



The Putnam County Health Department led the initiative to complete the 2019 LPHSA. Eighteen members of the Partners for a Healthy Putnam County group, representing 15 different community agencies and organizations, attended an all-day meeting to assess the public health system's services, based on the *10 Essential Services of Public Health.* Version 3.0 of the National Public Health Performance Standards Program (NPHPSP) local instrument was used. The intention of the LPHSA is to provide the following:

- Measure and summarize the performance of the current public health system in Putnam County using nationally established performance standards and a methodology to conduct the assessment.
- Improve and/or establish connections with existing and new community partners to establish and strengthen collaborations that could contribute to improving the public health in Putnam County.
- Provide information for quality improvement of the public health system, identify priorities for the development of the community health improvement plan and provide input that may help with the development and/or implementation of the health department's strategic plan.

The LPHSA was also conducted in August 2013 and in November 2016, therefore we are able to have an understanding of how the level of activity by public health system changed over the years in providing the *10 Essential Public Health Services.* The LPHSA also helps to identify areas in which more efforts may need to be made to improve the health of our community. A strong collaboration of organizations, agencies, businesses, schools and community members is vital for the completion of not only the LPHSA, but the other assessments of the Mobilizing for Action through Planning and Partnership (MAPP) process as well. The end result is an updated Community Health Assessment (CHA) that is used to develop and implement a Community Health Improvement Plan (CHIP) that is implemented by the public health system.



Process

The Local Public Health System Assessment was held on November 7, 2019 at Pathways Counseling Center. After an overview of the MAPP process and an orientation of the LPHSA process, participants participated in a "Gallery Walk", which was used to identify resources already available in the community that address each of the *10 Essential Public Health Services.* The draft list of resources was then sent to the Partners group so that additional resources could be added to the list. Please note that this list of resources is ever-changing as new programs and services are made available in the community, or as some are no longer offered.

A list of LPHSA participants can be found in Appendix A of this report. The agenda of the day can be found in Appendix B. The "Gallery Walk" can be found in Appendix C of this document.

The National Public Health Performance Standards Program (NPHPSP) was followed for the Local Public Health System Assessment. This uses the *10 Essential Public Health Services* as a framework in which 30 Model Standards describe how an optimally performing local public health system should operate. In assessing each Model Standard, questions serve as a measures of performance. Responses to these questions indicate how well the Model Standard is being met by the public health system of Putnam County.

Participants in the LPHSA were assigned to small groups based on expertise, area of contribution to public health services and the desire to achieve balanced representation within each groups. Each group addressed at least three of the 10 *Essential Services*. Consensus scores for each assessment question were the goal; when a consensus was not reached, vote was taken with majority rule. A health department staff person was the facilitator and recorder for each group. Notes were taken as the group discussed each measure and question. Those notes, as well as the decided upon score, are reflected in this report. After each group completed their task, the entire group was gathered again to discuss the process of the day and complete an evaluation.

For each of the *10 Essential Public Health Services*, there are two to four Model Standards that describe an optimal, or "gold standard," of performance. Each standard is followed by a series of questions with five response options related to an associated level of activity in which the public health system is engaged:

Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity described within the question is met.
Minimal Activity (1-25%)	Greater than zero, but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

Due to the COVID-19 pandemic, work on the Community Health Assessment (CHA) was not completed in 2020 as originally planned. In mid-2021, the PCHD and health partners decided to move forward with the CHA, using the MAPP process. Due to inability to meet in person and the barriers meeting virtually often causes, it was determined that the LPHSA would be completed through a survey. Partners were asked to review the 2019 LPHSA summaries for each of the 10 Essential Public Health Services. They then indicated to what extent (not at all, a little, about the same, some, a great deal) they feel the scores from the LPHSA 2019 reflect the current functioning of the public health system for each Essential Service. Respondents were also asked to provide input regarding their thoughts of how the public health system in Putnam County is, or isn't, addressing the model standards related to the Essential Service. In this report, you will find the summary of comments and results that were provided by those partners that completed the survey. This will be found within each of the 10 Essential Service summaries.

Results

After completing the assessment with the participants, the performance scores, priorities and comments were entered by health department staff into a pre-formatted Excel spreadsheet provided by the Public Health Foundation. The results were then reviewed and provided in this report.

Based upon the responses provided in the assessment, an average score was calculated for each of the *10 Essential Public Health Services.* Figure 1 below shows the average overall score as well as the average score for each of the essential services. The score of each can be interpreted as the degree in which the local public health system meets the performance standards for each of the *10 Essential Public Health Services*. Again, it is important to note that the entire public health system, which includes many agencies and organizations in the community, are assessed during the Local Public Health System Assessment.

As described above, scores in the 76-100% range indicate that activity in the corresponding essential service is at an optimal level. Figure 1 shows that 8 of the 10 essential services have optimal activity and the average overall score is 80.6%, which is also in the optimal activity category.

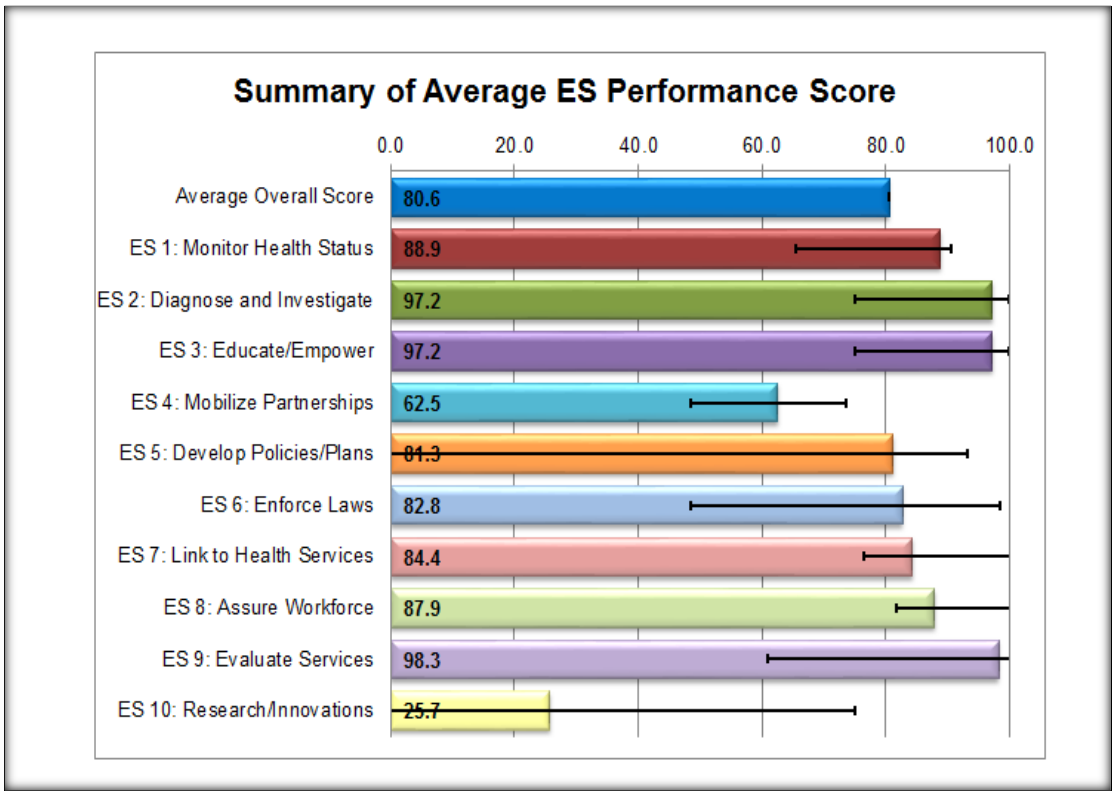


Table 1 below provides a summary of the performance scores (an average of the scores given for each of the model standards in the respective Essential Service) for each of the *10 Essential Public Health Services.* The 2013 and 2016 Performance Scores are also provided for reference. Table 1 shows improvement in 7 of the 10 Essential Services, with the greatest improvement from 2016 to 2019 in Essential Service 3: Educate and Empower, and Essential Service 8: Assure Workforce. There are a few areas in which there was a decline in the

performance scores that may need to be addressed. The greatest decrease was in Essential Service 4: Mobilize Partnerships. A breakdown of the score for each Model Standard within each Essential Service can be found in Appendix D.

Table 1: Performance Scores and Priority Rating

Essential Service	Performance Score 2019*	Performance Score 2016*	Performance Score 2013 *
ES1: Monitor Health Status	88.9%	80.6%	61.1%
ES2: Diagnose and Investigate	97.2%	89.6%	95.8%
ES3: Educate and Empower	97.2%	72.2%	66.7%
ES4: Mobilize Partnerships	62.5%	89.6%	64.6%
ES5: Develop Policies and Plans	81.3%	85.4%	68.8%
ES6: Enforce Laws	82.8%	73.3%	55.3%
ES7: Link to Health Services	84.4%	81.3%	56.3%
ES8: Assure Workforce	87.9%	54.7%	36.6%
ES9: Evaluate Services	98.3%	83.3%	77.1%
ES10: Research and Innovation	25.7%	38.9%	37.5%
Overall Score (Average)	80.6%	74.9%	62.0%

*Average score for all Model Standards associated with each Essential Service

After completing the assessment, a small committee met to complete the optional prioritization portion of the system assessment. Prioritizing may help with identifying areas for improvement or where additional resources may be needed. The following question was answered for each of the model standards: "On a scale of 1 to 10 (1=lowest and 10=highest), what is the priority of this model standard to our public health system?"

The performance score and priority rating for each model standard are arranged by the priority-performance matrix quadrants and shown in Table 2. This information was shared with the Partners, and is helpful in determining the strategic priorities for the Community Health Improvement Plan.

Quadrant A: *high priority, low performance* May need increased attention	**Quadrant B:** *high priority, high performance* Important to maintain efforts
Quadrant D: *low priority, low performance* May need little or no attention	**Quadrant C:** *low priority, high performance* Potential area to reduce

Table 2: Priority-Performance Matrix Quadrant Placement of Model Standards

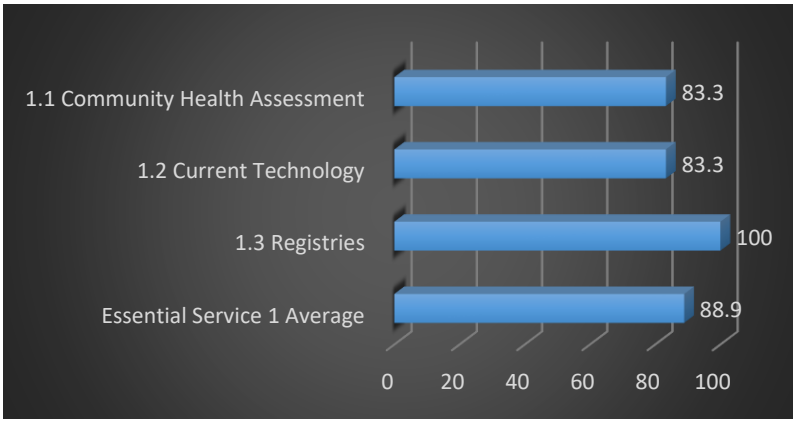
Quadrant	Model Standard	Performance Score (%)	Priority Rating
Quadrant A	5.4 Emergency Plan	75.0	9
Quadrant A	5.3 CHIP/Strategic Planning	75.0	8
Quadrant A	5.2 Policy Development	75.0	8
Quadrant A	4.2 Community Partnerships	75.0	9
Quadrant B	7.2 Assure Linkage	87.5	9
Quadrant B	7.1 Personal Health Services Needs	81.3	8
Quadrant B	6.3 Enforce Laws	90.0	10
Quadrant B	6.2 Improve Laws	83.3	8
Quadrant B	3.3 Risk Communication	100.0	10
Quadrant B	3.2 Health Communication	91.7	9

Quadrant B	3.1 Health Education/Promotion	100.0	8
Quadrant B	2.2 Emergency Response	100.0	10
Quadrant B	2.1 Identification/Surveillance	91.7	9
Quadrant B	1.1 Community Health Assessment	83.3	9
Quadrant C	9.3 Evaluation of LPHS	100.0	4
Quadrant C	9.2 Evaluation of Personal Health	95.0	5
Quadrant C	9.1 Evaluation of Population Health	100.0	7
Quadrant C	8.4 Leadership Development	100.0	5
Quadrant C	8.3 Continuing Education	85.0	6
Quadrant C	8.2 Workforce Standards	100.0	4
Quadrant C	5.1 Governmental Presence	100.0	6
Quadrant C	2.3 Laboratories	100.0	7
Quadrant C	1.3 Registries	100.0	7
Quadrant C	1.2 Current Technology	83.3	6
Quadrant D	10.3 Research Capacity	18.8	2
Quadrant D	10.2 Academic Linkages	33.3	3
Quadrant D	10.1 Foster Innovation	25.0	5
Quadrant D	8.1 Workforce Assessment	66.7	4
Quadrant D	6.1 Review Laws	75.0	7
Quadrant D	4.1 Constituency Development	50.0	5

Summary of Scores and Comments

The following pages of this document provide a summary of the activity within each of the *10 Essential Public Health Services*. More detail about each Essential Service and the strengths, weaknesses and opportunities related to the model standards within each of the Essential Services can be found in Appendix E of this report.

Essential Service 1: Monitor health status to identify health problems



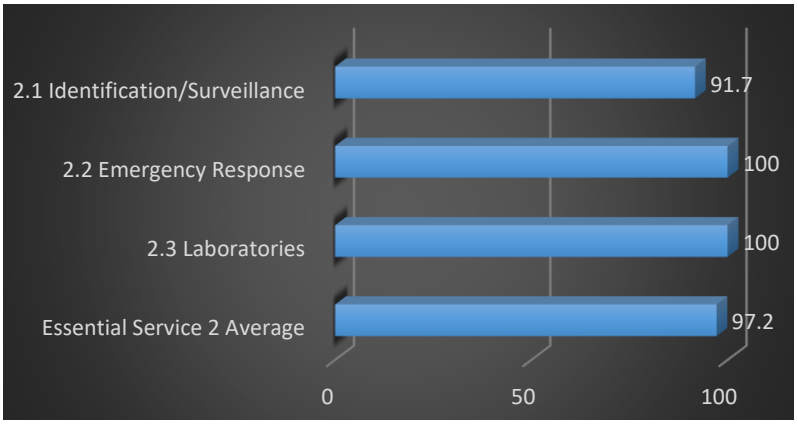
Participants indicated that the local public health system displays optimal activity in all of model standards related to Essential Service 1. A community health assessment is regularly completed and the Pride Survey is completed with Putnam County youth every two to three years. The participants recognize that there is often a lack of manpower and funds to always do a robust assessment. Our small population sometimes makes it difficult to obtain data that would be helpful in planning. Electronic (EMR) has been identified as data that would be valuable to have an up-to-date and complete picture of the health status of our community. The group also sees the value in ensuring that the community health assessment data is reaching the appropriate parties in the agencies and organizations within the county. While the participants believe that the local public health system exhibits optimal activity related to maintaining health registries that

are necessary for data gathering, it would still be beneficial to consolidate data from all the partners for a true picture of the state of our county's health.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is about the same (40%), somewhat the same (30%) or a great deal (30%) as it was in November 2019 for the model standards in Essential Service 1.

Input from the respondents indicate that the public health system in Putnam County has always worked well together to identify health problems, but is even more evident during the pandemic. Partners use limited resources, especially for a rural area, effectively. Improvements needed in reporting diseases was identified and efforts made to address. Monitoring mental health status and identifying problems has improved over the last two years.

Essential Service 2: Diagnose and investigate health problems and health hazards in the community

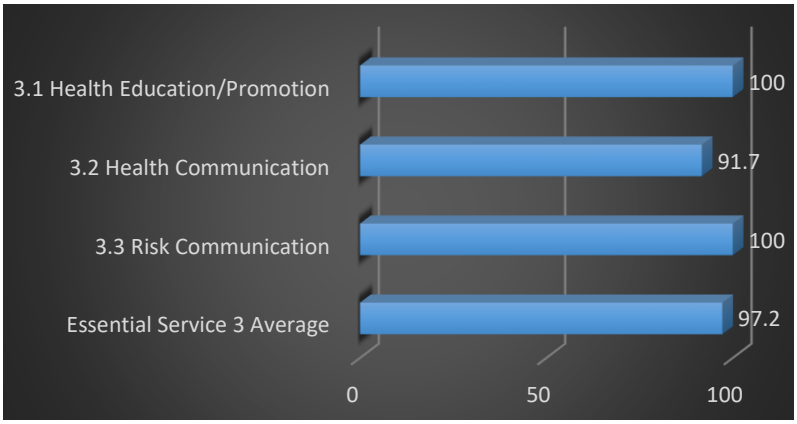


Similar to the 2016 LPHSA, Essential Service 2 received one of the highest overall performance scores in the 2019 assessment, with a score of 97.2. This increased from 89.6 in 2016. Many partners are involved in identifying disease and conducting surveillance of diseases that affect the community. The health department, healthcare providers, EMA, law enforcement and others are all very active and aware of the importance of disease investigation. Infectious diseases are reported to the health department and proper follow-up is conducted in an effort to minimize the spread and risk to the population. Much effort has been made to ensure that proper emergency response plans are in place at various organizations including the health department and healthcare providers. These plans are exercised so that staff are able to comfortably implement them in the event of a crisis. It was noted that it is important to have enough properly trained staff to support the surveillance process. The Ohio Department of Health laboratory is available for testing to support the various disease investigations that occur, and is typically very responsive when needed. The health department provides monthly reports to healthcare providers about the prevalence of reportable diseases in Putnam County so that there is an awareness of diseases of concern.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is little (bit the same as previous reported, 20%), about the same (20%), somewhat the same (30%) or a great deal (30%) as it was in November 2019 for the model standards in Essential Service 2.

Input from respondents indicate that the county has grown stronger in this essential service and the pandemic has shown how well we work together. Disease investigation and surveillance during the pandemic has been tested greatly and partners have assisted with outbreak investigations. Communication since the start of the pandemic has been phenomenal. The health department has done a great job, but the population has not done as much as needed for prevention.

Essential Service 3: Inform, educate and empower people about health issues

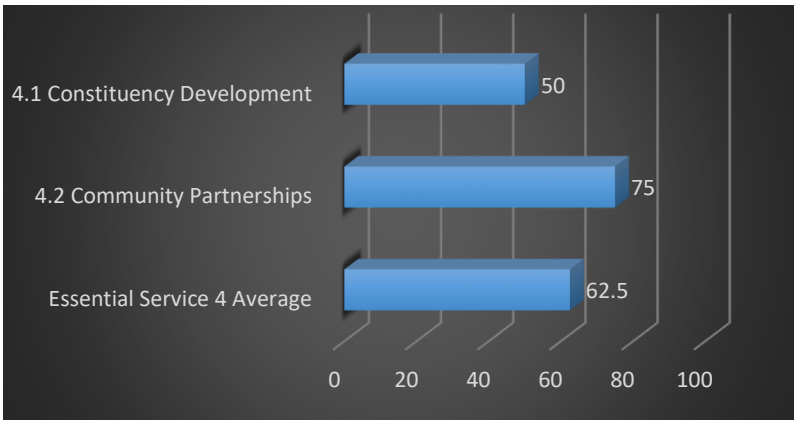


The participants that reviewed Essential Service 3 during the LPHSA felt that the local public health system has optimal activity in the three model standards. There was significant improvement in both Health Education/Promotion (66.7 in 2016 to 100 in 2019) and Health Communication (50 in 2016 to 91.7 in 2019) discussed by the partners during the assessment. While there are still some suggestions for improvement, it was noted that efforts are made to reach out to all areas of the county and that there is an understanding of our unique communication and media barriers. However, efforts are made to ensure that information is provided in a variety of ways to the different populations in our community. The group also acknowledged the strong partnerships that are in the county, which help to coordinate programs and provide valuable health information when necessary. Opportunities for improvement include developing a general website in the county that could will contain valuable information regarding programs, services and events that promote health. It would also be used to share important information during a crisis or emergency situation. The partners acknowledge that there is a need to become creative in how we get information out to the various populations in our community. This would require some additional work for all involved.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is about the same (20%), somewhat the same (30%) or a great deal (40%) as it was in November 2019 for the model standards in Essential Service 3.

Respondents indicate that the entire health system does a great job in the area of providing information and education. There are partnerships within the county (for children, families, older adults, etc.) that help with this. The pandemic has forced everyone to communicate to help get information to clients and the community. There seemed to be an increase in electronic communication and communication in general as a great deal of information was provided by the health department and their partners.

Essential Service 4: Mobilize community partnerships to identify and solve health problems

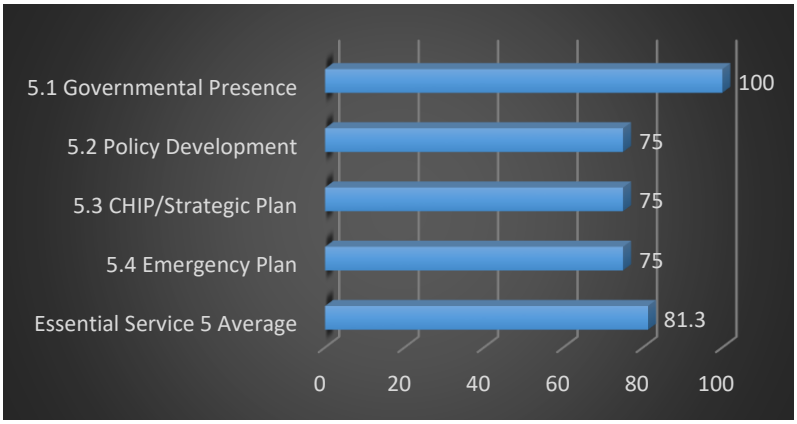


There was a bit of a decrease in the scores for Essential Service 4 model standards, with moderate to significant activity. This is down from 2016, in which both model standards were determined to be in the optimal level of activity. In the most recent assessment, the participants noted a need for more comprehensive partnerships and acknowledged that while there are many active groups providing great programs and services in the community, there could be better coordination between the groups to ensure that the community is served in the best possible way. Some weaknesses identified included a need for a comprehensive and continually updated directory of services and identifying a point of contact for each agency or service. It was also noted that a community calendar with a comprehensive listing of events, programs and services would be helpful for not only the community, but the partners as well. This idea is one that has been discussed in the past and has also been identified by other groups participating in this assessment. It may be something that is considered during the next improvement cycle.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is not at all the same (20%), about the same (30%), somewhat the same (20%) or a great deal (30%) as it was in November 2019 for the model standards in Essential Service 4.

Respondents indicate that the development of a community directory has not occurred yet, as was indicated as a possible improvement in this area. There is hope that the "Build Putnam County" site from the Putnam County CIC may help in this area. There are great partnerships, but working together has been challenged during the pandemic. While some partnerships were strengthened in the last two years, some things were not able to be accomplished due to the COVID response.

Essential Service 5: Develop policies and plans that support individual and community health efforts



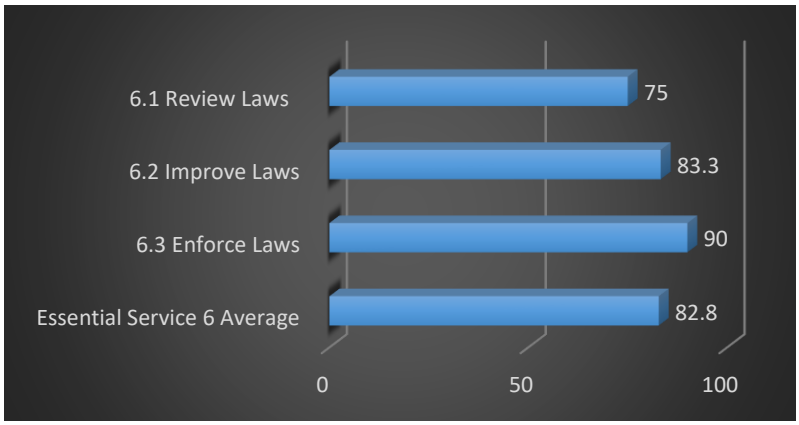
The participants identified significant and optimal activity in the model standards of Essential Service 5. The Putnam County Health Department recently obtained accreditation from the Public Health Accreditation Board, which is the main focus of Model Standard 5.1. It was noted that partnerships with a variety of organizations and agencies in the community were vital in the accreditation process. Many partnerships and collaborations in different public health related areas help to address the needs of the community. However, it is important not to become complacent with the existing partnerships, but to make efforts to continue to build on them for optimal activity in policy developments, improvement and

strategic planning, and emergency planning. Policy change should be addressed as needed to provide a solid base for community improvement. Partners on all levels are needed to work toward effective changes in policies. "Health in All Policies" is an area that should be explored to ensure that the effect on public health is considered when making a policy change. While there is significant activity in community health improvement planning, strategic planning and emergency planning, it is important to continue to develop partnerships and work together as a community to create change to ensure the public's health and safety.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is about the same (30%), somewhat the same (40%) or a great deal (30%) as it was in November 2019 for the model standards in Essential Service 5.

Respondents indicated that there needs to better implementation of policies and plans to support community health efforts, while also understanding that most of the efforts over the last two years was around emergency response to the pandemic. Everyone is working to stay on top of individual and community health efforts, but there is a need for more people to work in some of these fields, including home health aides.

Essential Service 6: Enforce laws and regulations that protect health and ensure safety



In Essential Service 6, the review of laws shows activity at a significant level, while activity in law improvement and enforcement are in the optimal level. The participants identified that efforts are made to provide information to licensed entities regarding laws and law changes, however there could be improvement in the overall education of the public in regards to public health related laws. It was also noted that with a small community such as Putnam County, the voices of our community may not always be heard to improve laws. An opportunity for improvement is to strengthen relationships so that one, strong voice may be heard when discussing change or the need for improvement in laws. Enforcement of public health and safety laws was noted to be at an optimal level. It may be useful to focus on quality improvement to ensure that proper and effective enforcement of laws occurs. Similar to the 2016 assessment, education is identified as an area of improvement throughout. It remains important for those that are charged with enforcing laws and those that are required to follow the law have a clear understanding so that the health of the community is protected.

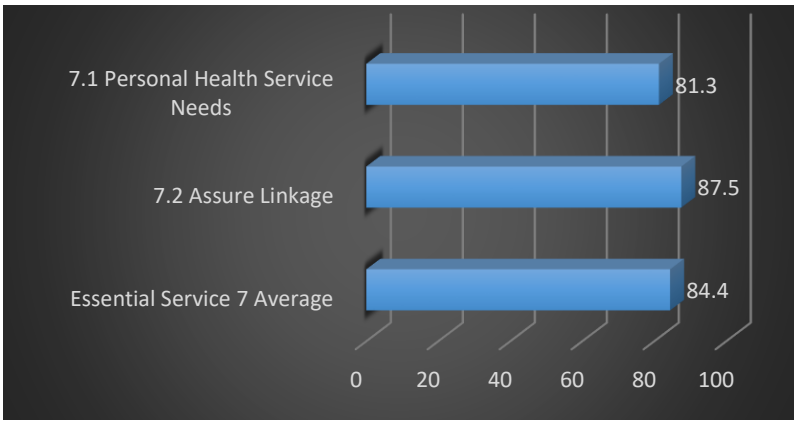
December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is about the same (30%), somewhat the same (60%) or a great deal (20%) as it was in November 2019 for the model standards in Essential Service 6.

Respondents indicate that prior to the pandemic, many of the laws and regulations of the public health system dealt with environmental health and reporting of disease. Laws for isolation and quarantine have been tested during the pandemic and more is now known about these laws and regulations. Laws in terms of public health

general guidance have been upheld, but the public is not always following the suggestions of ODH and PCHD. Law enforcement will assist others that enforce state orders if needed.

Essential Service 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

The scores for the two model standards in Essential Service 7 were within the optimal range for activity. While the public health system is active in identifying personal health service needs, the group acknowledged that it is often difficult to know the needs of the certain groups if they do not seek care. However, healthcare navigators can be helpful with this. Hospitals and mental health providers are starting to utilize this service, but there may be need for more. There are programs and resources available to provide needed care and many agencies and organizations work to provide that connection (ex: Open Access at Pathways, BCMH program at the health department, social workers at hospitals, etc.), however, transportation or knowledge of where to go for services may be a barrier. Children may receive services during the school year, but that may not be available to them during school breaks. There is also a need to provide services to help people sign up for benefits to alleviate the concern of insurance needs or cost of services.



December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is a little (bit the same, 20%), about the same (20%), somewhat the same (40%) or a great deal (20%) as it was in November 2019 for the model standards in Essential Service 7.

Respondents indicated that the community is not often aware of services until they are needed. Training for staff members across the service industry is suggested, so that everyone who serves the public (regardless of the population they serve) is aware of the options available in all areas. Other counties provide this training (Wood County, Hancock County). There continues to be a need to address concerns around costs for services and those with no insurance. "Digital divide" related to access to care and health outcomes/disparities is a concern. The pandemic likely increased the concern among very low income and elderly in Putnam County. There is also a need for more people to work in the service area fields.

Essential Service 8: Assure a competent public and personal health care workforce

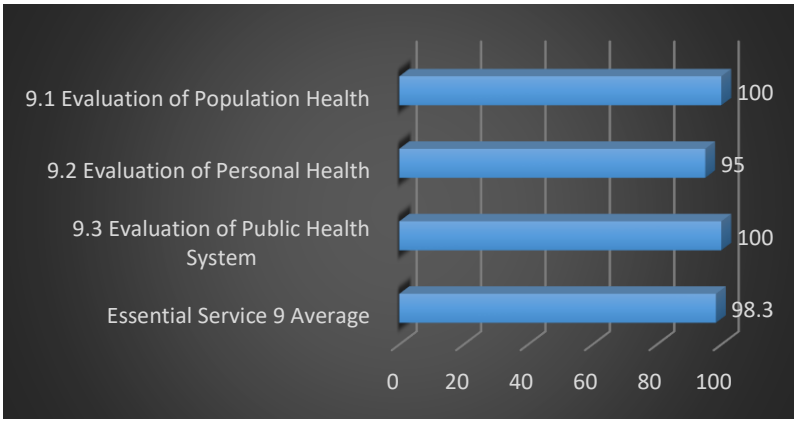
There was improvement in all of the model standards in Essential Service 8 from the assessment conducted in 2016, with significant or optimal activity taking place in all areas. Discussion regarding public and personal health care workforce showed that while licensures and certifications are checked, some organizations, mostly hospitals are not considering public health competencies. Healthcare systems do, however, periodically conduct workforce assessments to identify gaps. Continuing education and leadership development is a priority in many organizations. Employees are often provided with opportunities for development and growth. The Putnam Business Education Partnership is a new organization in the community that may be valuable in the area of employee and leadership development.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is a little (bit the same, 10%), about the same (30%), somewhat the same (30%) or a great deal (30%) as it was in November 2019 for the model standards in Essential Service 8.

Respondents indicate that a result of the pandemic brought the opportunity for more online trainings and development. The use of virtual meetings and social media to spread information has increased significantly recently. There have not been many workforce development opportunities within public health or with partners. It is unknown if other agencies have this same experience. It was noted that it would be wonderful to have more trainings locally, especially leadership trainings.

Essential Service 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services

Organizations within the public health system in Putnam County are very active in evaluating their services and strive toward continuous quality improvement. Overall, the activity score for Essential Service 8 increased greatly from 2016, with most improvement in Evaluation of Population Health (68.8 in 2016 to 100 in 2019) and Evaluation of Public Health System (83.3 in 2016 and 100 in 2019). These scores indicate that there is great interest in assessing and improving the system and the services provided to the community. Despite the scores, there are still areas of improvement that were identified. For example, the availability of Electronic Medical Record information would greatly benefit those that are assessing data

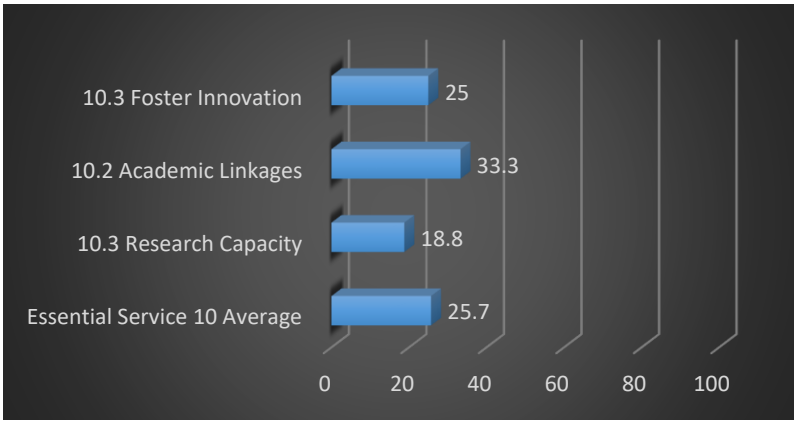


related to the health needs and concerns of the community. Also, a long-term goal would be to continue to improve evaluation processes and to effectively conduct gap analysis to provide additional data. Resources, both workforce and funding, is often a barrier for evaluation of services. It was also noted, however, that there is great partnerships that have developed between agencies, and therefore data and information is often shared for the common good.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is about the same (40%), somewhat the same (30%) or a great deal (30%) as it was in November 2019 for the model standards in Essential Service 9.

Respondents indicate that the public health system is high quality. The Putnam County Council on Aging is acknowledged as a service that provides transportation for seniors and make healthcare more accessible as a result. PCHD does a great job communicating and providing services. COVID has caused a decrease in the accessibility of services in general. Respondents also recognized that improvements or gains in evaluation have not occurred since the 2019 assessment.

Essential Service 10: Research for new insights and innovative solutions to health problems



Essential Service 10 is one area of the public health system in which there is minimal to moderate activity. As a small, rural county, the participants felt that the area is often overlooked for public health research. Also, without a university in the county, it is often difficult to foster the partnership needed to conduct research. The hospitals in the areas surrounding Putnam County, however, do have physicians and patients that participate in clinical trials. Many of the agencies in the community do partner with universities to provide student mentoring opportunities. It was encouraged to continue to do this to help build the relationships needed, which may lead to research in the future.

December 2021 Update: Survey results indicate that all respondents believe that the current functioning of the LPHS is about the same (60%), somewhat the same (10%) or a great deal (30%) as it was in November 2019 for the model standards in Essential Service 10.

Respondents point out that the issues related to Essential Service 10 still exist. More rural focused research and collaborations with institutions of higher education could happen in the future. The service area here in Putnam County is a big deterrent. Countywide financial investment to bring a higher learning institution, such as a trade school or 2 year college, would help to entice a population growth that would, in turn, allow for more state and federal money to be allotted to this county. Some do feel that Putnam County seems to look for new ways to do things and be more innovative.

Evaluation of the Local Public Health System Assessment

The participants of the LPHSA felt that participating in the day was a good use of their time and that the process allowed for contributions from all group members. They also felt that they accomplished what they had hoped to accomplish by the end of the day and the majority of participants acknowledged that they had learned of a resource or program in our community that they did know of before the assessment. The entire evaluation can be found in Appendix F.

When asked what they liked best about the process, some of the comments from the participants included:

Partnership and working together

Small group collaboration. Productive conversations to learn and grow.

The collaboration with different community groups, between services and different disciplines

The day was fast-paced, stimulating and very informative. As a participant, I learned a great deal. We covered a lot of material. Intense day, but a very positive and productive day.

Getting to know more about services

Working along people with the same mindset to make improvement

Limitations

It must be noted that there are some limitations in the Local Public Health System Assessment. Although many Partners were invited to participate in the assessment, some were unable to attend. Therefore, the knowledge in regards to some of the activities related to the Model Standards may not have been as great as it would have been if more Partners were present. Also, each participant is responding to the questions based on his or her experiences and perspectives, so gathering responses incudes some subjectivity.

It is also important to note that the performance scores for each Model Standard is an average of the responses to a number of questions related to that Model Standard. Also, the performance score for each Essential Service is an average of the Model Standard score of each Essential Service.

In addition to the limitations noted above, it is important to acknowledge that the December 2021 update of the LPHSA was completed virtually, through a survey of partners. Only 10 members completed the survey, however, those that did respond provided some interesting thoughts regarding how the public health system of Putnam County is performing. Many of the essential services and model standards were noted to be affected, both negatively and positively, by the COVID-19 pandemic.

Finally, the optional priority rating was completed by a small subset of the LPHSA and represents the best thinking of that group only. This information is shared with the entire group of Partners at a later meeting for comment and consideration.

These limitations should not diminish the value of the assessment or the results, but rather underscore the need to consider them in the context of the other community data, assessments and dialogue.

Appendix A: LPHSA Participants

Local Public Health System Assessment Participants

November 7, 2019

Barhorst	Brian	Putnam County YMCA
Donley	Lyndsey	Defiance College BSN Student
Fruchey	Becky	Ottawa Area Chamber of Commerce
Fry	Dunel	Putnam County Health Department
Horstman	Jennifer	Putnam County ADAMHS Board
Keuneke	Nicole	Bluffton Hospital
Kline	Joan	Putnam County Health Department
Konst	Donna	Pathways Counseling Center
Kuhlman	Kendra	Putnam County HomeCare and Hospice
McGraw	Michelle	Blanchard Valley Hospital
Osborn	Jan	Putnam County Educational Service Center
Recker	Sherri	Putnam County Health Department
Rigali	Jacob	Lima Memorial
Samuel	Lauren	Putnam County WIC
Schrader	Brandi	Putnam County Health Department
Vorst	Karen	Mercy Health – Putnam County ACC
Ward	Kelly	Putnam County Library
Warnecke	Jodi	Putnam County Council on Aging
Wischmeyer	Suzy	Putnam County Job and Family Services
Siefker	Brian	Putnam County Sheriff's Office

Appendix B: LPHSA Agenda

Putnam County Local Public Health System Performance Assessment
November 7, 2019 ~ 9:00 am – 2:00 pm
Pathways Counseling Center

Agenda

9:00 – 9:10 am	Welcome, purpose and introductions *Joan Kline, Putnam County Health Department*
9:10 – 9:45 am	Description of assessment process & group assignments Gallery Walk *Joan Kline, Putnam County Health Department* Group A: Essential Services 2, 7, 8 *Main meeting room* Group B: Essential Services 1, 3, 9 *Main meeting room* Group C: Essential Services 4, 5, 6 *Group Room*
9:45 – 11:45 am	Assessment
11:45 – 12:45 pm	**Lunch (provided)** **Forces of Change Assessment** *Margaret Nashu, Executive Director, Public Health Services Council of Ohio*
12:45 – 1:45 pm	Assessment, *continued*
1:45 – 2:00 pm	Wrap up, next steps, and evaluation *Joan Kline, Putnam County Health Department*

PUTNAM COUNTY HEALTH DEPARTMENT
Prevent Promote Protect

Appendix C: Gallery Walk

Gallery Walk – November, 2019

Essential Service 1 – Monitor health status to identify health problems

What's going on in our community? Do we know how healthy we are?

- Home Health – prevent hospitalizations
- Blood Pressure checks at Ottawa Senior Center 1 time a month
- WIC – growth, hemoglobin checks
- Wellness visit – family doctor
- CHA – health assessment
- Pride Survey
- Kiwanis Health Fair
- BCMH (Bureau for Children with Medical Handicaps) - PCHD
- Death data (PCHD)
- Disease monitoring – communicable disease stats (PCHD)

Essential Service 2 – Diagnose and investigate health problems and health hazards

Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?

- LEPC (Local Emergency Planning Commission) – investigates spills, planning, drills
- School consultation – mental health and substance use
- Communicable Disease monitoring and reporting – Healthcare providers and PCHD
- BWC – free disposal bags for injured workers
- Emergency Response and Preparedness – PCHD and EMA
- Outbreak investigations
- Epi center alerts
- Lead screenings at Head Start

Essential Service 3 – Inform, educate and empower people about health issues

How well do we keep all people and segments of our community informed about health issues so they can make healthy choices?

- Matter of Balance – Fall Prevention for Seniors
- Healthy U Diabetes
- WIC
- Help Me Grow
- Extension (Snap-Ed)
- Pride Survey – Survey of students in grades 6, 8, 10 and 12
- Task Force for Youth
- Prevention Programs and education – Mental Health and Substance Use
- Recovery Navigator – Mental Health and Substance Use
- Stroke and Cardiovascular education provided at Health Fair

- Health Fair
- Silver Sneakers program
- Water safety
- Baby Fair
- Heartbeat
- O&M (Operation and Maintenance for septic systems) community meetings – benefits and need of program
- Parent Project
- OBB car seats – car seats to WIC eligible families
- Opiate task force

Essential Service 4 – Mobilize partnerships to identify and solve health problems

How well do we really get people and organizations engaged in health issues?

- Senior Expo
- Fall Prevention Awareness Day
- Elder Abuse I-Team
- Sexual Assault and Domestic Violence Task Team
- Transportation Committee
- Summer Migrant School Health Fair
- Opiate Task Force
- O&M Stakeholder meetings and Community meetings
- Drug take back/DeTerra bags
- FCFC meetings – shared planning
- LEPC – local emergency planning commission
- Police chief's meetings
- Leipsic community center – free health clinic
- Running clubs
- Community meals/summer meals
- Backpack program

Essential Service 5 – Develop policies and plans that support individual and statewide health efforts

What policies promote health in our community? How effective are we in planning and in setting policies?

- CHIP (Community Health Improvement Plan)
- Vaccinations
- SBIRT at provider visits
- Emergency preparedness
- O&M
- Mandatory food training
- Wellness policies at workplace

Essential Service 6 – Enforce laws and regulations that protect health and ensure safety

When we enforce health regulations are we up-to-date, technically competent, fair and effective?

- Mental health and substance use diversion group programs
- Environmental Health Rules – Food, Septic, Water, schools, etc.
- Law enforcement officers – enforce laws
- Car Seat program

Essential Service 7 – Link people to needed health services and assure the provision of health care when otherwise unavailable

Are people receiving the health services they need?

- Home health and Hospice
- Palliative Care
- Primary Care Physicians
- Lab/Radiology
- General Surgery
- OB/GYN
- Orthopedics
- Pain Management
- Urology
- Recovery Navigator
- Transportation (Medicaid)
- Behavioral Access Center – open access
- Leipsic Community Center Free Clinic
- BCMH
- Car Seat program
- Senior Transportation
- WIC
- Head Start family support
- Wraparound
- Glasses/Medication through United Way
- Vision/Scoliosis screenings in schools

Essential Service 8 – Assure competent public and personal health care workforce

Do we have a competent public health staff? How can we be sure that our staff stays current?

- Pay for continuing ed for staff
- Inservices
- Tuition assistance from employer
- Staff wellness programs
- Associate/occupational health
- Mandatory education for all employees yearly at health care systems/facilities

Essential Service 9 – Evaluate effectiveness, accessibility, and quality of personal and population-based health services

Are we doing any good? Are we doing things right? Are we doing the right things?

- Quality Improvement projects internally
- County Health Rankings – Doctor/Patient and Dental/Patient ratios
- Transportation Services Surveys
- Home Health Compare
- Hospice Compare
- Nursing Home Compare
- State visits
- 65+ Silver Sneaker pre test and continued evaluation – strength flexibility
- Client satisfaction surveys
- Matter of Balance program evaluations

Essential Service 10 – Research for new insights and innovative solutions to health problems

Are we discovering and using new ways to get the job done?

- O&M Program
- Open Access – Walk-in appointment for mental health and substance use
- Primary care and specialty consultation available through Mayo Clinic
- Senior Isolation Initiative
- Psych services - telehealth

Appendix D: Performance Scores

Performance Scores and Priority Rating of Model Standards

Model Standards by Essential Services	Performance Scores	Priority Rating
ES 1: Monitor Health Status	**88.9**	**7.3**
1.1 Community Health Assessment	83.3	9.0
1.2 Current Technology	83.3	6.0
1.3 Registries	100.0	7.0
ES 2: Diagnose and Investigate	**97.2**	**8.7**
2.1 Identification/Surveillance	91.7	9.0
2.2 Emergency Response	100.0	10.0
2.3 Laboratories	100.0	7.0
ES 3: Educate/Empower	**97.2**	**9.0**
3.1 Health Education/Promotion	100.0	8.0
3.2 Health Communication	91.7	9.0
3.3 Risk Communication	100.0	10.0
ES 4: Mobilize Partnerships	**62.5**	**7.0**
4.1 Constituency Development	50.0	5.0
4.2 Community Partnerships	75.0	9.0
ES 5: Develop Policies/Plans	**81.3**	**7.8**
5.1 Governmental Presence	100.0	6.0
5.2 Policy Development	75.0	8.0
5.3 CHIP/Strategic Planning	75.0	8.0
5.4 Emergency Plan	75.0	9.0
ES 6: Enforce Laws	**82.8**	**8.3**
6.1 Review Laws	75.0	7.0
6.2 Improve Laws	83.3	8.0
6.3 Enforce Laws	90.0	10.0
ES 7: Link to Health Services	**84.4**	**8.5**
7.1 Personal Health Service Needs	81.3	8.0
7.2 Assure Linkage	87.5	9.0
ES 8: Assure Workforce	**87.9**	**4.8**
8.1 Workforce Assessment	66.7	4.0
8.2 Workforce Standards	100.0	4.0
8.3 Continuing Education	85.0	6.0
8.4 Leadership Development	100.0	5.0
ES 9: Evaluate Services	**98.3**	**5.3**
9.1 Evaluation of Population Health	100.0	7.0
9.2 Evaluation of Personal Health	95.0	5.0
9.3 Evaluation of LPHS	100.0	4.0
ES 10: Research/Innovations	**25.7**	**3.3**
10.1 Foster Innovation	25.0	5.0
10.2 Academic Linkages	33.3	3.0
10.3 Research Capacity	18.8	2.0

Appendix E: Notes from Local Public Health System Assessment

Essential Service #1: Monitor health status to identify community health problems

- Accurate, ongoing assessment of the community's health status.
- Identification of threats to health.
- Determination of health service needs.
- Attention to the health needs of groups that are at higher risk than the total population.
- Identification of community assets and resources that support the public health system in promoting health and improving quality of life.
- Use of appropriate methods and technology to interpret and communicate data to diverse audiences.
- Collaboration with other stakeholders, including private providers and health benefit plans, to manage multi-sectorial integrated information systems.

Model Standard	Strengths	Weaknesses	Opportunities
1.1: Population-Based Community Health Assessment	The CHA process is very good Good partnerships Done consistently (CHA every 3 years, Pride every 2 years)	Lack of man power and funds Need more access to the raw data from CHA surveys EMR data needed Most up-to-date data difficult to obtain CHA data gets out, but maybe not to all the right people	Put links to CHA on partner websites Track data over the years for trends Tap into data that all partners have Library can keep hard copies of CHA for people to see Data in newsletters to keep updating Personalize the data by agency to improve the use Access to Electronic Medical Records
1.2: Current Technology to Manage and Communicate Population Health Data	CHA provides good data every three years	Lack of funds and certain members to partners group to analyze data Electronic medical record info not widely available Difficult to have most up-to-date data	Work together to share posts on social media regarding data and related health info PCHD will be using Clear Impact software that may help with monitoring and updating the data Having an epidemiologist on hand would help with analyzing data Gathering data by census tract may help with determining populations in most need
1.3: Maintenance of Population Health Registries	PCHD maintains several registries, etc, (animal bites, immunization, vital stats, lead testing) Uncertain what other agencies track	Need chronic disease registry Some data not always available Need to know more about who (what agencies/organizations) and what data they track	Chronic disease registry would help with having necessary data Develop process for getting data or providing data to registries that may be used later

Essential Service #2: Diagnose and investigate health problems and health hazards

- Access to a public health laboratory capable of conducting rapid screening and high-volume testing.
- Active infectious disease epidemiology programs.
- Technical capacity for epidemiologic investigation of disease and outbreaks and patterns of the following: 1) infectious and chronic diseases; 2) injuries; 3) and other adverse health behaviors and conditions.

Model Standard	Strengths	Weaknesses	Opportunities
2.1: Identification and Surveillance of Health Threats	Mostly electronic automatic submission to ODRS/LHD from hospital and lab. EpiCenter helps identify potential health threats early. Overdose alerts system. Track employee wellness and flu shots	Infectious disease staff at hospitals are the only ones specialized in the reporting and follow up, so if they leave employment, it would be a big gap	Need more professionals in facilities to support surveillance of disease Cross-train more staff in infectious disease process
2.2: Investigation and Response to Public Health Threats and Emergencies	PCHD and all healthcare systems have emergency response coordinator and drill regularly. AAR and improvement plan done at hospitals and PCHD Staff training done routinely. Hospitals have strike team in case of a disaster/Ebola	Volunteer recruitment and management during a crisis LMH uses students from Rhodes as volunteers	Policies and protocols can always be improved - identified in drills and exercises Would help if doctor lets patients know of positive test result and PCHD will be calling and following up Reactivate MRC or tap into other community volunteer network
2.3: Laboratory Support for Investigation of Health Threats	All labs at hospital and outsources labs are credentialed. ODH lab has protocol with local labs to send specimens Electronic reporting Written lab protocols for collecting, labeling, storing, transporting	None noted	None noted

Essential Service #3: Inform, educate and empower people about health issues

- Community development activities.
- Social marketing and targeted media public communication.
- Provision of accessible health information resources at community levels.
- Active collaboration with personal healthcare providers to reinforce health promotion messages and programs.
- Joint health education programs with schools, churches, worksites and others.

Model Standard	Strengths	Weaknesses	Opportunities
3.1: Health Education and Promotion	Partnerships work to reach goals in the CHIP Make effort to reach other areas in the county when possible	May be some gaps in partnerships Need to involve different (atypical) partners	Central website to post events and opportunities Social Isolation Initiative in the works and may address issues with elderly

	Many programs available in the county – offered by various agencies	Limited traditional media, so use social media quite often – but may not reach all populations Those in most need are difficult to reach or difficult to engage	Health in All Policies considered when developing policies (businesses, organizations, government)
3.2: Health Communication	Relationship with local media is strong Partners willing to share information with their clients and community Schools helpful in disseminating info	PIOs are not always identified in all organizations Not all organizations have a communication plan	Offer training for spokesperson/PIO Find out who the "go to" person is to receive information and distribute it appropriately to staff, clients, community Identify PIO in all organizations Present at Lunch and Learns offered by Chambers General website with variety of information for community Use text alerts
3.3: Risk Communication	PCHD has plan and partnerships Drills and exercises are conducted that often focus on communication PCHD serves as resource for risk communications	Not everyone is trained in risk communication Information not always getting to all parts of the county	Training of partners in communication and offer regularly due to staff turnover Improve staffing for communication Consider innovative or different partnerships

Essential Service #4: Mobilize community partnerships to identify and solve health issues

- Convening and facilitating partnerships among groups and associations (including those not typically conserved to be health related).
- Undertaking defined health improvement planning process and health projects, including preventive, screening, rehabilitation, and support programs.
- Building a coalition to draw on the full range of potential human and material resources to improve community health.

Model Standard	Strengths	Weaknesses	Opportunities
4.1: Constituency Development	Some programs that are happening are done by individual agencies Partners group works to complete the CHA	Need improvement in community engagement Communication about the programs. Not everyone knows about them. Need to be better about making connections	Directory for social services - continually update Community calendar with all events - have website with information
4.2: Community Partnerships	There are many groups and coalitions in Putnam County The groups are very active	Need better work and organization between the different groups	Establish point of contact for groups to help with better communication Ownership and follow-through Groups continue to meet to address issues

Essential Service #5: Develop policies and plans that support individual and community health efforts

- Leadership development at all levels of public health.
- Systematic community-level and state-level planning for health improvement in all jurisdictions.
- Development and tracking of measurable health objectives from the community health plan as a part of continuous quality improvement strategy plan.
- Joint evaluation with medical healthcare system to define consistent policies regarding prevention and treatment services.
- Development of policy and legislation to guide the practice of public health.

Model Standard	Strengths	Weaknesses	Opportunities
5.1: Governmental Presence at the Local Level	Accreditation for PCHD Partnerships for the CHA and CHIP Programs available in the community Events planned for the community	Promotion of services needs to be better	Improve awareness and promotion Continued awareness Reaccreditation for PCHD
5.2: Public Health Policy Development	Staying on top of policies, procedures and laws	Public health impact not always considered	Continue to promote policy change Consider Health in All Policies
5.3: Community Health Improvement process and Strategic Planning	Collaboration is very good for completing CHA and working on some CHIP objectives	Need more improvement in implementing the CHIP Financial concerns in implementation of some programs	Reinforce positive behaviors to improve health Update improvements that have been made and share with community and partners
5.4: Plan for Public Health Emergencies	PCHD has emergency response plan. Healthcare organizations are active in emergency response Drills are conducted	Uncertain funding	

Essential Service #6: Enforce laws and regulations that protect health and ensure safety

- Enforcement of sanitary codes, especially in the food industry
- Protection of drinking water supplies
- Enforcement of clean air standards
- Animal control activities
- Follow-up of hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings
- Monitoring quality of medical services (laboratories, nursing homes, and home healthcare providers)
- Review of new drug, biologic, and medical device applications

Model Standard	Strengths	Weaknesses	Opportunities
6.1: Review and Evaluation of Laws, Regulations, and Ordinances	Information is provided to appropriate entities.	Education of public regarding laws, regulations, etc needs improvement	Community education

	Education provided to contractors of environmental health services		
6.2: Involvement in the Improvement of Laws, Regulations, and Ordinances	Representation	Small county, smaller voice. Often not heard like larger areas	Work to strengthen relationships Strong relationships to help with addressing laws and regulations
6.3: Enforcement of Laws, Regulations and Ordinances	Follow up	None noted	Quality improvement

Essential Service #7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Link people to needed personal health services and assure the provision of health care when otherwise unavailable

- Assurance of effective entry for socially disadvantaged people into a coordinated system of clinical care.
- Culturally and linguistically appropriate materials and staff to ensure linkage to services for special population groups.
- Ongoing "care management."
- Transportation services.
- Targeted health education/promotion/disease prevention to at-risk population groups.

Model Standard	Strengths	Weaknesses	Opportunities
7.1: Identification of Personal Health Service Needs of Populations	Hospitals look at where clients seek care and why need to go to other cities for care Community health survey identifies need Schools refer students to mental health and doctor office Hospitals look at registration data and payer types ED tries to get patients to primary care provider	Difficult to identify groups and needed services if they don't seek care	Starting to utilize care navigators in hospitals and mental health. May need more Figure out ways to identify people in the shadows - what are their needs
7.2: Assuring the Linkage of People to Personal Health Services	ER sets people up with primary care office Social worker at hospitals work with clients BCMH links people to service Open Access at Pathways Knapsack and LCC food program Car Seat program	Lack transportation if not elderly/disabled Limited assistance available to help people sign up for public benefits ED population needs more education on resources available People lack knowledge of where to go and resources Not enough social workers/time	Offer somewhere people can get assistance with signing up for public benefits More transportation options for patients

		to follow up on doctor office patient needs Mental health needs for kids in schools - rises throughout the school year	

Essential Service #8: Assure a competent public health and personal health care workforce

- Education, training, and assessment of personnel (including volunteers and other law community health workers) to meet community needs for public and personal health services.
- Efficient processes for licensure of professionals.
- Adoption of continuous quality improvement and lifelong learning programs.
- Active partnerships with professional training programs to ensure community-relevant learning experiences for all students.
- Continuing education in management and leadership development programs for those charged with administrative/executive roles.

Model Standard	Strengths	Weaknesses	Opportunities
8.1: Workforce Assessment, Planning, and Development	Healthcare systems do their own workforce assessment regularly and identify gaps PCHD conducts training needs assessment	Dentists and mental health providers very low in Putnam County. Provider/patient ratio is very high No county-wide assessment done	Continue to assess open positions and staff turnover Partner with colleges to identify gaps
8.2: Public Health Workforce Standards	All healthcare licensures are checked Job descriptions are done for all staff Competency checks done for staff	Job competencies in hospitals not based on public health competencies Job standards based on professional and technical skills and abilities - not 10 Essential Services	
8.3: Life-long Learning through Continuing Educations, Training and Mentoring	Training provided in-house to meet CEU needs Resources and budget are allocated for training and education Tuition reimbursement and classes offered Collaborate with other agencies to provide training Conduct cultural competence training	Public health and healthcare workers not regularly trained on 10 Essential Services	Incorporate 10 Essential Services in training programs throughout the year
8.4: Public Health Leadership Development	Starting Putnam Business and Education Partnership Leaders involved in community coalitions and task forces Routine leadership meetings Systematic plan to develop leaders over yearlong program at BVHC	Leadership in many organizations do not represent diversity of community	Sustain Putnam County Business Education Partnership

	Monitor within own organization All equal opportunity employers		

Essential Service #9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services

- Assessing program effectiveness through monitoring and evaluation implementation, outcomes and impact
- Providing information necessary for allocating resources and reshaping programs.

Model Standard	Strengths	Weaknesses	Opportunities
9.1: Evaluation of Population-Based Health Services	Most agencies evaluate services and work to improve	General overall improvement may be needed Not always getting information for vulnerable population	Regular training to help with evaluation, gap analysis and improvement
9.2: Evaluation of Personal Health Services	Physician evaluate health services offered Hospice continually evaluates services by surveying family members PCHD evaluates for immunization services, BCMH WIC conducts evaluation of services	No access to EMR to have full understanding of health needs or performance Need digital access to conduct evaluations	Digital access for surveys and evaluation
9.3: Evaluation of the Local Public Health System	Communication between agencies is good Agencies are typically willing to work together to provide improved services	Sometimes difficult to find funding to provide needed services	Assess the partnership to learn more about needs of the agencies and organizations

Essential Service #10: Research for new insights and innovative solutions to health problems

- Full continuum of innovations, ranging from practical field-based efforts to fostering change in public health practice, to more academic efforts that encourage new directions in scientific research.
- Continuous linkage with institutions of higher learning and research.
- Internal capacity to mount timely epidemiologic and economic analyses and conduct health services

Model Standard	Strengths	Weaknesses	Opportunities
10.1: Fostering Innovation	Hospitals have doctors and patients participating in clinical trials and research programs Cancer programs often participate in research BVHC has own IRB process and project management group Mercy has committee for research Use only evidence-based programs	Small, rural county doesn't get approached for public health research No major universities doing research here	Consider partnerships when approached Monitor surveillance system for need to do community research

	Innovation in BVHC value statement		
10.2: Linkage with Institutions of Higher Learning and/or Research	Partner with colleges for student education Student mentoring	Do not partner with colleges to conduct public health research	Consider partnerships when approached Maintain student mentoring partnerships
10.3: Capacity to Initiate or Participate in Research	Share health assessment with community and have community forums	Not a lot of opportunities here	Collaborate and support research when able

Appendix F: LPHSA Evaluation Summary

Putnam County Local Public Health System Assessment

Evaluation Summary

November 7, 2019 ~ 9:00 a.m. – 2:00 p.m.

Please circle which group you participated in today:

Group A: Essential Services 2, 7, 8, 10

Group B: Essential Services 1, 3, 9

Group C: Essential Services 4, 5, 6

Rate today's assessment by indicating your responses to the following statement:

	1 Strongly disagree	**2** Disagree	**3** No opinion	**4** Agree	**5** Strongly agree
We accomplished what we hoped to accomplish today				7	9
The right amount of time was spent on each Essential Service.		1	1	5	9
The format/structure of the time helped us to be productive.				5	10
The process used allowed for contributions from all group members				5	11
The Gallery Walk was a useful activity.				9	7
I learned of a resource/program in our community that I did not know of before today.				6	10
The Forces of Change Assessment was a useful activity				8	8
Overall, today was a good use of my time.			1	5	10

What I liked best about this process was…

- Partnership and working together
- The collaboration with different community groups
- Good to get together with area health professionals
- Working along people with the same mindset to make improvement
- Collaboration between services

- Collaboration of different disciplines
- Getting to know more about the services
- The people in the group were appropriate to address our services
- Small group collaboration. Productive conversations to learn and grow
- Great to work with other agencies and to see what they are doing
- Good effective process using different styles to get input
- Discussion – gained knowledge of other programs
- Small group discussions
- Discussion of small groups
- Meeting people in the community
- The day was fast-paced, stimulating and very informative. As a participant, I learned a great deal. We covered a lot of material. Intense day, but a very positive and productive day

The process used today could have been improved by…

- All was great!
- Having a better background of CHA
- Nothing
- More explanation of the CHA
- Not sure if all the people represented were complete to address the service area
- Understanding how the Forces of Change ties into the 10 health elements
- I thought it was well thought out and planned
- Nothing that I can think of
- Having more time
- No suggestions

Additional Comments (use back of page, if needed)…

- Not sure I was best fit to come from my organization (checked "no opinion" for "overall, today was a good use of my time)
- This was my first time attending. Enjoyed the opportunity to participate and provide information about Blanchard Valley Health System
- Liked seeing BVH and LMH participate
- Good day
- Thank you! I greatly appreciate the opportunity to participate. Joan, et.al did a great job!

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Forces of Change Assessment

The Forces of Change Assessment is designed to help determine what is occurring or might occur that affects the health of the community or the local public health system. Participants in the assessment were asked to identify specific threats or opportunities that are generated by these occurrences. Trends (patterns over time), factors (discrete elements such as a rural setting or population demographics) and events (one-time occurrences such as a natural disaster) are considered when reviewing the results of the Community Health Assessment as a whole and in determining priorities for the Community Health Improvement Plan.

Methodology

The participants that contributed to the Forces of Change Assessment included the members of the Partners for a Healthy Putnam County and staff and leadership of the Putnam County Health Department. This year we had two options for our members to participate in our survey. They could either fill out a survey monkey via a link that was emailed out on February 14, 2022, or attend a virtual meeting held on February 23, 2022. The virtual meeting was led by Sherri Recker, Director of Nursing at the Putnam County Health Department.

The Forces of Change Brainstorming Worksheet was emailed to all participants to prepare them for either completing the survey monkey or to attend the virtual meeting. The 6 categories in which feedback was requested, both positive and negative, were the following:

1. Social
2. Economic
3. Political
4. Technological
5. Environmental
6. Health

How to Identify Forces of Change

Think about forces of change – outside of your control – that affect the local public health system or community.

1. What has occurred recently that may affect our local public health system or community?
2. What may occur in the future?
3. Are there any trends occurring that will have an impact? Describe the trends.
4. What forces are occurring locally? Regionally? Statewide? Nationally? Globally?
5. What characteristics of our county may pose an opportunity or threat?
6. What may occur or has occurred that may pose a barrier to achieving a shared vision?

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Be sure to consider health equity and disparities. Are there populations in our county that may have factors that affect their health? Identify those populations in your answers.

Also, consider whether forces identified were unearthed in other community/agency discussions.

1. Did discussions during other meetings with partners bring to light any other trends, factors, or events that you feel may affect the public health system or community?

The above information was sent out to all participants as a brainstorming worksheet prior to the survey monkey or virtual meeting. Participants were also asked that once a force of change was recognized, to identify threats that force could pose to our community and what opportunities could be created from this force. We collected all input from the survey monkey and from the brainstorming session via Microsoft Teams and compiled it into the matrix below.

Assessment Results

The Forces of Change Assessment provided an overview of key trends, events, or factors, identified by participants, as current or potential influences on the overall health of the Putnam County community. The common trends that were identified for Putnam County included:

Social/Health

- Workforce
- Health Education
- Mental Health

Economic/Political

- Health Equity
- Health Care Policy
- Health Education

Environmental/Technological

- Health Information and Communication Technology
- Program Education
- Health Education

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Forces of Change Assessment

Force of Change (Trend, Events, Factors)	Threats Posed to the Putnam County Community	Opportunities Created to the Putnam County Community
Social/Health		
Aging population	• Increase in chronic conditions • Lack of care (family not living close by) • Staffing shortages due to retirement	• More staying in workforce longer (ex. Volunteer) • Plenty of Healthcare jobs
Younger population leaving area	• Workforce shortage • Frequent job changes	• Economic development opportunities create jobs younger population want
Shifting work styles (internet/e-commerce)	• Lack of workforce for healthcare and other areas	• Immigration workforce programs
Vaping	• Increase in vaping in children • Health and addiction concerns	• Education and prevention programs
Mental Health	• Teen eating disorders • Increased depression/ suicide/suicidal ideation • Isolation, anxiety	• Creation of support groups • Mentor programs • Awareness • Text 4 help program
COVID	• Increased fear, anxiety, and isolation • Increased demands on healthcare	• Education for coping skills
Non-GMO/Organic	• Misinformation or mislabeling • Falsely advertised for increased price • Lack of knowledge on what's important	• Education

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Force of Change (Trend, Events, Factors)	**Threats Posed to the Putnam County Community**	**Opportunities Created to the Putnam County Community**
Economic/Political		
Medicare/Medicaid Reimbursement	• Inability to maintain competitive wages in healthcare due to low/decreased reimbursement • Programs vary and coverage is confusing – many companies advertise or call residents to switch plans	• Lobby for increase in Medicaid/Medicare reimbursement • System or program to help aging population select insurance plans
Lack of Grocery Stores	• Lack of availability to fresh produce or nutritious foods • Poor nutrition	• Program for food delivery • Education on preparation of healthy foods
Inflation	• Rising prices for basic goods • Stress and strain on families • Inability to afford sports or extracurricular programs for children	• More community programs for children • Scholarship or equipment loan programs for extracurricular activities
Political Climate	• Increased partisanship • Growing disillusionment with government	•
Governmental Assistance	• Lack of knowledge and support to become independent and self sufficient	• Educational and skills development
COVID Mandates	• Workers leaving • Anger/resentment toward leaders • Division among residents	• Education for dispelling misinformation
Workforce Shortage	• Loss of businesses and growth • Lack of healthcare workers to care for aging population	• Immigration workforce programs • Potential for remote monitoring programs for senior residents

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Force of Change (Trend, Events, Factors)	Threats Posed to the Putnam County Community	Opportunities Created to the Putnam County Community
Environmental/Technological		
Social Media	• Bullying • No regulation/ misinformation	• Education on risks/dangers of social media • Information on reliable sources to "follow" • Use social media platforms to educate and offer help/various resources
Increased screen time	• Increased inactivity/ Childhood obesity • Decreased parent/child interaction • Potential for predators	• Education on effects of screen time
Telehealth	• Difficult for older population to use • Expense to patient and low reimbursement rates for providers	• Increased access to specialty providers
Climate Change	• Increase in extreme weather	• Education • Recycling programs
Wind Turbines	• Potential loss in property value	• Renewable energy
Emergency Communication	• Alerts sometimes difficult to find – i.e. only on Facebook page or certain websites • Difficult for senior residents to be aware	• County text or automated call alert system for roadway alerts, roadway closures (high water, etc.), severe weather alerts, etc.

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Community Themes and Strengths

The Community Themes and Strengths Assessment is a combination of focus group discussions and a survey with a variety of groups in the community and key informants. The purpose of the Community Themes and Strengths Assessment is to determine what is important to the community and how the quality of life in the community is perceived. This assessment is also a way to discover possible resources for addressing some of the community needs.

Methodology

The focus group questions were chosen and finalized by the Partners for a Healthy Putnam County steering committee in the Summer to Fall of 2021. To obtain a good picture of the health of the community from the viewpoint of our residents, nine focus group discussions were conducted with a number of different groups. The following participated in the focus group meetings: senior citizens, Head Start parents, school guidance counselors, P.A.R.T.Y. youth, police chiefs, business and social agency leaders, ministers, and at-risk youth parents. The focus groups were held between October 2021 through February 2022. There was a total of 63 participants.

Throughout the focus group process, several themes were identified by most or all the groups. Those themes include:

- Mental Health
- Substance Use and Abuse
- Access to resources in the community (Awareness)
- Lack of supportive services
- Isolation

Focus Group Results

Below are the questions and responses from all the focus groups discussions.

COMMUNITY PERCEPTION AND NEEDS

1. **When you think of a healthy community, how would you describe it? What makes a community healthy? What is your vision for a healthy community?**
    - Equality/Access to all resources-10
    - Connectedness as a community-8
    - Caring of others-7
    - Adequate Resource-7
    - Access to healthy and affordable foods-6
    - Counselors and support services-3

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- Transportation-1
- Safety-6
- No drugs/gangs-1
- Programs for the elderly-4
- Good Economy/thriving business-3
- Education/Good Schools-3
- Students being active in sports and extracurricular activities-1
- Active health department-2
- Housing kept up-2
- Cleanliness/Clean water-2
- Access to exercise-1
- Increase volunteerism-1
- Leipsic Community Center-1
- Low COVID cases-1
- Vaccinations-1
- Partnership-1

2. **What is HEALTHY about the community you live in, or in Putnam County in general? Can you think of any specific examples of people or groups working together to improve the health and quality of life in your community or in the county?**
    - People coming together in the community-5
    - Habitat for Humanity-2
    - Church-related activities-3
    - Leipsic Community Center-3
    - Food Banks/Knapsacks-4
    - Statistically we seem to be pretty healthy

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- Communities try to provide places for walking-2
- Strong faith-based community-3
- Families
- Benefits/Fundraisers-2
- Diaper bank
- Community Meals
- Council on Aging
- Meals on wheels
- Work-out equipment in almost every community-3

- Great work ethic
- Community involvement/volunteer in community-4
- Safety-1
- Community events-1
- There are options but not sure people know about them
- A lot of organizations that help
- Many resources available
- Clean streets and buildings School system
- Caring people
- Mental health support
- Optimal club
- Big brother and big sister
- Pathway, grief camps, community resources

3. **What is UNHEALTHY about your community? What do you think are some of the MOST important HEALTH issues facing your community?**
    - Substance Abuse/Use/activity=10
    - Isolation from Pandemic-4
    - Family issues-4
    - Mental Health -4
    - Run down homes – 3
    - Lack of resources=3
    - COVID – its's affects beyond the illness – job, housing drugs-3
    - Transportation for non-seniors-2

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- Lack of knowledge of resources-2
- People not being open – Pride stands in the way
- If you are not connected with the community, things can be very difficult
- Lack of childcare
- Screentime
- Safety concerns
- No funding for help with utilities, water
- Lack of assistance for minorities/pending immigration status (afraid to ask for help, lack of assistance for them)
- Lack of pride in their life (including property, car, job, self)
- Village administration sets policy and enforcement activities)
- Technical issues with telehealth
- No access to social events
- Lack of Follow-up after mental health crisis
- Resources and consulting
- Anxiety and social anxiety in school
- Homelessness students (they choice to be homeless)
- Cutting, vaping, chat rooms with strangers
- Eating disorders needed in students

4. What services do you use or what behaviors do you have that keep you and your family healthy?

- Cleaning, hygiene, masks
- Ring doorbell (video doorbell) for safety
- Yearly physicals, vision, dental
- School does screenings
- The Leipsic Community Center
- Free health clinic
- Council on aging-2
- Try to be active
- PARTY Group
- Other support groups
- Boy Scouts
- Peer Support
- Hobbies to reduce stress
- Pathways
- Help me grow

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- Resource officer
- Probate officer

5. **Is there anything that keeps you and those around you from being healthy? What could make you healthier?**

- Lack of Support Services-6
- Lack of support for single-parent homes
- Not supporting elementary youth as much as needed. Often focus on teens, but elementary may need some support also
- Family support is needed
- Lack of support from parents/peers when seeking help for mental health
- Family not supporting keeping drugs and alcohol out of the house
- Lack of local drug/alcohol rehab
- Access and affordable to health foods-3
    - Cost of healthy foods often too much
    - Access to healthy food may be an issues – buy at Dollar General or Dollar Tree Junk food
    - Being Busy – hard to do the healthy foods when busy
- Lack of local mental health services
- Poor mental health
- Mental health services are booked
- Adults without children and elderly slip through the cracks (most assistance programs require children in the house)
- Lack of Motivation
- Lower income have needs that may not be addressed
- Cultural competence for all and understanding of others and their cultures needed. Kids are more accepting of diversity. Adults are getting better, but have work to do
- Stereotyped if use school counselors
- Parents bad choices leads to teens making bad choices
- Peer pressure to fit in or fit their mold to use alcohol and drugs
- Outcasted or isolated for not going to parties
- Pressured at school and at home to go to parties
- Parents and teachers do not understand the importance of mental health

RESOURCES

1. **If you needed help for some reason, to whom or where would you turn?**

- Health Department-3
- Family-3

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- Friends-2
- Guidance counselor at school-2
- Council meetings
- JFS
- Community action
- HUD
- Coworkers, help line
- Council on aging
- Healthcare provider
- Usually know where to go, but some people may not always know. A directory would be good. Central hub for resources and guidance
- Some resources are out of the county and don't always have "a person" to help connect to services
- PARTY Group

2. **What resources (agencies, institution, and programs) do we have in our community that seems to be working to address issues or concerns that you have seen?**

- Thrift store
- Council on aging-2
- Health department-2
- Rural county – can be good and bad. Services aren't always available
- Food Pantry
- Grief counselors
- Telehealth
- pathways

3. **What resources or activities would you like to see more of in the community that would impact health in a positive way?**
    - Transportation-2
    - More prevention programs -3
        - Health Fairs for younger population/Clinics/Screenings
        - Services for youth – ability to get them ready for school
        - More outreach by agencies
    - Translation and interpreters-5
        - Non-English community – need more translation and interpreters available
        - Ipad translation apps are helpful but not that great
        - Need to know where to go to get translator
        - Need help interpreting "doctor speak"

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    - Sign language interpreter
- Mental health resource-6
    - Community needs to be better informed about mental health to help
    - More mental health support
    - Grief counselors
    - Mental health and social isolation of seniors is a concern.
    - Something to help kids with stresses – school, social media, sports, don't know how to have conversations or make eye contact
- More alcohol/drug awareness/treatment/support
- Access to resource-6
    - More info about resources that are available
    - Navigators to help people get linked to what they need
    - Individuals to help people apply for health insurance
    - More resources for under privilege
    - A comprehensive resource guide – something that both individuals and agencies can have access to. An online resource directory may be good for individuals who don't want to ask for help because of stigma
    - Better alignment of resources
- Family needs-5
    - Youth/HS/College age – need to engage them more to keep them in the community
    - Kids are so busy that they are often missing family time. COVID helped to give family time together again
    - Lots of sports in the community – but recognize that some kids are not part of that
    - Parents want to keep kids busy so that there is no time for kids to get into trouble
    - More support for LBGT
- Aging Population needs-3
    - Church communities – to help with checking in with those in need
    - Caregivers take care of elders – there is a decrease in aides available
    - Dementia friendly community
    - More support for caregivers
- More support for people incarcerated
- More opportunities for safe social gatherings
- Opportunities to share personal history and cultures
- Expand the reach of the COA newsletter
- More family doctor's vs CNP, more specialists in the area
- More/different newsletters (on white paper)
- More focus groups in all villages

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- Computer education

4. **What would excite you enough to become involved in improving our community?**

- People are on a waitlist for housing vouchers
- Families are having a hard time getting into subsidized housing
- incarcerated – rehab, compassion, services needed
- Care packages for families
- Adopt-a-family program
- Mental health activities for kids – help them belong
- Love of the sport and get involved
- Festival planning
- Pride in the community and want to see it nice

ACCESS TO HEALTHCARE (PHYSICAL, MENTAL, BEHAVIORAL, ETC.)

1. **What makes it hard for people in Putnam County to get the help or services they need. This includes services like seeing a doctor or specialist, mental health services or prescription services, to name a few**
    - Transportation to services-4
    - Prices of some medications/cost of sesrvivcs-3
    - Stigma mental health -2
    - Mental Health-6
        - Residents do not appear to like the telehealth option
        - Increase in Mental Health needs in adolescents
        - So much stigma on mental health
        - Many people don't believe poor mental health exists
        - For youth with behavioral and mental health needs it is difficult to find respite care and homebased services – especially in intense situations
        - Parents denial that poor mental health is a problem
    - Unaware of services available to them/Not knowing where to start-6
        - Lack of resources – if client needs something more after initial visits, and they don't know where to get resources, they quit looking
        - Services to help navigate red tape
    - For addictions, it is difficult to get people to see a counselor and get on medications-2
    - Cannot find parenting education/ Lack of parental support-2
    - Optometrist don't take the medical card
    - Dental resources – very few (or none) take Medicaid – none local
    - Vision resources – very few or none take Medicaid

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- Emergency Room – people use ER for urgent care needs
- Support for single parents
- People know about services
- Help for working poor
- Kids want to leave Putnam County as soon as they can
- Lack a willingness to seek help
- Can find it if needed – do a search on phone
- Access to care may not be a problem, but getting the OK from insurance is a problem

2. **Do you feel that people in our community know about the health services and options that are available to them? Why or why not? If you can't find needed services, where do you go to get help?**

- Need more resource info on where to go for assistance
- People are unaware of services available to them or for others.
- Don't know where to look for services and resources
- Housing assistance – no info available. Give kick-back to those that rent houses to those in need
- Often have three generations living in one house
- Hard to get referrals to specialist
- Small network of providers locally
- Not as much help from JFS now to help people sign up for Medicaid
- Youth too young to drive or no access to transportation
- Parents won't pay for mental health treatment or services
- **Yes, people know about services-5**
    - People know about services
    - Can find it if needed – do a search on phone
    - Council on aging
    - Health department
    - The ESC resource guide has a QR code to scan with your phone and brings up a long list of resources

3. **Do you have any suggestions to help improve access to health-related services?**

- Communication of Resources-4
    - Better alignment of resources
    - More providers and hub or website for resources
    - More resources for under privilege
    - List of people/experts willing to talk in the community about issues
- More opportunities for safe social gatherings
- Opportunities to share personal history and cultures
- More free support groups

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- More support for people incarcerated
- Transportation-2
- Assistance with daycare/more daycare providers
- More outreach by different agencies
- Help navigating doctor's appointments
- Mental health resources – remind people that it's OK to ask for help – start educating at young age
- Lunch and Learns

QUALITY OF LIFE

1.Are the following issues in your community?

A. Access to healthy foods
- Didn't feel it was an issue -5
- Fresh produce not always available
- Knapsack helps some
- Kids usually get healthy lunch at school
- Community gardens
- It depends on the community, some do and some don't

B. Access to Places for Physical Activity
- Didn't feel it was an issue-3
- Not much for little ones. Often a cost related to some things
- See people walking/running
- Some gyms around the community
- Too expensive
- people can use schools, community centers to exercise

C. Safety
- Not an issue-1
- Need more police patrol
- Unnecessary racial profiling
- people watch out for each other, can't stop random acts of violence, not statistically more than in city
- Many reported being followed, stared at, having pictures taken w/o consent
- Many reported being harassed to join groups they felt were unsafe
- any reported being harassed to not get vaccinated because they were young and fertile

D. Access to doctor's office
- Can usually see doc, but people may not always follow up
- Lack of transportation
- Lack of specialists within PC or PC providers not in their network
- Lack of specialist within PC
- Lack of family doctors (most see NP)

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- Limited doctors, however they are urgent cares free mobile dental van

E. Exposure to lots of advertisements for alcohol/tobacco

- Not an issue
- Yes, teens don't understand the consequence of social media

F. Housing

- Housing is an issue
- Lack of affordable housing
- Some rentals are not safe, lack heating, needed of repairs
- Unfair rental practices. Charging per person instead of as a whole unit.
- Lack of housing that allows pets
- yes, mowing property, assess nuisance clean-up costs to homeowner's taxes if not cleaned up after citation
- No, but families move from house to house with other family members

2.What do you believe is keeping your community from doing what needs to be done to improve health and quality of life?

- Lack of motivation of people in power. They may not always see the needs-1

HEALTH EDUCATION AND COMMUNICATION

1. Where do you currently get health related information?

- Online/Internet/website-5
- Health Department-4
- Social Media-3
- Doctor/pharmacy-4
- Newspaper-2
- Other (Health fair)
- School nurse-1
- School counselors-1

2. How would you like to receive health information in the future?

- Written information-2
- Welcome packet given to people when they sign up for electric, water, etc
- Flyers given to kids to take home
- Churches
- Social media
- Virtual
- News but wants it honest
- Newsletter on resources available in the community

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CLOSING

1. **Of everything we talked about today, which one issue or item is the most important thing for our community to address**
    - Centralized information, need more resources and education, especially with the parent, Get out more health education and resources-5
    - Mental health and Suicide-3
    - Support groups-2
    - Work with young children – less screen time, more family time, time for God
    - Bullying
    - Drugs/alcohol

Key Informant Survey/Community Leader Survey

Methodology

A key informant survey was also completed as part of the Community Themes and Strengths Assessment consisted of collecting qualitative data to provide some contextual information to the primary and secondary data. The survey was created by The Center for Marketing and Opinion Research (CMOR) in partnership with Putnam County Health Department. The survey was finalized in January 2022. The survey was provided to healthcare providers, mental health providers and representatives of area businesses via an email with a survey link on February 2, 2022. Key informants had three weeks to complete the survey. These individuals were asked to respond to a series of questions relating to health issues in Putnam County. Key Informants were then asked a follow-up question as to what needs to be done to address the issue(s) they mentioned. Both questions were open-ended in which the respondents could give multiple responses. To review a copy of the survey, contact Putnam County Health Department.

A total of 19 individuals completed the survey. Some of the questions were more specific, relating to the results of the community survey that had been completed. This was done to gather a better understanding of the role of the key informants in helping to address health issues.

Similar themes as those found in the focus groups were also identified by the county's key informants. Some of the top health issues were:

- Substance abuse and addiction issues
- Healthy living and obesity
- Mental Health
- COVID-19 related issues

The key informants were also asked to provide suggestions for ways to address some of the issues. More education on the various concerns was a common recommendation provided by those surveyed. The key 19 informants also acknowledged barriers, such as transportation, awareness of what is available, cost, personal unwillingness to seek care/Social norms. Below are the results from the survey.

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Survey Results

Most Important Health Related Issue or Challenge		
	# of TOTAL Responses	% of Leaders
Substance abuse and addiction issues	8	44.4%
Healthy living and obesity	8	44.4%
Mental Health	7	38.9%
COVID-19 related issues	6	33.3%
Food accessibility	3	16.7%
Violence and abuse	3	16.7%
Senior services	2	11.1%
Access to care	2	11.1%
Politicized/Lack of trust with health experts	2	11.1%
Caregiving and Respite care	1	5.6%
Parenting	1	5.6%
Poverty	1	5.6%
Total	**43**	**(n=18)**
Question: Given your professional experience, what do you think are the most important health related issues or needs in Putnam County right now?		

What needs to be done to address issues	
Issue	**What Needs Done**
Substance abuse and addiction issues	• There are a lot of good programs and services available to implement, but there is a lack of funding to hire additional staff to implement the programs • Education, increased access to resources • Prevention services for families and for youth • Inform people and let them make their own choices • Educational, cultural changes in the way alcohol is used.
Healthy living and obesity	• More wellness training & programs • More positive social activities • Parents need to be a positive image to their kids • Educational, cultural changes in the way food is used. • Parents should teach their children about portion control and self-control related to food. • Parents to be informed, aware and accountable.
Mental health	• There are a lot of good programs and services available to implement, but there is a lack of funding to hire additional staff to implement the programs • Inform people and let them make their own choices • Continued education on mental health services

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	• The County needs to address the mental health of all its citizens like never before. At one time, we had mental hospitals of which we never need to see these again, but we need good mental health hospitals in our state and in the county. • Awareness activities, MTSS- Multi-Tier System of Service for health/mental Health/ and Education
COVID-19 related issues	• More protective gear for people going into homes. • Continued education on COVID
Food accessibility	• Return of grocery stores to all towns • Increased access to healthy foods.
Violence and abuse	• Education
Senior services	• More affordable housing
Access to care	• More resources to meet the needs of the people • No dentists accept Medicaid in Putnam County. • Transportation • Increased public transportation options
Lack of trust with trust issues	• Adults who do not have politicized views should bring awareness to their children and friends.
Parenting	• Well-established adults need to take parents in need under their care so that higher standards can be learned by the next generation.

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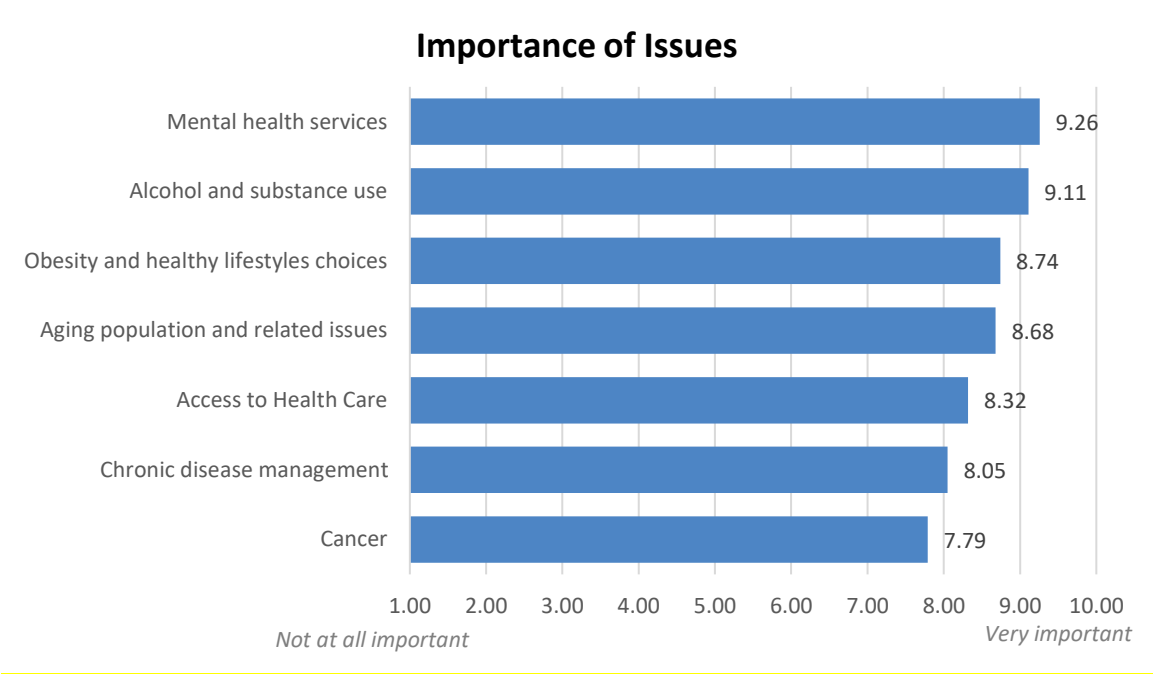
Community Leaders were given a list of health-related issues that were identified through the community survey and secondary data analysis and asked, based on their professional experience, how important they thought the issue was on a scale of 1=Not at all Important to 10= Very Important. Responses were averaged in order to rank the importance of the issues. It should be noted that six of the seven issues had an average importance of 8.0 or higher. The top three issues, based on the rankings, were (1) mental health services, (2) alcohol and substance abuse, and (3) obesity and healthy lifestyle choices.



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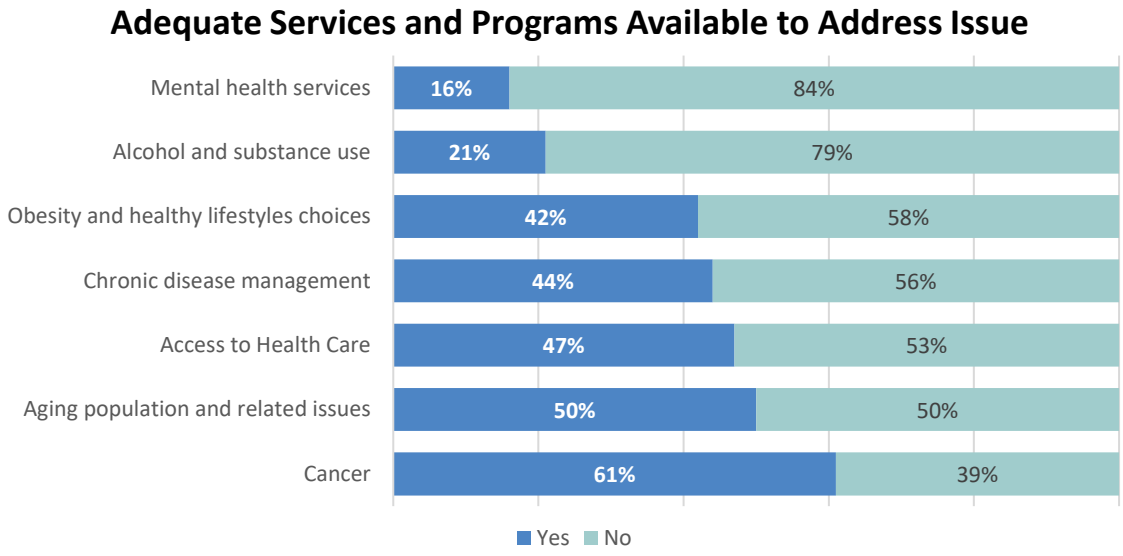
Health Leaders were also asked if they thought there were adequate services and programs already in place to address each issue. The only issue that Health Leaders thought already had adequate resources in place was for cancer. If they indicated there were not enough services or programs in place, they were then asked what is missing. Responses to this question are listed, verbatim, on the table on the next page.



What is missing from Putnam County to address issue	
Issues	**What is Missing**
Aging Population and Related Issues	• Information & awareness of the existing services. • Navigators to help citizens navigate to the best services • Transportation • Legal resources • Financial resources • More support systems for grandparents raising grandchildren *(mentioned by 2 respondents)* • More support systems for caring elder family members. • Options for day care for elderly • There are not enough people to support all the baby boomers who are aging Resource in helping them. The aging population have their own medical issues • Support groups and organizations *(mentioned by 2 respondents)*
Chronic disease management	• Access to medical care • Comprehensive team that navigates the patient doctor visits, medicines, therapy so they all are working together *(mentioned by 2 respondents).*

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What is missing from Putnam County to address issue	
Issues	**What is Missing**
	• Don't think that enough money is spent towards this and many other health needs. • Lack of access to assistance within the county • More general public events to educate on Chronic disease management • Nutrition services • Recognizing that treatment is needed • Transportation to get elderly to Dr. • Lack of elderly using tele medicine • There are many evidenced-based programs that can be implemented, but employees and/or volunteers are needed to implement programs and keep them going.
Access to Health Care	• Limited number of health care specialists • Counselors that specialize in sexual assault victims • Counselors who utilize play therapy • Dental care for Medicare/Medicaid patients *(mentioned by 3 respondents)* • No pediatricians • Primary Care Physicians are retiring • Health care services for families who don't qualify for Medicaid but can't afford marketplace insurance. • Transportation *(mentioned by 2 respondents)* • Lack of internet for telehealth visits
Alcohol and Substance Use	• Access to qualified providers in the county *(mentioned by 2 respondents)* • Awareness/acknowledgement of problems • Prevention services/Education *(mentioned by 4 respondents)* • Tougher enforcement of laws • People (parents) don't think it is a problem *(mentioned by 4 respondents)*
Mental health services	• Lack of 211 services or 24-hour local help line *(mentioned by 2 respondents)* • Awareness of hotline and other resources *(mentioned by 2 respondents)* • Access to qualified providers in county *(mentioned by 4 respondents)* • Services for students/youth, including having licensed counselor in the schools *(mentioned by 5 respondents)* • Parental/guardian involvement • Mental Health for sexual assault victims • Play therapy • More work is needed to reduce the stigma of receiving help • Not enough providers especially those that accept Medicaid • Not enough funding *(mentioned by 2 respondents)*
Obesity and healthy lifestyles choices	• Nutrition services and access to healthier choices for food *(mentioned by 2 respondents)* • Access to gyms, etc. • In many homes that it is acceptable for kids to spend hours upon hours on their devices and gaming systems at home.

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What is missing from Putnam County to address issue	
Issues	**What is Missing**
	• Lack of awareness *(mentioned by 2 respondents)* • More physical/exercise activities • More programs for people to participate in to get active at no or low cost • Need to have something that includes the whole family. • Need prevention programs • Health Fairs are just not enough. They are superficial, lack substance and real education. These fairs ought to have classes, folks need to be educated; they just don't know enough especially with obesity and lifestyle choices.
Cancer	• Access to medical care *(mentioned by 2 respondents)* • Doctors/Oncologists in county • Facilities in county • Prevention screening and education of their importance • There needs to be a better support system for those suffering or enduring this difficulty. The immediate family is not enough, there needs to be more support here.

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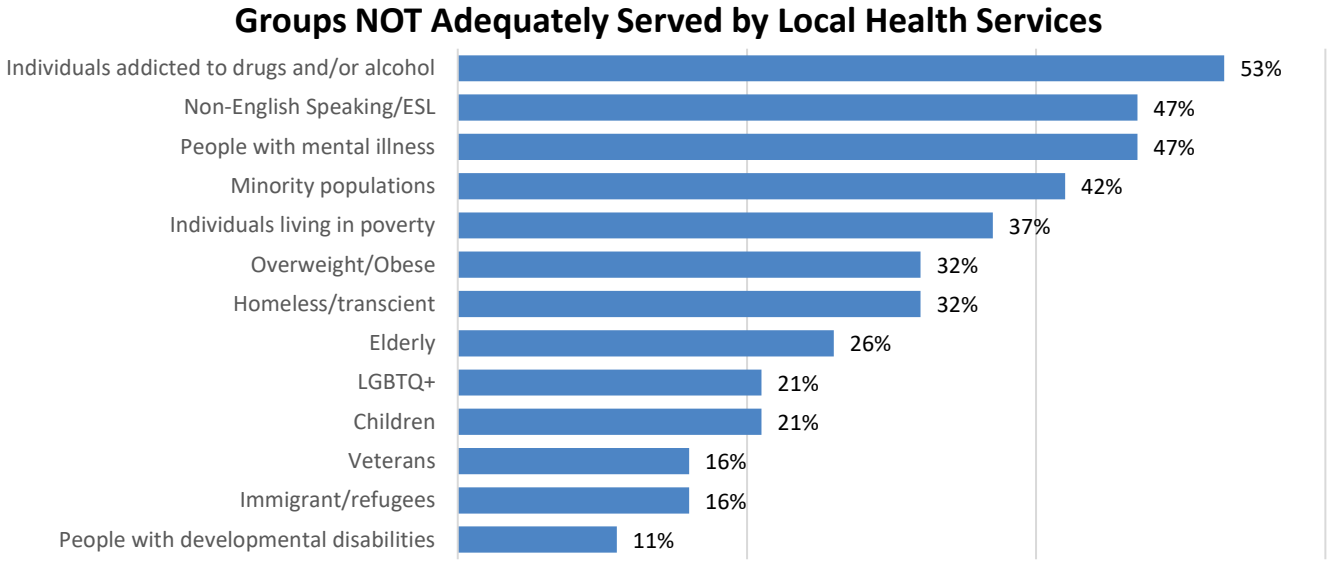
Next, community leaders were given a list and asked what **demographic groups** in Putnam County they thought were not being adequately served by local health services. More than half of community leaders, 53%, thought individuals addicted to drugs and or alcohol are not being adequately served by local health services. Slightly less than half, 47%, felt that non-English speaking/ESL residents and people with mental illness were not being adequately served. Other groups are listed in the graph below.



Community leaders were also asked to list some **problems, barriers, or gaps in services** that prevent residents from receiving health related care and services they need. This was an open-ended question in which the respondent could give multiple responses. The most common barriers mentioned were transportation issues (22%), lack of awareness of available programs and resources (14%) and cost (14%).

Problems, barriers, or gaps in services		
	# of TOTAL Responses	% of Leaders
Transportation issues	8	22.2%
Awareness of what is available	5	13.9%
Cost	5	13.9%
Personal unwillingness to seek care/Social norms	3	8.3%
Busy lifestyles/work schedules	2	5.6%
Language/Cultural competency	2	5.6%
Being a rural county	2	5.6%
Not enough caregivers	2	5.6%
Eligibility for middle class families	1	2.8%
Lack of mental health providers	1	2.8%
COVID-19 related issues	1	2.8%
Providers not accepting Medicaid	1	2.8%
Lack of internet or internet skills for Telehealth	1	2.8%
Waiting lists	1	2.8%

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Problems, barriers, or gaps in services		
	# of TOTAL Responses	% of Leaders
Childcare	1	2.8%
Total	**36**	**(n=18)**
Question: What are some problems, barriers, or gaps in services that prevent residents from receiving health related care and services they need?		

Community Leaders were asked what is being done well in the areas of health and quality of life. This was open ended question in which the respondent could give multiple responses. More than a third of respondents, 35%, mentioned something related to the health department. Specific to the health department, the following were mentioned: the quality of the staff, the variety of programs and services offered, and the amount of information they provide to the community.

Additional things that are being done well in Putnam County include, in order of importance, the quality of the organizations in the county and how well they work together (29%), the availability of multiple fitness opportunities that are affordable (24%), how the county addressed the pandemic (24%), access to family doctors and providers (12%), and transportation to appointments for elderly residents (12%).

Being done well in Putnam County		
	# of TOTAL Responses	% of Leaders
Health department	6	35.3%
Agencies work together/Strong organizations	5	29.4%
Multiple affordable fitness opportunities	4	23.5%
Addressing the pandemic	4	23.5%
Access to family doctors/providers	2	11.8%
Transportation for elderly to appointments	2	11.8%
Access to counseling	1	5.9%
Food drives/pantries/knapsack available	1	5.9%
Vaccinating county's children	1	5.9%
Servicing low-income families	1	5.9%
Many opportunities for health-related education	1	5.9%
Many/variety of programming/services available	1	5.9%
Free clinic (Leipsic Community Center)	1	5.9%
Total	**30**	**(n=17)**
Question: In your opinion, what is being done well in the Putnam County in the areas of health and quality of life?		

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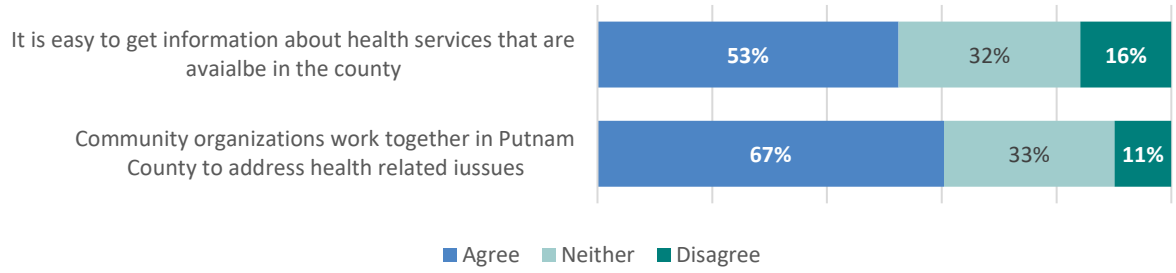
Two thirds of community leaders, 66.7%, agreed that "*Community organizations work together in Putnam County to address health related issues"* with 16.7% strongly agreeing. More than one-tenth, 11.1%, disagree. More than half of community leaders, 52.6%, agreed that *"It is easy to get information about health services that are available in the county"* with 10.5% strongly agreeing. Nearly a sixth, 15.8%, disagreed with this statement.



2021 Putnam County Community Health Assessment

Prepared for: Putnam County Health Department

Pre-Release Date: April 28, 2022

Prepared by:

CMOR
Center for Marketing & Opinion Research, LLC

Table of Contents

Executive Summary

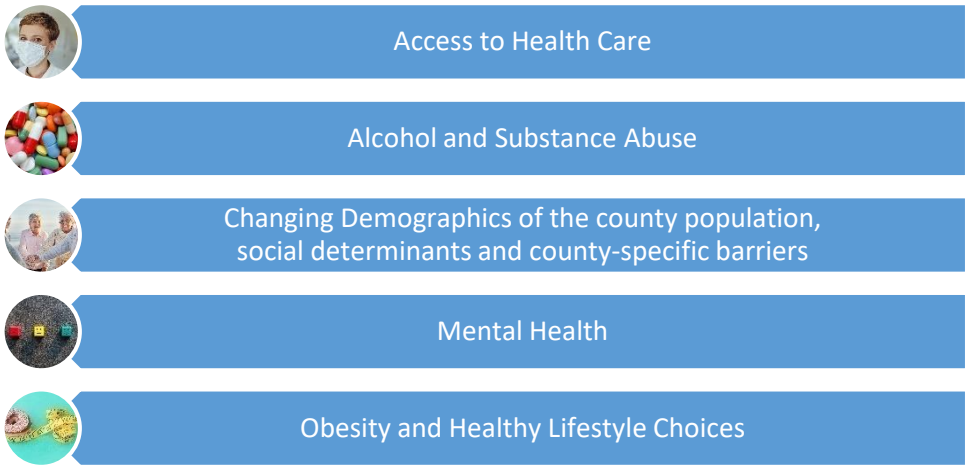
This report is intended to meet the Public Health Accreditation Board standards for health departments. The assessment process is an ongoing cycle that includes building partnerships; coordinating a consortium; assessing data, community needs, and capacity; and conducting planning, prioritization, interventions, implementation, and evaluation. This report begins the 3-year cycle. The Center for Marketing and Opinion Research (CMOR) was selected by the Putnam County Health Department to conduct data collection and analysis for the CHA through three project components.

The first component of the project, a Community Survey, consisted of a random sample telephone survey of Putnam County households. This method was used to ensure representativeness of the adult population and to warrant statistical validity. The final sample size was 400 which resulted in an overall sampling error of +/- 5.0% within a 95% confidence level. The survey questions focused on the following areas: community need and social determinants, access to care, mental health and substance abuse, healthy living, vaccinations, chronic diseases, housing, safety and transportation.

The second phase of the project, Secondary Data Analysis, consisted of reviewing and analyzing secondary data sources to identify priority areas of concern when compared to survey data. CMOR gathered and compiled health and demographic data from various sources. The sources of data are outlined in the Research Methodology section of this report.

The third and final phase, consisted of collecting qualitative data to provide some contextual information to the primary and secondary data outlined above. The qualitative data included a Community Leader survey which consisted of an on-line survey completed by 19 community leaders with knowledge of and experience in community health related issues.

When available, data was compared to previous years' information and other geographic areas such as Ohio or the United States. Analysis included survey data and health and demographic data. After compiling and analyzing the data from all three components, CMOR identified five priority health needs for the county including (in alphabetical order):



Throughout the report, statistically significant findings and statistical significance between groupings (i.e. between age groups or between races) are indicated by an asterisk (*)

Contributing Factors to Health Challenges

There are a number of factors that affect the health of a community. Putnam County is one of the least populated counties in the state (70 out of 88). In addition, Putnam County has a disproportionate percentage of the population ages 65 and over compared to both Ohio and the country as a whole (20% in Putnam County compared to 17% in Ohio). *(Source: U.S. Census Bureau).* Also, the number of grandparents raising grandchildren has increased from 132 in 2009 to 255 in 2018, which is a 93% increase (*Source: PCSAO).*

Education is also a contributing factor to the county's health challenges. Only 20.9% of the county population have a bachelor's degree or higher (compared to 28.3% in the state). *(Source: US Census Bureau, American Fact Finder)* In addition, there are no colleges, universities, or branches in the county meaning that there are no secondary education options within the county limits. *(Source ODSA)*

Putnam County is considerably more rural (83%) than Ohio (22%) and the country as a whole (19%) *(Source: U.S. Census Bureau).* Being so rural creates challenges that make it more difficult for Putnam County residents to get the health-related services they need. For example, the percentage of Putnam County residents with access to locations for physical activity is alarmingly low. Less than half of county residents, 47%, have access compared to a statewide average of 84% *(Source: County Health Rankings)*. In our community survey, we found that more than a quarter of residents, 25.5%, did not exercise in the past month. Also from the community survey, based on the residents self-reported weight and height, more than three-quarters of residents, 77.7%, are overweight or obese based on their BMI.

Social norms around alcohol consumption also contribute to the county's health challenges. In the community survey, the average number of alcoholic beverages a week was 6.61. In addition, more than one in ten, 11.6% residents reported driving after drinking any alcoholic beverages. When comparing Putnam County to other counties in Ohio, only one county had a higher percentage of adults who reported binge or heavy drinking in the past 30 days (Putnam's percentage was 21%). *(Source: County Health Rankings)*

Process for Identifying Priority Health Needs

Analysis for the CHA included survey data in conjunction with health and demographic data. Using all data available, CMOR identified priority community health needs for the county. The data is included in this document. The findings from the secondary data reinforce the findings of the CHA Community Survey and Community Health Leader Survey.

Priority Health Needs

This section presents a summary of the priority health needs for Putnam County *(in alphabetical order)*. For each area, data is given to support the identified health need. In many cases there were significant differences between demographic groups. The priority health needs were identified after analyzing multiple sources of data as outlined in the Research Methodology appendix. The five priority health need areas were identified as common themes that appeared throughout the multiple sources of data and had adequate support to identify them as a significant issue.

ACCESS TO HEALTH CARE

HEALTH NEED: A portion of county residents do not have access to affordable basic health care services including primary care doctors. Access to medical specialists, dentists, and mental health professionals were also issues.

- In Putnam County, there is 1 Primary Care Physician for every 1,780 residents. In Ohio, the ratio is much smaller; 1 Primary Care Physician for every 1,310 residents. *(Source: County Health Rankings)*
- In Putnam County, there is 1 Dentist for every 3,750 residents. In Ohio, the ratio is much smaller; 1 Dentist for every 1,610 residents. *(Source: County Health Rankings)*
- Nearly one in ten, 8%, reported there were health related services they needed in the past year that they were unable to get. Prescriptions were the top needed service that they were unable to get. *(Source: Community Survey)*
- On a 10-point scale in which 1 was 'Not at all important' and 10 was 'Very important', access to health care was given an average importance rating of 8.68 by community leaders. *(Source: Community Leader Survey)*
- Nearly one-sixth, 14%, of residents relied on something other than a primary care doctor as their primary source of health care, for residents ages 18 to 44, the percentage of residents who relied on something other than their primary care doctor rose to 22%. *(Source: Community Survey)*
- Nearly a quarter of residents, 24%, reported being unable to find a specialist or doctor locally or having to wait more than 30 days to make an appointment. *(Source: Community Survey)*
- More than a quarter of community leaders, 27.8%, agreed that *"Family planning services are accessible and available to adequately address the reproductive health needs in the community.* Nearly a quarter, 22.2%, disagreed. *(Source: Community Leader Survey)*

ALCOHOL AND SUBSTANCE USE

HEALTH NEED: High alcohol use and associated issues were found in multiple data sources. Excessive alcohol use can lead to an increased risk of other health problems such as injuries, violence, liver disease, and cancer.

- One-sixth, 16.7%, of community residents named 'Addiction' or 'Alcohol' as an important health related issue or challenge facing their community. *(Source: Community Survey)*
- On a 10-point scale in which 1 is 'Not at all important' and 10 is 'Very important', alcohol and substance abuse was given an average importance rating of 9.11 by community leaders, the second highest average importance of the seven health related issues included in the survey. Furthermore, nearly half, 44.4%, of community health leaders named substance abuse and addiction issues as an important issue or challenge facing the county. Alcohol and drunk driving were mentioned specifically. *(Source: Community Leader Survey)*
- More than half, 53%, of community leaders reported that individuals addicted to drugs and/or alcohol are not being adequately served by local health services. *(Source: Community Leader Survey)*
- Nearly two-thirds of residents, 63.2%, reported drinking alcoholic beverages such as beer, wine, malt beverages or liquor at least some days. The average number of alcoholic beverages a week was 6.61. *(Source: Community Survey)*
- More than one in ten, 11.6% reported driving after drinking any alcoholic beverages. *(Source: Community Survey)*
- Half, 49.5%, of residents reported being aware of any drug and alcohol addiction treatment options available in their community. *(Source: Community Survey)*

- In 2020, the percentage of driving deaths with alcohol involvement in Putnam was 35%. *(Source: County Health Ranking)*
- Only one county had a higher percentage of adults who reported binge or heavy drinking in the past 30 days (Putnam's percentage was 21%). *(Source: County Health Rankings)*
- On average, 48.0% percent of client admissions for treatment in the county were associated with a primary diagnosis of alcohol abuse or dependence in SFY 2019. *(Source: Ohio Mental and Addition Services)*

CHANGING DEMOGRAPHICS, SOCIAL DETERMINANTS, AND OTHER COUNTY-SPECIFIC BARRIERS

HEALTH NEED: More than a quarter of households in the county have a resident age 65 and over. In addition, the number of grandparents raising grandchildren has also been rapidly increasing. As the county continues to age, there will be significant challenges to meet the health needs of the aging population.

- The median age of Putnam County residents is slightly higher, 39.8, than Ohio (39.4) and the U.S. (38.1). Furthermore, one-fifth of County residents are ages 65 and over, compared to 17% in the state. Over a quarter of households in the county, 28.4%, have at least one resident aged 65 or over. *(Source: US Census Bureau)*
- The number of grandparents raising grandchildren in the county has risen from 132 to 164, a 20% increase. *(Source: Public Children Services Association of Ohio)*
- Nearly one in ten residents, 8.6%, reported they are responsible for providing regular care or assistance for an elderly parent or loved one. *(Source: Community Survey)*
- On a 10-point scale in which 1 was 'Not at all important' and 10 was 'Very important', aging population and related issues was given an average importance rating of 8.68 by community leaders. *(Source: Community Leader Survey)*

MENTAL HEALTH

HEALTH NEED: The need for mental health treatment and intervention continues to increase, especially for youth. High diagnosis rates for anxiety, emotional problems and number of residents feeling lonely/ isolated substantiate this issue.

- In Putnam County, there is 1 Mental Health provider for every 1,780 residents. In Ohio, the ratio is more than 5 times better; 1 Mental Health Provider for every 380 residents. *(Source: County Health Rankings)*
- More than one-tenth, 13.5%, of community residents named 'Mental Health' as an important health related issue or challenge facing their community. *(Source: Community Survey)*
- More than 5% of residents reported seeking mental health assistance in the past year. *(Source: Community Survey)*
- On a 10-point scale in which 1 was 'Not at all important' and 10 was 'Very important', mental health services was given an average importance rating of 9.26 by community leaders, the highest average importance of the seven health related issues included in the survey. Furthermore, more than a third, 38.9%, of community health leaders named mental health as an important issue or challenge facing the county. *(Source: Community Leader Survey)*
- Nearly half, 47%, of community leaders reported that people with mental illness are not being adequately served by local health services. *(Source: Community Leader Survey)*
- Nearly half, 48.0%, of residents had at least one day in the past 30 days that their mental health was not good. One-sixth, 16.3%, indicated that their mental health was not good 11 or more days in the past 30. *(Source: Community Survey)*
- More than one-quarter of residents reported that they or an immediate family member had been diagnosed by a medical professional with anxiety or emotional problems. *(Source: Community Survey)*
- Nearly a third, 31.8%, feel lonely or isolated from others occasionally or more often. *(Source: Community Survey)*
- More than one in ten residents, 11.2%, had felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities in the past 12 months. *(Source: Community Survey)*
- Half of community leaders, 50%, felt that there were not a sufficient number of mental and behavioral health providers in the area. *(Source: Community Leader Survey)*

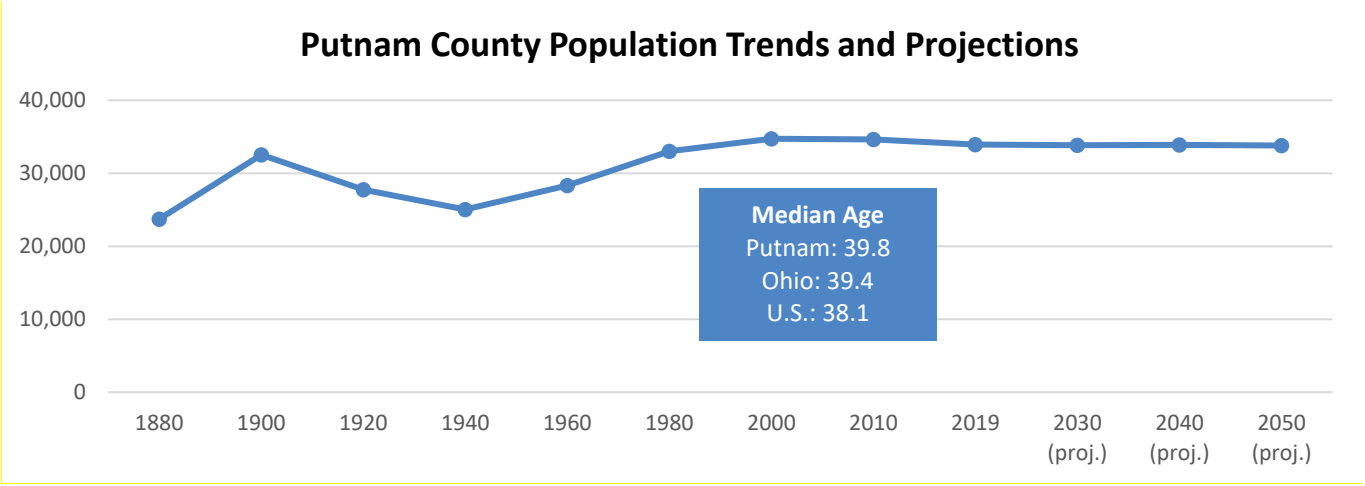
OBESITY AND HEALTHY LIFESTYLE CHOICES

HEALTH NEED: Living a healthy lifestyle means a lower risk of developing many illnesses, like heart disease and diabetes, which are prevalent in the county. A healthy lifestyle can also lead to better mental health as well.

- More than one-sixth, 17.2%, of community residents named 'Obesity' as an important health related issue or challenge facing their community. *(Source: Community Survey)*
- On a 10-point scale in which 1 was 'Not at all important' and 10 was 'Very important', obesity and healthy lifestyle choices were given an average importance rating of 8.74 by community leaders, the third highest average importance of the seven health related issues included in the survey. Furthermore, nearly half, 44.4%, of community health leaders named healthy living and obesity as an important issue or challenge facing the county. *(Source: CLS)*
- More than a third of residents, 36.6%, have smoked 100 or more cigarettes in their lifetime. Also, nearly a fifth or 19.3% of residents indicated they currently smoke cigarettes, cigars, chewing tobacco or use other tobacco products. *Every day users* amounted to 14.5% of all residents. *(Source: Community Survey)*
- More than a quarter of residents, 25.5%, did not exercise in the past month. The most common reasons for not exercising were health issues and not having enough time. *(Source: Community Survey)*
- More than a third of the residents, 38.1%, reported that their weight is about right. More than half, 60.2%, reported being overweight. Based on the residents self-reported weight and height, more than three-quarters of residents, 77.7%, are overweight or obese based on their BMI. *(Source: Community Survey)*
- On average, residents spend 0.57 hours a day playing video games, 1.45 hours using their computer outside of work or school, 2.98 watching TV, and 3.30 using their cellphone, including talking, texting, or going on the internet. *(Source: Community Survey)*
- Nearly a quarter of residents, 21.1%, reported having difficulty getting fresh fruits and vegetables in their neighborhood. A tenth, 10.1%, eat fresh fruits and vegetables 0-1 times a week while 37.4%, eat fresh fruits and vegetables 2 to 4 times a week, and more than a quarter, 27.9%, eat fresh fruits and vegetables once a day. Only a quarter of residents, 24.6%, eat fresh fruits or vegetables 2 or more times a day. *(Source: Community Survey)*
- Nearly a fifth of residents, 18.4%, eat out at a restaurant or take out meal 3 or more times a week. *(Source: CS))*
- More than a third of residents, 39.6%, drink soda or other unhealthy drinks at least once a day. *(Source: CS)*
- More than a third of adults in Putnam County have a BMI of 30 or more. The percentage of obese adults has slightly increased over the past several years and is higher than the state average. *(Source: County Health Rankings)*
- The percentage of Putnam County residents with access to locations for physical activity is very low. Less than half of county residents, 47%, have access compared to a statewide average of 84%. *(Source: County Health Rankings)*
- The most common challenges mentioned by community leaders that residents face in trying to maintain healthy lifestyles were the availability and affordability of healthy food (38.9%) access to affordable gyms (27.8%), making the time/effort needed for a healthy lifestyle (27.8%), and lack of healthy eating and nutrition programs in the community (16.7%). *(Source: Community Leader Survey)*
- Nearly a third of residents, 32.1%, said that they or a member of their household had been diagnosed with Diabetes.
- Heart disease was the leading cause of death in Putnam County in 2020. In addition, the death rate for heart disease has increased by 42% over the past five years. *(Source: Ohio Department of Health)*

Putnam County Demographic Profile

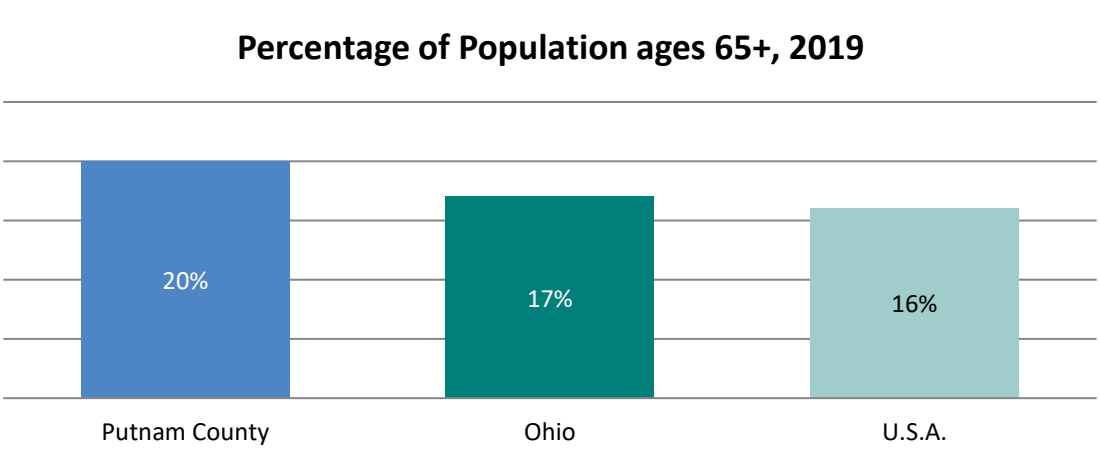
Putnam County is one of the smaller counties in Ohio, ranking 70 out of 88 in terms of population, with a current population of 34,430. Putnam County's population is projected to remain stable between now and 2050 as is the population of the state. The median age in the county, 39.8, is slightly higher than the median age of 39.4 for the state.



County Population Trends- Children				
	Putnam County		Ohio	
	Under 5	Under 18	Under 5	Under 18
2010	2,507	9,352	718,534	2,723,195
2011	2,515	9,233	708,922	2,694,664
2012	2,480	9,9099	699,363	2,668,994
2013	2,430	8,979	695,657	2,652,685
2014	2,375	8,886	696,733	2,640,987
2015	2,345	8,803	696,816	2,627,298
2016	2,329	8,761	697,923	2,612,172
2017	2,294	8,653	695,704	2,627,168
2018	2,283	8,674	695,933	2,618,168
2019	2,271	8,656	694,711	2,605,010
Change 2010 to 2019	**-9.4%**	**-7.4%**	**-3.3%**	**-4.3%**

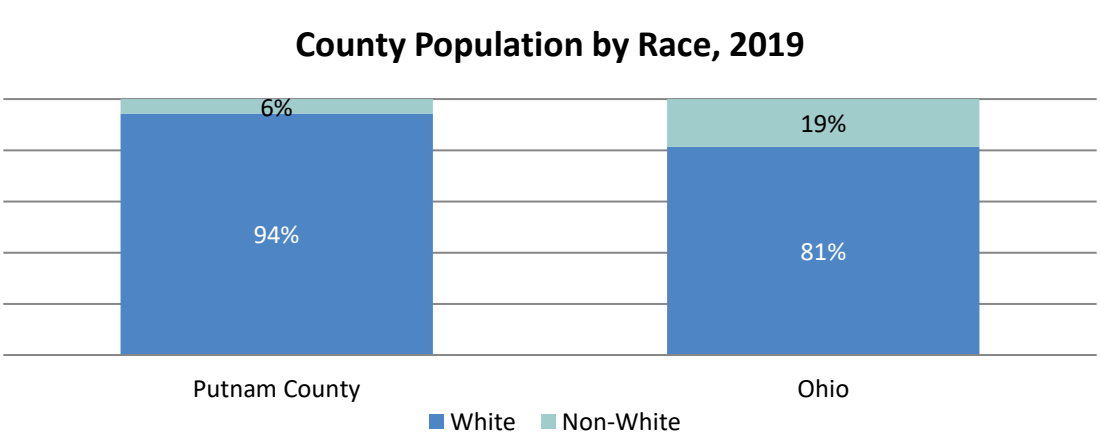
SOURCE: U.S. Census Bureau, American Fact Finder

As shown in the graph below, Putnam County has a disproportionate percentage of the population ages 65 and over compared to both Ohio and the country as a whole.



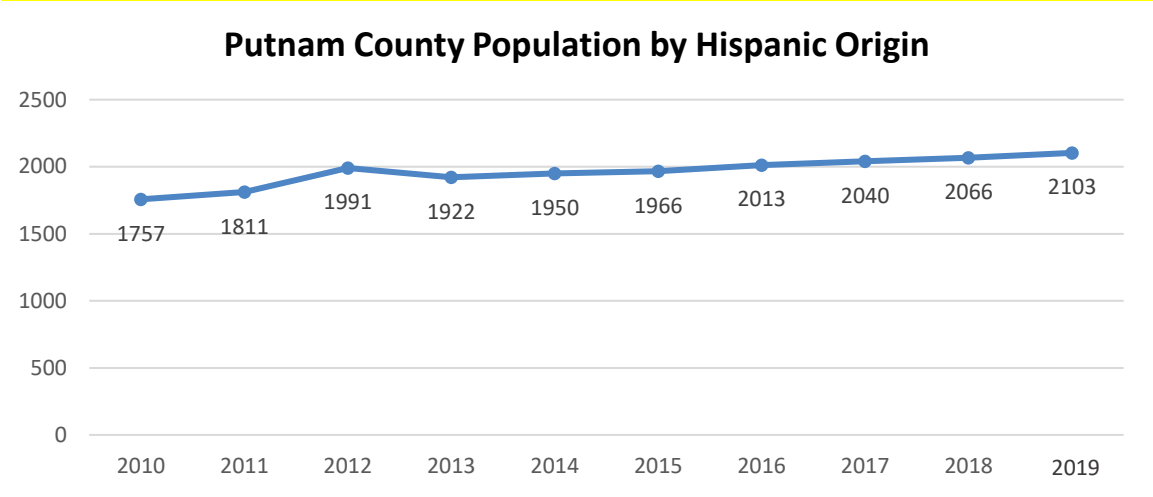
Data Source: US Census Bureau

Putnam County is much less diverse than the state of Ohio with only 6% of the population being non-white compared to 19% in the state. Over the past five years, the racial make-up of the county has only minutely changed.



County Population by Race, 2019							
	White	African American	Native American	Asian	Pacific Islander	Other Race	Two or more races
Ohio	9,476,047	1,446,193	22,816	258,199	3,880	112,836	335,426
Putnam	31,974	137	8	53	11	1,290	438
SOURCE: U.S. Census Bureau							

County Language Spoken at Home, 2019		
Population 5 years and over	Total	Percent
Speak only English	30,269	95.7%
Speaks Spanish	1,219	3.9%
Other Languages	148	0.4%
SOURCE: U.S. Census Bureau		



Source: U.S. Census

The number of Hispanic or Latino residents has increased 20% from 2010 to 2018.

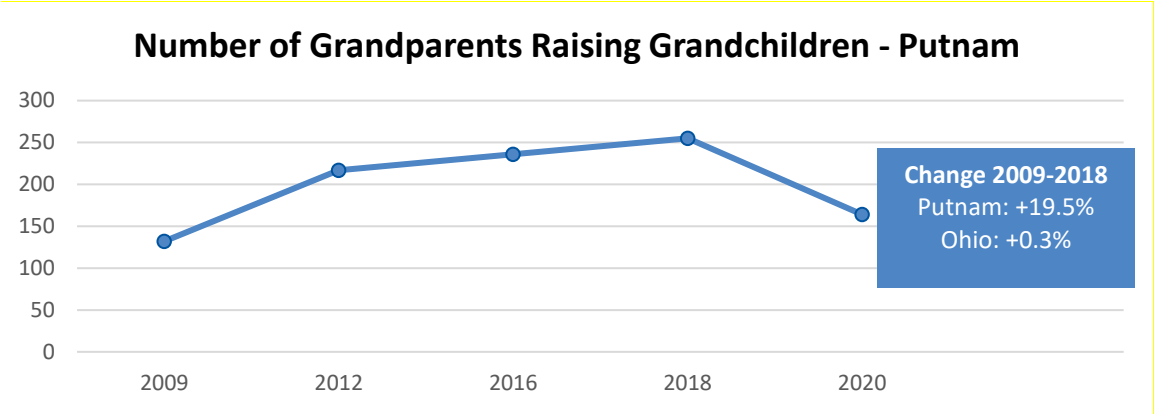
A slightly higher percentage of households in the county have more children in the household than in the state (32% compared to 29%). This percentage has remained stable over the past five years.

Families with Children as a Percent of Households						
County	**2015**	**2016**	**2017**	**2018**	**2019**	**Change**
Putnam	32.9%	33.3%	33.1%	31.9%	32.2%	***-0.7%***
Ohio	30.2%	30.0%	29.8%	29.6%	29.3%	***-0.9%***
SOURCE: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates						

In 2019, nearly two-thirds, 61.7%, of households were married couple households. Nearly a third of households, 32.2%, had children under the age of 18 in them and more than a quarter, 28.4%, had at least one adult age 65 and over. Both average household and family size has remained relatively stable over the past five years.

Putnam County Households by Type						
	2015	**2016**	**2017**	**2018**	**2019**	**% Change**
Total households	**13,049**	**13,092**	**13,159**	**13,236**	**13,327**	**+2.1%**
Married couple	64.0%	63.7%	63.5%	61.7%	61.7%	-2.3%
Married couple with children	26.2%	25.3%	24.4%	23.5%	23.5%	-2.7%
Male householder, with own kids	2.0%	2.0%	2.2%	2.0%	2.0%	-
Female householder, with own kids	3.0%	4.0%	4.7%	4.6%	3.7%	+0.7%
Households with children	32.9%	33.3%	33.1%	31.9%	32.2%	-0.7%
Households with 65+	27.8%	27.7%	27.7%	28.1%	28.4%	+0.6%
Average household size	2.60	2.58	2.56	2.54	2.52	-0.08
Average family size	3.08	3.05	3.01	3.01	2.97	-0.11
SOURCE: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates						

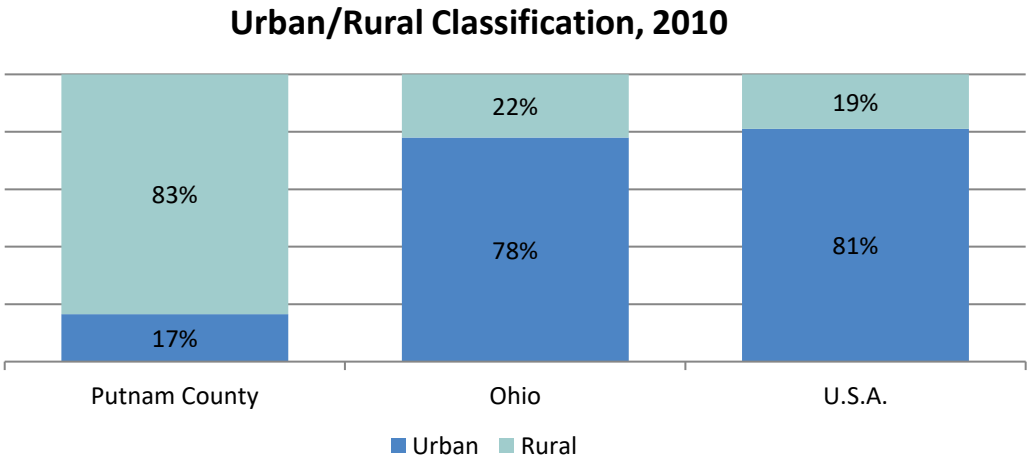
The change in percentage of children living with their grandparents in Putnam County shows that there were times in the past 10 years with higher numbers but overall saw approximately a 20% increase.



Number of Grandparents Raising Grandchildren						
County	2009	2012	2016	2018	2020	Change '09- '18
Putnam	132	217	236	255	164	+19.5%
Ohio	91,513	99,487	100,667	97,811	91,845	+0.3%

SOURCE: Public Children Services Association of Ohio (PCSAO). https://www.pcsao.org/pdf/factbook/2019/Putnam.pdf

Putnam County is considerably more rural (83%) than Ohio (22%) and the country as a whole (19%).



Data Source: US Census Bureau, Decennial Census. 2010. Source geography: Tract

Residents of Putnam County tend to be slightly less geographically mobile than Ohio with the majority, 92%, living in the same house as last year.

Geographic Mobility, 2019					
	Same house as previous year	Different house, in county	Different County, in state	Different state	Abroad
Putnam County	91.5%	4.7%	3.4%	0.2%	0.1%
Ohio	85.2%	9.2%	3.4%	1.7%	0.4%

SOURCE: Ohio Development Services Agency, Ohio County Profiles https://development.ohio.gov/files/research/C1070.pdf

Community Assets & Resources

Health Care Assets and Resources

The ratio of population to primary care physicians, mental health providers, and dentists is significantly higher in Putnam County than Ohio; (1) for primary care physicians, the ratio was more than 0.5 times higher in Putnam, (2) for mental health providers, the ratio was more than 5 times higher in Putnam, (3) for dentists, the ratio is almost 3 times higher in the county than the state.

There are no registered hospitals located in Putnam County. Hospitals in surrounding areas include Blanchard Valley Hospital, Bluffton Hospital, Mercy Health, Lima Memorial Health System, ProMedica Defiance Regional Hospital, serve patients from Putnam County. However, there is Mercy Ambulatory Care and Lima Memorial Urgent Care in Putnam County.

Health Care Summary, 2020		
	Putnam County	Ohio
Primary Care Physicians	19	-
Ratio of population to primary care	*1,780:1*	*1,300:1*
Mental Health Providers	19	-
Ratio of population to mental health	*1,780:1*	*380:1*
Dentists	9	-
Ratio of population to dentists	*3,760:1*	*1,560:1*
Number of registered hospitals*	-	215
*Number of hospital beds**	-	*44,212*
*Licensed nursing homes**	*5*	*954*
*Number of beds**	*311*	*88,097*
Licensed residential care*	7	771
*Number of beds**	*354*	*62,292*

SOURCE: County Health Rankings which used data from Area Health Resource File/American Medical Association for PCP and Dentists, original source of mental health data was CMS, National Provider Identification.
** Ohio Development Services Agency, Ohio County Profiles*

Major Employers

Six of the major employers in Putnam County are listed in the table below.

Putnam County Major Employers	
Iams Co	Pro-Tec Coating Co Inc
Kalida Manufacturing Inc	Progressive Stamping
Ottawa-Glandorf Local Schools	Production Products, Inc

SOURCE: Ohio Development Services Agency, Ohio County Profiles
PUTNAM COUNTY: https://www.development.ohio.gov/files/research/C1070.pdf

Education Assets and Information

There are 9 school districts in the County: Columbus Grove, Continental, Ft. Jennings, Kalida, Leipsic, Miller City, Ottawa-Glandorf, Ottoville, and Pandora-Gilboa. The average expenditure per student is less than the state average. However, the graduation rate for Putnam County is higher than the state, 98.1% compared to 91.4%.

There are no public or private colleges or universities located within Putnam County.

County Education Information, 2021		
	Putnam	Ohio
Public school buildings	22	3,696
# public students	5,823	1,805,6181,535,460
# public teachers (FTE's)	467.8	110,338.5
Expenditures per student	$9,628	$10,669
Graduation Rate	98.1%	91.4%
# private schools	3	707
# private students	445	167,892
# 4-yr public universities	0	13
# 4-year branches	0	23
# 2-year public colleges	0	38
# Ohio Technical Centers	0	52
# Private colleges and universities	0	48
Public libraries (Main/Branches)	1/9	251/734
SOURCE: Ohio Development Services Agency, Ohio County Profiles *PUTNAM COUNTY: https://devresearch.ohio.gov/files/research/C1070.pdf* *OHIO: https://devresearch.ohio.gov/files/research/C1001.pdf*		

Community Health Assessment:
Detailed Results

The three data components included in this assessment include:

- **Community Survey -** A community survey of a representative sample of 400 adults in the county. The survey questions focused on the following areas: community need and social determinants, access to care, mental health and substance abuse, healthy living, vaccinations, chronic diseases and transportation.
- **Secondary Data Analysis -** Main sources of data include the American Fact Finder, Ohio Department of Health, and County Health Rankings.
- **Community Health Leader Survey-** In addition to the data mentioned above, additional qualitative data was gathered in order to provide some contextual information to the primary and secondary data. The qualitative data included a Community Leader survey which consisted of an online survey completed by 19 community leaders who have knowledge of and/or experience in community health issues.

More detailed information about the data components can be found in the Research Methodology appendix.

THE RESULTS ARE BROKEN DOWN INTO THE FOLLOWING TOPIC AREAS:

- Community Needs
- Social Determinants
- Personal Health Status
- Access to Health Care
- Mental Health
- Oral Health
- Smoking/Tobacco Use
- Alcohol and Substance Abuse
- Maternal, Infant, and Child Health
- Healthy Living
- Communicable Diseases, Vaccinations and Prevention Services
- Chronic Disease Management
- Transportation
- Housing
- Environmental Quality
- Safety, Injury and Violence
- Reproductive and Sexual Health

COMMUNITY NEEDS

COMMUNITY SURVEY

Summary: Community Needs			
		% of responses	*N*
Most important health issue *(open ended, Top 3)*	Cancer	36.7%	344
	Obesity	17.2%	
	Flu	13.5%	
Responsible for providing regular care or assistance for.	Elderly parent or loved one	8.6%	400
	Someone with special needs	6.1%	
	Someone with physical or mental problem	4.5%	
	Child with severe behavioral issues	3.2%	
	An adult child	2.8%	
	Grandchildren	2.7%	
Sought assistance in past year for	Medicare or other health insurance	6.0%	400
	Mental health issues	6.0%	
	Food	5.7%	
	Healthcare	5.5%	
	Prescription assistance	3.8%	
	Employment	3.5%	
	Utilities	3.0%	
	Home repair	2.1%	
	Legal aid services	2.1%	
	Transportation	1.9%	
	Clothing	1.8%	
	Dental care	1.8%	
	Affordable childcare	1.4%	
	Rent/mortgage	1.4%	
	Unplanned pregnancy	0.6%	
	Any kind of addiction	0.4%	

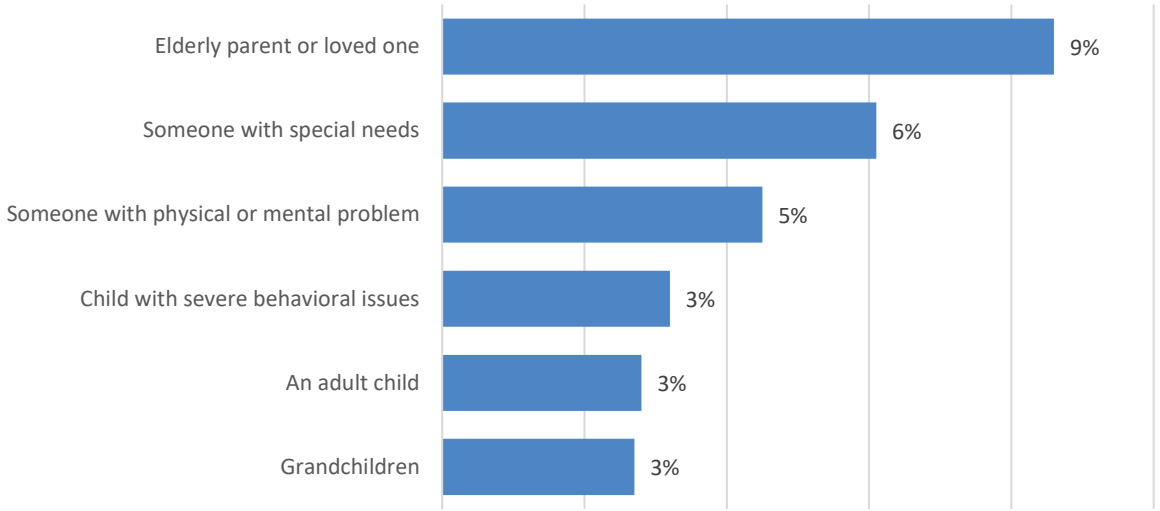
All residents were asked what they thought was the MOST important health related issue or challenge in Putnam County, other than COVID-19. More than a third, 37%, felt that cancer was the most important health issue in the county. The second largest health-related issue was obesity, given by 17% of residents. Other health related issues or challenges include, in order of importance, flu (14%), mental health (13%), addiction (9%), the divide caused by the COVID vaccination (8%), alcohol (8%), heart disease (8%), and healthcare costs (8%).

Most Important Health Related Issue or Challenge				
	# of FIRST Responses	% of FIRST Responses	# of TOTAL Responses	% of Residents
Cancer	92	26.7%	126	36.7%
Obesity	38	11.1%	59	17.2%
Flu	33	9.6%	46	13.5%
Mental health	22	6.5%	46	13.5%
Addiction	17	4.9%	30	8.6%
Covid vaccine Divide	18	5.1%	29	8.3%
Alcohol	11	3.1%	28	8.1%
Heart disease	10	3.0%	28	8.0%
Healthcare costs	21	6.0%	26	7.6%
Diabetes	11	3.3%	25	7.3%
Elder care	9	2.6%	18	5.1%
Shortage of health resources	7	2.1%	17	4.9%
Socioeconomic factors	6	1.8%	14	4.0%
Upper respiratory	6	1.6%	14	4.0%
Lack of nutrition	6	1.6%	13	3.9%
Lack of health education	5	1.5%	12	3.4%
Environmental factors	7	1.9%	11	3.1%
Children and youth needs	4	1.2%	10	3.0%
Basic needs	4	1.1%	10	2.9%
Lack of exercise	3	0.9%	7	2.1%
Lung conditions	2	0.5%	7	2.1%
Dementia	2	0.4%	7	2.1%
Other health conditions	2	0.5%	6	1.6%
Smoking	3	0.9%	5	1.3%
Suicide	1	0.2%	3	1.0%
Safety factors	1	0.3%	3	0.7%
Mobility	2	0.4%	2	0.5%
Shingles	0	0.0%	2	0.5%
Prenatal	1	0.2%	2	0.4%
Persons with disabilities	1	0.2%	2	0.4%
Vaping	1	0.2%	1	0.2%
Dental and Vision focus	1	0.2%	1	0.2%
Total	**344**	**(n=344)**	**537**	**(n=344)**

Question: Other than COVID-19, what do you think is the MOST important health related issue or challenge facing your community?

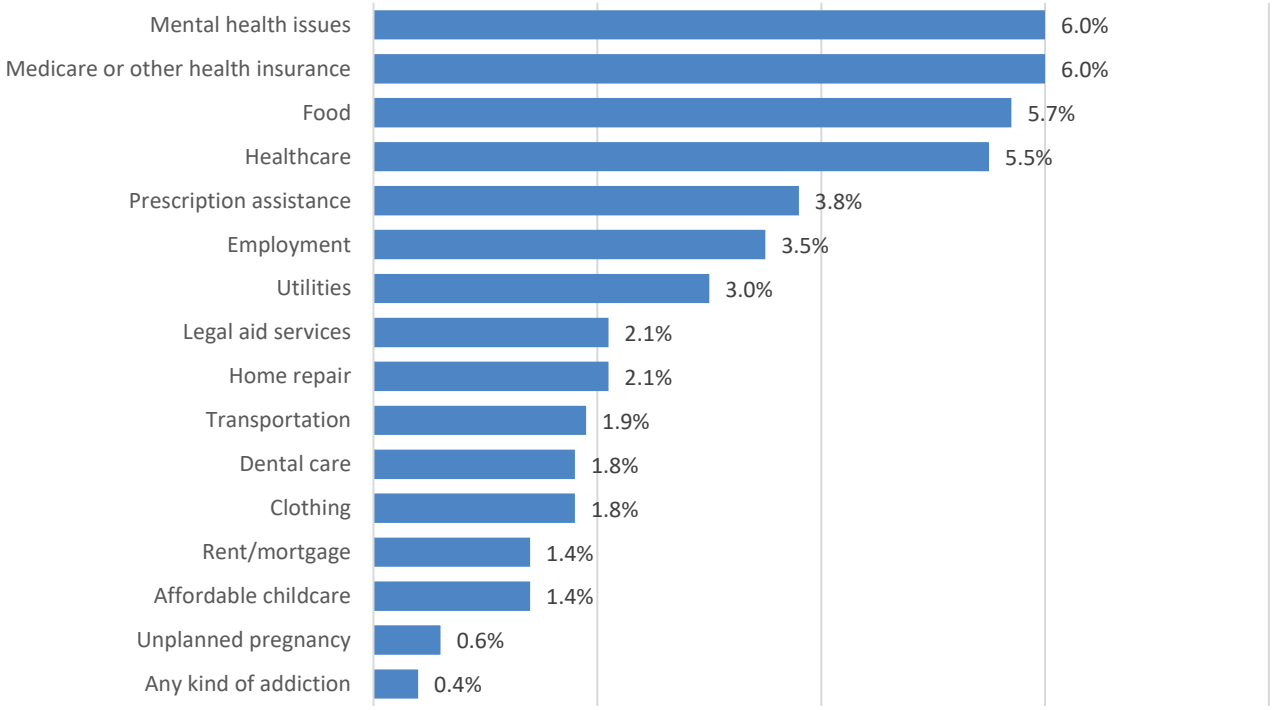
Nearly one in ten residents, 9%, are responsible for providing regular care or assistance to an elderly parent or loved one. Slightly fewer residents were responsible for someone with special needs (6%) or a friend, family member, or spouse with a physical or mental problem. Three percent of residents reported providing regular care to a child with severe behavioral issues, an adult child or their grandchildren.

Responsible for Providing Regular Care or Assistance to. . .



All residents were also given a list of sixteen issues and asked if they or someone in their household sought assistance for any of the issues. The issues that residents sought assistance for most often were mental health issues, Medicare or other health insurance, food, and healthcare.

Sought Assistance in Past Year for. . . . .



COMMUNITY LEADER SURVEY

The 19 community leaders who completed the on-line survey were first asked what they thought were the most important health related issues or need in Putnam County right now. Community leaders were then asked a follow-up question as to what needs to be done to address the issue(s) they mentioned. Both questions were open-ended in which the respondents could give multiple responses.

The two most common needs or issues named were substance abuse and addiction issues and healthy living and obesity, each mentioned by 44% of community leaders. In terms of substance abuse and addiction issues, alcohol use, underage alcohol use, drunk driving and methamphetamine and fentanyl exposure. For healthy living and obesity, the following were mentioned: nutrition, exercise, Type 2 Diabetes, and sedentary lifestyles. Prevention and education programs were common themes for both issues in terms of what needs done to address each.

More than a third of community leaders, 38.9%, mentioned mental health as an important health related issue or challenge. This included things such as isolation and loneliness (teens, college age residents and seniors were specifically mentioned), depression and anxiety, and issues stemming from social media. Once again, prevention and education programs were common themes of what needs done.

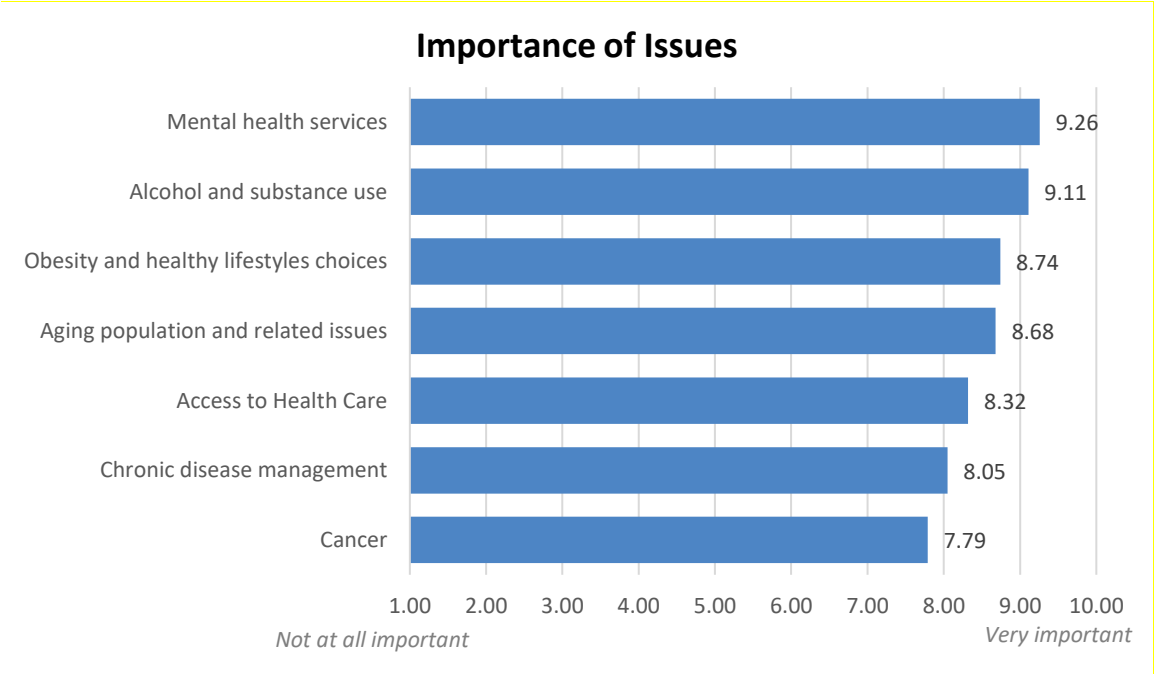
A third of community leaders, 33.3% mentioned COVID-19 related issues as an important health related issue or challenge. This included things such as educating the public, mask requirements, and potential risk of exposure for those who work face to face with the public.

Other issues named by community leaders include, in order of importance, food accessibility (such as not all towns have a grocery store), violence and abuse (teen dating violence and intimate partner violence), services for seniors, access to care (specifically mentioned were dental care and health care for low-income residents) and politicized lack of trust of health experts.

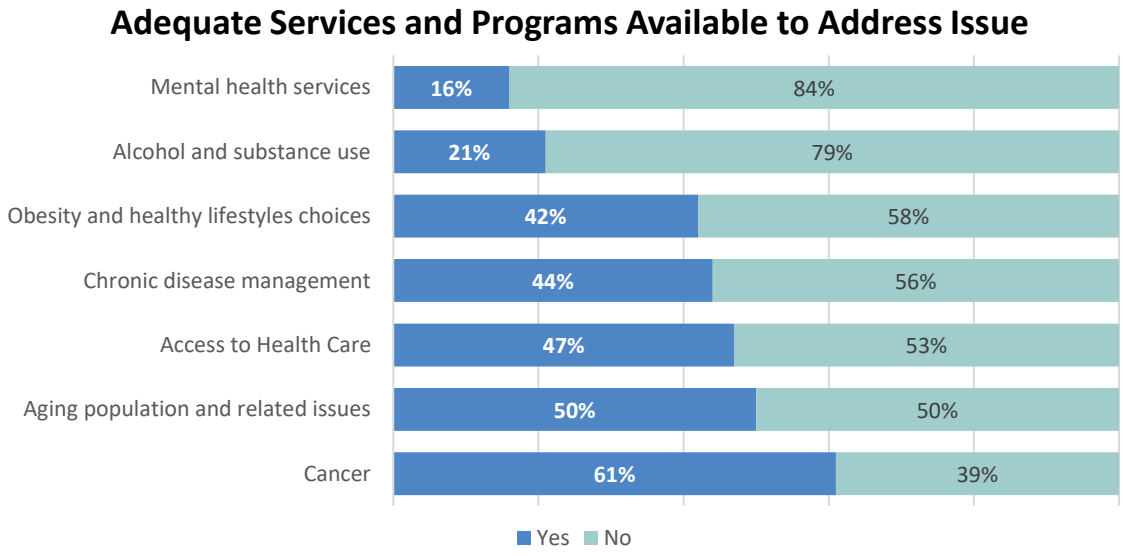
Most Important Health Related Issue or Challenge		
	# of TOTAL Responses	% of Leaders
Substance abuse and addiction issues	8	44.4%
Healthy living and obesity	8	44.4%
Mental Health	7	38.9%
COVID-19 related issues	6	33.3%
Food accessibility	3	16.7%
Violence and abuse	3	16.7%
Senior services	2	11.1%
Access to care	2	11.1%
Politicized/Lack of trust with health experts	2	11.1%
Caregiving and Respite care	1	5.6%
Parenting	1	5.6%
Poverty	1	5.6%
Total	**43**	**(n=18)**
Question: Given your professional experience, what do you think are the most important health related issues or needs in Putnam County right now?		

What needs done to address issues	
Issue	**What Needs Done**
Substance abuse and addiction issues	• There are a lot of good programs and services available to implement, but there is a lack of funding to hire additional staff to implement the programs • Education, increased access to resources • Prevention services for families and for youth • Inform people and let them make their own choices • Educational, cultural changes in the way alcohol is used.
Healthy living and obesity	• More wellness training & programs • More positive social activities • Parents need to be a positive image to their kids • Educational, cultural changes in the way food is used. • Parents should teach their children about portion control and self-control related to food. • Parents to be informed, aware and accountable.
Mental health	• There are a lot of good programs and services available to implement, but there is a lack of funding to hire additional staff to implement the programs • Inform people and let them make their own choices • Continued education on mental health services • The County needs to address the mental health of all its citizens like never before. At one time, we had mental hospitals of which we never need to see these again, but we need good mental health hospitals in our state and in the county. • Awareness activities, MTSS- Multi-Tier System of Service for health/mental Health/ and Education
COVID-19 related issues	• More protective gear for people going into homes. • Continued education on COVID
Food accessibility	• Return of grocery stores to all towns • Increased access to healthy foods.
Violence and abuse	• Education
Senior services	• More affordable housing
Access to care	• More resources to meet the needs of the people • No dentists accept Medicaid in Putnam County. • Transportation • Increased public transportation options
Lack of trust with trust issues	• Adults who do not have politicized views should bring awareness to their children and friends.
Parenting	• Well-established adults need to take parents in need under their care so that higher standards can be learned by the next generation.

Community Leaders were given a list of health-related issues that were identified through the community survey and secondary data analysis and asked, based on their professional experience, how important they thought the issue was on a scale of 1=Not at all Important to 10= Very Important. Responses were averaged in order to rank the importance of the issues. It should be noted that six of the seven issues had an average importance of 8.0 or higher. The top three issues, based on the rankings, were (1) mental health services, (2) alcohol and substance abuse, and (3) obesity and healthy lifestyle choices.



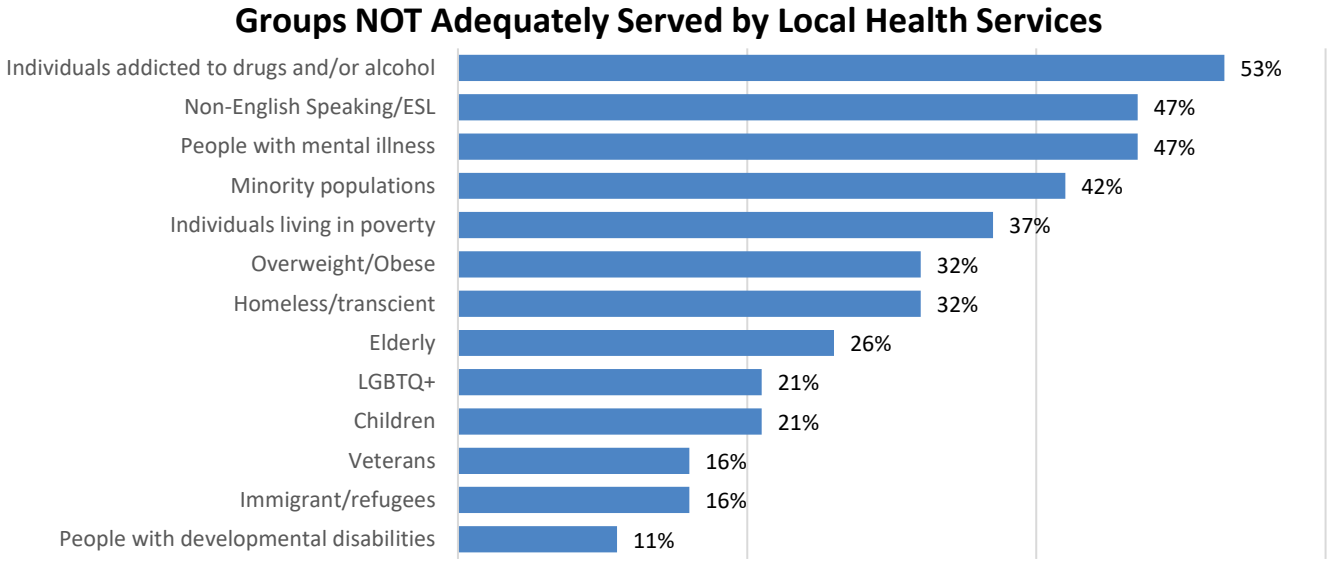
Health Leaders were also asked if they thought there were adequate services and programs already in place to address each issue. The only issue that Health Leaders thought already had adequate resources in place was for cancer. If they indicated there were not enough services or programs in place, they were then asked what is missing. Responses to this question are listed, verbatim, on the table on the next page.



What is missing from Putnam County to address issue, responses are from community leaders	
Issues	**What is Missing**
Aging Population and Related Issues	• Information & awareness of the existing services. • Navigators to help citizens navigate to the best services • Transportation • Legal resources • Financial resources • More support systems for grandparents raising grandchildren *(mentioned by 2 respondents)* • More support systems for caring for elder family members. • Options for day care for elderly • There are not enough people to support all the baby boomers who are aging or the resource in helping them. The aging population have their own medical issues • Support groups and organizations *(mentioned by 2 respondents)*
Chronic disease management	• Access to medical care • Comprehensive team that navigates the patient doctor visits, medicines, therapy so they all are working together *(mentioned by 2 respondents).* • Don't think that enough money is spent towards this and many other health needs. • Lack of access to assistance within the county • More general public events to educate on Chronic disease management • Nutrition services • Recognizing that treatment is needed • Transportation to get elderly to Dr. • Lack of elderly using tele medicine • There are many evidenced-based programs that can be implemented, but employees and/or volunteers are needed to implement programs and keep them going.
Access to Health Care	• Limited number of health care specialists • Counselors that specialize in sexual assault victims • Counselors who utilize play therapy • Dental care for Medicare/Medicaid patients *(mentioned by 3 respondents)* • No pediatricians • Primary Care Physicians are retiring • Health care services for families who don't qualify for Medicaid but can't afford marketplace insurance. • Transportation *(mentioned by 2 respondents)* • Lack of internet for telehealth visits
Alcohol and Substance Use	• Access to qualified providers in the county *(mentioned by 2 respondents)* • Awareness/acknowledgement of problems • Prevention services/Education *(mentioned by 4 respondents)* • Tougher enforcement of laws • People (parents) don't think it is a problem *(mentioned by 4 respondents)*
Mental health services	• Lack of 211 services or 24-hour local help line *(mentioned by 2 respondents)* • Awareness of hotline and other resources *(mentioned by 2 respondents)* • Access to qualified providers in county *(mentioned by 4 respondents)* • Services for students/youth, including having licensed counselor in the schools *(mentioned by 5 respondents)*

What is missing from Putnam County to address issue, responses are from community leaders	
Issues	**What is Missing**
	• Parental/guardian involvement • Mental Health for sexual assault victims • Play therapy • More work is needed to reduce the stigma of receiving help • Not enough providers especially those that accept Medicaid • Not enough funding *(mentioned by 2 respondents)*
Obesity and healthy lifestyles choices	• Nutrition services and access to healthier choices for food *(mentioned by 2 respondents)* • Access to gyms, etc. • In many homes that it is acceptable for kids to spend hours upon hours on their devices and gaming systems at home. • Lack of awareness *(mentioned by 2 respondents)* • More physical/exercise activities • More programs for people to participate in to get active at no or low cost • Need to have something that includes the whole family. • Need prevention programs • Health Fairs are just not enough. They are superficial, lack substance and real education. These fairs ought to have classes, folks need to be educated; they just don't know enough especially with obesity and lifestyle choices.
Cancer	• Access to medical care *(mentioned by 2 respondents)* • Doctors/Oncologists in county • Facilities in county • Prevention screening and education of their importance • There needs to be a better support system for those suffering or enduring this difficulty. The immediate family is not enough, there needs to be more support here.

Next, community leaders were given a list and asked what **demographic groups** in Putnam County they thought were not being adequately served by local health services. More than half of community leaders, 53%, thought individuals addicted to drugs and or alcohol are not being adequately served by local health services. Slightly less than half, 47%, felt that non-English speaking/ESL residents and people with mental illness were not being adequately served. Other groups are listed in the graph below.



Community leaders were also asked to list some **problems, barriers, or gaps in services** that prevent residents from receiving health related care and services they need. This was an open-ended question in which the respondent could give multiple responses. The most common barriers mentioned were transportation issues (22%), lack of awareness of available programs and resources (14%) and cost (14%).

Problems, barriers, or gaps in services		
	# of TOTAL Responses	% of Leaders
Transportation issues	8	22.2%
Awareness of what is available	5	13.9%
Cost	5	13.9%
Personal unwillingness to seek care/Social norms	3	8.3%
Busy lifestyles/work schedules	2	5.6%
Language/Cultural competency	2	5.6%
Being a rural county	2	5.6%
Not enough caregivers	2	5.6%
Eligibility for middle class families	1	2.8%
Lack of mental health providers	1	2.8%
COVID-19 related issues	1	2.8%
Providers not accepting Medicaid	1	2.8%
Lack of internet or internet skills for Telehealth	1	2.8%
Waiting lists	1	2.8%
Childcare	1	2.8%
Total	**36**	**(n=18)**
Question: What are some problems, barriers, or gaps in services that prevent residents from receiving health related care and services they need?		

Community Leaders were asked what is being done well in the areas of health and quality of life. This was open ended question in which the respondent could give multiple responses. More than a third of respondents, 35%, mentioned something related to the health department. Specific to the health department, the following were mentioned: the quality of the staff, the variety of programs and services offered, and the amount of information they provide to the community.

"The many services offered by local social service organizations. (Examples: Exercise classes/fitness, sport programs for youth, fall prevention classes, transportation for older adults, flu/covid shot clinics, emergency preparedness, wrap around program, activities for youth and adults, help me grow, 4-H, etc.)"

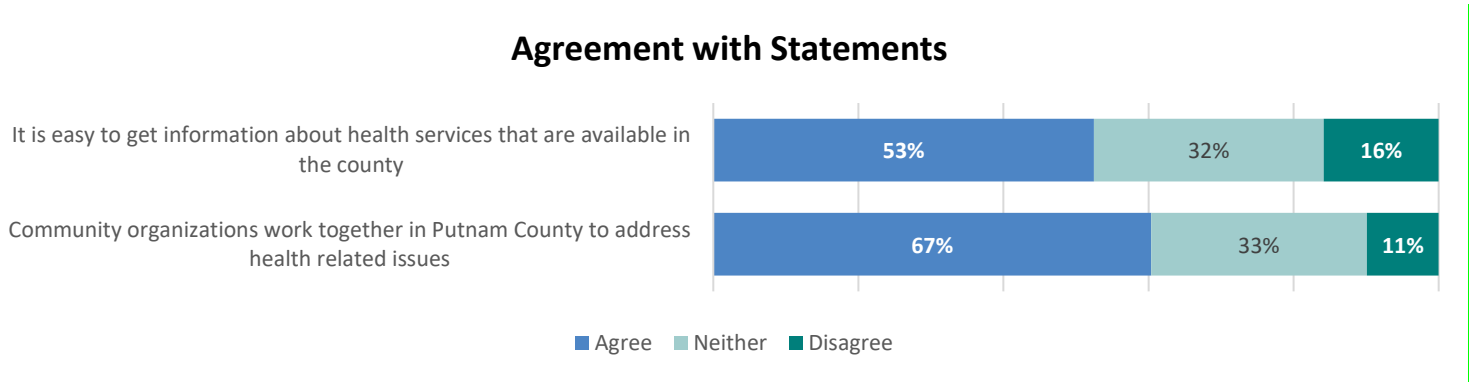
Participant on what Putnam County does well

Additional things that are being done well in Putnam County include, in order of importance, the quality of the organizations in the county and how well they work together (29%), the availability of multiple fitness opportunities that are affordable (24%), how the county addressed the pandemic (24%), access to family doctors and providers (12%), and transportation to appointments for elderly residents (12%).

Being done well in Putnam County		
	# of TOTAL Responses	% of Leaders
Health department	6	35.3%
Agencies work together/Strong organizations	5	29.4%
Multiple affordable fitness opportunities	4	23.5%
Addressing the pandemic	4	23.5%
Access to family doctors/providers	2	11.8%
Transportation for elderly to appointments	2	11.8%
Access to counseling	1	5.9%
Food drives/pantries/knapsack available	1	5.9%
Vaccinating county's children	1	5.9%
Servicing low-income families	1	5.9%
Many opportunities for health-related education	1	5.9%
Many/variety of programming/services available	1	5.9%
Free clinic (Leipsic Community Center)	1	5.9%
Total	30	(n=17)

Question: In your opinion, what is being done well in the Putnam County in the areas of health and quality of life?

Two thirds of community leaders, 66.7%, agreed that "*Community organizations work together in Putnam County to address health related issues"* with 16.7% strongly agreeing, more than one-tenth, 11.1%, disagree. More than half of community leaders, 52.6%, agreed that *"It is easy to get information about health services that are available in the county"* with 10.5% strongly agreeing. Nearly a sixth, 15.8%, disagreed with this statement.



SOCIAL DETERMINANTS

SECONDARY DATA ANALYSIS

In terms of educational attainment for adults ages 18 to 24, the percentage of the population with a high school degree or higher is slightly lower in the county than in the state. However, the percentage of the population with a high school degree or higher, ages 25 and older, is slightly higher than the state average (93% for Putnam County and 90% for state). Only 21% of Putnam County residents have a bachelor's degree or higher, significantly less than the state average, 28%.

Educational Attainment

	2015	2016	2017	2018	2019	Change 2015-2019
Percentage that have high school degree or higher, ages 18-24						
Putnam	83.8%	84.6%	84.0%	85.5%	83.5%	-0.3%
Ohio	85.7%	86.0%	86.4%	86.8%	87.0%	+1.3%
Percentage that have high school degree or higher, ages 25 and older						
Putnam	92.7%	92.8%	92.7%	93.2%	92.8%	+0.1%
Ohio	89.1%	89.5%	89.8%	90.1%	90.4%	+1.3%
Percentage that have bachelor's degree or higher						
Putnam	19.4%	19.4%	19.0%	20.3%	20.9%	+1.5%
Ohio	26.1%	26.7%	27.2%	27.8%	28.3%	+2.2%

SOURCE: United States Census Bureau, American Fact Finder

The unemployment rate for the county in 2020 was slightly lower than it was for the state, rates for both the county and state increased over the five-year period. For this table, unemployment includes persons who were not employed, but who were actively seeking work, waiting to be called back to a job from which they were laid off, or waiting to report within thirty days.

Unemployment Countywide

	2016	2017	2018	2019	2020	% Change 16 -20
Putnam County	3.7%	3.5%	3.3%	3.1%	**5.6%**	**+1.9%**
Ohio	5.0%	5.0%	4.5%	4.2%	**8.1%**	**+3.1%**

SOURCE: Ohio Department of Job and Family Services, Office of Workforce Development, Bureau of Labor Market Information, Local Area Unemployment Statistics. Data extracted from Civilian Labor Force Estimates Query tool

The percentage of the population in poverty in Putnam County is nearly half of what it is for the state (7.6% compared to 14.0%).

Total Percentage of Population in Poverty

	# Pop (2019)	2015	2016	2017	2018	2019	Change 2015-2019
Putnam	33,911	5.8%	7.8%	7.2%	6.7%	7.6%	**+1.8%**
Ohio	11,689,100	14.8%	15.4%	14.9%	14.5%	14.0%	**-0.8%**

SOURCE: U.S. Census Bureau, American Fact Finder, American Community Survey 5-Year Estimates

Nearly a fifth of children under 5 are in poverty in Putnam County, slightly lower than the state percentage but increasing at a more rapid rate than the state. When looking just at children under the age of 18 in poverty, the percentage is significantly lower, 11% (also significantly lower than the state). Poverty levels for children remained unchanged over the past 5 years.

Putnam County Percentage of Children under 18 in Poverty							
	# Children (2019)	2015	2016	2017	2018	2019	Change 2015-2019
Putnam	8,656	11.4%	10.7%	9.7%	9.5%	11.4%	**0.0%**
Ohio	2,574,847	22.8%	22.1%	21.3%	20.8%	19.9%	**-2.9%**

Percentage of Children under 5 years in Poverty					
	# Children (2019)	2017	2018	2019	Change 2017-2019
Putnam	2,271	13.7%	13.1%	19.4%	**+5.7%**
Ohio	686,672	25.1%	24.3%	23.0%	**-2.1%**

SOURCE: U.S. Census Bureau, American Fact Finder, American Community Survey 5-Year Estimates

Looking specifically at the population in Putnam County in poverty by key demographic measures, children under the age of 5 had the highest level of poverty (19.4%), while those ages 35-64 had the lowest level (5%). Females were more likely than males to be in poverty (9% to 6%). In terms of race and ethnicity, Hispanic/Latina residents had the highest poverty levels (22%) followed by multi-racial residents (10%). Additionally, the lower the education level, the higher the poverty level for that demographic group (poverty rate for those with less than a high school diploma was 19% compared to 1% for college graduates). The poverty rate for the unemployed is nearly ten times that of the employed population (40% compared to 3%).

Putnam County Percentage of Population in Poverty by Age Group							
	Pop 2019	2015	2016	2017	2018	2019	Change
Under 5	2,271	7.2%	15.3%	13.7%	13.1%	19.4%	**+12.2%**
5-17	6,385	6.1%	9.0%	8.2%	8.2%	8.6%	**+2.5%**
18-34	6,392	7.7%	9.0%	8.4%	7.6%	9.4%	**+1.7%**
35-64	13,141	5.0%	6.3%	5.4%	4.9%	4.8%	**-0.2%**
65+	5,722	4.4%	5.4%	6.1%	6.0%	6.6%	**+2.2%**
Putnam County Percentage of Population in Poverty by Gender							
Male	16,944	4.9%	6.6%	5.9%	5.3%	6.3%	**+1.4%**
Female	16,967	6.7%	9.1%	8.4%	8.2%	9.0%	**+2.3%**
Putnam County Percentage of Population in Poverty by Race and Ethnicity							
White	31,978	5.4%	7.5%	6.8%	6.4%	7.1%	**+1.7%**
Black	136	51.5%	58.8%	35.7%	28.6%	8.4%	**-43.1%**
Asian	68	9.4%	0.0%	3.8%	4.6%	3.8%	**-5.6%**
Two or more	441	13.6%	12.4%	12.4%	10.2%	10.2%	**-3.4**
Hispanic/Latino	2,102	16.6%	17.8%	18.8%	18.6%	21.9%	**+5.3%**
Putnam County Percentage of Population in Poverty by Education Level							
Less than HS	2,441	20.2%	21.7%	20.8%	19.5%	18.9%	**-1.3%**
HS grad	1,4005	4.9%	6.1%	5.6%	5.5%	7.2%	**+2.3%**
Some college	1,0342	4.3%	6.0%	5.3%	5.0%	4.9%	**+0.6%**
College grad	3,3911	1.2%	1.4%	1.0%	0.7%	0.7%	**-0.5%**
Putnam County Percentage of Population in Poverty by Employment Status							
Employed	18,086	2.6%	3.2%	2.5%	2.6%	2.8%	**+0.2%**
Unemployed	8,163	26.1%	46.4%	33.8%	32.9%	40.1%	**+14.0%**

SOURCE: U.S. Census Bureau, American Fact Finder, American Community Survey 5-Year Estimates

The poverty rates for female headed households, both overall and with children under 18, are approximately 3 to 4 times higher than married family households.

Percentage of Families in Poverty by Family Status							
	Pop-2017	2013	2014	2015	2016	2017	Change
All families	7,809	10.5%	11.5%	10.4%	9.8%	10.9%	**+0.4%**
Married families	6,380	5.7%	6.4%	5.2%	5.6%	6.5%	**+0.8%**
Female headed	896	47.2%	53.0%	47.9%	38.3%	43.4%	**-3.8%**
Percentage of Families with Children under 18 in Poverty by Family Status							
All families	3,096	21.2%	24.0%	21.9%	17.8%	18.9%	**-2.3%**
Married families	2,232	11.5%	13.4%	11.8%	9.1%	10.8%	**-0.7%**
Female headed	572	64.4%	72.6%	63.2%	57.7%	58.4%	**-6.0%**

SOURCE: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Below are tables with poverty rates by zip code. Poverty levels are highest in Continental and Leipsic.

Poverty Number and Rates by Zip Code, 2020					
Zip Code	Population	# below poverty	% below poverty	# at 125% of poverty level	# at 200% of poverty level
45827 (Cloverdale)	2,012	87	4.4%	107	213
45856 (Leipsic)	5,251	516	10.0%	698	1,462
45831 (Continental)	3,752	630	17.1%	718	1,094
45875 (Ottawa)	11,063	775	7.1%	937	1,747
45830 (Columbus Grove)	5,212	365	7.1%	472	1,141
45844 (Fort Jennings)	2,967	50	1.7%	176	389
45864 (Miller City)	173	6	3.5%	7	32
45877 (Pandora)	2,047	143	7.2%	160	412
45853 (Kalida)	1,620	26	1.7%	55	158
45876 (Ottoville)	863	31	4.0%	42	117

SOURCE: U.S. Census Bureau, American Fact Finder, American Community Survey 5-Year Estimates

The median monthly housing costs for mortgage holders as a percent of household income (homeowners) is slightly lower for the county ($1,201) compared to the state ($1,248). The median gross rent as a percent of household income (renters) is also slightly lower for the county ($683) nearly a quarter of renters suffer from severe renter cost burdens, for the county, the percentage is lower.

Homeowner Affordability, 2019		
	Median Monthly Housing Cost for Mortgage Holders	Median Monthly Housing Cost for Mortgage Holders as % of Household Income
Putnam	$1,201	18.0%
Ohio	$1,248	19.1%

^FHA guidelines state that a household should avoid buying a home that costs more than 2.5 times its annual income. Numbers in red are above the 2.5 threshold.

Renter Affordability, 2019			
	Median Monthly Gross Rent	Median Gross Rent as % of Household Income	Severe Renter Cost Burden
Putnam	$683	22.4%	16.3%
Ohio	$797	27.6%	23.0%

SOURCE: OHFA, Draft Ohio Housing Needs Assessment, Fiscal Year 2021 Annual Plan

The percentage of residents with broadband access is the same in the county as it is for the state.

Number of Internet Providers in Area, 2021				
	NO PROVIDERS	1 OR MORE PROVIDERS	2 OR MORE PROVIDERS	3 OR MORE PROVIDERS
PUTNAM COUNTY	**0.0%**	**100%**	**100%**	**99.9%**
OHIO	**0.0%**	**100%**	**100%**	**97.8%**
NATIONWIDE	**0.4%**	**99.9%**	**99.8%**	**95.9%**
SOURCE: *Data Source: FCC Broadband Availability Comparison Tool*				

PERSONAL HEALTH STATUS

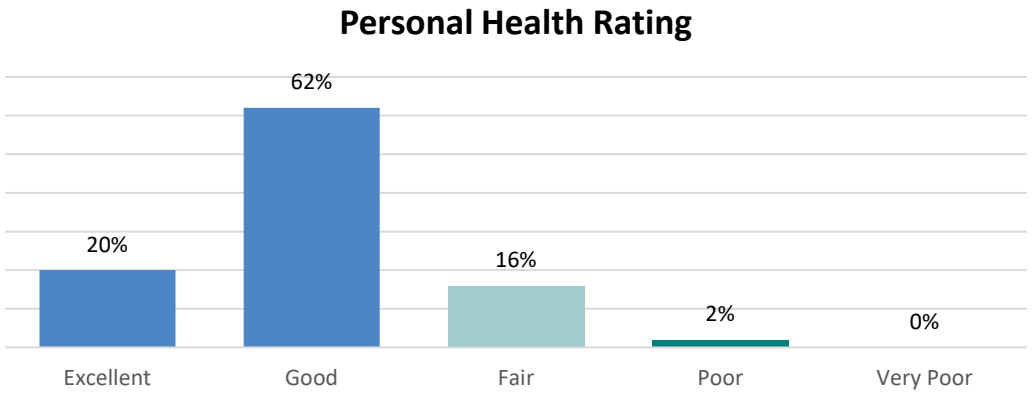
COMMUNITY SURVEY

Summary: Personal Health Status			
		% of Residents	*N*
Personal description of health	Excellent	20.1%	400
	Good	62.0%	
	Fair	15.9%	
	Poor	1.7%	
	Very Poor	0.2%	
Number of days in past month that PHYSICAL health was not good	Average number of days not well	3.5	398
	None	57.5%	
	1-5	26.5%	
	6-10	5.9%	
	11-20	5.4%	
	More than 20	4.8%	
Number of days in past month that MENTAL health was not good	Average number of days not well	4.8	398
	None	52.0%	
	1-5	25.9%	
	6-10	5.8%	
	11-20	8.7%	
	More than 20	7.6%	
Poor Health Kept from Usual Activities	Yes	21.6%	398
	No	78.4%	
Limited because of physical, mental, or emotional issues	Yes	21.0%	398
	No	79.0%	

All residents were asked to describe their health on a five-point scale: excellent, good, fair, poor, or very poor. One-fifth of residents, 20.1%, rated their health as excellent. Another 62.0% rated their health as good. Combined, 82.1% had a favorable rating of their health. Another 15.9% of residents rated their health as fair. Only a small percentage of residents, 1.9%, had an unfavorable rating of their health, with 1.7% rating their health as poor and 0.2% as very poor.

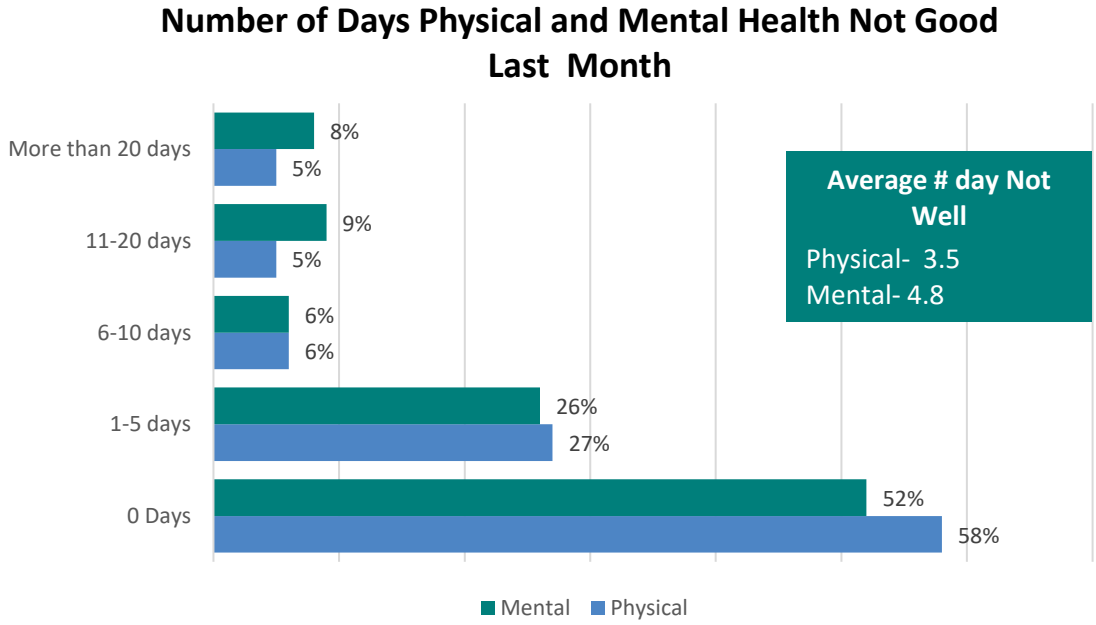
Groups of residents more likely to rate their health favorably include residents with children in the home, college graduates, residents with an annual income of $50,000 or more, white residents, those who are married, and residents who are employed full-time. Groups of residents more likely to have a fair or unfavorable rating of their health include

residents with a high school diploma or less education, those with an annual income of $25,000 or less, non-white residents, those who are single or divorced, and unemployed residents.



More than half residents, 52.0%, reported that they didn't have any days in the past 30 days in which their **mental health** was not good (which includes stress, depression, and problems with emotions) while over one quarter, 25.9%, reported that their mental health was not good 1 to 5 days in the past 30 days. Nearly a sixth of residents 16.3%, indicated that their mental health was not good for 11 or more days in the past month. Groups of residents more likely to have 11 or more bad mental health days in the past 30 days include: obese residents, those ages 18 to 44, residents with a high school diploma or less education, those with an annual income under $50,000 (especially those with an annual income under $25,000), non-white residents, those who are single or divorced, and unemployed residents.

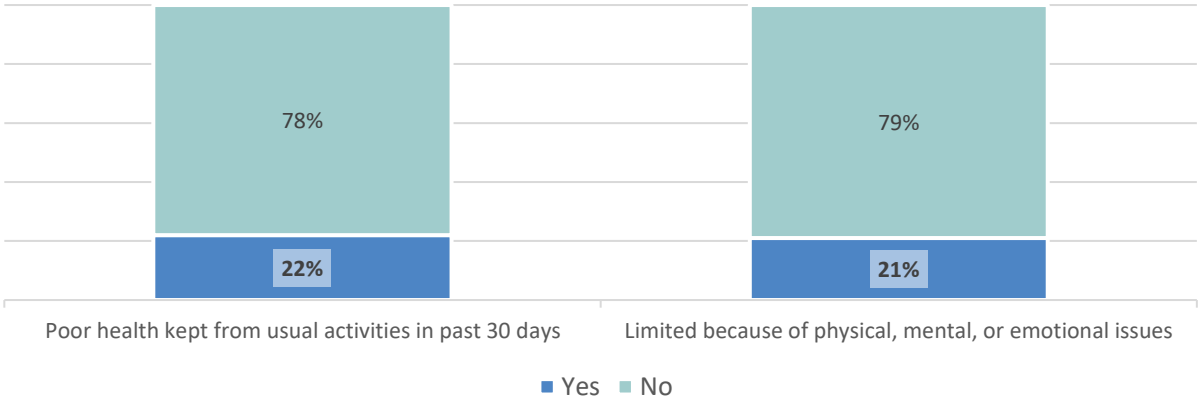
Likewise, more than half of residents, 57.5%, reported that they didn't have any days in the past 30 days in which their **physical health** was not good (which includes physical illness and injury) while over one quarter, 26.5%, reported that their physical health was not good 1 to 5 days in the past 30 days. More than one-tenth of residents 10.2%, indicated that their physical health was not good for 11 or more days in the past month. Groups of residents more likely to have 11 or more bad physical health days in the past 30 days include: obese residents, those with an annual income under $50,000 (especially those with an annual income under $25,000), non-white residents, and those who are widowed.



Over a fifth of respondents, 21.6%, reported that poor or mental health kept them from doing their usual activities such as self-care, work, or recreation in the past 30 days. Of these respondents, 44%, were kept from their usual activities because of their physical health, 21% due to their mental health and 35% because of both their physical and mental health. Groups of respondents more likely have been kept from usual activities in the past 30 days because of poor physical or mental health include obese residents, females, those ages 18 to 44, those with an annual income under $50,000, residents who are single or divorced, and those who are employed part-time or unemployed.

Later in the survey all residents were asked if they were limited in any way in any activities because of physical, mental or emotional problems. More than one in five residents, 21.0%, indicated that they were limited in some way. The most common impairments or health problems that limit their activities include limited mobility, arthritis/pain, knee issues, back or neck issues, and mental health issues. Groups of respondents more likely to have been limited because of poor health include obese residents, those with children in the home, females, those ages 65 and over, residents with some college education, those with an annual income under $50,000, residents who are divorced or widowed, and those who are retired or unemployed.

Past 30 Days, Poor Physical Health Kept from Usual Activities



Major Impairments or Health Problems that Limit Activity				
	# of Responses	% of Responses	Total Responses	% of residents with issues
Limited mobility	13	14.0%	17	18.7%
Arthritis/Pain	11	11.8%	16	17.6%
Back/Neck	10	10.8%	12	13.2%
Knee	7	7.5%	12	13.2%
Mental health- Depression, anxiety	3	3.2%	9	9.9%
Nervous system issues	6	6.5%	7	7.7%
Hip	4	4.3%	6	6.6%
Bone fracture	5	5.4%	5	5.5%
Spinal issues	4	4.3%	4	4.4%
Elderly	3	3.2%	4	4.4%
Weight	1	1.1%	4	4.4%
Socializing	3	3.2%	3	3.3%
Lungs- COPD, breathing	3	3.2%	3	3.3%
Ankles/Feet/Legs	3	3.2%	3	3.3%
Heart	2	2.2%	2	2.2%
Narcolepsy - sleep	2	2.2%	2	2.2%
Shoulder	2	2.2%	2	2.2%
Meniere's disease - ears	2	2.2%	2	2.2%
Relationships	2	2.2%	2	2.2%
Elbow	1	1.1%	2	2.2%
Fatigue	1	1.1%	1	1.1%
Pregnancy	1	1.1%	1	1.1%
Lupus	1	1.1%	1	1.1%
Migraines	1	1.1%	1	1.1%
Eyes	1	1.1%	1	1.1%
Irritable bowel syndrome - digestive	1	1.1%	1	1.1%
Total	**93**	**(n=93)**	**123**	**(n=93)**

ACCESS TO HEALTH CARE

COMMUNITY SURVEY

Summary: Insurance Coverage			
		% of Residents	*N*
Currently has health insurance	Insured	98.0%	398
	Not insured	2.0%	
Type of Insurance coverage *(of those with insurance)*	Private insurance- employer paid	52.2%	388
	Private insurance- self paid	11.2%	
	Medicare	27.9%	
	Medicaid	8.7%	
Services covered by insurance *(of those with insurance)*	Hospitalization	91.8%	390
	Emergency room care	88.8%	
	Prescription assistance	87.1%	
	Preventative care	86.7%	
	Vision services	65.0%	
	Dental services	65.2%	
	Long term care	39.0%	
	Family planning (birth control)	38.6%	
Summary: Access to Health Care			
Have primary care provider	Yes	89.4%	397
	No	10.6%	
Length of time since last routine check-up	Within past year	77.5%	398
	Within past 2 years	9.3%	
	Within past 5 years	5.9%	
	5 or more years ago	6.0%	
	Never	1.3%	
Where receive health care most often	Primary care or family doctor	85.5%	397
	The emergency room	2.2%	
	Urgent Care	5.2%	
	VA hospital	1.6%	
	Leipsic Community Center Clinic	0.8%	
	Somewhere else	4.8%	
Services needed unable to get in past year	Yes	7.9%	398
	No	92.1%	
Service unable to get *(open ended top 3)*	Prescriptions	43.3%	30
	Specialist	16.7%	
	Surgery	16.7%	
Why unable to get needed service *(open ended top 3)*	Service not available in area	32.0%	25
	High cost/Couldn't afford	24.0%	
	No insurance	20.0%	
Specialist needed unable to find locally	Yes	23.9%	398
	No	76.1%	
Type of Specialist/ Doctor needed *(open ended top 3)*	Orthopedic surgeon/Orthopedics	11.2%	116
	Neurologist	10.3%	
	ENT	6.9%	

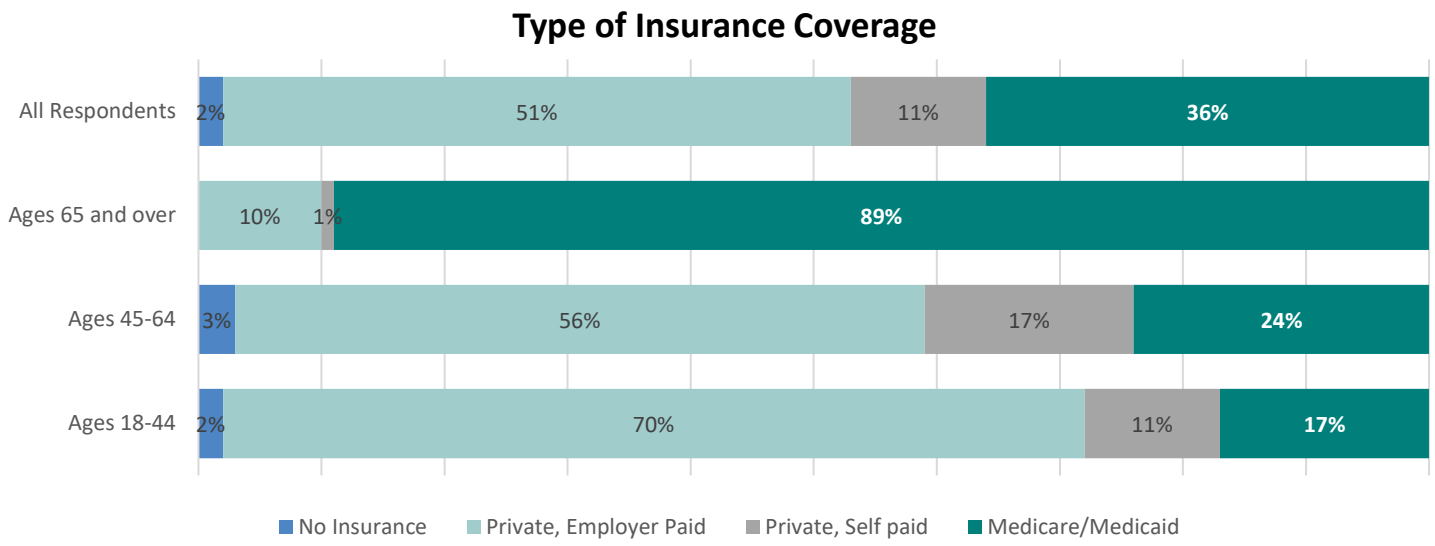
Insurance Coverage

All residents were asked if they had health insurance coverage. A small portion, 2% did not have health insurance. More than half, 52% were covered by employer paid plans, 11% were covered by private insurance, 28% were covered by Medicare and 9% by Medicaid. The most common reason for not having health insurance was the cost of insurance.

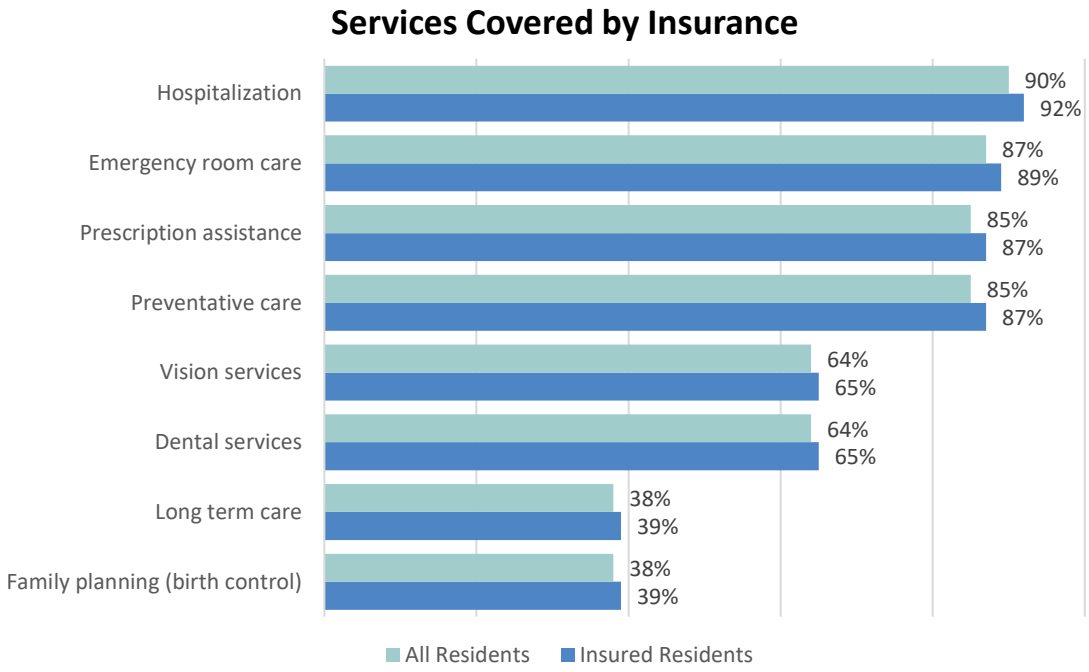
Why No Insurance
(asked of those with no insurance)

	#	%
High costs	3	50.0%
Switched jobs	1	16.7%
Have Medicare	1	16.7%
Other	1	16.7%
Total	**6**	**(n=6)**

Whether or not a given resident has health insurance coverage and what type of insurance they had varied according to several demographic and other identifying characteristics. Groups of respondents more likely to **NOT have insurance** coverage include widowed residents, those who are unemployed, and residents with an annual income under $25,000. Groups of respondents more likely to have **private insurance** include respondents with children in the home, males, those ages 18 to 64, college graduates, married residents, those who are employed, and residents with an annual income of $75,000 or more. Groups of respondents more likely to have **Medicare or Medicaid** include respondents without children in the home, females, those ages 65 and over, respondents with a high school diploma or less education, those who are not married, retirees and unemployed residents, and those with an annual income under $50,000.

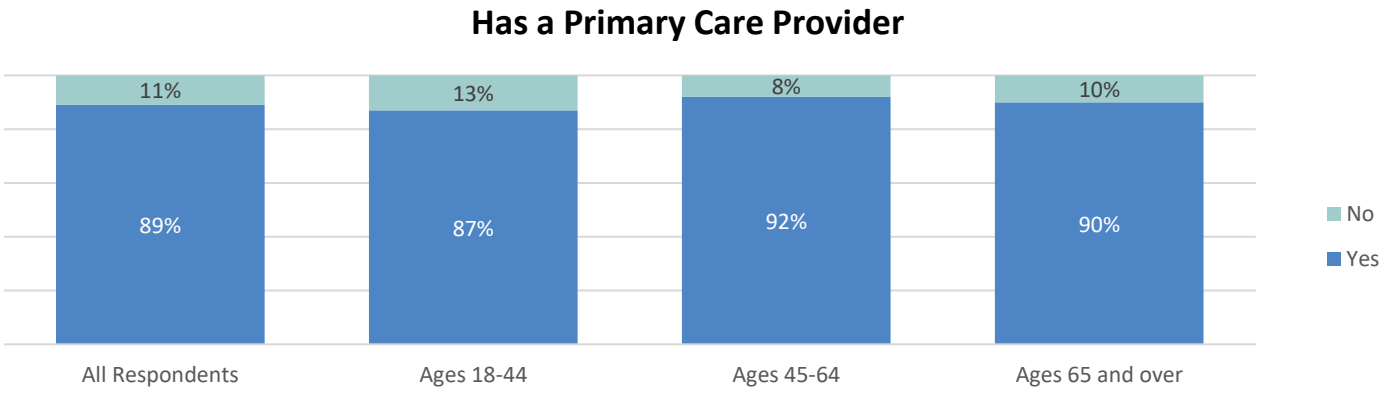


Residents with insurance were given a list of services sometimes covered by insurance and asked if their insurance covered each service or not. The services that were covered for most residents were hospitalization (91.8%), emergency room care (88.8%), prescription assistance (87.1%), and preventative care (86.7%). Only approximately two-thirds of residents with insurance have vision (65.0%) or dental (65%) coverage. Less than half of insured residents have long term care (39.0%) or family planning/birth control coverage (38.6%).

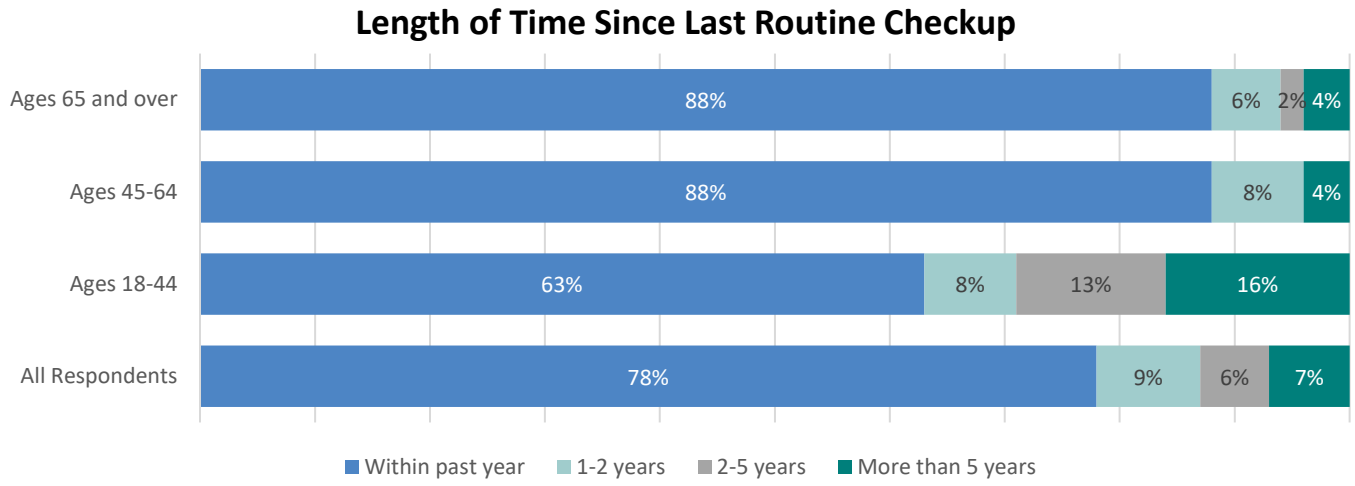


Primary Care Provider

Most residents, 88%, reported having one person or group that they think of as their doctor or health care provider. Groups of residents more likely to have a primary care doctor or health care provider include white residents and those with an annual income of $75,000 or more.

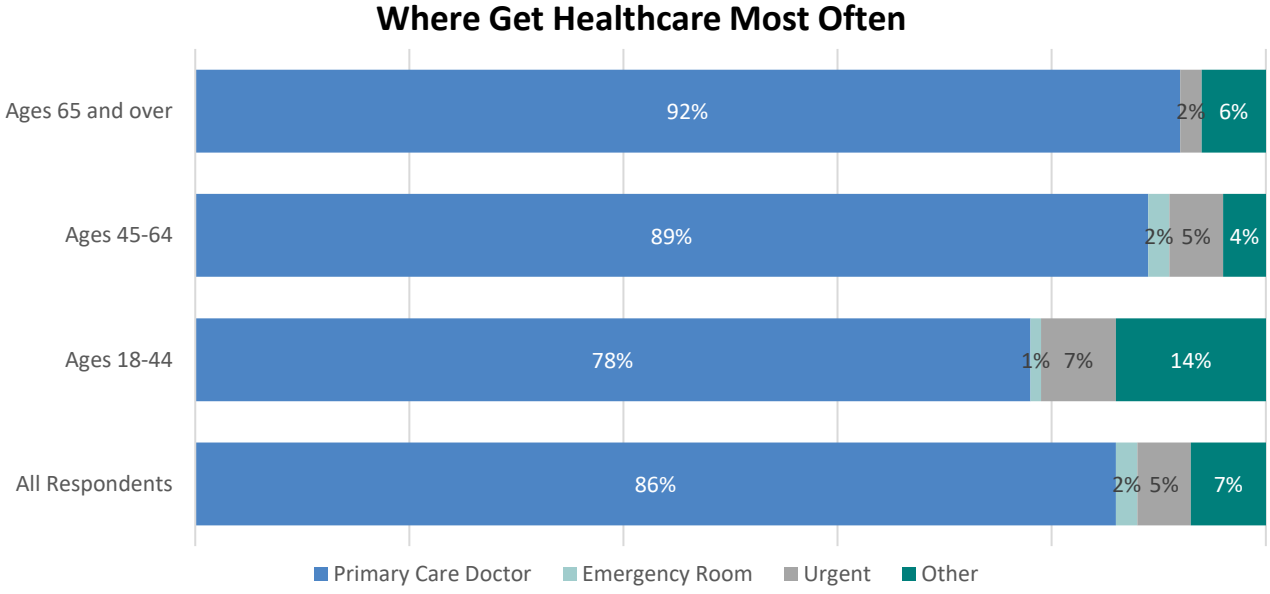


More than three-quarters of residents, 78%, had received a routine checkup within the past year. A notable percentage, 7%, had not received a routine medical checkup in more than five years. Not surprisingly, the older the resident, the more likely they were to have had a routine checkup in the past year (as seen in the graph below). Other groups of respondents more likely to have had a routine checkup in the last year include respondents without children in the home, those ages 45 and over, retirees, and residents with an annual income of $25,000 to $50,000.



Access to Care

Next, residents were asked when they receive health care, where do they receive it most often: a primary care or family doctor, the emergency room, an urgent care center, a VA hospital or clinic, a free clinic, the Leipsic Community Center Clinic or somewhere else. The majority or 85.5% of residents indicated they receive their health care most often from a primary care doctor. Another 5.2% of residents relied on an urgent care center as their primary source of health care, while 2.2% relied on an emergency room. Groups of residents more likely to use a **primary care or family doctor** include respondents without children in the home, those ages 65 and over, white residents, retirees, and residents with an annual income of $25,000 to $50,000. Groups of residents more likely to use something **Other than a primary care or family doctor** include respondents with children in the home, males, those ages 18 to 44, non-white residents, those who are unemployed, and residents with an annual income under $25,000.

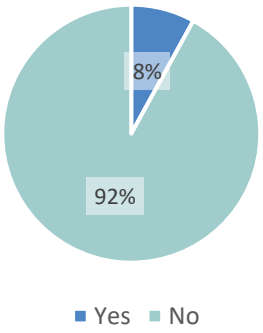


Needs Services and Specialists

A notable portion of residents, 8%, reported that there were healthcare or prescription services that they or a family member needed in the past year that they were unable to get. Groups of residents more likely to have needed services they were unable to get include respondents with children in the home, females, those ages 18 to 44, respondents with some college education, those who are divorced or widowed, residents who are employed part-time or unemployed, and those with an annual income of $50,000 or less.

The three services that were needed most often were prescriptions, specialist services and surgery. The most common reasons for not being able to get the needed service was that the service was not available in their area followed by the high cost and that their insurance doesn't cover the needed service.

Healthcare Services Needed but Unable to Get



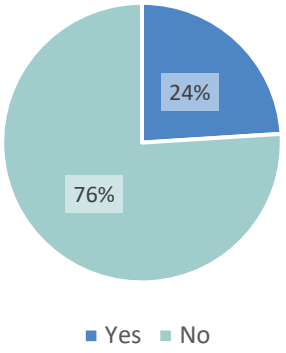
Why Unable to Get Needed Services	# of Responses	% of Responses
Service not available in area	8	32.0%
High cost/Couldn't afford	6	24.0%
No insurance	5	20.0%
Insurance doesn't cover it	3	12.0%
Doctor didn't approve request	2	8.0%
Miscellaneous	1	4.0%
Total	**25**	**(n=25)**

Services Needed	# of TOTAL Responses	% of Residents
Prescriptions	13	43.3%
Specialist	5	16.7%
Surgery	5	16.7%
Diagnostic test	2	6.7%
Dental/Vision	2	6.7%
Mental health	2	6.7%
Physical/Occupational therapy	1	3.3%
Lab work/testing	1	3.3%
Miscellaneous	1	3.3%
Total	**30**	**(n=30)**

Question: Were there any healthcare or prescription services, that you or a family member needed in the past year that you were unable to get?

Next, residents were asked if they or a family member needed to see a specialist or doctor that they were unable to find locally or had to wait more than 30 days to schedule an appointment. Nearly a quarter of residents, 24%, reported experiencing this issue in the past two years. Groups of residents more likely to report being unable to find a specialist or doctor locally or having to wait more than 30 days to make an appointment include respondents with children in the home, females, those ages 18 to 44, respondents with some college or more education, and those who are employed part-time. The types of doctors or specialists most needed were Orthopedics or Orthopedic Surgeons, Neurologists, an ENT, and a Gastroenterologist.

Needed Specialist/Doctor Unable to Find



Specialist Needed		
	# of Responses	% of Responses
Orthopedic surgeon/Orthopedics	13	11.2%
Neurologist	12	10.3%
ENT	8	6.9%
Gastroenterologist	7	6.0%
Cardiologist	6	5.2%
Dentist/Orthodontist/Oral Surgeon	6	5.2%
Dermatologist	6	5.2%
Ophthalmologist/Optometrist	6	5.2%
Endocrinologist	5	4.3%
Mental health/Psychiatrist	5	4.3%
Oncologist	5	4.3%
Pulmonologist	5	4.3%
Rheumatologist	5	4.3%
Pain Management	4	3.4%
Cancer/Oncologist	3	2.6%
Podiatrist	3	2.6%
Primary care	3	2.6%
Colonoscopy	2	1.7%
Developmental Autism specialist	2	1.7%
Hematologist	2	1.7%
OBGYN/Women's Health	2	1.7%
Miscellaneous	6	5.2%
Total	**116**	**(n=116)**
Question: What type of specialist or doctor you were unable to find?		

SECONDARY DATA ANALYSIS

The table below represents the estimated percent of the population under age 65 that has no health insurance coverage in Putnam County. Over the past five years, the percentage of individuals without health insurance decreased by 1.8%. The percentage of residents without insurance is five times as high for black residents (12.2%) than white residents (2.2%). In addition, the percentage of residents without insurance under the age of 18 (2.2%) is half the percentage of residents 18 and over (4.7%).

Putnam County Percent Uninsured						
	2015	2016	2017	2018	2019	% Change
Putnam County	4.8%	4.0%	3.3%	3.1%	3.0%	-1.8%
White	4.5%	3.8%	2.9%	2.5%	2.2%	-2.3%
Black	9.3%	12.5%	8.0%	9.2%	12.2%	+2.9%
Under 18	1.9%	2.0%	1.5%	1.6%	2.2%	+0.3%
18 and older	10.2%	6.1%	5.5%	4.9%	4.7%	-5.5%
SOURCE: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates						

Primary Care Physicians is the ratio of the population to primary care physicians in the area in the chart below. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. In Ohio, there is 1 Primary Care Physician for every 1,310 residents. Putnam's County's ratio is higher than the State ratio at 1 Primary Care Doctor for every 1,780 residents.

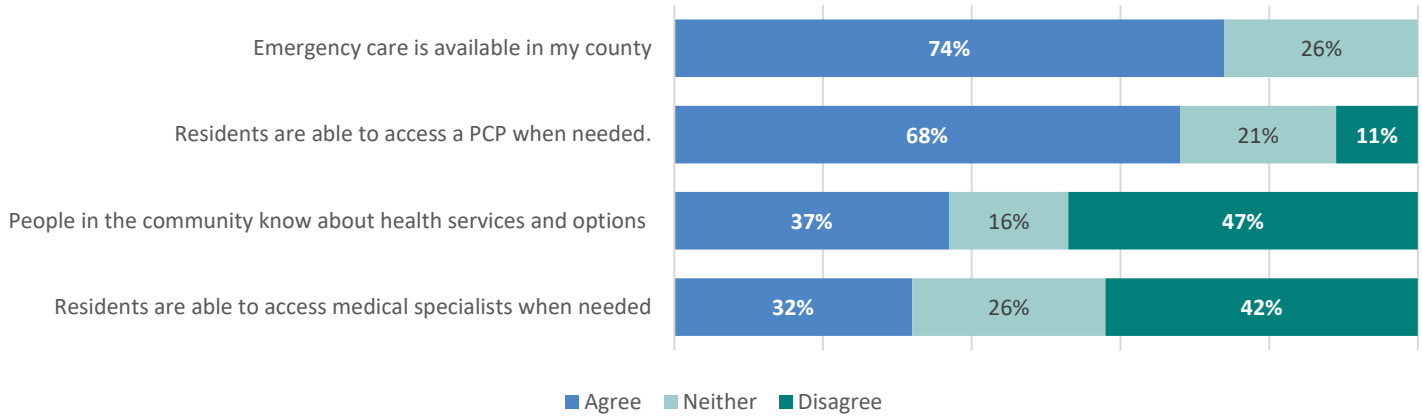
Primary Care Physicians											
	2016		2017		2018		2019		2020		% Change
	# of PCP	Ratio	# of PCP	Ratio	# of PCP	Ratio	# of PCP	Ratio	# of PCP	Ratio	
Putnam	17	2,005	16	2,140	17	2,000	19	1,790	19	1,780	+11.8
Ohio	8,925	1,296	8,919	1,300	8,887	1,310	8,904	1,300	8,886	1,310	-0.4
SOURCE: County Health Ranking. Original Source: HRSA Area Resource File. http://www.countyhealthrankings.org/											

COMMUNITY LEADER SURVEY

The community leaders were given a list of four statements about access to care issues and asked how much they agreed with each. The low amount of agreement on all three statements supports that access to care is an issue in Putnam County. Each statement is discussed in more detail below.

- Nearly three quarters of community leaders, 73.6%, agreed that "*Emergency care is available in my county"* with 31.6% strongly agreeing. No respondents disagreed with this statement.
- More than two-thirds of community leaders, 68.4%, agreed that *"Residents in Putnam County are able to access a primary care doctor when needed"* with 31.6% strongly agreeing. More than a tenth, 10.5%, disagreed with this statement.
- More than a third of community leaders, 36.8%, agreed that "*People in the community know about the health services and options that are available to them".* No respondents strongly agreed with this statement. Nearly half, 47.4%, disagreed.
- Less than a third of community leaders, 31.6%, agreed that *"Residents in Putnam County area able to access medical specialists when needed (Cardiologist, Dermatologist, etc.)"* with 10.5% strongly agreeing. Nealy half, 42.1%, disagreed.

Agreement with Access to Care Statements



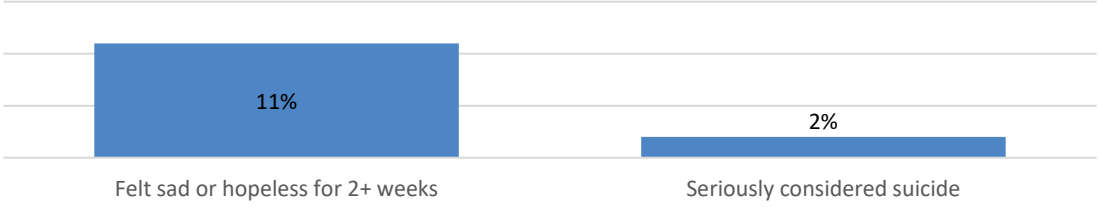
MENTAL HEALTH

COMMUNITY SURVEY

Summary: Mental Health			
		% of residents	*#*
During past 12 months…	Felt sad or hopeless 2+ weeks	11.2%	398
	Ever seriously consider suicide	2.2%	
Resident/Immediate Family Member Diagnosed by Medical Professional	Anxiety or emotional problems	25.2%	400
	Depression	21.7%	
	Anxiety disorder such as OCD or panic	11.2%	
	ADD/ADHD	8.9%	
	Posttraumatic stress disorder	5.4%	
	Seasonal affective disorder	4.7%	
	Alcohol/Substance Abuse/Dependence	4.3%	
	Postpartum depression	4.0%	
	Bipolar	3.8%	
	Developmental disability	3.2%	
	Autism spectrum	2.4%	
	Life adjustment disorder	2.2%	
	Other mental health disorder	1.8%	
	Other trauma	1.4%	
	Eating disorder	1.3%	
	Schizophrenia	1.0%	
How often feel lonely or isolated from others.	Often or always	5.6%	398
	Some of the time	10.6%	
	Occasionally	15.6%	
	Hardly ever	29.1%	
	Never	39.1%	

More than one in ten residents, 11.2%, had felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities in the past 12 months. Groups of respondents more likely to have felt sad or hopeless for two weeks or more in a row include females, residents ages 18 to 44, those with some college or less education, non-white residents, those who are single or divorced, residents who work part-time or are unemployed, those with an annual income under $25,000, residents who live alone, and obese residents. Only a small percentage of residents, 2.2%, seriously considered suicide in the past year. Groups of respondents more likely to have seriously considered suicide include respondents with children in the home, and those ages 18 to 44.

During the Past 12 Months. . . . . .



Next, all residents were given a list of fifteen different mental health conditions and asked if they or any member of their immediate family had ever been diagnosed with each. Each condition is discussed in more detail below.

Anxiety or Emotional Problems- More than a quarter of residents, 25.2%, had either been diagnosed or had an immediate family member who had been diagnosed with anxiety or emotional problems. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with anxiety include respondents with children in the home, females, residents ages 18 to 44, those with some college education, divorced residents, those who are employed part-time or unemployed, residents with an annual income of $25,000-$75,000, those who live in a household of 3-4 people, and obese residents.

Depression- Nearly a quarter of residents, 21.7%, had either been diagnosed or had an immediate family member who had been diagnosed with depression. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with depression include respondents with children in the home, females, residents ages 18 to 44, those with some college education, non-white residents, those who are not married, unemployed residents, those with an annual income under $75,000 (especially those with an income under $25,000), and residents who live in a household of 3-4 people.

Anxiety Disorder such as OCD or Panic Disorder- More than one in ten residents, 11.2%, had either been diagnosed or had an immediate family member who had been diagnosed with an anxiety disorder such as Obsessive-Compulsive Disorder (OCD) or Panic Disorder. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with an anxiety disorder include residents ages 18 to 44, those with some college education, divorced residents, and those who are unemployed.

ADD/ADHD- Less than a tenth of residents, 8.9%, had either been diagnosed or had an immediate family member who had been diagnosed with Attention Deficit Disorder or ADD/ADHD.

Posttraumatic Stress Disorder- A small percentage of residents, 5.4%, had either been diagnosed or had an immediate family member who had been diagnosed with posttraumatic stress disorder or PTSD. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with PTSD include respondents with children in the home, those with some college education, divorced or widowed residents, those who are unemployed, and residents with an annual income of $25,000 or $50,000.

Seasonal Affective Disorder- A small percentage of residents, 4.7%, had either been diagnosed or had an immediate family member who had been diagnosed with seasonal affective disorder. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with seasonal affective disorder include respondents with children in the home, residents ages 18 to 44, those with some college education, divorced or widowed residents, those who are unemployed, and residents who live in a household of 3-4 people.

Alcohol/Substance Abuse Dependence- A small percentage of residents, 4.3%, had either been diagnosed or had an immediate family member who had been diagnosed with alcohol/substance abuse dependence. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with alcohol/substance abuse dependence include respondents with children in the home, males, residents ages 18 to 44, those who are divorced or widowed, and unemployed residents.

Postpartum Depression- A small percentage of residents, 4.0%, had either been diagnosed or had an immediate family member who had been diagnosed with postpartum depression. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with postpartum depression include

respondents with children in the home, females, residents ages 18 to 44, non-white residents, those who are unemployed, and residents who live in a household of 3 or more people.

Bipolar- Slightly fewer residents, 3.8%, had either been diagnosed or had an immediate family member who had been diagnosed with bipolar. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with bipolar include respondents with children in the home.

Developmental Disability- A small percentage of residents, 3.2%, had either been diagnosed or had an immediate family member who had been diagnosed with a developmental disability.

Autism Spectrum- A small percentage of residents, 2.4%, had either been diagnosed or had an immediate family member who had been diagnosed with Autism Spectrum.

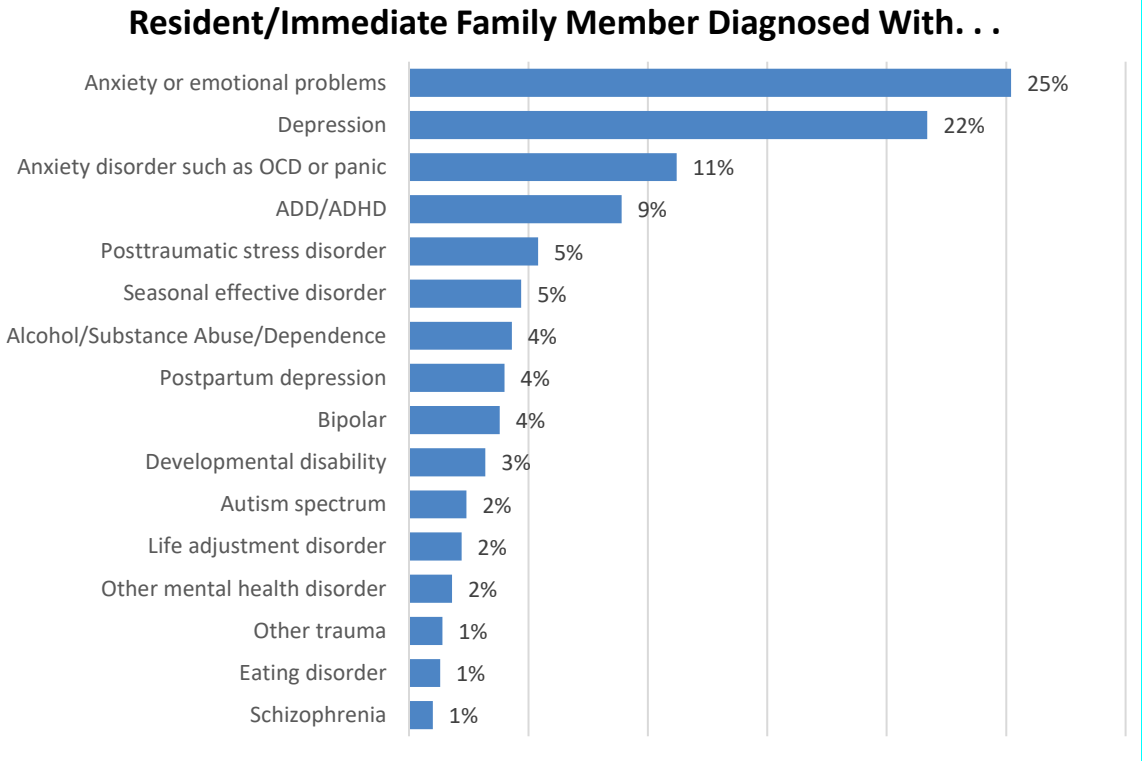
Life Adjustment Disorder- A small percentage of residents, 2.2%, had life adjustment disorder. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with life adjustment disorder include those with some college education, and divorced residents.

Other Mental Health Disorder- A small percentage of residents, 1.8%, had other mental health disorder.

Other Trauma- A small percentage of residents, 1.4%, had other trauma.

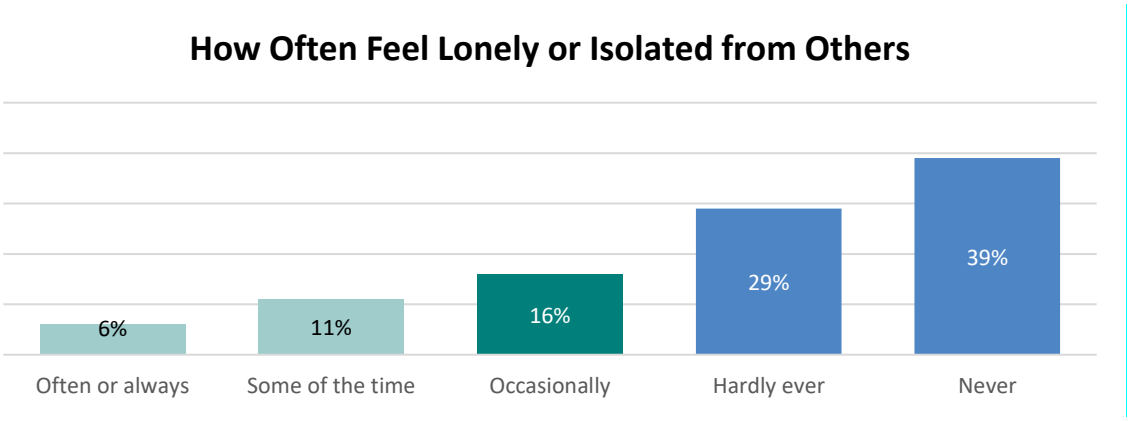
Eating Disorder- A small percentage of residents, 1.3%, had either been diagnosed or had an immediate family member who had been diagnosed with an eating disorder. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with an eating disorder include those with some college education and residents who are employed part-time.

Schizophrenia- A small percentage of residents, 1.0%, had either been diagnosed or had an immediate family member who had been diagnosed with schizophrenia. Groups of residents who were more likely to have been diagnosed or had an immediate family member who was diagnosed with Schizophrenia include divorced or widowed residents.



About a sixth of residents, 16.2%, reported that they often or sometimes feel lonely and isolated from others, with 5.6% saying that they often or always feel that way. Nearly one-sixth of residents, 15.6%, occasionally feel lonely or isolated from others while 29.1% hardly ever feel this way. More than a third of residents, 39.1%, reported that they never feel lonely or isolated from others.

Residents who were more likely to often or some of the time feel lonely or isolated include residents ages 18 to 44, non-white residents, those who are not married, unemployed residents, those with an annual income under $50,000 (especially those with an annual income under $25,000), residents who live alone, and obese residents. Residents who were more likely to hardly ever or never feel lonely or isolated include males, residents ages 45 and older, white residents, those who are married, retirees and residents who are employed full-time, those with an annual income over $75,000, and residents who live in 2-person households.



SECONDARY DATA ANALYSIS

Mental Health Providers refers to the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure. In Ohio, there is 1 Mental Health Provider for every 409 residents. The ratio in Putnam County is much, much worse with there being 1 Mental Health Provider for every 1,778 county residents. There are only nineteen mental health providers, total, in Putnam County.

Mental Health Providers

	2016		2017		2018		2019		2020	
	# of Provider	Ratio	# of Provider	Ratio	# of Provider	Ratio	# of Provider	Ratio	# of Provider	Ratio
Putnam	16	2,136	16	2,128	16	2,129	17	1,993	19	1,778
Ohio	16,662	696:1	18,351	633	20,710	561	24,748	471	28,567	409

SOURCE: County Health Ranking. Original Source: HRSA Area Resource File.

The number of suicide deaths in Putnam County has only slightly varied over the past five years. In the state of Ohio, however, there has been a 10% increase in the number of suicide deaths over the past five years.

Number of Suicide Deaths

	2015	2016	2017	2018	2019	% Change
Putnam County	4	5	5	2	3	-25.0%
Ohio	1,645	1,705	1,751	1,838	1,813	+10.2%

SOURCE: Ohio Department of Health, Data Warehouse. NA=Indicates rates have been suppressed for counts < 10

Poor mental health days is based on survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported the average number of days a county's adult residents report that their mental health was not good. The average number of poor mental health days was slightly less in Putnam County than it was in the state.

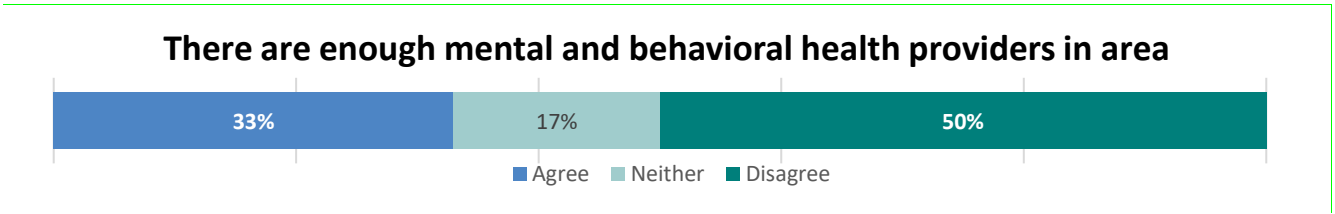
Number of Poor Mental Health Days

	2017	2018	2019	2020	2021	Change
Putnam	3.4	3.6	3.6	3.9	4.5	+1.1
Ohio	4.0	4.3	4.3	4.6	4.8	+0.8

SOURCE: County Health Ranking. Original Source: The Behavioral Risk Factor Surveillance System (BRFSS),

COMMUNITY LEADERS

Half of community leaders, 50%, disagreed that "*There is a sufficient number of mental and behavioral health providers in the area".* Only a third, 33.3%, agreed.



ORAL HEALTH

COMMUNITY SURVEY

Less than three-quarters of residents, 73.2%, had seen a dentist in the past year. An additional 11.3% had seen a dentist in the past two years and 6.4% in the last five years. Nearly one in ten residents, 9.0%, has not seen a dentist in 5 or more years. Groups of residents most likely to have visited the dentist in the past year include residents with children in the home, college graduates, married residents, those who are employed, residents with an annual income over $75,000, those from 2-person households, and residents with dental insurance. Groups of residents most likely to have not had a dental visit in the past five years include: females, residents with a high school diploma or less education, those who are divorced, unemployed residents, those with an annual income under $25,000, residents from single family households, and those without dental insurance.

The 26.8% of residents who had not been to the dentist in the past year were asked the main reason for not seeing a dentist in the past year. This was an open-ended question in which the respondent could give one response. The most common reasons for not visiting a dentist in the past year were the cost, not having time to see the dentist, having no problems with teeth, and not having dental insurance.

Summary: Access to Oral Health Care			
		% of Residents	*N*
Last Dental Checkup	Within past year	73.2%	398
	Within past 2 years	11.3%	
	Within past 5 years	6.4%	
	5 or more years ago	7.4%	
	Never	1.6%	

Reason Not Visited the Dentist		
	# of Responses	% of Responses
Cost	22	22.9%
Time	11	11.5%
No problems with teeth	11	11.5%
No dental insurance	10	10.4%
Limitations due to pandemic	8	8.3%
Motivation	7	7.3%
Wear dentures	6	6.3%
Will not accept Medicaid or my insurance	4	4.2%
Scared	4	4.2%
Difficulty getting appointment	3	3.1%
Have not made the appointment	3	3.1%
Need to find another dentist	2	2.1%
Distance	2	2.1%
Busy schedule	2	2.1%
Do not have a dentist	2	2.1%
Total	**96**	**(n=96)**
Question: What is the main reason have not visited the dentist		

SECONDARY DATA ANALYSIS

The ratio below represents the population per dentist in the county. While the ratio of population per number of dentists has been steadily improving over the past five years in the state while staying the same in the county, the ratio for the number of dentists per population is considerably higher in Putnam County than it is for the state as a whole.

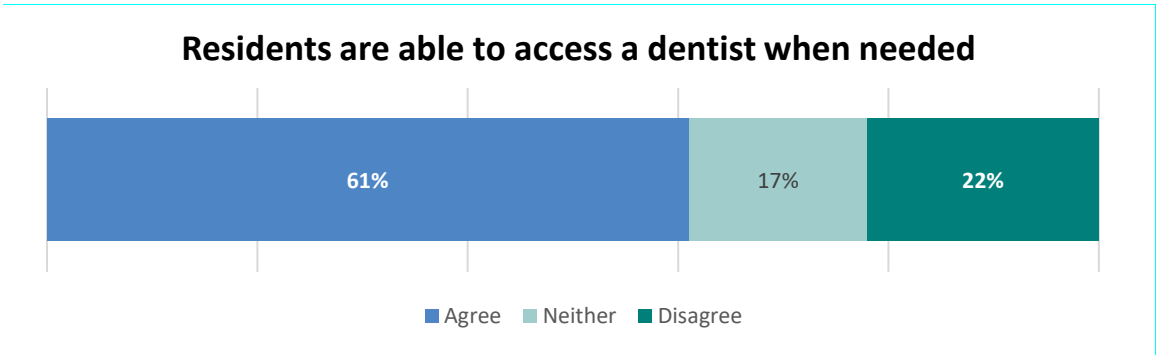
Ratio of Population per Dentists

	2016		2017		2018		2019		2020		% Change
	# of Dentists	Ratio	# of Dentists	Ratio	# of Dentists	Ratio	# of Dentists	Ratio	# of Dentists	Ratio	
Putnam	9	3,797	8	4,260	8	4,260	8	4,230	9	3,750	**0.0%**
Ohio	6,770	1,713	6,864	1,690	7,014	1,660	7,176	1,620	7,260	1,610	**+7.2%**

SOURCE: County Health Ranking. Original Source: HRSA Area Resource File.http://www.countyhealthrankings.org/app/ohio/2018/measure/factors/88/map

COMMUNITY LEADER SURVEY

Nearly a sixth of community leaders who were surveyed, 61.1%, agreed that *"Residents in Putnam County are able to access a dentist when needed"* with 27.8% strongly agreeing. Nearly a quarter, 22.3%, disagreed.

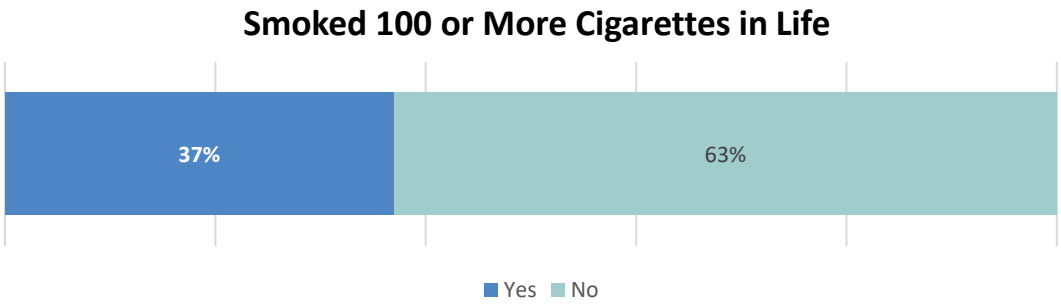


SMOKING/TOBACCO USE

COMMUNITY SURVEY

Summary: Smoking and Tobacco Use			
		% of Residents	*N*
Smoked 100 or more cigarettes in life	Yes	36.6%	398
	No	63.4%	
Tobacco usage	Everyday	14.5%	397
	Some days	4.8%	
	Not at all	80.7%	
Electronic Cigarette/Vape Usage	Everyday	1.6%	397
	Some days	2.6%	
	Not at all	95.8%	
Likelihood of quitting smoking or vaping	Very likely	16.5%	82
	Somewhat likely	50.7%	
	Not at all likely	32.8%	
Interest in smoking cessation program	Very interested	9.9%	82
	Somewhat interested	25.8%	
	Not at all interested	64.3%	
Seriousness of youth vaping problem	Very serious	16.6%	380
	Moderately serious	40.3%	
	Not too serious	25.8%	
	Not really a problem	17.3%	

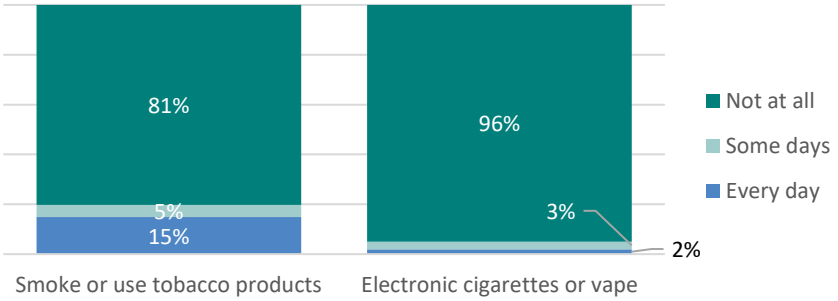
More than a third of residents, 36.6%, have smoked 100 or more cigarettes in their lifetime. Groups of respondents more likely to have smoked 100 or more cigarettes in their lifetime include residents without children in the home, males, those with a high school diploma or less education, divorced or single residents, those with an annual income under $25,000, and residents who live alone.



Nearly one fifth, 19.3%, of residents indicated they currently smoke cigarettes, cigars, chewing tobacco or use other tobacco. ***Every day users*** amounted to 14.5% of all residents. The remaining proportion of tobacco users indicated they smoke cigarettes or use tobacco less frequently or only ***some days,*** amounting to 4.8% of all residents. Groups of residents more likely to smoke or use tobacco include males, residents ages 18 to 44, those with some college or less education, divorced or single residents, those who are employed part-time or unemployed, and residents with an annual income under $50,000.

Less than one-twentieth or 4.2% of residents indicated they currently smoke e-cigarettes or vape. Groups of residents that were more likely to smoke e-cigarettes or vape include females, residents ages 18 to 44, those with some college education, non-white residents, divorced or single residents, those who are employed part-time or unemployed, and residents with an annual income under $50,000.

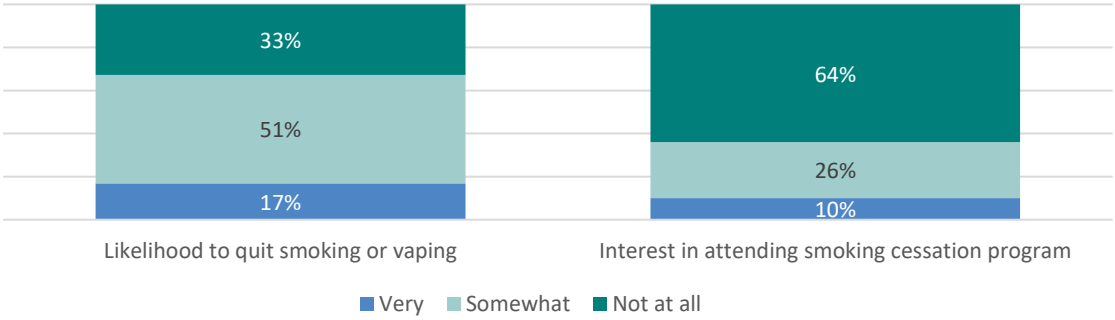
Tobacco use and Vaping



Of the residents who currently smoke or vape, two-thirds, 67.2%, are at least somewhat likely to quit (16.5% were very likely, the remaining 50.7% were somewhat likely). There is a small amount of interest in a smoking cessation program among those who currently smoke or vape, with 9.9% being very interested and 25.8% being somewhat interested. As would be expected, tobacco users that reported that they were likely to quit were much more interested in the smoking cessation program than those who were not looking to quit.

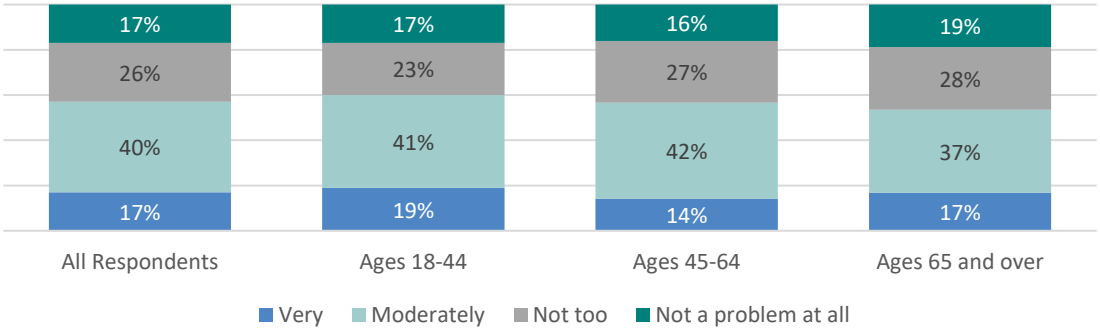
Likelihood to Quit and Interest in Smoking Cessation Program

Asked of Current Smokers/Vapers Only



More than half of all residents, 56.9%, felt that vaping among youth was a serious problem, with 16.6% feeling that it was a very serious problem and 40.3% feeling that it was a moderately serious problem. More than one-sixth of residents, 17.3%, thought that it was not a problem at all. Groups of respondents more likely to feel that vaping among youth is a serious problem include residents without children in the home, those with an annual income under $25,000, and residents who live alone.

Seriousness of Youth Vaping



Adult smoking prevalence is the estimated percent of the adult population that currently smokes every day or "most days" and has smoked at least 100 cigarettes in their lifetime. The percentage of adults who smoke in the county is slightly lower than the state average, 16% in the county compared to 21% in Ohio.

Percent of Adults that Currently Smoke						
	2016	2017	2018	2019	2020	Change
Putnam County	17%	15%	16%	16%	16%	-5.9%
Ohio	21%	22%	23%	23%	21%	0.0%

SOURCE: County Health Ranking. Original Source: The Behavioral Risk Factor Surveillance System (BRFSS)

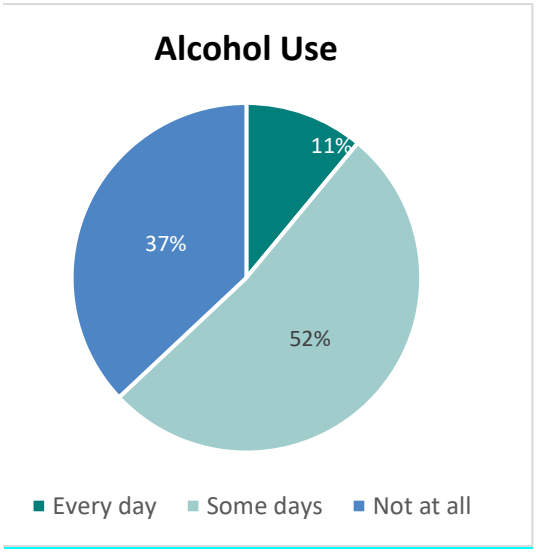
ALCOHOL AND SUBSTANCE USE

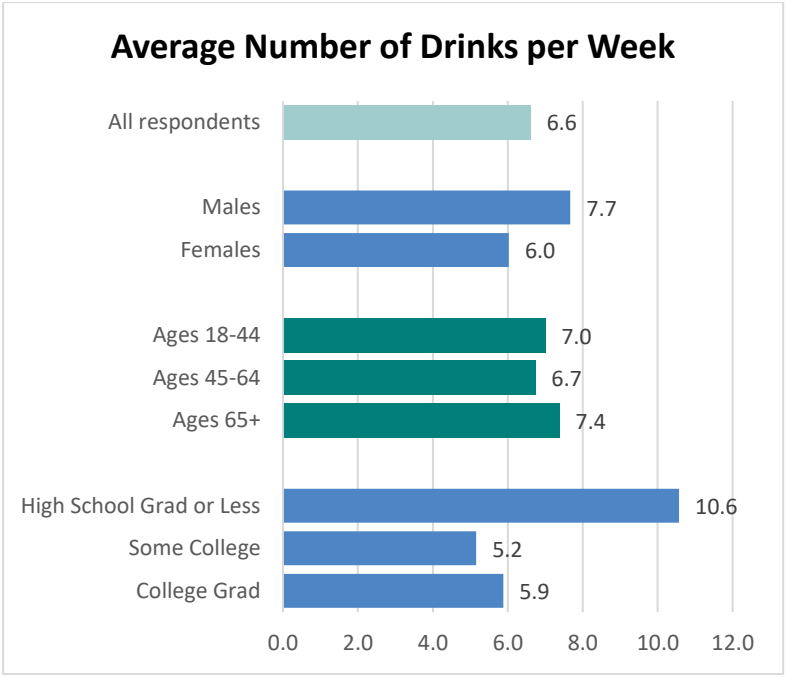
COMMUNITY SURVEY

Summary: Alcohol and Substance Abuse			
		%	*N*
Alcohol consumption	Every day	10.9%	398
	Some days	52.3%	
	Not at all	36.8%	
	Average number of drinks per week	***6.61***	***248***
	# of days had 5+ drinks past month (men)	***2.49***	***141***
	# of days had 4+ drinks past month (women)	***3.65***	***103***
Driven after drinking alcohol in past month	Yes	11.6%	400
	No	88.4%	
During the last 6 month, anyone in household use. . .	Marijuana	7.4%	400
	Amphetamines, methamphetamines or speed	0.4%	
	Cocaine or crack	0.2%	
	Heroin	0.2%	
	LSD or other hallucinogen	0.2%	
	Inhalants	0.2%	
	Ecstasy or GHB	0.2%	
	Bath salts used illegally	0.2%	
	Something else	0.8%	
In past year. . .	Taken prescriptions not belonging to them	1.6%	398
	Taken prescriptions different than prescribed	2.8%	397
How typically get rid of unused prescription medication	Take to Take Back Center	34.9%	387
	Keep them in case I need them in the future	26.1%	
	Throw them in trash	16.4%	
	Flush down toilet	13.2%	
	Something else	8.9%	
	Give them to someone else who needs them	0.4%	
Aware of drug or alcohol addiction treatment	Yes	49.5%	398
	No	50.5%	
Have you or someone you know needed treatment in past year	Yes	7.1%	397
	No	92.9%	

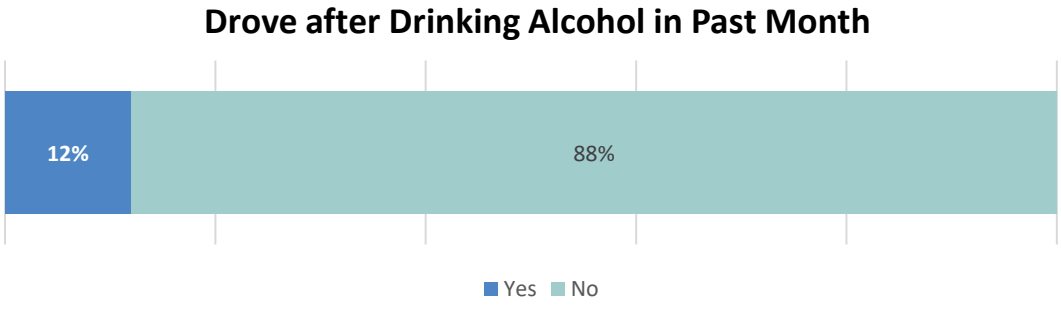
Nearly two-thirds of residents, 63.2%, reported drinking alcoholic beverages such as beer, wine, malt beverages or liquor at least some days with 10.9% reporting drinking alcohol every day. More than a third of residents, 36.8%, reported that they don't drink alcoholic beverages at all. Groups of residents more likely to drink alcoholic beverages include males, residents ages 18 to 44, those with some college or less education, residents with an annual income of $50,000 or less, those who are divorced, employed residents, and those with children in the home. The average number of alcoholic beverages per week was 6.61 for all residents. Groups of residents with significantly higher averages include males (7.7), residents ages 65 and over (7.4) and those with a high school diploma or less education (10.6).

All men were asked how many days during the past month did they had five or more alcoholic drinks on an occasion. Females were asked about how many days they had four or more alcoholic drinks on an occasion. For males, over half 52.1%, drank 5 or more alcoholic drinks zero times while 11.7% binged one time. The remaining 36.2% of males drank 5 or more drinks on one occasion two or more times in the past month. The average number of times males drank 5 or more drinks in the past month was 2.49. For females, over a third, 39.2%, drank 4 or more alcoholic drinks zero times while 14.8% binged one time. The remaining 46.0% of females drank 4 or more drinks on one occasion 2 or more times in the past month. The average number of time females drank 4 or more drinks in the past month was 3.65.

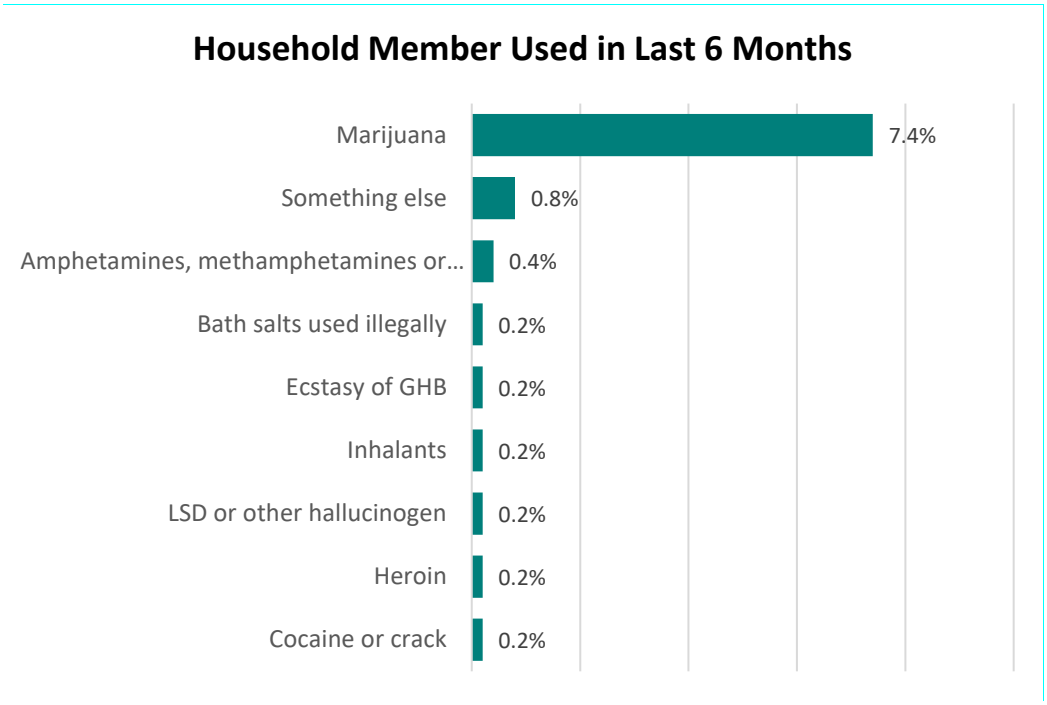




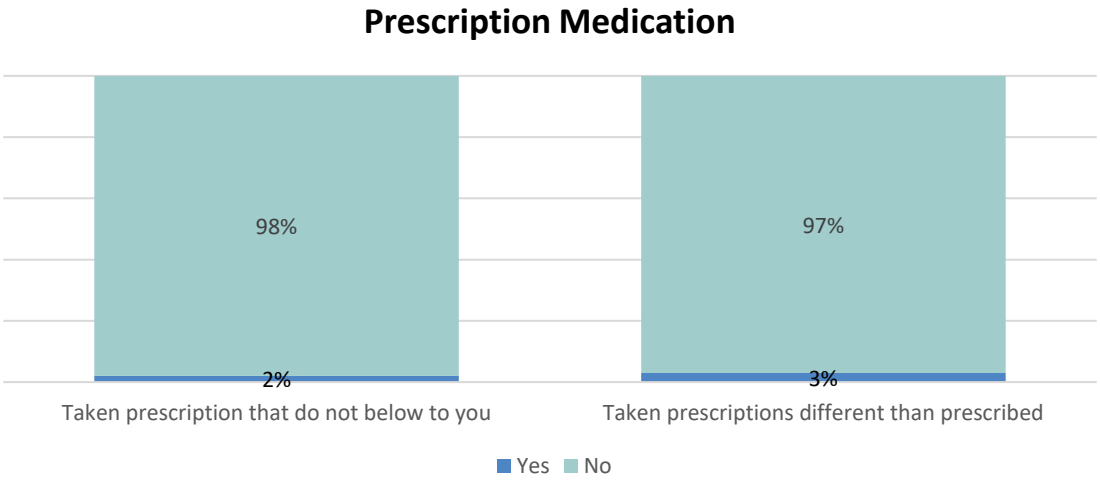
More than one in ten residents, 11.6%, reported driving after drinking any alcoholic beverages during the past month. The average number of times that residents drove after drinking alcoholic drinks was 3.16.



Less than one in ten, 7.4%, reported that they or someone in their household had used marijuana in the past six months. Only a tiny fraction of residents, 0.4%, reported that they or someone in their household had used amphetamines, methamphetamines, or speed. Even fewer residents, 0.2%, reported using cocaine or crack, heroin, LSD or other hallucinogen, inhalants, ecstasy or GHB, and bath salts used illegally. Groups of residents more likely to have used marijuana in the past six months include residents ages 18 to 44, those with some college education, residents with an annual income of $25,000 or less, those who are not married, and unemployed residents.

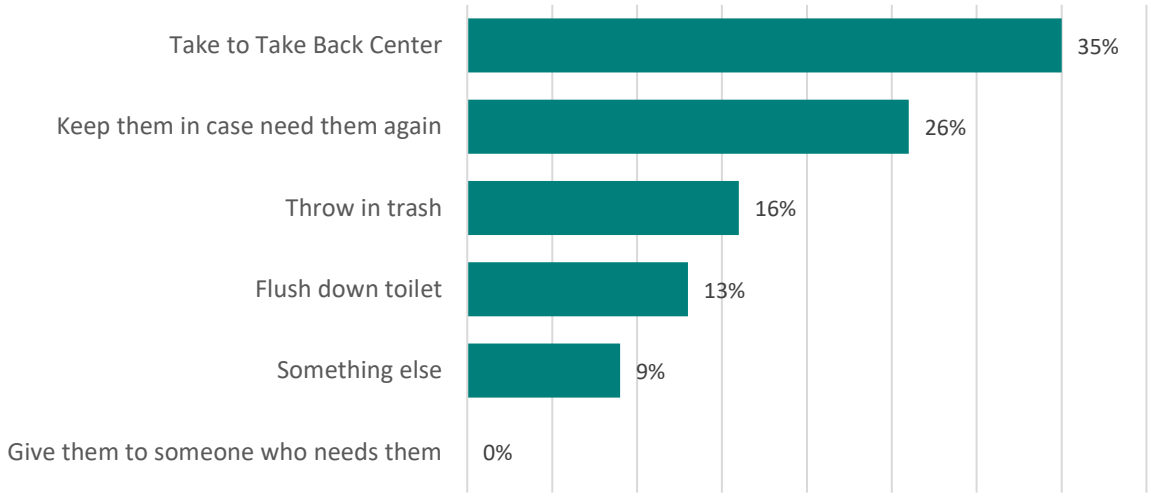


Only a small percentage of residents reported taking prescriptions that did not belong to them (1.6%) or taken a prescription differently than prescribed such as more frequently or in higher doses than directed by the doctor (2.8%). Groups of residents more likely to have taken prescription medicine that did not belong to them include residents with an annual income under $25,000 and single residents. Groups of residents more likely to have taken prescription medicine differently than prescribed include residents ages 18 to 44, those with a high school diploma or less education, residents with an annual income under $25,000, those who are not married, and unemployed residents.



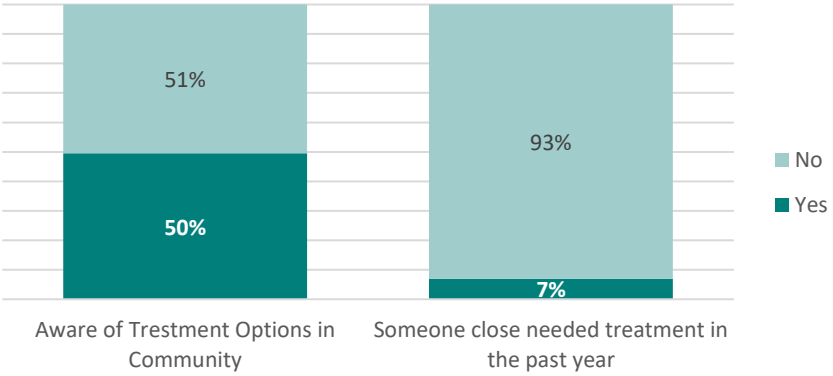
More than a third of residents, 34.9%, report that they get rid of unused medication by taking it to a take back center. More than a quarter of residents, 26.1%, reported that they keep unused medication in case they need it again. One sixth, 16.4%, reported that they throw unused medication in the trash. Other ways of disposing of medication include, flush them down the toilet (13%). Groups of respondents more likely to use a **Take Back Center** include females, residents ages 45 and older, those with some college education, residents with an annual income over $75,000, those who are widowed, retirees, and residents without children in the home. Groups of respondents more likely to **keep medicines** in case they need them in the future include males, residents ages 18 to 44, those with some college or more education, divorced residents, those who are employed full-time, and residents with children in the home. Groups of respondents more likely to **throw unused medication in the trash** include residents ages 18 to 44, those with a high school diploma or less education, residents with an annual income over $75,000, those who are married, and residents who are unemployed or employed part-time. Groups of respondents more likely to **flush unused medicine in the toilet** include females, residents ages 65 and over, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced, and residents who are unemployed or employed part-time.

How Typically Get Rid of Unused Medication



Half, 49.5%, of residents reported being aware of any drug and alcohol addiction treatment options available in their community. Groups of respondents more likely to be aware of available treatment options include males and residents with an annual income of $50,000 to $75,000. Less than one-tenth, 7.1%, of reports indicated that they, a member of their family, or close friend needed drug or alcohol treatment services in the past year. Of those residents 75.0% were able to find the services that they needed in a timely manner.

Alcohol or Drug Treatment



SECONDARY DATA ANALYSIS

Excessive drinking reflects the percent of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average. The percentage of adults reporting binge or heavy drinking was slightly higher in Putnam County than the state.

Percentage of Adults Reporting Binge or Heavy Drinking						
	2014	2015	2016	2017	2018	Change
Putnam	23%	21%	21%	20%	21%	-2.0%
Ohio	19%	19%	19%	20%	18%	-1.0%
SOURCE: County Health Ranking. Original Source: The Behavioral Risk Factor Surveillance System (BRFSS)						

In 2020, the percentage of driving deaths with alcohol involvement in Putnam County was slightly higher than the state.

Percentage of Driving Deaths with Alcohol Involvement						
	2016	2017	2018	2019	2020	Change
Putnam County	35%	44%	43%	43%	35%	0%
Ohio	35%	34%	34%	33%	33%	-2%
SOURCE: County Health Ranking. Original Source: National Center for Health Statistics						

The table below represents the percentage of unduplicated clients in treatment with a primary diagnosis of alcohol use disorder. On average, 48.0% percent of client admissions in the county were associated with a primary diagnosis of alcohol abuse or dependence in SFY 2019. It should be noted that this data comes from the Ohio Mental Health & Addiction Services (OhioMHAS) Multi Agency Community Information System (MACSIS). While MACSIS data is required for billing purposes, there are minimal sanctions for failing to submit, so underreporting of these numbers is likely. It should also be noted that reported data only reflects information for clients whose treatment was provided with public dollars.

Percentage of Unduplicated Clients - Treatment for Alcohol Use Disorder						
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	Change
Putnam	55.1%	40.4%	41.4%	35.0%	48.0%	-7.1%
Ohio Avg.	29.7%	20.3%	24.1%	21.2%	21.5%	-8.2%
SOURCE: Ohio Mental Health & Addiction Services, Multi Agency Community Information Systems.						

The number of unintentional drug overdose deaths in Putnam County has remained the same since 2012. The unintentional drug overdose death rate for Ohio was higher than the rate for Putnam County.

Number of Unintentional Drug Overdose Deaths, 2012-2019										
	2012	2013	2014	2015	2016	2017	2018	2019	Change	Rate*
Putnam	1	2	3	4	4	3	3	1	0%	10.2
Ohio	1,914	2,110	2,531	3,050	4,050	4,854	3,764	4,028	110.4%	33.6
**Rate per 100,000 Population 2014-2019, SOURCE: Ohio Drug Overdose Data: General Findings*										

The table below represents the percentage of unduplicated clients in treatment with a primary diagnosis of opiate use disorder. On average, 20.7% percent of client admissions in the county were associated with a primary diagnosis of opiate abuse or dependence in SFY 2019, significantly lower than 28.3% in SFY 2015.

Percentage of Unduplicated Clients - Treatment for Opiate Use Disorder						
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	Change
Putnam	28.3%	40.4%	32.5%	36.9%	20.7%	-7.6%
Ohio Avg.	43.7%	49.9%	48.1%	49.4%	48.4%	+4.7%
SOURCE: Ohio Mental Health & Addiction Services, Multi Agency Community Information Systems.						

The table below represents the percentage of unduplicated clients in treatment with a primary diagnosis of cannabis use disorder. On average, 17.3% percent of client admissions in the county were associated with a primary diagnosis of cannabis abuse or dependence in SFY 2019 which was slightly higher than the state average.

Percentage of Unduplicated Clients - Treatment for Cannabis Use Disorder						
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	Change
Putnam	-	10.6%	18.5%	-	17.3%	+17.3%
Ohio Avg.	7.5%	17.2%	17.0%	15.5%	14.7%	+7.2%

SOURCE: Ohio Mental Health & Addiction Services, Multi Agency Community Information Systems.

The table below examines the number of both prescription opioids and benzodiazepine with data from The Ohio State Board of Pharmacy's automated prescription reporting system (OARRS). Rates are likely underestimated because data from drugs dispensed at physician offices and the Veteran's administration are not included in the calculations. Rates for both prescriptions for both drugs have been on a significant downward trend over the past five years.

Opioid Prescriptions per 100K Residents-Putnam County						
	2017	2018	2019	2020	2021	Rate Change
Opioids	51,622	45,851	40,650	37,705	32,897	-36.3%
Benzodiazepine	24,291	21,409	20,412	19,354	19,169	-21.1%

SOURCE: Ohio Automated Rx Reporting System (OARRS), PDMP Interactive Data Tool

MATERNAL, INFANT AND CHILD HEALTH

SECONDARY DATA ANALYSIS

One twentieth of births in Putnam County in 2019 were low birth weight (5.1%). The number of low-birth-weight births has slightly decreased over the past five years.

Putnam County Low Birth Weight						
	2015	2016	2017	2018	2019	Change
# Low birth weight (LBW)	29	31	28	29	22	-24.1%
% Low birth weight (LBW)	6.9%	7.2%	6.5%	6.8%	5.1%	-1.8%

LBW= Births less than 5 pounds, 8 ounces, SOURCE: Ohio Department of Health Data Warehouse.

Birth rates for very low birth weight and low birth weight were both lower in Putnam County than Ohio as a whole. The high birth weight case rate was considerably higher in Putnam County than Ohio. The percentage of births that were pre-term births was higher in Putnam County than it was for the state (11.7% in Putnam County compared to 8.7% for the state).

Birth Weight Distribution, 2020				
	Putnam County		Ohio	
	Case Count	Birth Count %	Case Count	Birth Count %
Very low birth weight (<1500g)	5	1.2%	1,805	1.4%
Low birth weight (1500-2500g)	20	4.9%	9,163	7.1%
Normal weight (2500-3999g)	333	80.8%	108,220	83.8%
High birth weight (4000g+)	54	13.1%	10,019	7.8%
Gestational Age Distribution, 2020				
Very pre-term (<32 weeks)	5	1.2%	2,073	1.6%
Pre-term (32-37 weeks)	48	11.7%	11,255	8.7%
Term (37 to 41 weeks)	359	87.1%	115,552	89.4%
Post-term (42+ weeks)	0	0.0%	292	0.2%

SOURCE: Ohio Department of Health Data Warehouse

The percentage of pregnant women accessing prenatal care in the first trimester in the county is significantly higher than the state (82.2% compared to 68.6%).

Trimester of Entry into Prenatal Care						
	2015	2016	2017	2018	2019	Change
PUTNAM COUNTY						
None	0.2%	0.2%	0.2%	0.7%	0.9%	+0.5%
First Trimester	81.7%	79.3%	85.5%	79.5%	82.2%	+0.5%
Second Trimester	9.5%	8.3%	8.3%	9.4%	14.2%	+4.7%
Third Trimester	1.2%	2.8%	1.4%	3.1%	2.4%	+1.2%
OHIO						
None	1.6%	1.5%	1.5%	1.5%	1.5%	-0.1%
First Trimester	64.8%	66.1%	66.5%	67.9%	68.6%	+3.8%
Second Trimester	19.2%	19.8%	19.8%	19.5%	19.5%	+0.3%
Third Trimester	4.6%	4.7%	4.7%	4.5%	4.4%	-0.2%

SOURCE: Ohio Department of Health Data Warehouse.

The number of births for women of childbearing age has increased slightly over the last five years in Putnam County while the number in Ohio has a whole has slightly decreased.

Live Birth Count						
	2015	2016	2017	2018	2019	Change
Putnam	420	430	433	424	427	+1.7%
Ohio	139,297	138,193	136,890	135,220	134,560	-3.4%
SOURCE: Ohio Department of Health Data Warehouse.						

The number of births to young mothers decreased slightly from 2015 to 2019 in both Putnam County and the state as a whole.

Number of Births by Young Mothers, 2015-2019									
	2015				2019				Change
	<15	15-17	18-19	Total	<15	15-17	18-19	Total	2015-2019
Putnam	0	5	15	20	0	8	8	16	**-20.0%**
Ohio	106	2,292	6,464	8,862	80	1,511	5,415	7,006	**-20.9%**
SOURCE: Ohio Health Department Secure Data Warehouse									

The adolescent birth rate for teens ages 15-19 in the county is slightly lower than the state. It should be noted that the teen adolescent birth rate in both the county and Ohio has been declining each year.

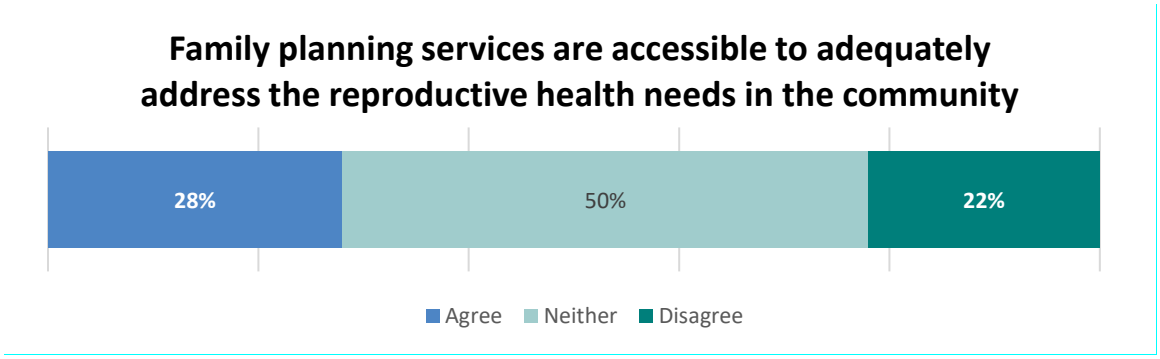
Teen Birth Rate						
	2016	2017	2018	2019	2020	Change
Putnam	21	18	16	14	15	-28.6%
Ohio	34	32	28	26	24	-29.4%
Rate is the Number of births per 1,000 female population ages 15-19, SOURCE: County Health Rankings						

In 2019, the infant mortality rate in Putnam County was 0.0, considerably lower than Ohio's infant mortality rate of 6.9.

Infant Mortality Rate, 2019			
	# of Deaths	# of Births	Rate*
Putnam County	0	427	**0.0**
Ohio	929	134,560	**6.9**
Number of all infant deaths (within 1 year), per 1,000 live births. *Rates of fewer than 10 deaths do not meet standards of reliability and are suppressed			

COMMUNITY LEADER

More than a quarter of community leaders, 27.8%, agreed that *"Family planning services are accessible and available to adequately address the reproductive health needs in the community."* No respondents strongly agreed with the statement. Nearly a quarter, 22.2%, disagreed.

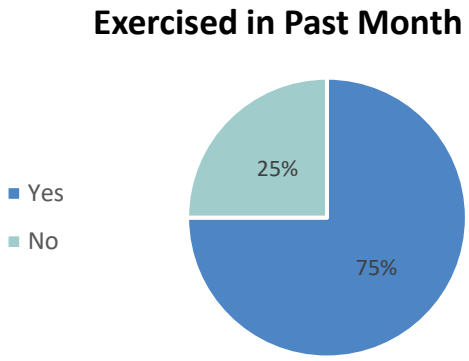


HEALTHY LIVING

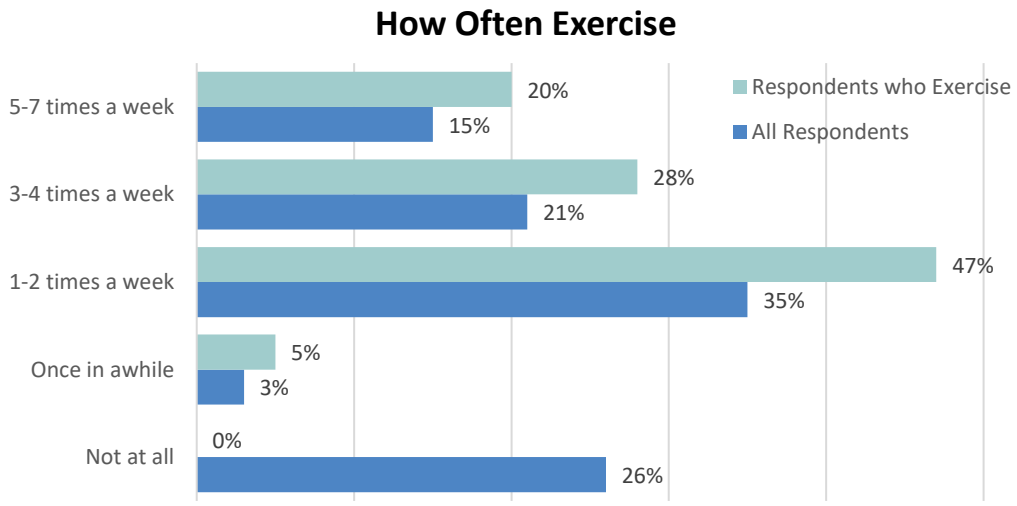
COMMUNITY SURVEY

Summary: Healthy Living- Weight and Exercise			
		# of Responses	*% of Responses*
Exercise in past month	Yes	74.5%	398
	No	25.5%	
Self-described weight	Overweight	60.2%	398
	About right	38.1%	
	Underweight	1.7%	
BMI *(calculated based on self-reported weight and height)*	Under weight	0.7%	396
	Normal weight	21.6%	
	Overweight	33.4%	
	Obese	44.3%	
Tried to lose weight over last 12 months	Yes	61.3%	398
	No	38.7%	
Average number of hours a day	Watch TV	2.98	391
	Play video games	0.57	339
	Use computer outside of work	1.45	365
	Use cell phone	3.30	379
Summary: Healthy Living- Food and nutrition			
What makes it difficult to get food needed *(residents could answer more than one)*	Cost of food	25.9%	400
	Quality of food	20.2%	
	Distance from the store	15.7%	
	Time for shopping	14.7%	
	Safety	2.4%	
	Something else	5.6%	
How difficult to get fresh fruits & vegetables neighborhood	Very difficult	2.3%	398
	Somewhat difficult	18.8%	
	Not at all difficult	78.9%	
How often eat fresh fruits and vegetables	0-1 times/week	10.1%	398
	2-4 times/week	37.4%	
	Once a day	27.9%	
	2-4 times a day	21.4%	
	5 or more times a day	3.2%	
# of restaurant or takeout meals a week	None	15.3%	398
	1-2 meals	66.3%	
	3-4 meals	14.8%	
	5 or more meals	3.6%	
# times drink pop or other unhealthy drinks	0	25.6%	398
	1-3 times per week	23.1%	
	4-6 times per week	11.7%	
	1 time per day	19.4%	
	2-3 times per day	14.5%	
	4 or more times per day	5.7%	

Nearly three-quarters of residents, 74.5%, had exercised in the past month Groups of residents more likely to exercise included college graduates, single residents, and those with an annual income of $100,000 or more. Groups of residents more likely to not have exercised in the past month include residents with a high school diploma or less education, those who are divorced or widowed, and residents with an annual income of $50,000-$100,000.



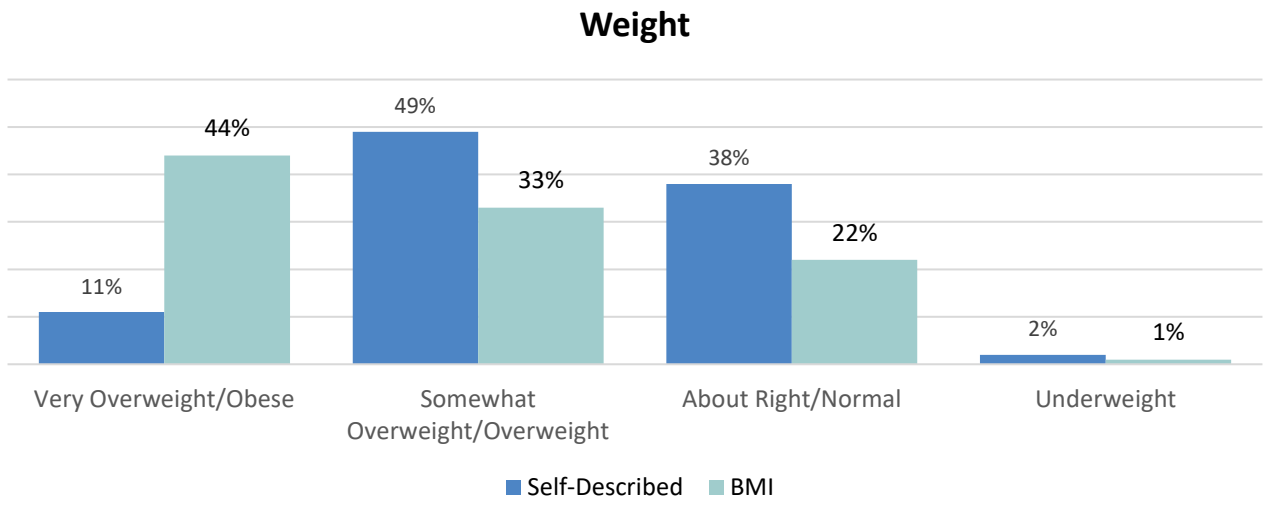
All residents, regardless of whether they exercised in the past month were asked how often they exercise in an average week. Of those who exercise, 5% only exercise once in a while (3% of all residents). Nearly half of exercising residents, 47%, exercise one to two times a week (35% of all residents). Another 28% of exercising residents exercise 3 to 4 times per week (21% of all residents), and 20% exercise 5 to 7 times a week (15% of all residents).



The 25.5% of residents who do not exercise on a regular basis were asked for some of the reasons that exercising is difficult. The most common response, given by less than half, 40.4%, was that they had a health problem that prevented them from exercising. The second most common reason, given by 31.5% of residents, was that they didn't have the time to exercise. Other reasons that exercise was difficult include, in order of importance, busy schedule (12.4%), lack of motivation (5.6%), and their job is physical (3.4%).

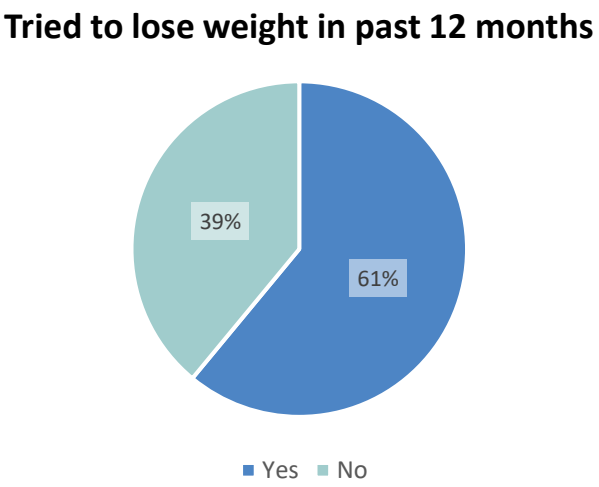
Reasons Exercising Is Difficult		
	#	%
Health problem	36	40.4%
Time	28	31.5%
Schedule	11	12.4%
Motivation	5	5.6%
Job is physical	3	3.4%
No energy	2	2.2%
Overweight	2	2.2%
Age	1	1.1%
No facilities	1	1.1%
Total	89	(n=89)

More than a third of residents, 38%, reported that their weight is about right. However, the percentage of residents who have a normal BMI based on their self-reported weight and height was much lower, 22%. Over half of residents, 60%, reported being overweight. Based on their BMI, a third of residents, 33%, were overweight and 44% were classified as obese. Groups of residents more likely to have a normal weight based on their BMI include females and residents ages 18 to 44. Groups of residents more likely to be overweight or obese based on their BMI include males and residents ages 45 to 64.



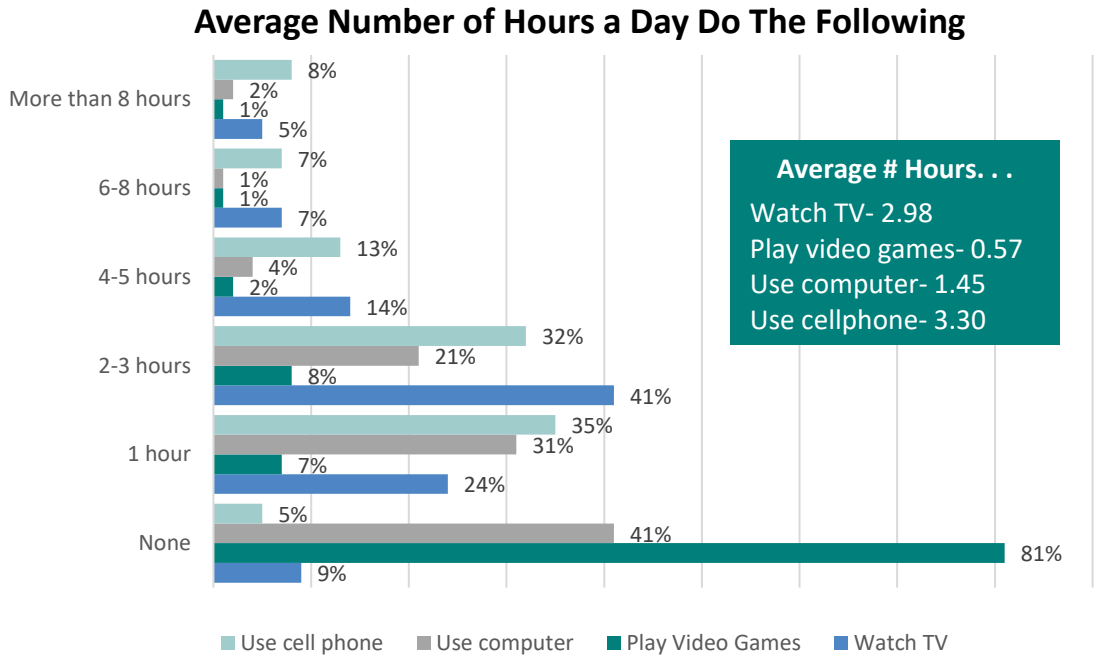
Less than two thirds of residents, 61.3%, reported that they have thought about or tried to lose weight in the past 12 months. Of those who tried to lose weight, 81.9% indicated that they have the resources needed to lose weight while 18.1% did not have the resources needed to lose weight.

Groups of residents more likely to report that they have thought about or tried to lose weight in the past 12 months include females, residents ages 18 to 44, those with some college or more education, employed residents, those with an annual income of $100,000 or more, and residents with children in the home.



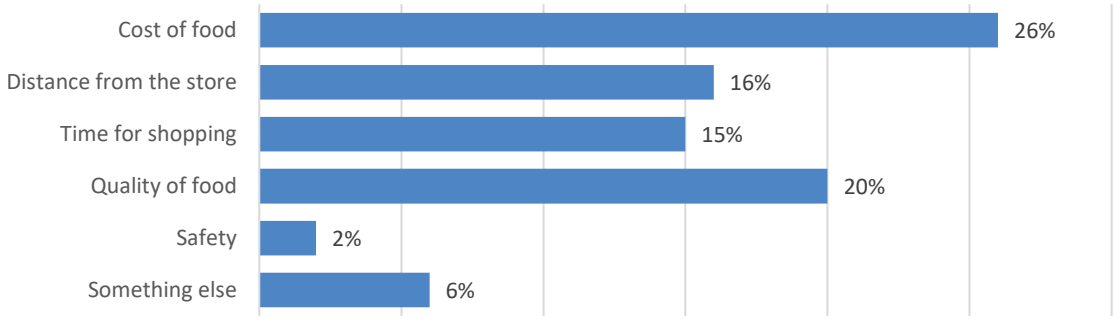
Next, residents were given four activities and asked about how many hours per day they spend on each activity: watching TV, playing video games, using a computer outside of work or school and using a cell phone including talking, texting, or going on the internet. The activity with the highest daily average use was ***using a cell phone***. Residents reportedly used their cell phones 3.30 hours a day. More specifically, nearly one-sixth of residents, 15%, use their cell phone 6 or more hours a day while 45% use it 2 to 5 hours a day. More than a third of residents, 35%, use their cell phone an average of 1 hour per day. Groups of residents more likely to use their cell phone 4 or more hours a day include residents ages 18 to 44, those with some college or less education, non-white residents, those who are single or divorced, unemployed residents, those with an annual income under $25,000, and residents with children in the home.

The activity with the next highest daily average use ***was watching TV***. Residents watched TV an average of 2.98 hours a day. More specifically, more than one-tenth of residents, 12%, watch TV 6 or more hours a day while 55% watch it 2 to 5 hours a day. Nearly a quarter of residents, 24%, watch TV an average of 1 hour per day. Less than one in ten, 9%, do not watch TV at all. Groups of residents more likely to watch TV 4 or more hours a day include residents ages 65 and over, those with a high school diploma or less education, residents who are divorced or widowed, residents who are retired or unemployed, those with an annual income of $50,000 or more, and residents without children in the home. Residents ***use a computer outside of work or school*** an average of 1.45 hours a day. More specifically, only a small percentage of residents, 3%, use their computer 6 or more hours a day while 25% use it 2 to 5 hours a day. Nearly a third of residents, 31%, use their computer an average of 1 hour per day. Less than half, 41%, do not use their computer outside of work or school at all. Groups of residents more likely to use their computer outside of work or school include residents ages 45 and over, those who are employed part-time or retired, residents with an annual income of $50,000 to $75,000, and residents without children in the home. Residents ***play video games*** an average of 0.57 hours a day. The majority of residents, 81%, do not play video games at all while 15% play video games 1 to 3 hours a day. Only a small percentage of residents, 4%, play video games 4 or more hours a day. Groups of residents more likely to play video games 2 or more hours a day include residents ages 18 to 44, those with some college education, single or divorced residents, those who are unemployed, and residents with an annual income of $50,000 or more.



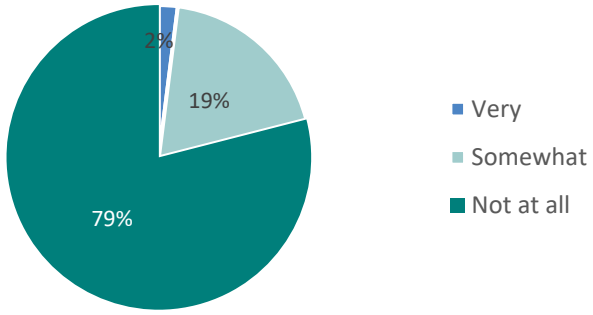
The most common problem making it difficult to get food was cost with over a quarter, 25.9%, stating this to be the case. More than a fifth of residents, 20.2%, stated that the quality of food made it difficult for them to get the food they need. Other things that made it difficult for residents to get the food they need include, in order of importance, distance to the store (15.7%), time to go shopping (14.7%), and safety (2.4%).

What Makes it Difficult to Get Needed Food



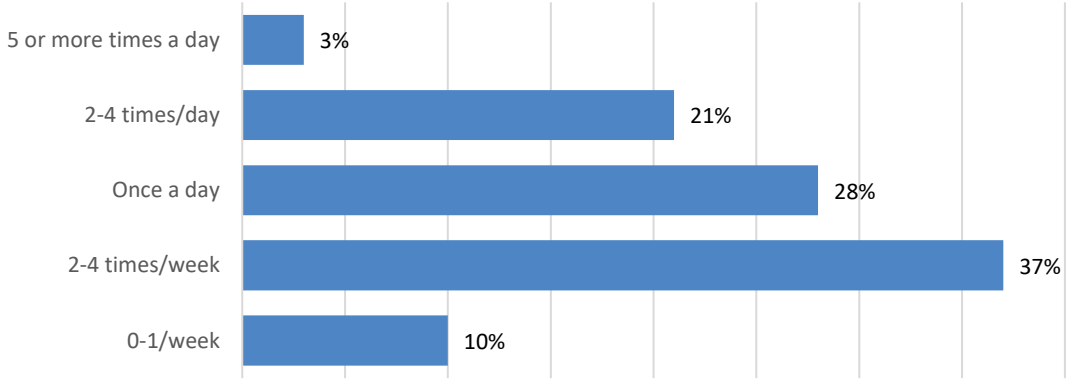
Nearly a quarter of residents, 21.1%, reported having difficulty getting fresh fruits and vegetables in their neighborhood, with 2.3% saying it was very difficult and 18.8% saying it was somewhat difficult. Groups of residents who were more likely to have difficulty getting fresh fruits and vegetables in their neighborhood include residents ages 18 to 44, those with some college education, divorced residents, those who are unemployed, residents with an annual income of $50,000 or less, and those with children in the home.

How Difficult to Get Fresh Fruits and Vegetables in Neighborhood

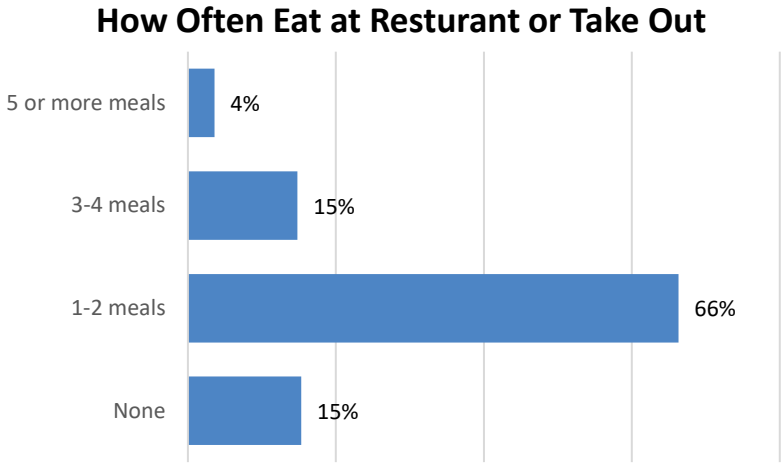


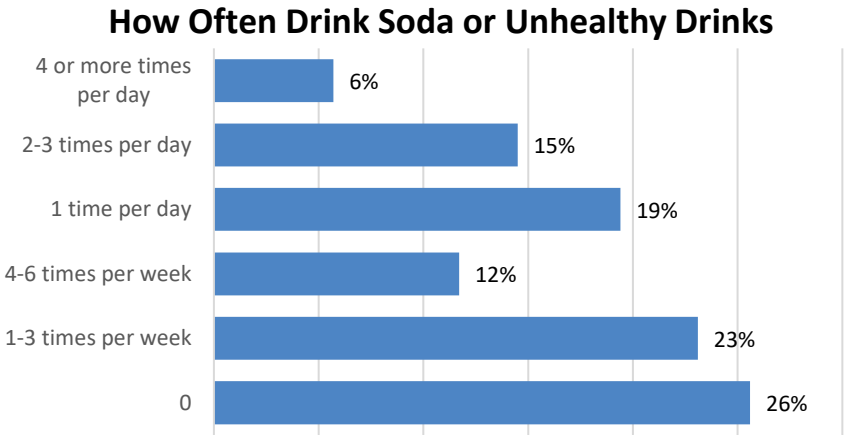
A tenth, 10.1%, eat fresh fruits and vegetables 0-1 times a week while 37.4%, eat fresh fruits and vegetables 2 to 4 times a week, and more than a quarter, 27.9%, eat fresh fruits and vegetables once a day. A quarter of residents, 24.6%, eat fresh fruits or vegetables 2 or more times a day. Groups of residents more likely to not eat fresh fruits and vegetables on a daily basis include residents with a high school diploma or less education, those with an annual income under $50,000 a year, non-white residents, those who are single or divorced, and residents who are unemployed or employed part-time.

How Often Eat Fresh Fruits and Vegetables



Two thirds of residents, 66.3%, eat out at a restaurant or take out meal 1 to 2 times a week while 18.4% eat out 3 or more times a week. Less than one-sixth of residents, 15.3%, don't eat out at all. Groups of residents more likely to eat at a restaurant or take out 3 or more times a week include males and residents with an annual income of $100,000 or more.





Over a quarter of residents, 25.6%, have not drank soda, iced coffee, punch, Kool-Aid, sports or energy drinks, or other fruit flavored drink in the past week. More than a third of residents, 34.8%, reported drinking soda or other unhealthy drinks less than once a day and the remaining 39.6% drink soda or other unhealthy drinks at least once a day. Groups of residents more likely to drink soda or unhealthy drinks at least once a day include males and residents with children in the home.

SECONDARY DATA ANALYSIS

Poor physical health days are based on survey responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The value reported is the average number of days a county's adult resident report that their physical health was not good. The average number of poor physical health days was slightly less for the county than the state.

Number of Poor Physical Health Days						
	2016	2017	2018	2019	2020	Change
Putnam	3.3	2.9	3.2	3.2	3.5	+0.2
Ohio	4.0	3.7	4.0	4.0	3.9	-0.1

SOURCE: County Health Ranking. Original Source: The Behavioral Risk Factor Surveillance System (BRFSS),

Physical inactivity is the estimated percent of adults ages 20 and older reporting no leisure time physical activity. Examples of physical activities provided include running, calisthenics, golf, gardening, or walking for exercise. Nearly a quarter of adults in Putnam County are considered physically inactive, a number that has decreased slightly over the last several years.

Percentage of Adults Physically Inactive						
	2013	2014	2015	2016	2017	% Change
Putnam	27%	26%	24%	25%	23%	-4%
Ohio	25%	26%	25%	26%	26%	+1%

SOURCE: County Health Rankings. Original Source: National Center for Chronic Disease Prevention and Health Promotion

The table below represents the percentage of population with adequate access to locations for physical activity. Locations for physical activity are defined as parks or recreational facilities. The percentage of Putnam County residents with access to locations for physical activity is very low. Less than half of county residents, 47%, have access compared to a statewide average of 84%.

Percentage of Population with Access to Exercise Opportunities						
	2015	2016	2017	2018	2019	% Change
Putnam	40%	40%	36%	37%	47%	+7%
Ohio	80%	83%	85%	84%	84%	+4%
SOURCE: County Health Rankings. Original Source: Business Analyst, Delorme map data						

The Food Environment Index equally weights two indicators of the food environment: (1) limited access to healthy foods, which estimates the percentage of the population who are low income and do not live close to a grocery store and (2) food insecurity, which estimates the percentage of the population who did not have access to a reliable source of food during the past year. The Food Environment Index ranges from 0 (worst) to 10 (best). The Food Environmental Index is better in Putnam County than Ohio.

Food Environment Index						
	2014	2015	2016	2017	2018	% Change
Putnam	8.4	8.6	8.9	8.8	8.7	+0.7
Ohio	6.9	7.0	6.6	6.7	6.7	-0.2
SOURCE: County Health Rankings. Original Source: United States Department of Agriculture (USDA)						

Putnam County has a lower percentage of the population who are food insecure or do not have access to a grocery store than the state.

Food Insecurity Rate						
	2017	2018	2019	2020 (projected)	2021 (projected)	% Change
Putnam	8.9%	9.0%	9.1%	11.3%	9.6%	+0.7%
Ohio	14.5%	13.9%	13.2%	16.0%	14.1%	-0.4%
Source: Feeding America. Map the Meal Gap: https://map.feedingamerica.org/county/2019/overall/ohio						

COMMUNITY LEADER SURVEY

All community leaders were asked what challenges people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic diseases like diabetes or heart disease. This was an open-ended question in which the respondent could give multiple responses. The most common challenge mentioned was the availability and affordability of healthy food. This response was given by 38.9% of community leaders. Other responses given, in order of importance, include access to affordable gyms (27.8%), making the time/effort needed for a healthy lifestyle (27.8%), and lack of healthy eating and nutrition programs in the community (16.7%).

"Access to affordable workout facilities. Those that are affordable are not accessible to all residents based on their location and transportation needs."

Participant on challenges that residents face in trying to stay healthy

Challenges trying to maintain healthy lifestyle		
	# of TOTAL Responses	% of Leaders
Healthy food options/affordability	7	38.9%
Access to affordable gyms	5	27.8%
Making time for healthy lifestyle/Making it a priority	5	27.8%
Lack of healthy eating/nutrition programs	3	16.7%
Lack of chronic disease management programs	2	11.1%
Lack of bike paths/activities/attractions in area	2	11.1%
Need programs for seniors (other than Silver Sneakers)	2	11.1%
High costs of medicines	1	5.6%
Lack of awareness	1	5.6%
Lack of mental health providers	1	5.6%
Transportation issues	1	5.6%
Total	**30**	**(n=18)**
Question: What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?		

COMMUNICABLE DISEASES, VACCINATIONS AND PREVENTION SERVICES

COMMUNITY SURVEY

Summary: Prevention, Testing and Screening			
		% of Residents	*N*
Ever had test?	Blood Pressure Check	96.9%	396
	PAP Smear (women only)	91.9%	201
	Blood Cholesterol Check	88.0%	398
	Mammogram (women 40+ only)	83.9%	153
	PSA test for prostate cancer (men 50+)	67.0%	102
	Colonoscopy	52.3%	398
	Skin Cancer Exam	33.6%	398

Summary: Immunizations		
	% of Residents	*N*
Tetanus booster (last 10 years)	64.0%	400
COVID-19 vaccine	61.1%	
Measles vaccine (in lifetime)	60.3%	
Annual flu vaccine	55.3%	
Chicken Pox vaccine (in lifetime)	41.2%	
Pneumonia vaccine (in lifetime)	33.6%	
Shingles vaccine (in lifetime)	30.6%	
HPV vaccine (in lifetime)	10.9%	

Blood Pressure Check

The majority of residents, 97%, have had their blood pressure checked sometime in the past with 90% having it checked within the past year. A small percentage of residents, 5%, have never had their blood pressure checked or have not had it checked in the past five years. Groups of residents more likely to have ***never*** had their blood pressure checked include residents without a primary care doctor, those without health insurance, single residents, those who are unemployed, and residents of normal weight. Groups of residents more likely to have had their blood pressure checked ***in the past year*** include residents with a primary care doctor, residents with health insurance, those ages 45 and over, residents who are not single, and those who are obese.

PAP Smear (women only)

The majority of female residents, 92%, have had a PAP Smear sometime in the past with 38% having one within the past year. Less than one in ten female residents, 8%, have never had a PAP Smear. Groups of residents more likely to have ***never*** had a PAP Smear include residents without health insurance, those with a high school diploma or less education, residents with an annual income under $50,000, single residents, and those who are unemployed. Groups of residents more likely to have had a pap smear ***in the past year*** include residents ages 18 to 44, those with some college or more education, residents with an annual income of $75,000 or more, married residents, those who are employed full-time, and residents with children in the home.

Blood Cholesterol Check

Most residents, 88%, have had their blood cholesterol checked sometime in the past with 69% having it checked within the past year. A small percentage of residents, 14%, have never had their blood cholesterol checked or have not had it checked in the past five years. Groups of residents more likely to have ***never*** had their blood cholesterol checked include residents without a primary care doctor, those ages 18 to 44, residents with an annual income of $25,000 to $75,000, those who are single, unemployed residents, those with children in the home, and residents who are normal weight. Groups of residents more likely to have had their blood cholesterol checked ***in the past year*** include residents in poor health, those with a primary care doctor, residents with health insurance, those ages 65 and over, residents with an annual income of $75,000 or more, those who are widowed or married, retirees, and residents without children in the home.

Mammogram (women ages 40 and over)

The majority of female residents ages 40 and over, 84%, have had a mammogram sometime in the past with 65% having one within the past year. Nearly a sixth of female residents ages 40 and over, 16%, have never had a mammogram. Groups of residents more likely to have ***never*** had a mammogram include residents who are single or divorced, unemployed residents, and those with children in the home. Groups of residents more likely to have had a mammogram ***in the past year*** include residents with a primary care doctor, those ages 45 to 64, residents who are married or widowed, and those without children in the home.

PSA test for Prostate Cancer (men ages 50 and over)

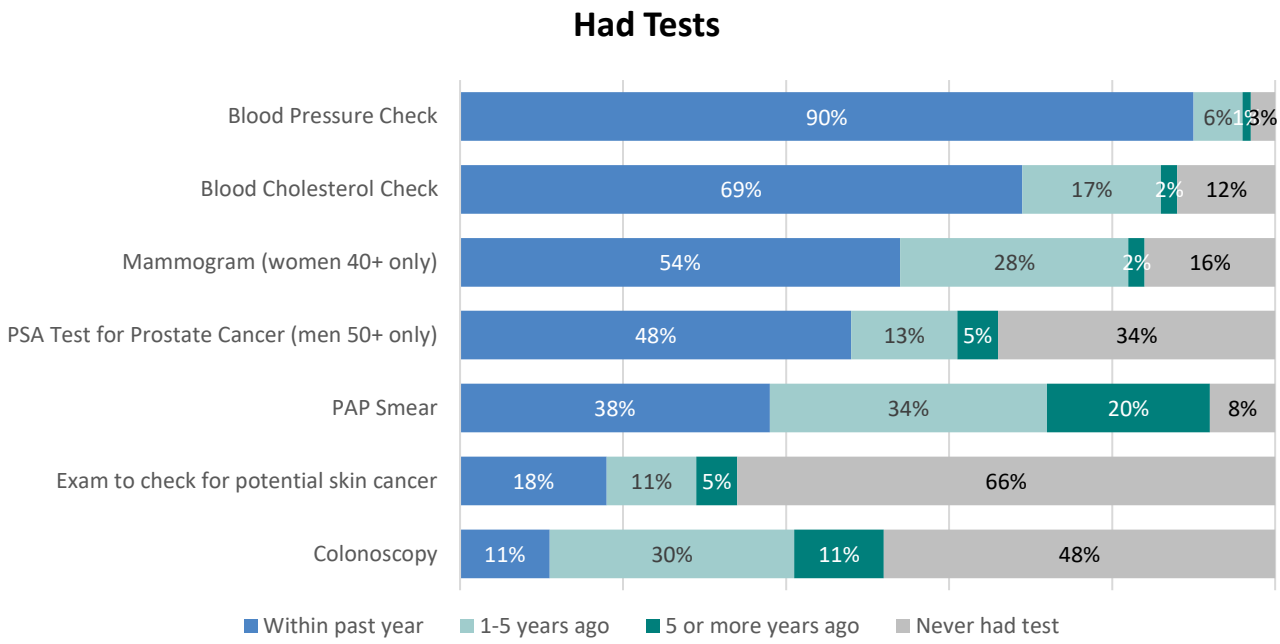
Two thirds of male residents ages 50 and over, 67%, have had a PSA test sometime in the past with 72% having the test within the past year. A third of male residents ages 50 and over, 33%, have never had a PSA test. Groups of residents more likely to have ***never*** had a PSA test include residents without a primary care doctor, single residents, those who are employed full-time or unemployed, residents with children in the home, and normal weight residents. Groups of residents more likely to have had a PSA test ***in the past year*** include residents ages 65 and over, those with an annual income of $50,000 to $75,000, divorced residents, those who are employed part-time or retired, residents without children in the home, and obese residents.

Colonoscopy

More than half of residents, 52%, have had a colonoscopy sometime in the past with 11% having the test within the past year. Nearly half, 48%, have never had a colonoscopy and an additional 11% have not had a colonoscopy in the past five years. Groups of residents more likely to have ***never*** had a colonoscopy include residents without a primary care doctor, those without health insurance, residents ages 18 to 44, those who are single, residents who are employed full-time or unemployed, and those with children in the home. Groups of residents more likely to have had a colonoscopy ***in the past year*** include residents ages 45 to 64, those who are employed part-time, residents without children in the home, and those of normal weight.

Skin Cancer Exam

A third of residents, 34%, have had an exam to check for potential skin cancer sometime in the past with 18% having the test within the past year. Two-thirds, 66%, have never had a skin cancer exam and an additional 5% have not had one in the past five years. Groups of residents more likely to have ***never*** had a skin cancer exam include residents without a primary care doctor, residents ages 18 to 44, those with a high school diploma or less education, residents with an annual income of $50,000-$100,000, those who are single or divorced, residents who are employed full-time or unemployed, and those with children in the home. Groups of residents more likely to have had a skin cancer exam ***in the past year*** include residents in good health, those ages 65 and over, residents with an annual income of $50,000 to $75,000, those who are widowed or married, residents who are employed part-time or are retired, and those without children in the home.



Tetanus Booster- Nearly two-thirds of residents, 64%, had received a tetanus booster in the past ten years. Groups of residents more likely to have received their tetanus booster include residents with health insurance, males, those with some college education, residents with an annual income of $50,000 or more, and those with children in the home.

COVID-19 Vaccine- Less than two-thirds of residents, 61%, had received their COVID-19 vaccine. Groups of residents more likely to have received their COVID-19 vaccine include residents with a primary care doctor, those ages 45 and over, college graduates, residents with an annual income over $25,000, those who are widowed or married, retired residents, and those without children in the home.

Measles Vaccine- Slightly fewer residents, 60%, had received a Measle vaccine in their lifetime. Groups of residents more likely to have received their Measles vaccine include residents with some college or more education, those who are employed, and residents with children in the home.

Flu Vaccine- More than half of residents, 55%, had received their annual flu vaccine. Groups of residents more likely to have received their flu vaccine include residents with health insurance, those ages 65 and over, college graduates, residents with an annual income of $50,000 or more, those who are widowed, and retirees.

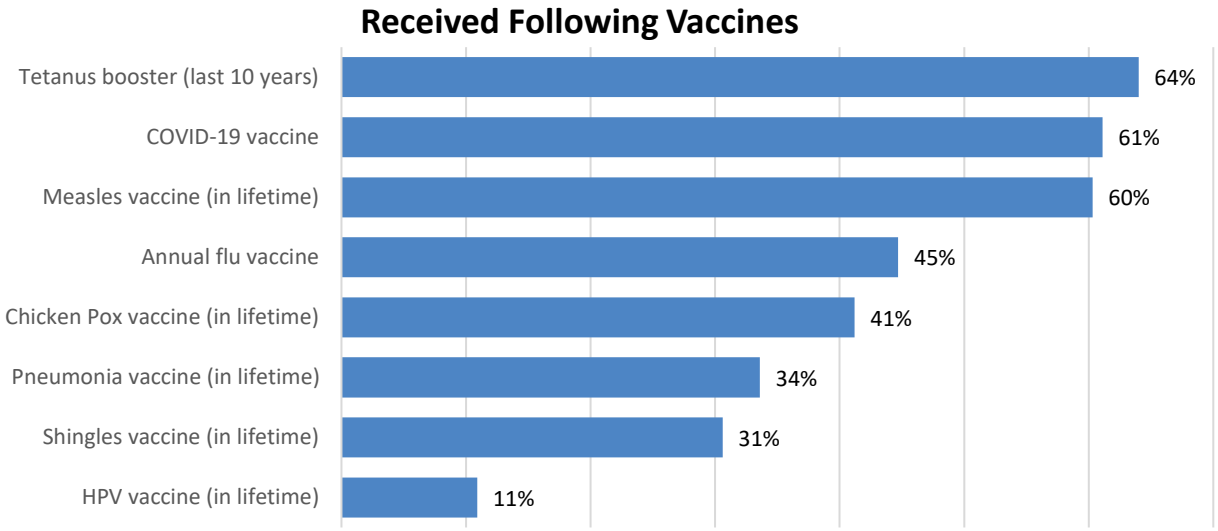
Chicken Pox Vaccine- Slightly fewer residents, 41%, had received a Chicken Pox vaccine in their lifetime. Groups of residents more likely to have received their Chicken Pox vaccine include males, those ages 65 and over, residents who are divorced or widowed, and those without children in the home.

Pneumonia Vaccine- More than a third of residents, 34%, had received a Pneumonia vaccine in their lifetime. Groups of residents more likely to have received their Pneumonia vaccine include those ages 65 and over, residents with an annual income of $25,000 to $75,000, widowed residents, retirees, and those without children in the home.

Shingles Vaccine- Less than a third of residents, 31%, had received a Shingles vaccine in their lifetime. Groups of residents more likely to have received their Shingles vaccine include those ages 65 and over, residents with an annual

income of $25,000 to $75,000, widowed residents, those who are retired or employed part-time, and residents without children in the home.

HPV Vaccine- Slightly more than one in ten residents, 11%, had received an HPV vaccine in their lifetime. Groups of residents more likely to have received their HPV vaccine include residents without a primary care doctor, those ages 18 to 44, single residents, unemployed residents, and those with children in the home.



SECONDARY DATA ANALYSIS

Communicable disease rates were higher for more than half of communicable diseases in Putnam County when compared to the state of Ohio. Communicable diseases that had significantly higher rates in Putnam County than the state of Ohio were Campylobacteria (+16.7 difference) and Cryptosporidiosis (+12.3 difference).

Communicable Disease Rates, 2018

	Putnam County		Ohio		Difference per 100,000
	Case Count	Rate per 100,000	Case Count	Rate per 100,000	
Campylobacteria	12	35.5	2,192	18.8	+16.7
Cryptosporidiosis	6	17.8	638	5.5	+12.3
E-coli	3	8.9	537	4.6	+4.3
Giardiasis	2	5.9	499	4.3	+1.6
Hepatitis A	2	5.9	1,838	15.7	-9.8
Hepatitis E	2	0.0	105	139.0	-139
Influenza associated hospitalizations	38	112.5	14,438	123.5	-11
Lyme Disease	1	3.0	295	2.5	+0.5
Mumps	0	0.0	38	0.3	-0.3
Salmonellosis	7	20.7	1,507	12.9	+7.8
Shigellosis	1	3.0	517	4.4	-1.4
Spotted Fever, Rickettsiosis	0	0.0	35	0.3	-0.3
Streptococcal, Group A, invasive	1	3.0	682	5.8	-2.8
Streptococcal pneumoniae, invasive	4	11.8	1,293	11.1	+0.7
Varicella	0	0.0	444	3.8	-3.8
Yersiniosis	1	3.0	54	0.5	+2.5

SOURCE: Ohio Department of Health Data Warehouse

Communicable disease rates that have risen significantly over the past four years include Influenza associated hospitalizations (17.9 rate increase) and Salmonellosis (14.8 rate increase).

Communicable Disease Counts and Rates, Putnam County, 2015-2018

	2015		2016		2017		2018		2019		Rate Change
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	
ENTERIC DISEASES											
Campylobacteria	5	14.7	8	23.5	6	17.7	12	35.5	7	20.7	+6.0
Cryptosporidiosis	3	8.8	8	23.5	5	14.8	6	17.8	7	20.7	+11.9
E-coli, unspecified	0	0.0	2	5.9	2	5.9	3	8.9	3	8.9	+8.9
Giardiasis	2	5.9	44	11.7	1	3.0	2	5.9	0	0.0	-5.9
Listeriosis	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0.0
Salmonellosis	4	11.8	4	11.7	8	23.6	7	20.7	9	26.6	+14.8
Shigellosis	1	2.9	0	0.0	0	0.0	1	3.0	0	0.0	-2.9
Yersiniosis	0	0.0	0	0.0	0	0.0	1	3.0	0	0.0	0.0
HEPATITIS											
Hepatitis A	1	2.9	0	0.0	1	3.0	2	5.9	0	0.0	-2.9
Hepatitis E	0	0.0	0	0.0	0	0.0	0	0.0	-	-	0.0
VACCINE PREVENTABLE DISEASES											
Influenza	15	44.1	15	44.0	40	118.1	38	112.5	21	62.0	+17.9
Pertussis	0	0.0	0	0.0	3	8.9	0	0.0	0	0.0	0.0
Varicella	0	0.0	0	0.0	1	3.0	0	0.0	0	0.0	0.0
VECTORBORNE AND ZOONOTIC											
Lyme Disease	0	0.0	0	0.0	0	0.0	1	3.0	0	0.0	0.0
Malaria	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0.0
OTHER REPORTABLE DISEASES											
Legionnaire's	3	8.8	0	0.0	0	0.0	1	3.0	1	3.0	-5.8
Meningitis (viral)	0	0.0	0	0.0	0	0.0	0	0.0	3	8.9	+8.9
Streptococcal, Group A	0	0.0	3	8.8	0	0.0	1	3.0	2	5.9	+5.9
STSS-	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0.0
Streptococcus pneumoniae	3	8.8	1	2.9	2	5.9	4	11.8	3	8.9	+0.1

Rate=per 100,000 population, number of cases is confirmed and probable, SOURCE: Ohio Department of Health Data Warehouse

Preventable hospital stays are measured as the hospital discharge rate for ambulatory care-sensitive conditions per 100,000 Medicare enrollees. Ambulatory-care sensitive conditions (ACSC) are usually addressed in an outpatient setting and do not normally require hospitalization if the condition is well-managed. Hospitalization for diagnoses treatable in outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent a tendency to overuse hospitals as a main source of care. Over the past five years, the number of preventable hospital stays has slightly increased in the county while slightly decreasing in the state.

Preventable Hospital Stays

	2014	2015	2016	2017	2018	% Change
Putnam	4,017	3,878	3,431	4,071	4,109	+2.3%
Ohio	5,220	4,701	5,135	5,168	4,901	-6.1%

SOURCE: County Health Rankings. Original Source: Dartmouth Atlas of Health Care

Mammography screening represents the percent of female Medicare enrollees ages 67-69 that had at least one mammogram over a two-year period. Less than half, 48%, of female Medicare enrollees ages 67-69 in Putnam County reported having a mammogram in the past two years.

Mammography Screening						
	2014	2015	2016	2017	2018	% Change
Putnam	46%	46%	47%	49%	48%	+2%
Ohio	39%	40%	41%	43%	43%	-4%
SOURCE: County Health Rankings. Original Source: Dartmouth Atlas of Health Care						

CHRONIC DISEASE MANAGEMENT

COMMUNITY SURVEY

Residents were given a list of eleven chronic diseases and risk factors and asked if they or a member of their immediate family have ever been diagnosed with the disease or risk factor by a health care professional. The chronic diseases and risk factors most prevalent were high blood pressure, arthritis, high cholesterol, diabetes, and cancer. Each chronic disease and risk factor is discussed in more detail below.

Summary: Been Diagnosed with Chronic Disease			
	Either Resident of Household Member	*Resident*	*Member of Household*
High blood pressure	50.8%	36.3%	23.1%
High cholesterol	39.9%	26.8%	18.9%
Arthritis	37.7%	27.9%	15.4%
Diabetes	32.1%	17.7%	16.3%
Any form of cancer	23.7%	11.7%	12.8%
Asthma	19.6%	9.2%	11.4%
Heart disease or heart attack	19.1%	9.8%	9.7%
Kidney disease	10.8%	2.5%	8.9%
Respiratory disease	10.3%	3.2%	7.1%
Stroke	8.5%	2.5%	6.4%
Alzheimer's	7.5%	0.0%	7.5%
**Asked only of residents diagnosed with condition*			

- ***HIGH BLOOD PRESSURE:*** More than half of residents, 51%, reported that either they or a member of their household was diagnosed with high blood pressure. More specifically, 36% of residents have been diagnosed with high blood pressure and 23% have a member of their household with the risk factor. Households more likely to have someone diagnosed with high blood pressure include females, residents ages 45 and over, those with some college or less education, residents with an annual income under $25,000, those who are divorced or widowed, residents who are unemployed or retired, those without children in the home, obese residents, and those with a primary care provider.
- ***HIGH CHOLESTEROL:*** Less than half of residents, 40%, reported that either they or a member of their household was diagnosed with high cholesterol. More specifically, 27% of residents have been diagnosed with high cholesterol and 19% have a member of their household with the risk factor. Households more likely to have someone diagnosed with high cholesterol include females, residents ages 65 and over, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced or widowed, residents who are unemployed or retired, those without children in the home, and obese residents.

- ***ARTHRITIS:*** Slightly fewer residents, 38%, reported that either they or a member of their household was diagnosed with arthritis. More specifically, 28% of residents have been diagnosed with arthritis and 15% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with arthritis include females, residents ages 65 and over, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced or widowed, residents who are not employed full-time, and those without children in the home.
- ***DIABETES:*** Less than a third of residents, 32%, reported that either they or a member of their household was diagnosed with diabetes. More specifically, 18% of residents have been diagnosed with diabetes and 16% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with diabetes include residents ages 45 and over, those with a high school diploma or less education, residents with an annual income under $25,000, those who are not married, residents who are unemployed or retired, those without children in the home, obese residents, and those without health insurance.
- ***CANCER:*** Less than a quarter of residents, 24%, reported that either they or a member of their household was diagnosed with any form of cancer. More specifically, 12% of residents have been diagnosed with cancer and 13% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with cancer include females, residents ages 65 and over, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced or widowed, residents who are unemployed or retired, and those without children in the home.
- ***ASTHMA:*** One fifth of residents, 20%, reported that either they or a member of their household was diagnosed with asthma. More specifically, 9% of residents have been diagnosed with asthma and 11% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with asthma include females, residents ages 18 to 44, residents with an annual income under $25,000, those who are not married, unemployed residents, those without a primary care provider, and those without health insurance.
- ***HEART DISEASE:*** Slightly fewer residents, 19%, reported that either they or a member of their household was diagnosed with heart disease or heart attack. More specifically, 10% of residents have been diagnosed with heart disease and 10% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with heart disease include residents ages 65 and over, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced or widowed, residents who are unemployed or retired, and those without children in the home.
- ***KIDNEY DISEASE:*** More than one in ten residents, 11%, reported that either they or a member of their household was diagnosed with kidney disease. More specifically, 3% of residents have been diagnosed with kidney disease and 9% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with kidney disease include females, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced or widowed, unemployed residents, and those without children in the home.
- ***RESPIRATORY DISEASE***: One in ten residents, 10%, reported that either they or a member of their household was diagnosed with respiratory disease. More specifically, 3% of residents have been diagnosed with respiratory disease and 7% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with respiratory disease include females, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced or widowed, unemployed residents, those without children in the home, and those without a primary care provider.
- ***STROKE:*** Less than one in ten residents, 9%, reported that either they or a member of their household was diagnosed with Stroke. More specifically, 3% of residents have been diagnosed with stroke and 6% have a member

of their household with the chronic disease. Households more likely to have someone diagnosed with stroke include females, residents ages 65 and over, those with a high school diploma or less education, residents with an annual income under $25,000, those who are not married, unemployed residents, those without children in the home, those without a primary care provider, and those without health insurance.

- ***ALZHEIMER'S:*** Slightly fewer residents, 8%, reported that either they or a member of their household was diagnosed with Alzheimer's. More specifically, no residents have been diagnosed with Alzheimer's and 8% have a member of their household with the chronic disease. Households more likely to have someone diagnosed with Alzheimer's include those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced or widowed, unemployed residents, and those of normal weight.

SECONDARY DATA ANALYSIS

The number of resident deaths in Putnam County has increased by approximately 34% over the past five years. The age groups that saw the largest increase in the last five years in Putnam County was ages 65 and over.

Putnam County Resident Deaths						
	2016	2017	2018	2019	2020	% Change
Putnam	307	334	321	325	412	+34.2%
Ohio	119,574	123,650	124,294	123,705	143,782	+20.2%
PUTNAM COUNTY BY AGE GROUP						
<1	3	1	4	0	4	33.3%
1-4	0	0	2	0	0	0.0%
5-14	0	1	0	0	1	100%
15-24	6	3	2	1	2	-5.0%
25-34	4	4	3	1	4	0.0%
35-44	6	6	5	1	6	0.0%
45-54	12	12	8	6	14	16.7%
55-64	35	38	35	37	32	-8.6%
65-74	47	53	59	48	78	+66.0%
75-84	75	80	87	85	111	+48.0%
85+	119	136	116	146	160	+34.5%

*SOURCE: Ohio Department of Health, ODH Data Warehouse, *2020 is not yet finalized and may change*

The top two causes of death in Putnam County in 2020 were cancer and heart disease. When looking at five-year trends, the causes of death that had the largest increase were diabetes, heart disease and chronic lower respiratory diseases (CLRD).

Death Rates for General Causes of Death *(death per 100,000 population)*												
	Putnam County						Ohio					
	2016	2017	2018	2019	2020*	Change	2016	2017	2018	2019	2020*	Change
Malignant Neoplasms	185.3	215.5	189.3	189.1	136.7	**+26%**	219.1	219.8	215.5	215.2	212.6	**-3%**
Diseases of the heart	167.6	224.4	236.6	283.7	237.7	**+42%**	235.5	240.0	250.1	249.3	261.1	**+11%**
Alzheimer's Disease	61.8	53.1	32.5	50.2	35.7	**-42%**	43.2	43.9	46.2	44.8	50.9	**+18%**
CLRD	55.9	53.1	73.9	59.1	65.4	**+17%**	60.3	62.7	64.4	61.3	60.2	**-0.2%**
Cerebrovascular	55.9	56.1	26.6	35.5	35.7	**-36%**	51.4	55.1	55.9	55.6	60.3	**+17%**
Diabetes	20.6	35.4	47.3	35.5	47.5	**+130%**	30.7	32.1	32.9	33.1	37.5	**+22%**
Suicide	14.7	14.8	5.9	8.9	11.9	**-19%**	14.7	14.9	15.7	15.5	14	**-5%**
Flu & Pneumonia	38.2	41.3	23.7	20.7	20.8	**-71%**	18.8	19.2	20.5	16.5	17.5	**-7%**
Accidents	70.6	38.4	47.3	20.7	50.5	**-28%**	68.7	76.9	66.4	70.9	80.7	**+17%**

*CLRD- Chronic Lower Respiratory Diseases, SOURCE: Ohio Department of Health, ODH Data Warehouse, *2020 is not yet finalized and may change*

The most prevalent cancers in Putnam County in 2018 were prostate, breast, and lung and bronchus. Cancer incidence rates were considerably higher in Putnam County than Ohio for the following types of cancer: kidney and renal pelvis, melanoma of the skin, non-Hodgkin's Lymphoma, prostate, and thyroid cancer.

Cancer Incidences in Putnam County and Ohio

	Number of Cases				Age Adjusted Rate (2018)	% Change 2015-2018
	2015	2016	2017	2018		
PUTNAM COUNTY						
Bladder	13	11	6	9	20.8	-30.1%
Brain and other CNS	2	1	2	1	-	-50.0%
Breast	32	26	34	26	58.3	-18.5%
Cervix	1	0	3	1	-	0.0%
Colon & Rectum	21	18	18	17	38.8	-19.0%
Esophagus	2	2	3	2	-	0.0%
Hodgkin's Lymphoma	4	0	1	2	-	-50.0%
Kidney & Renal Pelvis	11	9	9	11	25.9	0.0%
Larynx	2	1	2	1	-	-50.0%
Leukemia	9	5	4	5	11.9	-44.4%
Liver & Intrahepatic Bile Duct	2	2	1	1	-	-50.0%
Lung and Bronchus	20	30	29	23	51.8	+15.0%
Melanoma of the Skin	12	16	11	12	29.6	0.0%
Multiple Myeloma	1	4	1	2	-	+50.0%
Non-Hodgkin's Lymphoma	4	8	8	11	23.0	+175.0%
Oral Cavity & Pharynx	4	3	4	4	-	0.0%
Other Sites/Types	14	11	12	10	22.9	-28.9%
Ovary	3	2	2	0	-	-100%
Pancreas	6	2	5	2	-	-66.7%
Prostate	26	33	32	30	134.7	+15.4%
Stomach	0	2	2	2	-	+200.0%
Testis	2	3	0	1	-	-50.0%
Thyroid	8	8	7	8	18.8	0.0%
Uterus	7	7	8	6	23.9	-14.3%
TOTAL	**206**	**204**	**204**	**187**	**-**	**-9.2%**
OHIO						
Bladder	3,177	3,201	3,244	3,302	21.4	+3.9%
Brain and Other CNS	920	935	959	904	6.7	-1.7%
Breast	9696	9,818	9,956	9,909	69.1	+2.2%
Cervix	481	491	492	450	7.4	-6.4%
Colon & Rectum	6,121	5,834	5,828	5,819	39.9	-4.9%
Esophagus	779	823	833	860	5.6	+10.4%
Hodgkin's Lymphoma	342	332	330	288	2.4	-15.8%
Kidney & Renal Pelvis	2,542	2,519	2,540	2,529	17.3	-0.5%
Larynx	636	583	598	547	3.6	-14.0%
Leukemia	1,735	1,677	1,720	1,678	12	-3.3%
Liver & Intrahepatic Bile Duct	1,131	1,162	1,157	1,162	7.4	+2.7%
Lung and Bronchus	10,271	10,001	9,954	10,025	64.6	-2.4%
Melanoma of the Skin	3,441	3,615	3,406	3,403	24.2	-1.1%
Multiple Myeloma	880	953	902	920	6.1	+4.5%

Cancer Incidences in Putnam County and Ohio						
Non-Hodgkin's Lymphoma	2,801	2,691	2,777	2,768	18.8	-1.2%
Oral Cavity & Pharynx	1,793	1,765	1,843	1,857	12.4	+3.6%
Other Sites/Types	5,248	5,124	5,189	5,403	34.7	+3.0%
Ovary	848	743	775	709	9.4	-16.4%
Pancreas	1,981	1,897	2,008	2,189	14.3	+10.5%
Prostate	7,376	7,498	8,391	8,567	114.3	+16.1%
Stomach	886	891	886	835	5.7	-5.8%
Testis	335	295	282	305	5.8	-9.0%
Thyroid	1,856	1,909	1,848	1,838	14.8	-1.0%
Uterus	2,386	2,498	2,571	2,469	30.8	+3.5%
TOTAL	**67,662**	**67,255**	**68,489**	**68,376**	-	**+1.1%**
SOURCE: Putnam County General Health District, Originally extracted from Ohio Department of Health Data Warehouse						

The table below measures the percentage of the county population with a disability. Disabilities include difficulties with hearing, vision, cognition, ambulation, and self-care. The percentage of the population with disabilities has remained consistent over the past four years.

Disability Status by Age					
	2016	2017	2018	2019	Change
Total Population	33,851	33,778	33,707	33,646	-0.6%
% with a Disability	10.0%	10.5%	10.2%	9.7%	-0.3%
# with a Disability	3,426	3,547	3,450	3,258	-168
# under 18	*252*	*235*	*193*	*148*	*-41.3%*
# 18-64	*1,558*	*1,646*	*1,655*	*1,460*	*-6.3%*
#65 and over	*1,616*	*1,666*	*1,602*	*1,650*	*+2.1%*
SOURCE: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates					

The percentage of students with disabilities in the county is outlined in the table below. These children will have Individual Education Plans (IEPs) at school. Continental Local and Leipsic Local have the highest percentage of students with disabilities in the county.

Students with Disabilities, 2019-2020 District Level Data			
District	# Total Students	# Students Disabilities	% Students Disabilities
Columbus Grove Local	830	**120**	**14.5%**
Continental Local	438	**85**	**19.4%**
Jennings Local	362	**37**	**10.2%**
Kalida Local	615	**56**	**9.1%**
Leipsic Local	659	**121**	**18.4%**
Miller City-New Cleveland Local	492	**63**	**12.8%**
Ottawa-Glandorf Local	1,483	**215**	**14.5%**
Ottoville Local	459	**81**	**17.6%**
Pandora-Gilboa Local	518	**71**	**13.7%**
COUNTY TOTAL	***5,856***	***849***	***14.5%***
SOURCE: Ohio Department of Education			

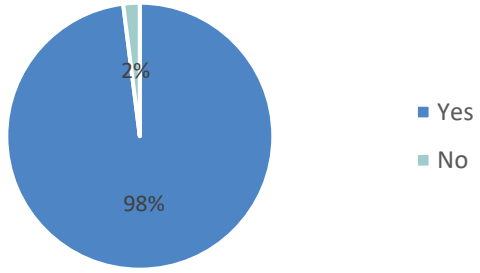
TRANSPORTATION

COMMUNITY SURVEY

Summary: Transportation			
		%	#
Have access to reliable transportation	Yes	98.0%	398
	No	2.0%	
How do you get where need to go	Own car	95.4%	400
	Walk	21.7%	
	Bike	9.4%	
	Friend/family member	7.9%	
	Council on Aging Transportation	2.2%	
	Borrow a car	1.6%	
	Faith based organization	1.3%	
	Other	0.9%	
	Job and Family Services	0.6%	

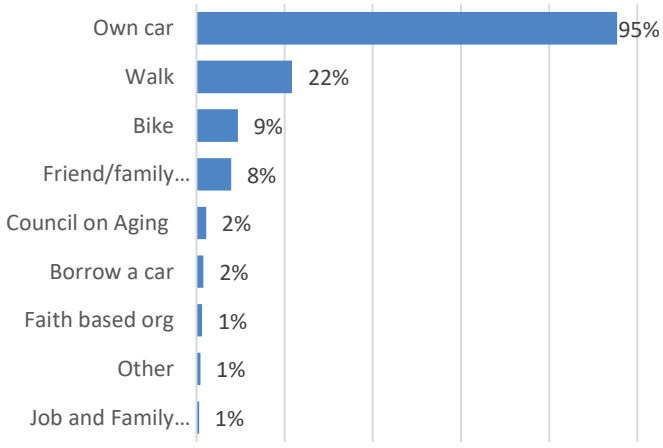
Most residents, 98.0%, indicated that they have access to reliable transportation. Residents who were more likely to NOT have access to reliable transportation include females, residents with an annual income under $50,000 (especially those with an income under $25,000), non-white residents, and those who are unemployed.

Have Reliable Transportation



Next, residents were asked how they regularly get to where they need to go. The mode of transportation used most often was a car owned by the resident, 95%. Groups of residents more likely to get where they need to go by car include residents with some college or more education, those with an annual income over $50,000, white residents, those who are married, residents who are employed full-time, and residents with health insurance.

How Get to Where Need to Go



More than one-fifth of residents, 22%, regularly walk when they need to go somewhere. Groups of residents more likely to walk include males, residents ages 45 to 64, those with an annual income under $25,000, residents without children in the home, and those without health insurance. Less than one-tenth of residents, 9%, regularly bike when they need to go somewhere. Groups of residents more likely to bike include males, divorced residents, and those of normal weight. Less than one-tenth of residents, 8%, regularly get to where they need to go by rides from family and friends. Groups of residents more likely to ride with family and friends include residents with a high school diploma or less education, those with an annual income under $25,000, non-white residents, those who are widowed, and unemployed residents. Other modes of transportation were used much less often: Council on Aging Transportation (2%), borrowing a car (2%), a faith-based organization (1%), and Job and Family Services.

SECONDARY DATA ANALYSIS

Driving alone to work is the percentage of the workforce that usually drives alone to work. The numerator is the number of workers who commute alone to work via a car, truck, or van. The denominator is the total workforce. Driving alone to work is an indicator of poor public transit infrastructure and sedentary behaviors. Most of the workforce in Putnam County, 87%, drives alone to work and this percentage has stayed stagnant over time.

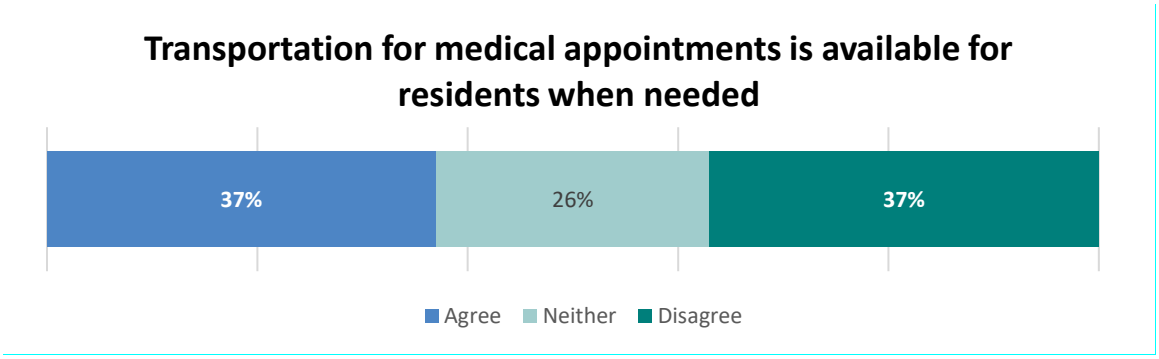
Driving Alone to Work: % of the workforce that drives alone to work						
	2016	2017	2018	2019	2020	% Change
Putnam	86%	86%	85%	86%	87%	+1%
Ohio	84%	83%	83%	83%	83%	-1%
SOURCE: County Health Rankings. Original Source: American Community Survey, 5-year estimates						

Among workers who commute in their car alone, the percentage that commute more than 30 minutes in Putnam County was 31%, the same as the state percentage.

Long Commute Driving Alone to Work: % of that drives alone to work that commute <30 minutes						
	2016	2017	2018	2019	2020	% Change
Putnam	33%	33%	32%	32%	31%	-2%
Ohio	29%	30%	30%	30%	31%	+2%
SOURCE: County Health Rankings. Original Source: American Community Survey, 5-year estimates *http://www.countyhealthrankings.org/app/ohio/2019/measure/factors/137/map*						

COMMUNITY LEADER SURVEY

More than a third of community leaders, 36.8%, agreed that "*Transportation for medical appointments in available for residents in Putnam County when needed,"* with 10.5% strongly agreeing. The same percentage, 36.8%, disagreed.



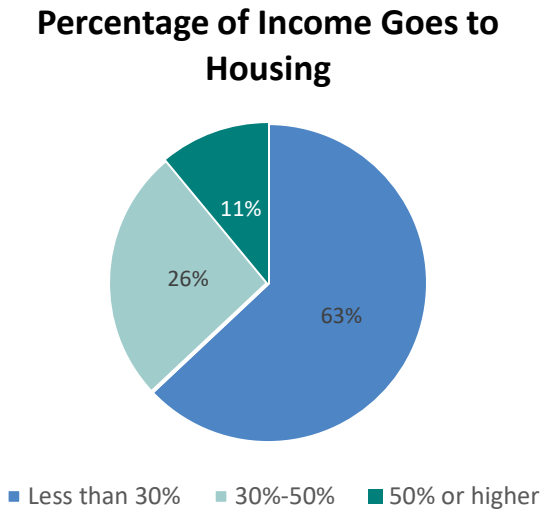
HOUSING

COMMUNITY SURVEY

Summary: Housing			
		%	#
Percentage of household income goes to housing	Less than 30%	63.1%	386
	30%-50%	25.9%	
	50% or higher	11.0%	

Less than two-thirds of residents, 63.1%, indicated that less than 30% of their household income goes to housing while another 25.9% spend between 30%-50% of their household income on housing. More than one in ten residents, 11.0%, spend 50% or more of their household income on housing.

Residents who were more likely to spend less than 30% of their income on housing include college graduates, those with an annual income of $50,000 or more, married residents, and those who are employed or retired. Residents who were more likely to spend 50% or more of their income on housing include residents with some college education or less education, those with an annual income under $50,000 (especially those with an income under $25,000), divorced or single residents, and those who are unemployed.



SECONDARY DATA

The majority of housing units in Putnam County, 81%, are owner occupied while 19% are renter occupied. The percentage of vacant houses is half as high in Putnam County (5%) than Ohio (10%). The median value of a house in Putnam County ($151,600) is higher than the state ($140,000). Monthly expenses for both homeowners and renters are slightly lower in Putnam County than the state.

Housing Units, 2019							
	% Owner Occupied	% Renter Occupied	% Vacant	Median Year Built	Median Value	Median Gross Rent	Median Monthly Owners Cost
Putnam County	80.7%	19.3%	4.7%	1971	$151,600	$683	$1,201
Ohio	66.0%	34.0%	10.3%	1968	$140,000	$788	$1,269
SOURCE: Ohio Development Services Agency, Ohio County Profiles, https://development.ohio.gov/files/research/C1011.pdf							

Putnam County is made up mostly of single-detached housing units (84%). While the percentage of housing units that are multi-family properties is much lower than the state average (3% compared to 15%), the percentage of housing units that are mobile homes in Putnam County is almost twice the state average (6% compared to 4%).

Percentage as Share of Housing Units, 2019			
	Single-Detached	Units of Multi-family Properties	Mobile Homes
Putnam County	83.7%	3.2%	5.9%
Ohio	68.4%	14.8%	3.6%
SOURCE: OHFA, 2021 Ohio Housing Needs Assessment			

ENVIRONMENTAL QUALITY

SECONDARY DATA ANALYSIS

The table below represents the average daily amount of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers. These particles can be directly emitted from sources such as forest fires, or they can form when gases emitted from power plants, industries and automobiles react in the air. Particulate matter has been getting slightly worse in the county since 2017 and is slightly higher than the state average.

Air Pollution - Particulate matter					
	2017	2018	2019	2020	Change
Putnam	11.3	11.3	12.1	12.1	+0.8
Ohio	11.3	11.3	11.5	11.5	+0.2
SOURCE: County Health Ranking. Original Source: CDC WONDER Environmental Data *http://www.countyhealthrankings.org/app/ohio/2019/measure/factors/125/map*					

SAFETY, INJURY AND VIOLENCE

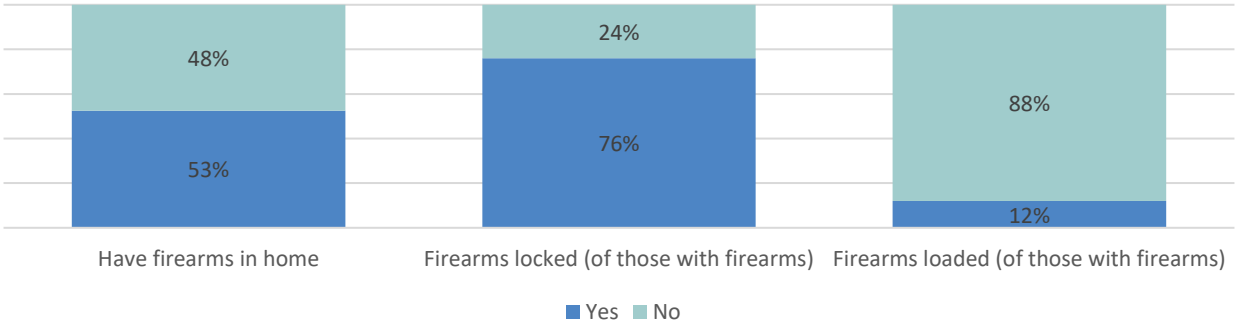
COMMUNITY SURVEY

Summary: Safety and Violence			
		% of residents	*# of residents*
Firearms in home	Yes	53.2%	386
	No	46.8%	
Firearms locked and loaded *(those with firearms)*	Firearms locked	75.8%	204
	Firearms loaded	12.4%	
Feel safe in home	Very safe	92.4%	398
	Somewhat safe	7.2%	
	Not at all safe	0.4%	
Feel safe in community	Very safe	84.8%	398
	Somewhat safe	14.8%	
	Not at all safe	0.4%	
Ever been abused	Yes	20.6%	398
	No	79.4%	
How abused *(of those who have been abused in past)*	Verbally	69.0%	82
	Emotionally	69.0%	
	By a spouse or partner	48.3%	
	Sexually	45.5%	
	By another person outside of home	41.8%	
	Physically	41.2%	
	By a parent	28.5%	
	Financially	26.3%	
	By a child	5.8%	
	By a paid caregiver	0.0%	

More than half, 53.2%, of residents currently keep firearms in or around their home. Groups of residents more likely to have firearms in or around their home include residents with children in the home, males, those ages 18 to 44, residents with an annual income of $75,000 or more, white residents, and those who are married.

Of those with firearms, the majority, 75.8%, keep them locked and 12.4% keep them loaded. Groups of residents more likely to keep their firearms locked include residents with children in the home, females, and those ages 18 to 44. Groups of residents more likely to keep their firearms loaded include residents without children in the home, those with a high school diploma or less education, residents with an annual income under $25,000, those who are divorced, and residents who are employed part-time or unemployed.

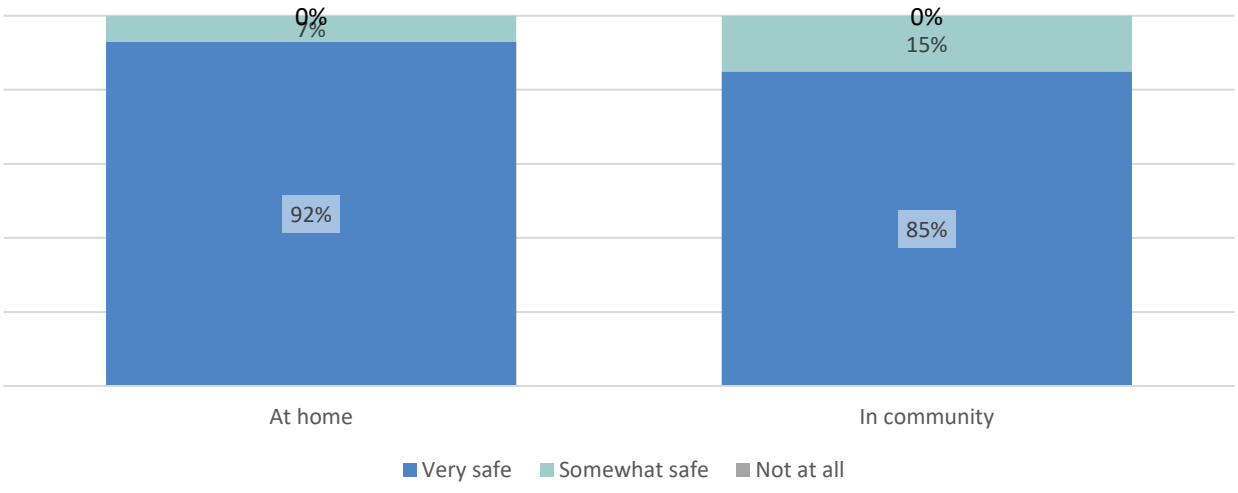
Firearms in Home



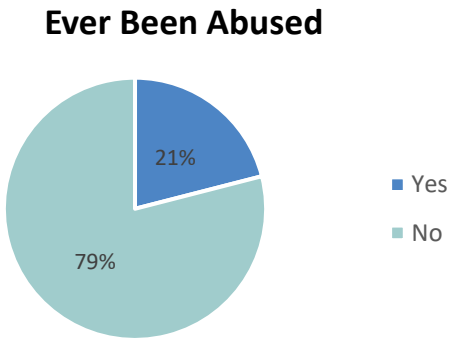
The majority, 92.4%, of residents feel very safe in their home while an additional 7.2% felt somewhat safe in their home. Only a tiny percentage of residents, 0.4%, do not feel safe in their home. Groups of residents more likely to feel very safe in their home include residents with an annual income of $75,000 or more.

The majority, 84.8%, of residents feel very safe in their community while an additional 14.8% felt somewhat safe in their community. Only a tiny percentage of residents, 0.4%, do not feel safe in their community. Groups of residents more likely to feel very safe in their community include residents ages 65 and over, college graduates, residents with an annual income of $50,000 or more, and retirees.

Sense of Safety



More than a fifth of residents, 20.6%, reported being abused in the past. Groups of residents more likely to have been abused in the past include residents with children in the home, obese residents, females, those ages 18 to 44, residents with an annual income under $25,000, those who are single or divorced, and those who are employed part-time or unemployed.



The residents who had been abused in the past were asked a couple of follow-up questions. First, in terms of who abused the resident, the most common response was by a spouse or partner, given by 48.3% of abused residents. Other abusers include another person outside of the home (41.8%), by a parent (28.5%), and by a child (5.8%). The most common forms of abuse were verbal abuse and emotional abuse (69% of abused residents). Other types of abuse include sexual (45.5%), physical (41.2%), and financial (26.3%).

SECONDARY DATA ANALYSIS

The death rate for unintentional injuries in Putnam County has decreased over the past five years and the rate in the county was about half the rate of the state in 2020. Homicides are rare in Putnam County with no homicides over the past 5 years.

Injury and Homicide Death Rate *(death per 100,000 population)*

	Putnam County						Ohio					
	2016	2017	2018	2019	2020	Change	2016	2017	2018	2019	2020*	Change
Unintentional	55.9	35.4	38.5	17.7	41.6	-25.6%	70.0	77.5	66.6	72.0	81.3	+16.1%
Homicide	0	0	0	0	0	0.0%	6.6	7.4	6.9	6.5	8.9	+34.8%

*SOURCE: Ohio Department of Health, ODH Data Warehouse, *2020 is not yet finalized and may change*

The violent crime rate below is represented as an annual rate per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault. The violent crime rate for Putnam County is lower than the state although it has been rapidly increasing.

Violent Crime Rate

	2016	2017	2018	2019	2020	% Change
Putnam	38	60	60	71	71	+86.8%
Ohio	307	290	290	293	293	-4.6%

SOURCE: County Health Ranking. Original Source: Uniform Crime Reporting – FBI.

Over the past five years the total number of maltreatment allegations in the county has increased, though it has declined from 2018 to 2020. In Putnam County, the number of allegations has been increasing for physical abuse, neglect, families in need of services or dependency, and incidents of multiple allegations. At the same time, allegations for sexual abuse and emotional maltreatment have been declining or staying the same.

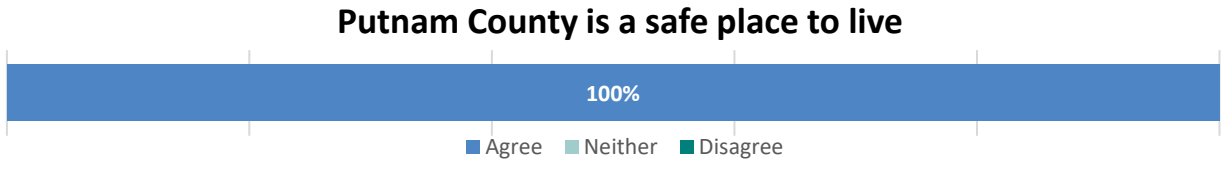
Total Number of Maltreatment Allegations, 2013- 2020					
	2013	2016	2018	2020	Change
Putnam County	114	118	148	132	**+15.7%**
Ohio	100,139	97,602	101,243	94,025	**-6.1%**
Count of Maltreatment Allegations by Maltreatment Type: PHYSICAL ABUSE					
Putnam County	22	24	28	24	**+9.0%**
Ohio	28,817	29,659	30,264	29,442	**+2.1%**
Count of Maltreatment Allegations by Maltreatment Type: NEGLECT					
Putnam County	32	36	47	67	**+109.3%**
Ohio	28,819	25,098	25,827	23,743	**-17.6%**
Count of Maltreatment Allegations by Maltreatment Type: SEXUAL ABUSE					
Putnam County	32	20	30	25	**-21.8%**
Ohio	10,153	9,040	9,137	8,548	**-15.8%**
Count of Maltreatment Allegations: EMOTIONAL MALTREATMENT					
Putnam County	0	0	0	0	**0.0%**
Ohio	1,505	1,301	1,203	950	**-36.8%**
Count of Maltreatment Allegations: MULTIPLE ALLEGATIONS					
Putnam County	11	10	13	6	**-45.4%**
Ohio	13,348	13,827	17,861	18,995	**+42.3%**
Count of Maltreatment Allegations: FAMILY IN NEED OF SERVICES/DEPENDENCY/OTHER					
Putnam County	17	28	30	10	**-41.1%**
Ohio	17,541	18,856	17,001	12,347	**-29.6%**
SOURCE: PCSAO Factbook					

The table below shows the number of youths under age 18 adjudicated for felony-level offenses over a 5-year period. The rate is the number of adjudications per 1,000 youths in the population. Overall, only 3 youth in Putnam County were adjudicated for felony-level offenses.

Adolescents Adjudicated for Felonies, Number per year and Rate per 1,000											
	2016		2017		2018		2019		2020		% Rate Change
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	
Putnam	14	1.6	11	1.3	7	0.8	6	0.7	3	0.3	***-81.3%***
Ohio	4,745	1.8	4,496	1.7	4,195	1.6	3,635	1.4	3,075	1.2	***-33.3%***
The # of those under age 18 adjudicated for felony-level offenses. The rate is the number of adjudications per 1,000 adolescents in the pop.											
SOURCE: Kids Count Data Center. http://datacenter.kidscount.org. Original Source: Ohio Department of Youth Services, Profile of Youth Adjudicated or Committed for Felony Offenses: Extracted from http://www.dys.ohio.gov/DNN/LinkClick.aspx?fileticket=LRjWax5QyWg%3d&tabid=117&mid=873.											

COMMUNITY LEADER SURVEY

All community leaders agreed that *"Putnam County is a safe place to live",* with 63.2% strongly agreeing.



REPRODUCTIVE AND SEXUAL HEALTH

SECONDARY DATA ANALYSIS

The rate below depicts the number of persons living with diagnosed HIV per 100,000 population. The rate in Putnam County is significantly lower than the state rate although it is increasing.

Rate of Population Living with Diagnosed HIV Infection						
	2016	2017	2018	2019	2020	Change
Putnam	23.5	23.6	32.6	32.5	35.7	+12.2
Ohio	194.7	200.2	204.4	209.4	214.6	+19.9
Source: Ohio Department of Health, Ohio HIV Surveillance Tables						

The Gonorrhea rate is the number of persons per 100,000 population with Gonorrhea. Once again, the rate in Putnam County is significantly lower than the state rate and is also increasing.

Gonorrhea Rate (per 100,000)						
	2016	2017	2018	2019	2020	Change
Putnam	23.5	20.7	26.6	38.5	35.5	+12.2
Ohio	176.8	205.8	216.2	224.0	262.8	+86.0
SOURCE: Ohio Department of Health, STD Surveillance						

The Chlamydia Rate is the number of persons per 100,000 population with Chlamydia. The rate in Putnam County is significantly lower than the state rate but is decreasing.

Chlamydia Rate (per 100,000)						
	2016	2017	2018	2019	2020	Change
Putnam	167.4	168.3	260.3	195.3	153.8	-13.6
Ohio	521.8	526.8	543.1	561.9	505.4	-16.4
SOURCE: Ohio Department of Health, STD Surveillance						

Appendix: Survey Results – Year to Year Comparisons

		2021	2016
Summary: Community Needs			
Responsible for providing regular care or assistance for. . .	Elderly parent or loved one	8.6%	5.0%
	Someone with special needs	6.1%	3.0%
	Person with physical/mental problem	4.5%	6.0%
	Child with severe behavioral issues	3.2%	2.0%
	An adult child	2.8%	3.0%
	Grandchildren	2.7%	5.0%
Sought assistance in past year for . . .	Medicare or other health insurance	6.0%	7.0%
	Mental health issues	6.0%	9.0%
	Food	5.7%	4.0%
	Healthcare	5.5%	8.0%
	Prescription assistance	3.8%	4.0%
	Employment	3.5%	2.0%
	Utilities	3.0%	4.0%
	Home repair	2.1%	2.0%
	Legal aid services	2.1%	1.0%
	Transportation	1.9%	1.0%
	Clothing	1.8%	<1.0%
	Dental care	1.8%	3.0%
	Affordable childcare	1.4%	<1.0%
	Rent/mortgage	1.4%	1.0%
	Unplanned pregnancy	0.6%	1.0%
	Any kind of addiction	0.4%	-
Summary: Personal Health Status			
Number of days in past month that PHYSICAL health was not good	Average number of days not well	3.5	3.0
	None	57.5%	50.0%
	1 or more	42.6%	50.0%
Number of days in past month that MENTAL health was not good	Average number of days not well	4.8	4.1
	None	52.0%	49.0%
	1 or more	48.0%	51%
Limited because of health issues	Yes	21.0%	18.0%
	No	79.0%	82.0%
Summary: Insurance Coverage			
Insurance coverage	Not insured	2.0%	5.0%
	Private insurance- employer paid	52.2%	54.0%
	Private insurance- self paid	11.2%	4.0%
	Medicare	27.9%	18.0%
	Medicaid	8.7%	6.0%
	Prescription assistance	87.1%	91.0%
	Preventative care	86.7%	81.0%
	Vision services	65.0%	61.0%
	Dental services	65.2%	66.0%

		2021	2016
Summary: Access to Health Care			
Have primary care provider	Yes	89.4%	70.0%
	No	10.6%	30.0%
Had routine check-up in past year		77.5%	63.0%
Specialist needed unable to find locally	Yes	23.9%	33.0%
	No	76.1%	67.0%
Summary: Mental Health			
During past 12 months…	Felt sad or hopeless 2+ weeks	11.2%	9.0%
	Ever seriously consider suicide	2.2%	3.0%
Resident/Immediate Family Member Diagnosed by Medical Professional	Anxiety or emotional problems	25.2%	32.0%
	Depression	21.7%	34.0%
	Anxiety disorder such as OCD or panic	11.2%	19.0%
	ADD/ADHD	8.9%	13.0%
	Posttraumatic stress disorder	5.4%	6.0%
	Alcohol/Substance Abuse/Dependence	4.3%	13.0%
	Bipolar	3.8%	9.0%
	Developmental disability	3.2%	6.0%
	Autism spectrum	2.4%	4.0%
	Life adjustment disorder	2.2%	3.0%
	Other mental health disorder	1.8%	6.0%
	Other trauma	1.4%	5.0%
Summary: Access to Oral Health Care			
Last Dental Checkup- Within past year		73.2%	80.0%
Summary: Smoking and Tobacco Use			
Smoked 100 or more cigarettes in life	Yes	36.6%	33.0%
	No	63.4%	67.0%
Summary: Alcohol and Substance Abuse			
Alcohol consumption	Every day/Some day	63.2%	74%
	Not at all	36.8%	26%
	Average number of drinks per week	***6.61***	***4.3***
Driven after drinking in past month	Yes	11.6%	30%
	No	88.4%	70%
During the last 6 months, anyone in household use. . .	Marijuana	7.4%	3.0%
	Amphetamines, methamphetamines	0.4%	<1%
	Cocaine or crack	0.2%	<1%
	Heroin	0.2%	<1%
	LSD or other hallucinogen	0.2%	<1%
	Inhalants	0.2%	<1%
	Ecstasy or GHB	0.2%	<1%
	Bath salts used illegally	0.2%	<1%
	Something else	0.8%	<1%
In past year taken prescriptions	Not belong to them	1.6%	5.0%
	Different than prescribed	2.8%	
	Take to Take Back Center	34.9%	5.0%
	Keep them in case I need them	26.1%	13.0%

		2021	2016
How typically get rid of unused prescription medication	Throw them in trash	16.4%	16.0%
	Flush down toilet	13.2%	13.0%
	Something else	8.9%	-
	Give them to someone else	0.4%	-
Aware of addiction treatment	Yes	49.5%	-
	No	50.5%	-
Know someone needed treatment for alcohol/substance abuse	Yes	7.1%	-
	No	92.9%	-
Summary: Healthy Living			
BMI *(calculated based on self-reported weight and height)*	Under weight	0.7%	-
	Normal weight	21.6%	25.0%
	Overweight	33.4%	36.0%
	Obese	44.3%	38.0%
Tried to lose weight over last 12 months	Yes	61.3%	42.0%
	No	38.7%	58.0%
Average number of hours a day	Watch TV	2.98	2.3
	Play video games	0.57	0.1
	Use computer outside of work	1.45	1.0
	Use cell phone	3.30	1.2
How often eat fresh fruits and vegetables	0-1 times/week	10.1%	-
	2-4 times/week	37.4%	-
	Once a day	27.9%	-
	2-4 times a day	21.4%	
	5 or more times a day	3.2%	1.0%
Summary: Prevention, Testing and Screening			
Had test	Blood Cholesterol Check	88.0%	88.0%
	Mammogram (women only)	68.6%	77.0%
	PAP Smear (women only)	91.9%	77.0%
	PSA test for prostate cancer	40.1%	47.0%
	Colonoscopy	52.3%	64.0%
Summary: Immunizations			
Had vaccines	Annual flu vaccine	44.7%	55.0%
	Tetanus booster (last 10 years)	64.0%	76.0%
	Pneumonia vaccine (in lifetime)	33.6%	27.0%
	HPV vaccine (in lifetime)	10.9%	8.0%
	Shingles vaccine (in lifetime)	30.6%	19.0%
	Chicken Pox vaccine (in lifetime)	41.2%	41.0%
	Measles vaccine (in lifetime)	60.3%	72.0%
Summary: Been Diagnosed with Chronic Disease			
Respondent diagnosed	High blood pressure	36.3%	30.0%
	Arthritis	27.9%	35.0%
	High cholesterol	26.8%	33.0%
	Diabetes	17.7%	9.0%
	Any form of cancer	11.7%	12.0%

		2021	2016
	Heart disease or heart attack	9.8%	3.0%[1]
	Asthma	9.2%	10.0%
	Stroke	2.5%	1.0%
Summary: Housing			
Percentage of household income goes to housing	Less than 30%	63.1%	49.0%
	30%-50%	25.9%	24.0%
	50% or higher	11.0%	9.0%
Summary: Safety and Violence			
Firearms in home	Yes	53.2%	55.0%
	No	46.8%	45.0%
Ever been abused	Yes	20.6%	20.0%
	No	79.4%	80.0%

[1] 2016 was heart attack only

Appendix: Survey Results by Income

		% of all residents	Under $25,000	$25-$75,000	Over $75,000
Summary: Community Needs					
Most important health issue *(open ended, Top 3)*	Cancer	36.7%	16.2%	21.7%	33.3%
	Obesity	17.2%	-	11.2%	12.5%
	Flu	13.5%	16.2%	14.5%	2.8%
Responsible for providing regular care or assistance for. . .	Elderly parent or loved one	8.6%	7.0%	8.0%	9.2%
	Someone with special needs	6.1%	4.8%	6.8%	6.1%
	Someone with physical/mental problem	4.5%	-	5.1%	4.3%
	Child with severe behavioral issues*	3.2%	-	5.6%	1.8%
	An adult child	2.8%	4.8%	2.3%	2.5%
	Grandchildren	2.7%	4.7%	2.8%	2.5%
Sought assistance in past year for . . .	Medicare or other health insurance*	6.0%	14.0%	7.3%	1.8%
	Mental health issues*	6.0%	11.6%	8.0%	3.1%
	Food*	5.7%	20.9%	7.4%	-
	Healthcare*	5.5%	11.6%	7.4%	1.2%
	Prescription assistance*	3.8%	4.7%	5.7%	1.2%
	Employment*	3.5%	11.6%	4.5%	0.6%
	Utilities*	3.0%	9.3%	4.5%	-
	Home repair	2.1%	4.8%	2.3%	1.2%
	Legal aid services	2.1%	-	-	1.2%
	Transportation*	1.9%	4.7%	2.8%	-
	Clothing*	1.8%	7.0%	2.3%	-
	Dental care*	1.8%	7.0%	1.7%	-
	Affordable childcare	1.4%	4.7%	1.7%	0.6%
	Rent/mortgage	1.4%	-	2.8%	0.6%
	Unplanned pregnancy	0.6%	-	-	1.2%
	Any kind of addiction	0.4%	2.3%	0.6%	-
Summary: Personal Health Status					
Personal description of health*	Excellent	20.1%	33.3%	83.6%	93.3%
	Good	62.0%	20.9%	69.5%	64.4%
	Fair	15.9%	61.9%	14.7%	5.5%
	Poor	1.7%	4.7%	1.7%	1.2%
	Very Poor	0.2%	4.8%	1.7%	1.2%
Number of days in past month that PHYSICAL health was not good*	Average number of days not well*	3.5	9.4	3.8	1.8
	None	57.5%	29.5%	52.8%	66.1%
	1-5	26.5%	22.7%	28.7%	26.1%
	6-10	5.9%	11.4%	6.2%	4.2%
	11-20	5.4%	18.2%	7.3%	1.2%
	More than 20	4.8%	18.2%	5.1%	2.4%
Number of days in past month that	Average number of days not well	4.8	8.5	5.2	3.5
	None	52.0%	43.5%	46.3%	57.8%
	1-5	25.9%	13.0%	29.9%	25.5%

		% of all residents	Under $25,000	$25-$75,000	Over $75,000
MENTAL health was not good*	6-10	5.8%	8.7%	6.2%	5.5%
	11-20	8.7%	19.5%	8.5%	6.7%
	More than 20	7.6%	15.2%	9.0%	4.3%
Poor Health Kept from Usual Activities*	Yes	21.6%	37.2%	27.7%	12.9%
	No	78.4%	62.8%	72.3%	87.1%
Limited because of health issues*	Yes	21.0%	44.2%	25.0%	11.0%
	No	79.0%	55.8%	75.0%	89.0%
Summary: Insurance Coverage					
Insurance coverage*	Not insured	2.0%	9.3%	1.7%	0.6%
	Private insurance- employer paid	52.2%	4.7%	40.3%	75.9%
	Private insurance- self paid	11.2%	4.7%	13.6%	9.9%
	Medicare	27.9%	48.8%	33.5%	13.6%
	Medicaid	8.7%	32.6%	10.8%	-
Services covered by insurance	Hospitalization*	91.8%	74.4%	93.1%	94.4%
	Emergency room care	88.8%	79.5%	87.9%	92.0%
	Prescription assistance	87.1%	79.5%	86.7%	90.1%
	Preventative care*	86.7%	61.5%	88.4%	91.4%
	Vision services	65.0%	56.4%	63.2%	71.6%
	Dental services*	65.2%	48.7%	60.7%	75.9%
	Long term care	39.0%	30.8%	41.0%	40.1%
	Family planning (birth control)*	38.6%	20.5%	36.2%	47.5%
Summary: Access to Health Care					
Have primary care provider	Yes	89.4%	81.4%	89.1%	92.0%
	No	10.6%	18.6%	10.9%	8.0%
Length of time since last routine check-up	Within past year	77.5%	76.7%	81.4%	73.0%
	Within past 2 years	9.3%	14.0%	9.0%	9.2%
	Within past 5 years	5.9%	2.3%	5.6%	8.0%
	5 or more years ago	6.0%	4.7%	3.4%	8.6%
	Never	1.3%	2.3%	0.6%	1.2%
Where receive health care most often*	Primary care or family doctor	85.5%	69.0%	90.4%	84.0%
	The emergency room	2.2%	9.5%	1.7%	1.2%
	Urgent Care	5.2%	14.3%	2.8%	5.5%
	VA hospital	1.6%	4.8%	1.1%	1.8%
	Leipsic Community Center Clinic	0.8%	-	-	1.8%
	Somewhere else	4.8%	2.4%	4.0%	5.5%
Services needed unable to get*	Yes	7.9%	14.0%	10.2%	3.7%
	No	92.1%	86.0%	89.8%	96.3%
Specialist needed unable to find locally*	Yes	23.9%	9.3%	27.3%	24.5%
	No	76.1%	90.7%	72.7%	75.5%
Summary: Mental Health					
During past 12 months…	Felt sad or hopeless 2+ weeks*	11.2%	30.2%	13.6%	3.7%
	Ever seriously consider suicide*	2.2%	7.0%	1.7%	1.2%
Resident/Immediate Family Member	Anxiety or emotional problems*	25.2%	25.6%	34.5%	16.6%
	Depression*	21.7%	39.5%	26.7%	12.9%

		% of all residents	Under $25,000	$25-$75,000	Over $75,000
Diagnosed by Medical Professional	Anxiety disorder such as OCD or panic	11.2%	14.0%	14.7%	7.9%
	ADD/ADHD	8.9%	9.3%	9.6%	8.6%
	Posttraumatic stress disorder*	5.4%	7.0%	9.1%	1.2%
	Seasonal effective disorder	4.7%	2.3%	6.8%	3.1%
	Alcohol/Substance Abuse/Dependence	4.3%	4.8%	6.3%	1.8%
	Postpartum depression	4.0%	-	4.0%	5.5%
	Bipolar	3.8%	7.0%	4.5%	2.5%
	Developmental disability*	3.2%	2.3%	5.6%	1.2%
	Autism spectrum	2.4%	-	3.4%	1.8%
	Life adjustment disorder	2.2%	-	3.4%	1.2%
	Other mental health disorder	1.8%	2.3%	2.8%	1.2%
	Other trauma*	1.4%	-	2.8%	-
	Eating disorder	1.3%	-	1.1%	1.8%
	Schizophrenia*	1.0%	-	2.3%	-
How often feel lonely or isolated from others.*	Often or always	5.6%	16.3%	5.1%	3.7%
	Some of the time	10.6%	16.3%	16.5%	3.7%
	Occasionally	15.6%	23.3%	18.2%	11.0%
	Hardly ever	29.1%	20.9%	27.3%	33.5%
	Never	39.1%	23.3%	33.0%	48.2%
Summary: Access to Oral Health Care					
Last Dental Checkup*	Within past year	73.2%	31.0%	70.5%	87.7%
	Within past 2 years	11.3%	26.2%	14.8%	4.3%
	Within past 5 years	6.4%	7.1%	9.7%	1.2%
	5 or more years ago	7.4%	26.2%	4.0%	6.8%
	Never	1.6%	9.5%	1.1%	-
Summary: Smoking and Tobacco Use					
Smoked 100 or more cigarettes in life*	Yes	36.6%	51.2%	38.6%	31.3%
	No	63.4%	48.8%	61.4%	68.7%
Tobacco usage*	Everyday	14.5%	21.4%	18.8%	6.8%
	Some days	4.8%	7.1%	4.0%	5.6%
	Not at all	80.7%	71.4%	77.3%	87.6%
Electronic Cigarette/Vape Usage*	Everyday	1.6%	4.7%	1.1%	1.2%
	Some days	2.6%	7.0%	4.0%	-
	Not at all	95.8%	88.4%	94.9%	98.8%
Likelihood of quitting	Very likely	16.5%	14.3%	12.2%	26.1%
	Somewhat likely	50.7%	42.9%	63.4%	39.1%
	Not at all likely	32.8%	42.9%	24.4%	34.8%
Interest in smoking cessation program*	Very interested	9.9%	15.4%	7.3%	9.1%
	Somewhat interested	25.8%	15.4%	39.0%	9.1%
	Not at all interested	64.3%	69.2%	53.7%	81.8%
Seriousness of youth vaping problem*	Very serious	16.6%	20.0%	18.9%	13.7%
	Moderately serious	40.3%	32.5%	36.6%	46.0%
	Not too serious	25.8%	7.5%	30.5%	26.1%
	Not really a problem	17.3%	40.0%	14.0%	14.3%

		% of all residents	Under $25,000	$25-$75,000	Over $75,000
Summary: Alcohol and Substance Abuse					
Alcohol consumption*	Every day	10.9%	18.6%	9.1%	12.3%
	Some days	52.3%	25.6%	49.4%	62.0%
	Not at all	36.8%	55.8%	41.5%	25.8%
	Average number of drinks per week	***6.61***	***12.5***	***5.9***	***7.2***
	# of days 5+ drinks past month (men)	***3.65***	***16.6***	***2.0***	***1.8***
	# of days 4+ drinks (women)	***2.49***	***3.1***	***2.3***	***2.6***
Driven after drinking in past month	Yes	11.6%	10.5%	18.4%	20.3%
	No	88.4%	89.5%	81.6%	79.7%
During the last 6 month, anyone in household use. . .	Marijuana*	7.4%	16.3%	8.5%	4.3%
	Amphetamines, methamphetamines	0.4%	-	1.1%	-
	Cocaine or crack	0.2%	-	0.6%	-
	Heroin	0.2%	-	0.6%	-
	LSD or other hallucinogen	0.2%	-	0.6%	-
	Inhalants	0.2%	-	0.6%	-
	Ecstasy of GHB	0.2%	-	0.6%	-
	Bath salts used illegally	0.2%	-	0.6%	-
	Something else	0.8%	-	1.1%	1.2%
In past year taken prescriptions	Not belong to them*	1.6%	7.0%	1.7%	-
	Different than prescribed*	2.8%	9.3%	2.8%	1.2%
How typically get rid of unused prescription medication*	Take to Take Back Center	34.9%	34.1%	30.6%	39.0%
	Keep them in case I need them	26.1%	19.5%	27.7%	25.2%
	Throw them in trash	16.4%	9.8%	16.2%	18.9%
	Flush down toilet	13.2%	29.3%	13.3%	10.1%
	Something else	8.9%	4.9%	11.6%	6.9%
	Give them to someone else	0.4%	2.4%	0.6%	-
Aware of addiction treatment	Yes	49.5%	34.9%	49.7%	52.1%
	No	50.5%	65.1%	50.3%	47.9%
Know someone needed tx for alcohol/substance abuse	Yes	7.1%	9.3%	6.8%	7.5%
	No	92.9%	90.7%	93.2%	92.5%
Summary: Healthy Living					
Exercise in past month*	Yes	74.5%	58.1%	71.6%	81.6%
	No	25.5%	41.9%	28.4%	18.4%
Self-described weight*	Overweight	60.2%	62.8%	62.4%	58.3%
	About right	38.1%	30.2%	36.0%	41.1%
	Underweight	1.7%	7.0%	1.7%	0.6%
BMI *(calculated based on self-reported weight and height**)*	Under weight	0.7%	7.0%	-	-
	Normal weight	21.6%	16.3%	23.2%	22.7%
	Overweight	33.4%	30.2%	29.4%	36.2%
	Obese	44.3%	46.5%	47.5%	41.1%
Tried to lose weight over last 12 months	Yes	61.3%	41.9%	65.0%	66.3%
	No	38.7%	58.1%	35.0%	33.7%

		% of all residents	Under $25,000	$25-$75,000	Over $75,000
Average number of hours a day	Watch TV	2.98	5.2	3.2	2.0
	Play video games	0.57	0.8	0.8	0.3
	Use computer outside of work	1.45	1.5	1.7	1.1
	Use cell phone	3.30	4.8	3.5	2.7
What makes it difficult to get food needed	Cost of food*	25.9%	41.9%	32.2%	16.6%
	Distance from the store*	15.7%	21.4%	18.6%	10.4%
	Time for shopping	14.7%	11.6%	18.8%	11.7%
	Quality of food*	20.2%	21.9%	14.8%	23.2%
	Safety*	2.4%	9.3%	1.7%	1.2%
	Something else	5.6%	7.0%	4.5%	6.7%
Difficulty getting fresh food & vegs neighborhood*	Very difficult	2.3%	4.7%	2.3%	1.2%
	Somewhat difficult	18.8%	25.6%	23.9%	10.4%
	Not at all difficult	78.9%	69.8%	73.9%	88.3%
How often eat fresh fruits and vegetables*	0-1 times/week	10.1%	23.8%	12.4%	3.7%
	2-4 times/week	37.4%	38.1%	42.4%	31.1%
	Once a day	27.9%	23.8%	28.2%	29.3%
	2-4 times a day	21.4%	9.5%	15.3%	31.1%
	5 or more times a day	3.2%	4.8%	1.7%	4.9%
# of restaurant or takeout meals a week*	None	15.3%	37.2%	13.6%	11.7%
	1-2 meals	66.3%	48.8%	71.0%	65.6%
	3-4 meals	14.8%	9.3%	11.4%	19.6%
	5 or more meals	3.6%	4.7%	4.0%	3.1%
# times drink pop or other unhealthy drinks*	0	25.6%	20.5%	28.1%	24.2%
	1-3 times per week	23.1%	18.2%	21.9%	25.5%
	4-6 times per week	11.7%	29.5%	9.0%	10.6%
	1 time per day	19.4%	11.4%	16.3%	22.4%
	2-3 times per day	14.5%	9.1%	18.0%	13.7%
	4 or more times per day	5.7%	11.4%	6.7%	3.7%
Summary: Prevention, Testing and Screening					
Ever had test?	Blood Pressure Check*	96.9%	92.7%	96.0%	98.8%
	Blood Cholesterol Check*	88.0%	86.0%	83.5%	93.9%
	Mammogram (women only)	68.6%	57.1%	73.0%	66.7%
	PAP Smear (women only)	91.9%	82.8%	92.0%	95.6%
	PSA test for prostate cancer	40.1%	33.3%	45.9%	35.1%
	Colonoscopy	52.3%	53.5%	56.3%	45.4%
	Skin Cancer Exam*	33.6%	18.6%	38.6%	31.3%
Summary: Immunizations					
Had vaccines	Annual flu vaccine*	44.7%	32.6%	58.8%	57.7%
	Tetanus booster (last 10 years)	64.0%	53.5%	62.7%	69.3%
	Pneumonia vaccine (in lifetime)*	33.6%	34.9%	41.2%	23.3%
	HPV vaccine (in lifetime)	10.9%	7.0%	12.4%	11.0%
	Shingles vaccine (in lifetime)*	30.6%	16.3%	39.2%	25.2%
	Chicken Pox vaccine (in lifetime)	41.2%	52.4%	41.5%	38.7%
	Measles vaccine (in lifetime)	60.3%	60.5%	55.9%	66.3%

		% of all residents	Under $25,000	$25-$75,000	Over $75,000
	COVID-19 vaccine*	61.1%	30.2%	67.0%	63.8%
Summary: Been Diagnosed with Chronic Disease					
Respondent diagnosed	High blood pressure*	36.3%	48.8%	36.7%	31.3%
	Arthritis*	27.9%	59.5%	33.3%	13.5%
	High cholesterol*	26.8%	53.5%	23.7%	23.8%
	Diabetes*	17.7%	44.2%	19.2%	9.5%
	Any form of cancer*	11.7%	32.6%	9.0%	9.2%
	Heart disease or heart attack*	9.8%	34.9%	8.5%	4.9%
	Asthma*	9.2%	20.9%	10.8%	4.9%
	Respiratory disease*	3.2%	11.6%	4.0%	1.2%
	Kidney disease*	2.5%	11.9%	1.1%	1.2%
	Stroke*	2.5%	11.6%	2.8%	-
	Alzheimer's	0.0%	-	-	-
Member of household diagnosed	High blood pressure	23.1%	23.3%	23.9%	20.9%
	Arthritis	15.4%	16.3%	17.5%	11.7%
	High cholesterol	18.9%	23.3%	19.9%	16.6%
	Diabetes	16.3%	23.3%	19.3%	12.3%
	Any form of cancer*	12.8%	23.3%	14.1%	8.6%
	Heart disease or heart attack	9.7%	14.0%	10.2%	8.0%
	Asthma*	11.4%	39.5%	13.1%	3.7%
	Respiratory disease*	7.1%	34.9%	6.3%	1.2%
	Kidney disease*	8.9%	34.9%	9.1%	2.5%
	Stroke*	6.4%	32.6%	4.5%	2.5%
	Alzheimer's*	7.5%	39.5%	4.5%	3.1%
Summary: Transportation					
Have access to transportation*	Yes	98.0%	90.7%	97.7%	100.0%
	No	2.0%	9.3%	2.3%	-
How get where need to go	Own car*	95.4%	81.4%	96.6%	98.8%
	Walk*	21.7%	34.9%	18.1%	22.6%
	Bike	9.4%	14.0%	8.5%	9.2%
	Friend/family member*	7.9%	25.6%	6.8%	4.3%
	Council on Aging Transportation*	2.2%	14.0%	1.7%	-
	Borrow a car	1.6%	-	2.3%	1.2%
	Faith based organization*	1.3%	9.3%	0.6%	-
	Other*	0.9%	-	2.3%	-
	Job and Family Services*	0.6%	4.7%	0.6%	-
Summary: Housing					
Percentage of household income goes to housing*	Less than 30%	63.1%	35.0%	56.9%	76.3%
	30%-50%	25.9%	35.0%	28.7%	21.3%
	50% or higher	11.0%	30.0%	14.4%	2.5%
Summary: Safety and Violence					
Firearms in home*	Yes	53.2%	31.0%	47.1%	67.1%
	No	46.8%	69.0%	52.9%	32.9%
	Firearms locked	75.8%	84.6%	70.7%	78.1%

		% of all residents	Under $25,000	$25-$75,000	Over $75,000
Firearms locked and loaded	Firearms loaded*	12.4%	53.8%	13.4%	6.6%
Feel safe in home*	Very safe	92.4%	81.4%	90.4%	97.5%
	Somewhat safe	7.2%	14.0%	9.6%	2.5%
	Not at all safe	0.4%	4.7%	-	-
Feel safe in community*	Very safe	84.8%	69.8%	85.2%	87.1%
	Somewhat safe	14.8%	25.6%	14.8%	12.9%
	Not at all safe	0.4%	4.7%	-	-
Ever been abused*	Yes	20.6%	34.9%	24.9%	14.1%
	No	79.4%	65.1%	75.1%	85.9%

Appendix: Survey Results by Age

		% of all residents	Ages 65+	Ages 45-64	Ages 18-44
Summary: Community Needs					
Most important health issue *(open ended, Top 3)**	Cancer	36.7%	21.3%	31.7%	24.8%
	Obesity	17.2%	11.3%	7.1%	13.8%
	Flu	13.5%	20.0%	9.5%	3.4%
Responsible for providing regular care or assistance for. . .	Elderly parent or loved one*	8.6%	3.3%	16.2%	4.3%
	Someone with special needs	6.1%	3.3%	6.1%	8.0%
	With physical/mental problem	4.5%	5.5%	5.4%	3.7%
	Child with severe behavioral issues*	3.2%	-	1.4%	6.8%
	An adult child	2.8%	2.2%	2.7%	3.7%
	Grandchildren*	2.7%	3.3%	4.7%	0.6%
Sought assistance in past year for . . .	Medicare or other health insurance	6.0%	6.6%	6.8%	5.6%
	Mental health issues*	6.0%	1.1%	4.7%	9.9%
	Food*	5.7%	2.2%	4.1%	9.3%
	Healthcare	5.5%	1.1%	6.1%	7.4%
	Prescription assistance	3.8%	3.3%	4.1%	3.7%
	Employment*	3.5%	-	1.4%	6.8%
	Utilities	3.0%	2.2%	2.7%	3.7%
	Home repair	2.1%	1.1%	2.7%	1.9%
	Legal aid services	2.1%	-	1.4%	-
	Transportation	1.9%	1.1%	1.4%	2.5%
	Clothing	1.8%	-	2.0%	2.5%
	Dental care	1.8%	1.1%	2.0%	1.2%
	Affordable childcare*	1.4%	-	-	3.7%
	Rent/mortgage*	1.4%	-	-	3.7%
	Unplanned pregnancy	0.6%	-	-	1.2%
	Any kind of addiction	0.4%	-	-	1.2%
Summary: Personal Health Status					
Personal description of health	Excellent	20.1%	15.4%	19.6%	23.6%
	Good	62.0%	60.4%	63.5%	60.9%
	Fair	15.9%	23.1%	14.2%	13.6%
	Poor	1.7%	1.1%	2.0%	1.9%
	Very Poor	0.2%	1.1%	2.7%	1.9%
Number of days in past month that PHYSICAL health was not good	Average number of days not well	3.5	3.9	3.6	3.1
	None	57.5%	53.8%	58.4%	56.8%
	1-5	26.5%	25.3%	27.5%	26.5%
	6-10	5.9%	9.9%	3.4%	6.1%
	11-20	5.4%	7.7%	4.7%	5.5%
	More than 20	4.8%	3.3%	6.0%	4.9%
Number of days in past month that	Average number of days not well	4.8	1.3	4.5	7.0
	None	52.0%	75.8%	55.3%	34.6%
	1-5	25.9%	19.8%	23.3%	31.4%

		% of all residents	Ages 65+	Ages 45-64	Ages 18-44
MENTAL health was not good	6-10	5.8%	-	5.3%	10.1%
	11-20	8.7%	2.2%	8.7%	12.6%
	More than 20	7.6%	2.2%	7.4%	11.3%
Poor Health Kept from Usual Activities*	Yes	21.6%	13.3%	19.6%	28.0%
	No	78.4%	86.7%	80.4%	72.0%
Limited because of health issues*	Yes	21.0%	33.3%	19.6%	15.0%
	No	79.0%	66.7%	80.4%	85.0%
Summary: Insurance Coverage					
Insurance coverage*	Not insured	2.0%	-	3.4%	1.9%
	Private insurance- employer paid	52.2%	10.0%	55.7%	70.3%
	Private insurance- self paid	11.2%	10.0%	55.7%	70.3%
	Medicare	27.9%	86.7%	15.4%	5.1%
	Medicaid	8.7%	2.2%	8.7%	12.0%
Services covered by insurance	Hospitalization*	91.8%	96.7%	95.8%	84.7%
	Emergency room care*	88.8%	94.4%	90.9%	83.4%
	Prescription assistance	87.1%	85.6%	90.9%	84.7%
	Preventative care*	86.7%	80.2%	90.2%	87.2%
	Vision services*	65.0%	40.0%	67.1%	77.1%
	Dental services*	65.2%	37.4%	67.1%	79.6%
	Long term care	39.0%	34.1%	41.3%	40.1%
	Family planning (birth control)*	38.6%	14.3%	37.8%	53.2%
Summary: Access to Health Care					
Have primary care provider	Yes	89.4%	90.1%	91.8%	86.9%
	No	10.6%	9.9%	8.2%	13.1%
Length of time since last routine check-up*	Within past year	77.5%	87.8%	87.8%	62.5%
	Within past 2 years	9.3%	5.6%	8.1%	11.9%
	Within past 5 years	5.9%	2.2%	-	13.1%
	5 or more years ago	6.0%	3.3%	4.1%	10.0%
	Never	1.3%	1.1%	-	2.5%
Where receive health care most often*	Primary care or family doctor	85.5%	92.2%	89.1%	78.0%
	The emergency room	2.2%	-	2.0%	3.8%
	Urgent Care	5.2%	2.2%	4.8%	6.9%
	VA hospital	1.6%	-	1.4%	3.1%
	Leipsic Community Center Clinic	0.8%	-	1.4%	1.3%
	Somewhere else	4.8%	5.6%	1.4%	6.9%
Services needed unable to get *	Yes	7.9%	1.1%	6.8%	13.1%
	No	92.1%	98.9%	93.2%	86.9%
Specialist needed unable to find*	Yes	23.9%	15.7%	20.4%	30.6%
	No	76.1%	83.3%	79.6%	69.4%
Summary: Mental Health					
During past 12 months…	Felt sad or hopeless 2+ weeks*	11.2%	1.1%	12.2%	15.6%
	Ever seriously consider suicide*	2.2%	-	1.4%	4.4%
	Anxiety or emotional problems*	25.2%	11.0%	25.0%	33.5%

		% of all residents	Ages 65+	Ages 45-64	Ages 18-44
Resident/Immediate Family Member Diagnosed by Medical Professional	Depression*	21.7%	11.0%	19.0%	30.2%
	Anxiety disorder such as OCD or panic*	11.2%	3.3%	10.9%	15.4%
	ADD/ADHD*	8.9%	2.2%	4.7%	16.7%
	Posttraumatic stress disorder	5.4%	3.3%	5.4%	6.8%
	Seasonal effective disorder*	4.7%	2.2%	2.7%	8.0%
	Alcohol/Substance Dependence*	4.3%	1.1%	3.4%	6.8%
	Postpartum depression*	4.0%	-	2.7%	7.4%
	Bipolar	3.8%	2.2%	3.4%	4.9%
	Developmental disability	3.2%	1.1%	2.7%	4.9%
	Autism spectrum	2.4%	-	2.0%	3.7%
	Life adjustment disorder	2.2%	-	3.4%	2.5%
	Other mental health disorder	1.8%	-	2.0%	2.5%
	Other trauma	1.4%	-	2.0%	1.2%
	Eating disorder	1.3%	1.1%	-	2.5%
	Schizophrenia	1.0%	1.1%	1.4%	0.6%
How often feel lonely or isolated from others.*	Often or always	5.6%	1.1%	6.1%	7.5%
	Some of the time	10.6%	4.4%	7.4%	17.5%
	Occasionally	15.6%	18.7%	10.8%	18.1%
	Hardly ever	29.1%	23.1%	32.4%	29.4%
	Never	39.1%	52.7%	43.2%	27.5%
Summary: Access to Oral Health Care					
Last Dental Checkup	Within past year	73.2%	72.2%	77.7%	69.4%
	Within past 2 years	11.3%	10.0%	12.2%	11.9%
	Within past 5 years	6.4%	6.7%	3.4%	8.8%
	5 or more years ago	7.4%	11.1%	5.4%	6.9%
	Never	1.6%	-	1.4%	3.1%
Summary: Smoking and Tobacco Use					
Smoked 100 or more cigarettes in life	Yes	36.6%	34.4%	36.1%	38.1%
	No	63.4%	65.6%	63.9%	61.9%
Tobacco usage*	Everyday	14.5%	5.6%	16.9%	17.6%
	Some days	4.8%	1.1%	2.7%	8.8%
	Not at all	80.7%	93.3%	80.4%	73.6%
Electronic Cigarette/Vape Usage*	Everyday	1.6%	-	2.7%	1.3%
	Some days	2.6%	1.1%	1.4%	5.1%
	Not at all	95.8%	98.9%	95.9%	93.7%
Likelihood of quitting smoking or vaping*	Very likely	16.5%	33.3%	3.1%	25.0%
	Somewhat likely	50.7%	33.3%	56.3%	50.0%
	Not at all likely	32.8%	33.3%	40.6%	25.0%
Interest in smoking cessation program	Very interested	9.9%	-	3.1%	15.9%
	Somewhat interested	25.8%	14.3%	37.5%	20.5%
	Not at all interested	64.3%	85.7%	59.4%	63.6%
Seriousness of youth vaping problem	Very serious	16.6%	16.5%	14.1%	18.6%
	Moderately serious	40.3%	36.5%	42.2%	41.0%
	Not too serious	25.8%	28.2%	27.4%	23.0%

		% of all residents	Ages 65+	Ages 45-64	Ages 18-44
	Not really a problem	17.3%	18.8%	16.3%	17.4%
Summary: Alcohol and Substance Abuse					
Alcohol consumption*	Every day	10.9%	14.4%	12.1%	8.1%
	Some days	52.3%	38.9%	47.7%	63.8%
	Not at all	36.8%	46.7%	40.3%	28.1%
	Average number of drinks per week	***6.61***	***7.3***	***6.7***	***7.0***
	# of days 5+ drinks past month (men)	***3.65***	***7.9***	***2.7***	***2.6***
	# of days 4+ drinks (women)	***2.49***	***2.1***	***1.6***	***3.3***
Driven after drinking in past month	Yes	18.6%	23.4%	18.2%	17.5%
	No	81.4%	76.6%	81.8%	82.5%
During the last 6 month, anyone in household use. . .	Marijuana*	7.4%	2.2%	8.1%	9.9%
	Amphetamines, methamphetamines	0.4%	-	-	1.2%
	Cocaine or crack	0.2%	-	-	0.6%
	Heroin	0.2%	-	-	0.6%
	LSD or other hallucinogen	0.2%	-	-	0.6%
	Inhalants	0.2%	-	-	0.6%
	Ecstasy or GHB	0.2%	-	-	0.6%
	Bath salts used illegally	0.2%	-	-	0.6%
	Something else	0.8%	-	1.4%	1.2%
In past year taken prescriptions	Not belong to them	1.6%	1.1%	1.4%	1.9%
	Different than prescribed*	2.8%	1.1%	1.4%	5.1%
How typically get rid of unused prescription medication*	Take to Take Back Center	34.9%	42.0%	40.0%	25.8%
	Keep them in case I need them	26.1%	15.9%	24.3%	33.3%
	Throw them in trash	16.4%	14.8%	13.6%	19.5%
	Flush down toilet	13.2%	21.6%	11.4%	10.7%
	Something else	8.9%	5.7%	10.7%	9.4%
	Give them to someone else	0.4%	-	-	1.3%
Aware of addiction treatment	Yes	49.5%	49.5%	48.3%	50.6%
	No	50.5%	50.5%	51.7%	49.4%
Know someone needed treatment*	Yes	7.1%	2.2%	6.8%	10.1%
	No	92.9%	97.8%	93.2%	89.9%
Summary: Healthy Living					
Exercise in past month	Yes	74.5%	73.3%	72.3%	77.0%
	No	25.5%	26.7%	27.7%	23.0%
Self-described weight	Overweight	60.2%	63.7%	63.5%	54.7%
	About right	38.1%	33.0%	35.1%	43.5%
	Underweight	1.7%	1.1%	0.7%	0.6%
BMI *(calculated based on self-reported weight and height)*	Under weight	0.7%	1.1%	0.7%	0.6%
	Normal weight	21.6%	18.9%	16.2%	27.7%
	Overweight	33.4%	38.9%	32.4%	31.4%
	Obese	44.3%	41.1%	50.7%	40.3%
Tried to lose weight in past year*	Yes	61.3%	50.5%	62.2%	66.3%
	No	38.7%	49.5%	37.8%	33.8%
	Watch TV	2.98	4.1	2.8	2.4

		% of all residents	Ages 65+	Ages 45-64	Ages 18-44
Average number of hours a day	Play video games	0.57	0.4	0.1	0.9
	Use computer outside of work	1.45	1.5	1.2	1.6
	Use cell phone	3.30	2.7	2.4	4.3
What makes it difficult to get food needed	Cost of food*	25.9%	14.3%	20.3%	37.7%
	Distance from the store	15.7%	19.8%	14.2%	14.9%
	Time for shopping	14.7%	8.8%	14.2%	18.5%
	Quality of food*	20.2%	9.9%	13.6%	31.5%
	Safety	2.4%	2.2%	2.0%	3.1%
	Something else	5.6%	2.2%	7.4%	6.2%
Difficulty getting fresh food & vegs neighborhood*	Very difficult	2.3%	1.1%	3.4%	1.3%
	Somewhat difficult	18.8%	13.2%	14.3%	26.4%
	Not at all difficult	78.9%	85.7%	82.3%	72.3%
How often eat fresh fruits and vegetables	0-1 times/week	10.1%	6.6%	10.2%	11.9%
	2-4 times/week	37.4%	39.6%	35.4%	37.5%
	Once a day	27.9%	35.2%	29.3%	23.1%
	2-4 times a day	21.4%	17.6%	21.1%	23.8%
	5 or more times a day	3.2%	1.1%	4.1%	3.8%
# of restaurant or takeout meals a week	None	15.3%	20.9%	12.8%	14.4%
	1-2 meals	66.3%	58.2%	68.5%	68.8%
	3-4 meals	14.8%	15.4%	17.4%	12.5%
	5 or more meals	3.6%	5.5%	1.3%	4.4%
# times drink pop or other unhealthy drinks	0	25.6%	28.1%	31.5%	19.3%
	1-3 times per week	23.1%	29.2%	17.1%	25.5%
	4-6 times per week	11.7%	10.1%	12.3%	11.8%
	1 time per day	19.4%	16.9%	19.9%	20.5%
	2-3 times per day	14.5%	14.6%	12.3%	16.1%
	4 or more times per day	5.7%	1.1%	6.8%	6.8%
Summary: Prevention, Testing and Screening					
Ever had test?	Blood Pressure Check	96.9%	97.8%	98.0%	98.5%
	Blood Cholesterol Check*	88.0%	95.6%	93.9%	77.5%
	Mammogram (women only)*	68.6%	83.7%	93.1%	36.3%
	PAP Smear (women only)	91.9%	92.0%	94.4%	88.8%
	PSA test for prostate cancer*	40.1%	80.0%	52.0%	8.9%
	Colonoscopy*	52.3%	81.3%	70.1%	19.4%
	Skin Cancer Exam*	33.6%	42.9%	39.2%	23.1%
Summary: Immunizations					
Had vaccines	Annual flu vaccine*	44.7%	67.0%	56.8%	47.2%
	Tetanus booster (last 10 years)	64.0%	64.4%	59.5%	67.9%
	Pneumonia vaccine (in lifetime)*	33.6%	70.3%	34.5%	12.3%
	HPV vaccine (in lifetime)*	10.9%	3.3%	6.1%	19.1%
	Shingles vaccine (in lifetime)*	30.6%	56.0%	36.7%	10.5%
	Chicken Pox vaccine (in lifetime)*	41.2%	51.6%	43.2%	33.5%
	Measles vaccine (in lifetime)	60.3%	53.3%	60.8%	63.6%
	COVID-19 vaccine*	61.1%	79.1%	66.2%	46.3%

		% of all residents	Ages 65+	Ages 45-64	Ages 18-44
Summary: Been Diagnosed with Chronic Disease					
Respondent diagnosed	High blood pressure*	36.3%	54.9%	48.6%	14.8%
	Arthritis*	27.9%	56.0%	30.6%	9.3%
	High cholesterol*	26.8%	47.8%	31.1%	11.1%
	Diabetes*	17.7%	22.0%	24.3%	9.3%
	Any form of cancer*	11.7%	24.4%	13.5%	3.1%
	Heart disease or heart attack*	9.8%	25.3%	8.2%	2.5%
	Asthma	9.2%	11.0%	7.4%	9.9%
	Respiratory disease*	3.2%	3.3%	6.1%	0.6%
	Kidney disease	2.5%	2.2%	3.4%	1.2%
	Stroke	2.5%	5.6%	1.4%	1.9%
	Alzheimer's	0.0%	-	-	-
Member of household diagnosed	High blood pressure	23.1%	24.4%	22.3%	22.8%
	Arthritis*	15.4%	22.0%	10.8%	16.0%
	High cholesterol	18.9%	20.9%	18.9%	17.9%
	Diabetes	16.3%	22.0%	15.6%	13.6%
	Any form of cancer	12.8%	8.8%	12.8%	14.9%
	Heart disease or heart attack	9.7%	7.8%	8.8%	11.7%
	Asthma*	11.4%	8.8%	6.1%	17.9%
	Respiratory disease	7.1%	11.0%	4.1%	7.4%
	Kidney disease	8.9%	10.0%	8.1%	9.3%
	Stroke	6.4%	8.8%	3.4%	8.0%
	Alzheimer's*	7.5%	9.9%	3.4%	9.9%
Summary: Transportation					
Have access to transportation	Yes	98.0%	98.9%	96.6%	98.8%
	No	2.0%	1.1%	3.4%	1.3%
How get where need to go	Own car	95.4%	95.6%	97.3%	95.6%
	Walk	21.7%	18.9%	27.9%	17.9%
	Bike	9.4%	5.6%	10.1%	11.1%
	Friend/family member	7.9%	6.6%	8.1%	9.3%
	Council on Aging Transportation*	2.2%	2.2%	4.7%	-
	Borrow a car	1.6%	1.1%	0.7%	3.1%
	Faith based organization	1.3%	1.1%	2.0%	0.6%
	Other	0.9%	2.2%	-	1.2%
	Job and Family Services	0.6%	-	1.4%	0.6%
Summary: Housing					
Percentage of household income goes to housing	Less than 30%	63.1%	72.4%	63.1%	58.2%
	30%-50%	25.9%	19.5%	24.8%	30.4%
	50% or higher	11.0%	8.0%	12.1%	11.4%
Summary: Safety and Violence					
Firearms in home*	Yes	53.2%	43.7%	51.0%	60.3%
	No	46.8%	56.3%	49.0%	39.7%
Firearms locked and loaded	Firearms locked*	75.8%	56.8%	76.7%	83.0%
	Firearms loaded	12.4%	15.8%	17.8%	7.4%

		% of all residents	Ages 65+	Ages 45-64	Ages 18-44
Feel safe in home	Very safe	92.4%	93.4%	93.9%	90.0%
	Somewhat safe	7.2%	6.6%	5.4%	9.4%
	Not at all safe	0.4%	-	0.7%	0.6%
Feel safe in community*	Very safe	84.8%	94.5%	84.5%	79.4%
	Somewhat safe	14.8%	5.5%	14.9%	20.0%
	Not at all safe	0.4%	-	0.7%	0.6%
Ever been abused*	Yes	20.6%	8.9%	19.0%	28.1%
	No	79.4%	91.1%	81.0%	71.9%

Appendix: Research Methodology

The Center for Marketing and Opinion Research (CMOR) conducted the 2022 Putnam County Community Health Needs Assessment on behalf of the Putnam County Health Department.

This report includes indicators in the following focus areas:

- Community Needs
- Social Determinants
- Personal Health Status
- Access to Health Care
- Mental Health
- Oral Health
- Smoking/Tobacco Use
- Alcohol and Substance Abuse
- Maternal, Infant, and Child Health
- Healthy Living
- Communicable Diseases, Vaccinations, and Prevention Services
- Chronic Disease Management
- Transportation
- Housing
- Environmental Quality
- Safety, Injury and Violence
- Reproductive and Sexual Health

**Throughout the report, statistically significant findings and statistical significance between groupings (i.e., between age groups or between races) are indicated by an asterisk (*).*

COMMUNITY SURVEY

The first phase of the project consisted of the collection of primary data utilizing a random sample telephone survey of Putnam County households that included a representative sample of Putnam County residents. A combination of telephone and web interviews were utilized in order to ensure representativeness of the population. This method also ensured that the correct number of interviews would be completed to meet the targeted sampling error.

The final sample of the survey consisted of a total of 400 residents. The general population statistics derived from the sample size provide a precision level of plus or minus 4.9% within a 95% confidence interval. Data collection began on October 20th and ended on December 8th, 2021. Most calling took place between the evening hours of 5:15 pm and 9:15 pm. Some interviews were conducted during the day and on some weekends to accommodate resident schedules. The interviews took an average of 23.9 minutes.

COMMUNITY LEADER SURVEY

In addition to the data mentioned above, additional data was gathered in order to provide some contextual information to the primary and secondary data. The data included a Community Leader survey which consisted of an online survey completed by 19 community leaders. These surveys were completed between February 4 and February 25, 2022.

SECONDARY DATA ANALYSIS

Another phase of the project consisted of reviewing and analyzing secondary data sources to identify priority areas of concern when analyzed alongside survey data. CMOR gathered and compiled health and demographic data from various sources (outlined below). After gathering the data, CMOR compiled the information, by category. In addition to the report narrative, data was visually displayed with charts and tables. When available, data was compared to previous five year's information as well as other geographic areas such as Ohio. Analysis included survey data in conjunction with health and demographic data. Using all data available, CMOR identified priorities for the county.

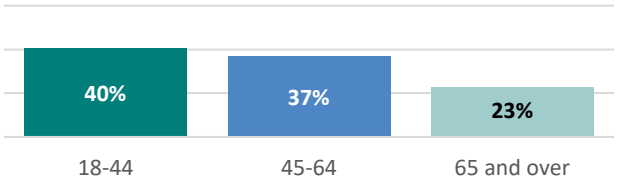
Sources of Data:

- ✓ Ohio Drug Overdose Data
- ✓ Behavioral Risk Factor Surveillance System (BRFSS)
- ✓ Business Analyst, Delorme map data
- ✓ Centers for Disease Control and Prevention WONDER Environmental Data
- ✓ County Health Rankings
- ✓ Dartmouth Atlas of Health Care
- ✓ Feeding America
- ✓ FCC Broadband Availability Comparison Tool
- ✓ HRSA Area Resource File
- ✓ Kids Count Data Center
- ✓ National Center for Health Statistics/Census Bureau
- ✓ National Center for Chronic Disease Prevention and Health Promotion
- ✓ Ohio Department of Education
- ✓ Ohio Department of Health Data Warehouse
- ✓ Ohio Department of Health, STD Surveillance
- ✓ Ohio Development Services Agency, Ohio County Profiles
- ✓ Ohio Housing Finance Agency (OHFA)
- ✓ Ohio Department of Youth Services
- ✓ Ohio Mental Health and Addiction Services
- ✓ Public Children Services Association of Ohio (PCSAO)
- ✓ Uniform Crime Reporting - FBI
- ✓ U.S. Census Bureau - American Fact Finder, American Community Survey
- ✓ U.S. Department of Agriculture (USDA)
- ✓ U.S. Department of Commerce; National Technical Information Service

Appendix: Participant Characteristics

COMMUNITY SURVEY

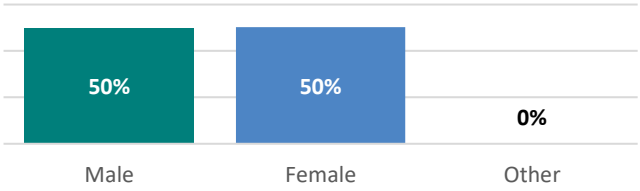
Respondent Age



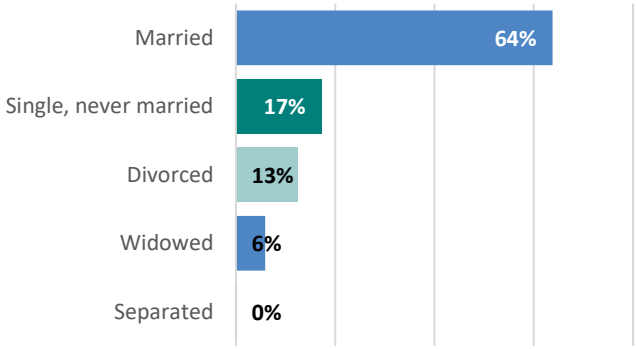
Age	N	%
18-44	162	40.4%
45-64	148	36.9%
65 and over	91	22.7%
Total	**400**	**100.0%**

Gender	N	%
Male	199	49.7%
Female	201	50.3%
Total	**400**	**100.0%**

Respondent Gender



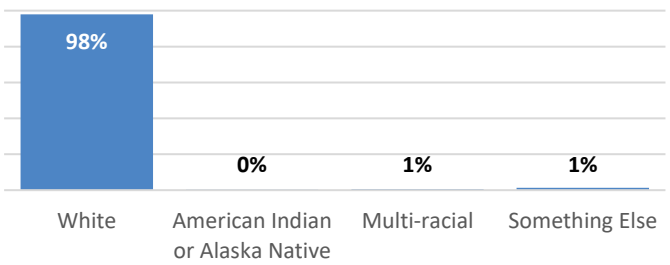
Marital Status



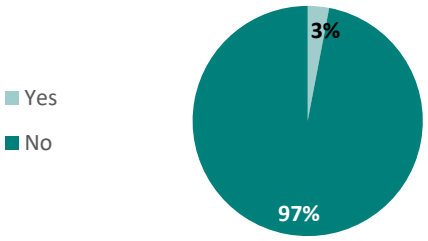
Marital Status	N	%
Married	255	64.1%
Single, never married	69	17.4%
Divorced	50	12.5%
Widowed	24	5.9%
Separated	1	0.2%
Total	**398**	**100.0%**

Race	N	%
White	388	97.9%
American Indian/Alaska Native	1	0.2%
Multi-racial	2	0.6%
Something else	5	1.3%
Total	**396**	**100%**

Race



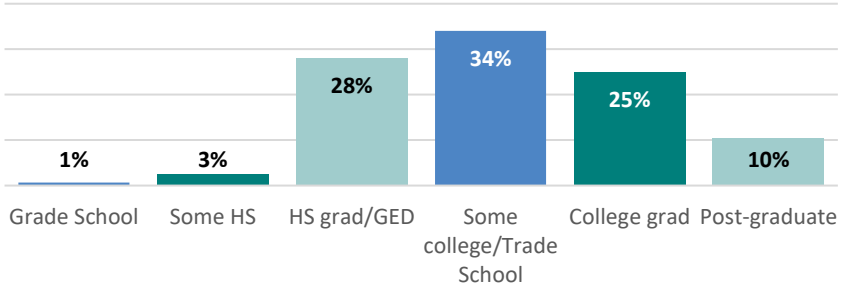
Hispanic or Latino Origin



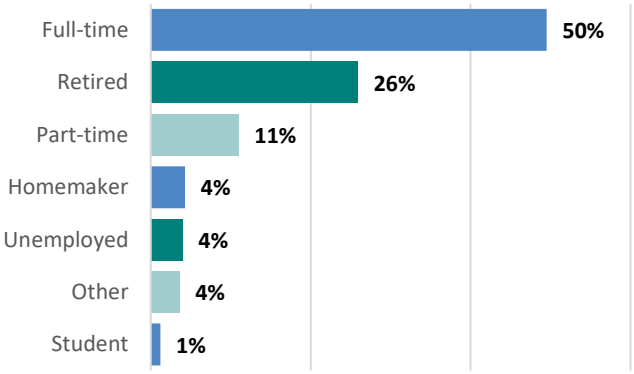
Hispanic or Latino Origin	N	%
Yes	12	3.1%
No	385	96.9%
Total	**398**	**100.0%**

Education	N	%
Grade School	3	0.7%
Some High School	10	2.6%
HS grad/GED	110	27.6%
Some college/Trade	136	34.2%
College grad	98	24.6%
Post-graduate	41	10.4%
Total	**397**	**100%**

Education Attainment



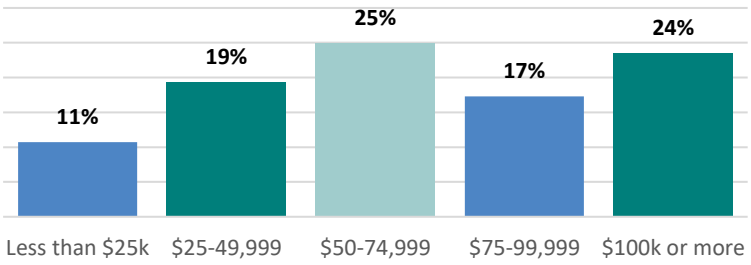
Employment Status



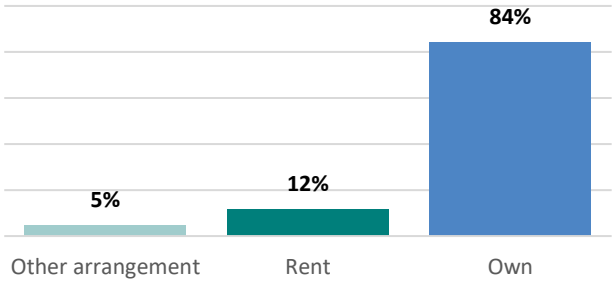
Employment Status	N	%
Full-time	198	49.7%
Retired	104	26.0%
Part-time	44	11.1%
Homemaker	17	4.4%
Unemployed	16	4.0%
Other	14	3.6%
Student	5	1.2%
Total	**398**	**100.0%**

Income	N	%
Less than $25k	43	10.7%
$25-49,999	77	19.3%
$50-74,999	99	24.9%
$75-99,999	69	17.3%
$100k or more	94	23.5%
Total	**383**	**95.7%**

Household Income



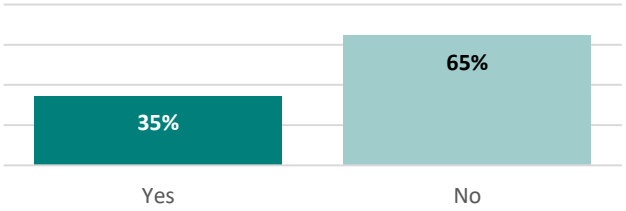
Own or Rent



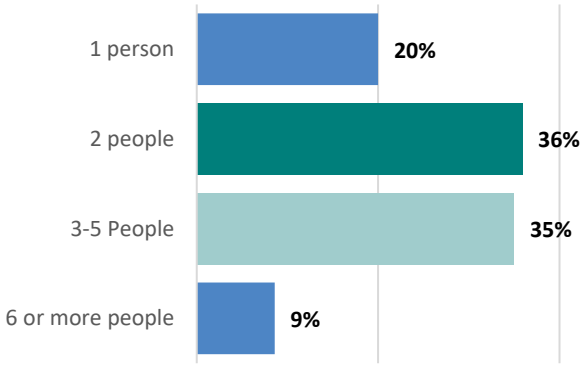
Own or Rent	N	%
Own	332	83.6%
Rent	46	11.7%
Other arrangement	19	4.7%
Total	**397**	**100.0%**

Have Children	N	%
Yes	139	34.6%
No	259	64.7%
Total	**400**	**100.0%**

Children in Household



Number of People in Household



Number of People in Household	N	%
1 person	78	19.6%
2 people	144	36.4%
3-5 people	139	35.2%
6 or more people	35	8.8%
Total	**395**	**100.0%**

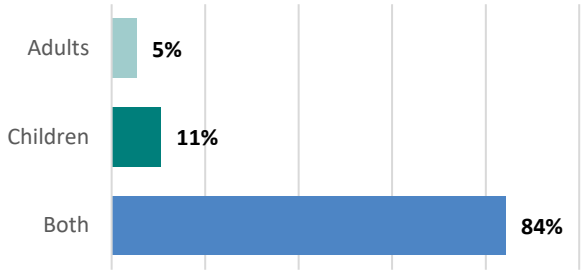
City/Township	N	%
Belmore	2	0.4%
Blanchard Township	7	1.6%
Cloverdale	10	2.5%
Columbus Grove	34	8.4%
Continental	16	4.1%
Dupont	1	0.3%
Fort Jennings	16	4.1%
Glandorf	7	1.7%
Greensburg Township	12	3.1%
Jackson Township	17	4.2%
Jennings Township	12	3.0%
Kalida	10	2.4%
Leipsic	20	4.9%
Liberty Township	16	4.1%
Miller City	6	1.4%
Monroe Township	16	3.9%
Monterey Township	12	3.0%
Ottawa Township	13	3.4%
Ottawa	89	22.2%
Palmer Township	9	2.2%
Pandora	16	4.1%
Perry Township	7	1.8%
Pleasant Township	11	2.8%
Riley Township	6	1.5%
Sugar Creek Township	11	2.8%
Union Township	8	1.9%
Van Buren Township	5	1.3%
Other	2	0.4%
Total	**400**	**100.0%**

School District	N	%
Columbus Grove	54	13.4%
Continental	47	11.9%
Fort Jennings	25	6.1%
Kalida	31	7.7%
Leipsic	32	7.9%
Miller City	26	6.5%
Ottawa Glandorf	113	28.3%
Ottoville	32	7.9%
Pandora Gilboa	31	7.8%
Other	4	1.0%
Total	**400**	**100.0%**

Zip Code	N	%
45075	1	0.3%
45815	2	0.5%
45827	33	8.3%
45830	57	14.3%
45831	40	10.1%
45833	7	1.8%
45837	1	0.3%
45844	39	9.8%
45848	2	0.5%
45853	7	1.8%
45856	41	10.3%
45864	2	0.5%
45875	138	34.7%
45876	4	1.0%
45877	23	5.8%
45893	1	0.3%
Total	**398**	**100.0%**

COMMUNITY LEADER SURVEY

Population Served by Organization



Population Served by Organization	N	%
Adults	1	5.3%
Children	2	10.5%
Both	16	84.2%
Total	**19**	**100.0%**

Sectors Org. Associates With	N	%
Nonprofit	7	36.8%
Government	5	26.3%
Health care	3	15.8%
Education	2	10.5%
Business/private sector	1	5.3%
Religious	1	5.3%
Total	**19**	**100.0%**

Primary Service Area	N	%
Putnam County	13	68.4%
Multi-county including Putnam County	3	15.8%
Ottawa	2	10.5%
Regionally/globally	1	5.3%
Total	**19**	**100.0%**

Putnam County Health Department

Health Equity Report

September 2022

Table of Contents

Putnam County General Health District

256 Williamstown Road, Ottawa, Ohio 45875

Phone: 419-523-5608 Fax: 419-523-4171

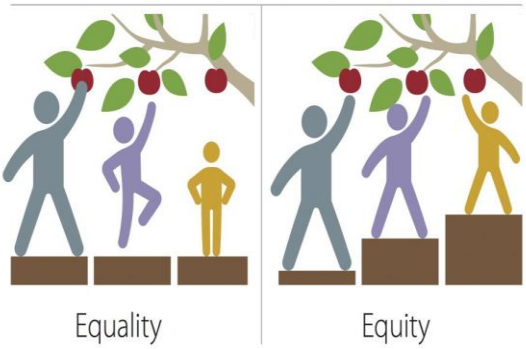
Prevent ● Promote ● Protect

Background & Methodology

Putnam County has a total population of 34,467 people. Using data from the American Community Survey and FBI Crime Data, Putnam County was ranked as the fifth best county to live in Ohio for 2022.

Health Equity vs. Health Equality

Health equality ensures that everyone regardless of race, sex, disability status, income status, etc., receives equal treatment and opportunities in healthcare. Health equity is a step further, a more involved process, that aims to help groups in society that need more support and resources to reach their full healthcare potential.



Why Health Equity is Important

It is important to recognize issues within a community that compromise health equality in order to ensure fair and inclusive opportunities for all. When health inequities are noted, it allows county health departments to better understanding surrounding communities. It also gives a chance to change or add to existing programs that better suit community needs. Additionally, discovering inequities can lead to future proposals and programs that will aim to eliminate disparities all populations of people to receive equal opportunities.

This report contains data and information from 2016-2020, unless otherwise noted. The following topics of relevance to health equity in Putnam County, Ohio are included:

Population Characteristics

Income Characteristics

Poverty Rates

Educational Attainment

Housing Characteristics

Grandparents Living with Grandchildren

Employment Rates

Health Insurance

Food Assistance Programs

Mortality

Leading Causes of Death

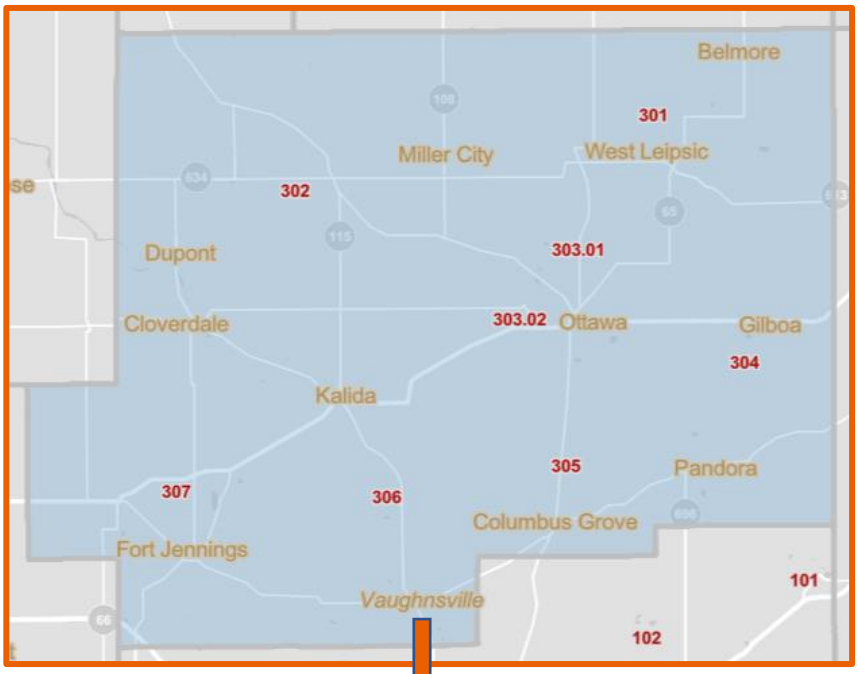
Cancer Incidence

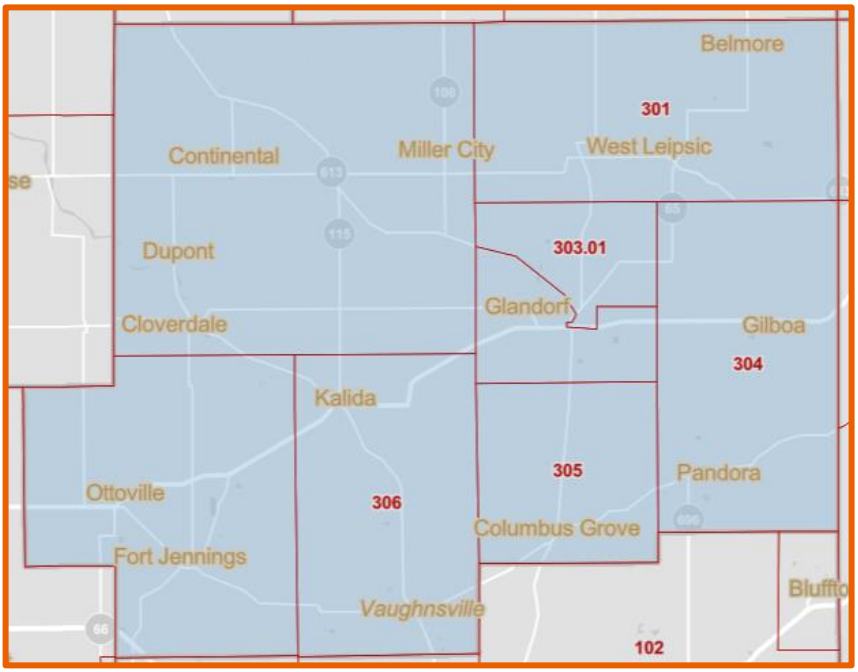
Demographics

Census Tract Number	Census Tract Name/Area	Population Size
301	Belmore & Leipsic	4,496
302	Miller City, Continental, Dupont, Cloverdale	5,619
303.01	Ottawa & Glandorf	3,608
303.02	Ottawa & Glandorf	4,442
304	Gilboa & Pandora	3,466
305	Columbus Grove	3,794
306	Kalida & Vaughnsville	4,126
307	Ottoville & Fort Jennings	4,916

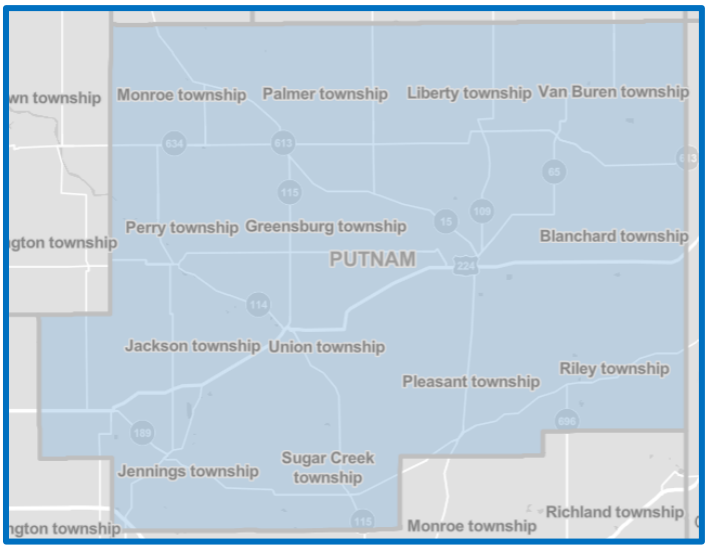
Table. This table shows each census tract number used in this report, along with the respective census tract name and total population.

Source. Table P1, 2020 Decennial Census. United States Census Bureau.





Township Breakdown



Source. Putnam County Ohio, Quick Facts. Census Bureau Maps. United States Census Bureau.

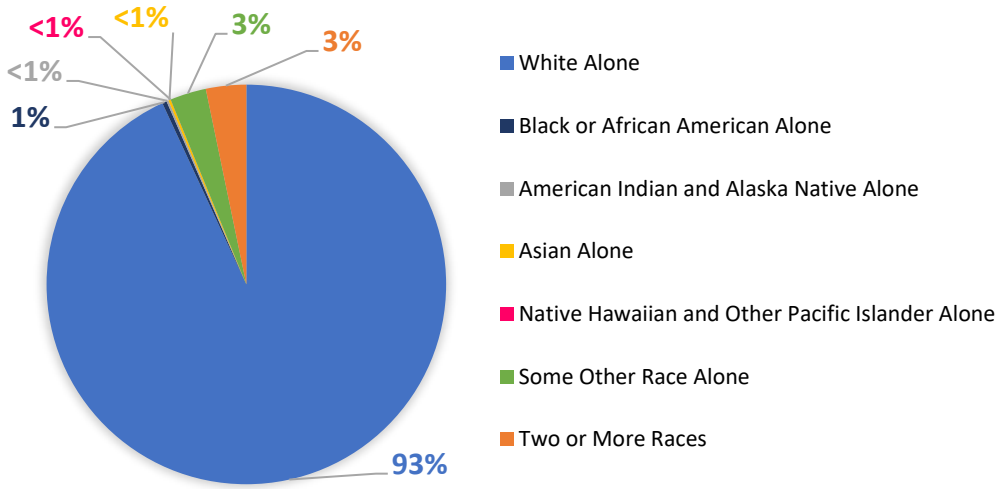
Population

Population of One Race Alone by Census Tract, 2016-2020

	301	302	303.01	303.02	304	305	306	307	Putnam County
White Alone	3,669	5,374	3,202	4,129	3,298	3,583	4,007	4,815	32,007
Black or African American Alone	28	16	29	25	9	6	5	7	125
American Indian and Alaska Native Alone	30	4	6	5	5	2	2	2	56
Asian Alone	8	7	14	17	1	3	8	6	64
Native Hawaiian and Other Pacific Islander Alone	0	0	0	0	0	1	0	2	3
Some Other Race Alone	451	51	180	124	65	84	38	13	1,006
Two or More Races	310	167	161	142	88	115	66	71	1,120

Source. Table P1, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Putnam County Racial and Ethnic Breakdown



Hispanic Population by Census Tract, 2016-2020

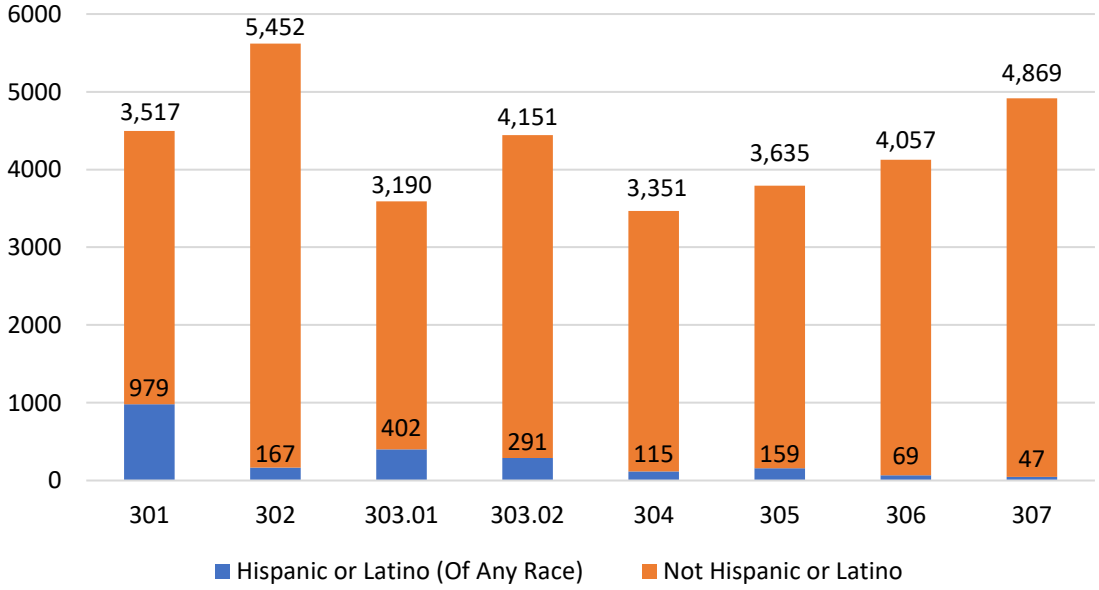
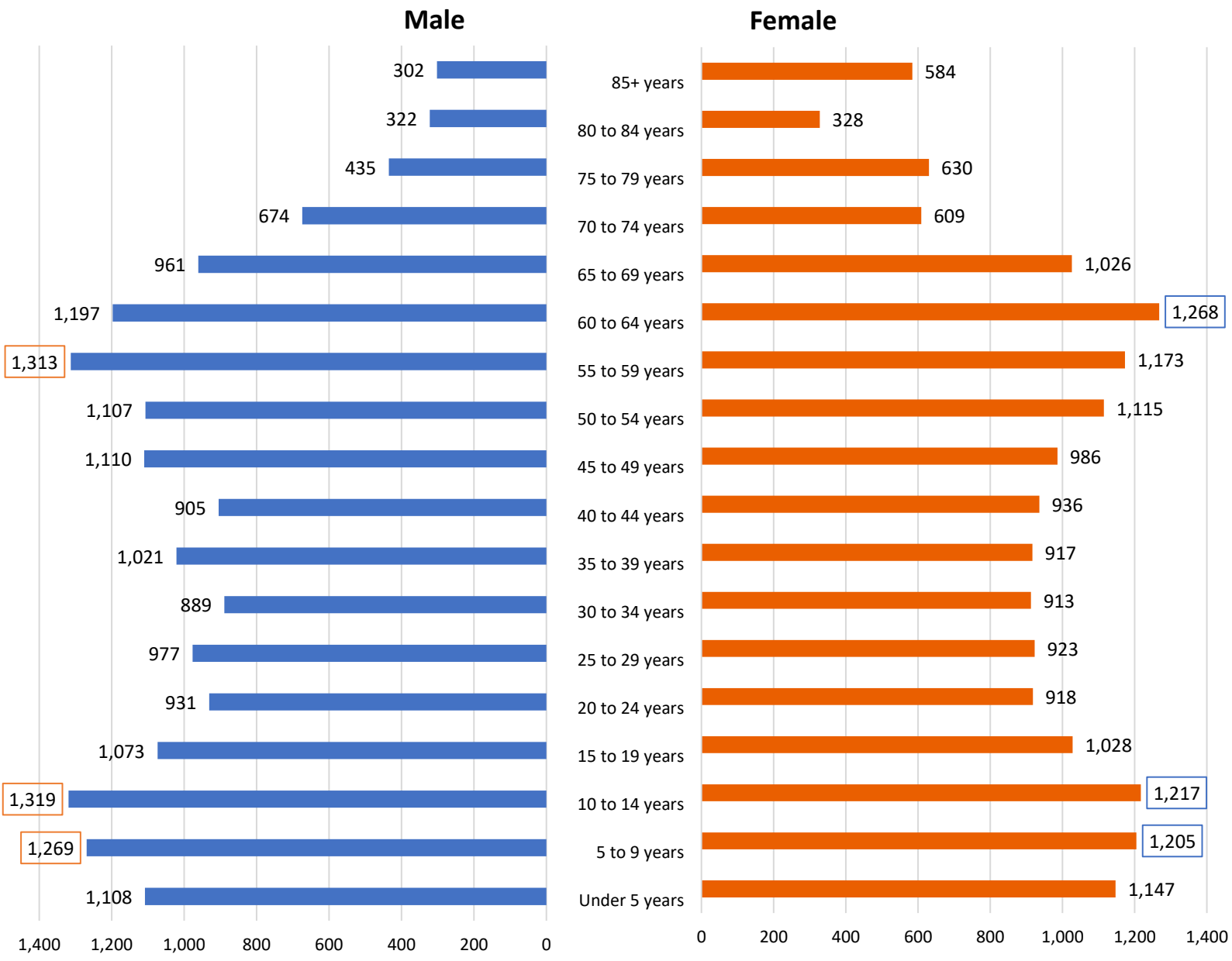


Figure. Census tract 301 has the highest Hispanic population in Putnam County at 979 residents. Census tract 307 has the second highest population size, but the lowest Hispanic population.

Source. Table P2, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Putnam County Total Population by Age and Sex



Source. Table S0101, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Employment

Employment Rate by Census Tract, 2016-2020

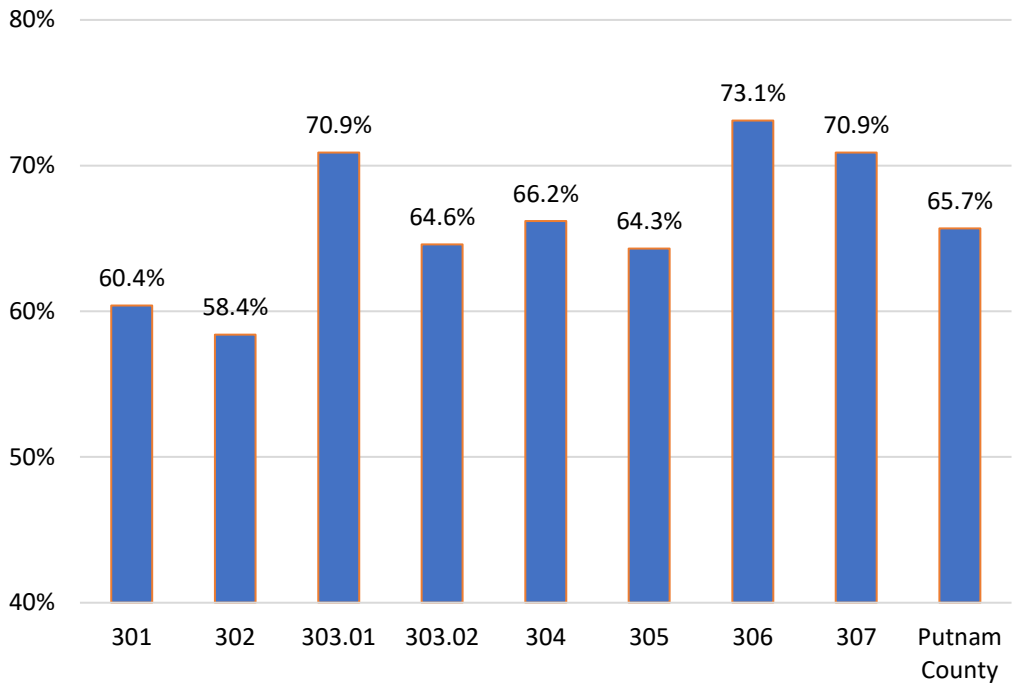


Figure. Census tract 302 has the lowest employment rate in Putnam County at 58.4%. Census tract 306 has the highest rate at 73.1%. This employment rate is based on the total population of 16 years and over.

Source. Table DP03, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Census Tract Number	Census Tract Name/Area	Population Size
301	Belmore & Leipsic	4,496
302	Miller City, Continental, Dupont, Cloverdale	5,619
303.01	Ottawa & Glandorf	3,608
303.02	Ottawa & Glandorf	4,442
304	Gilboa & Pandora	3,466
305	Columbus Grove	3,794
306	Kalida & Vaughnsville	4,126
307	Ottoville & Fort Jennings	4,916

Employment Status of Civilians in the Labor Force 16 Years and Over, 2016-2020

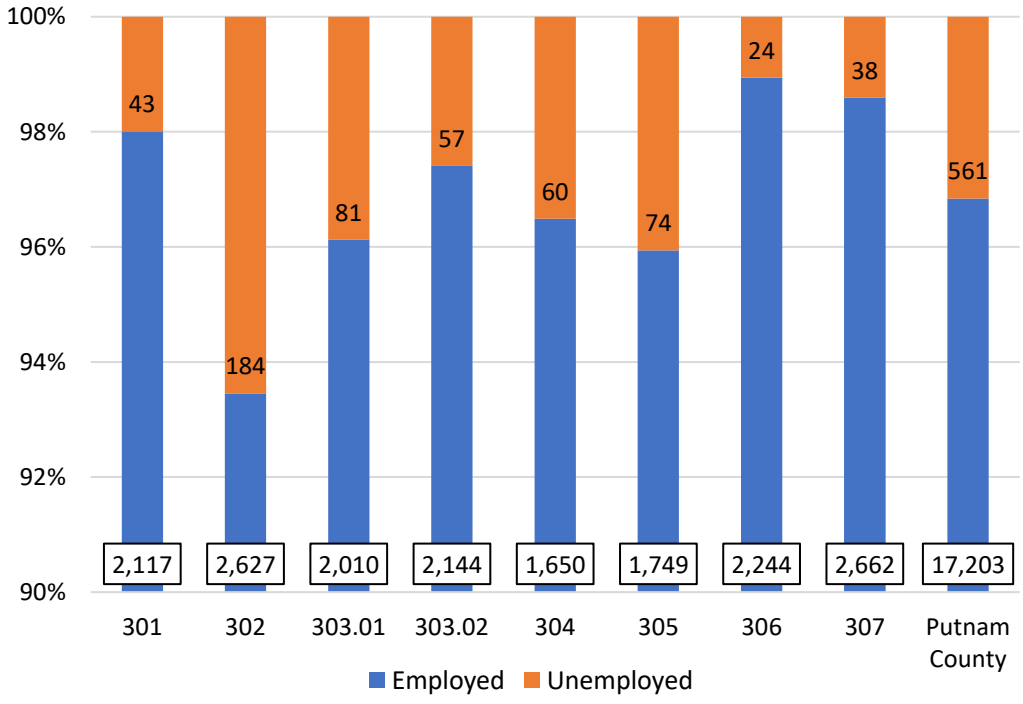
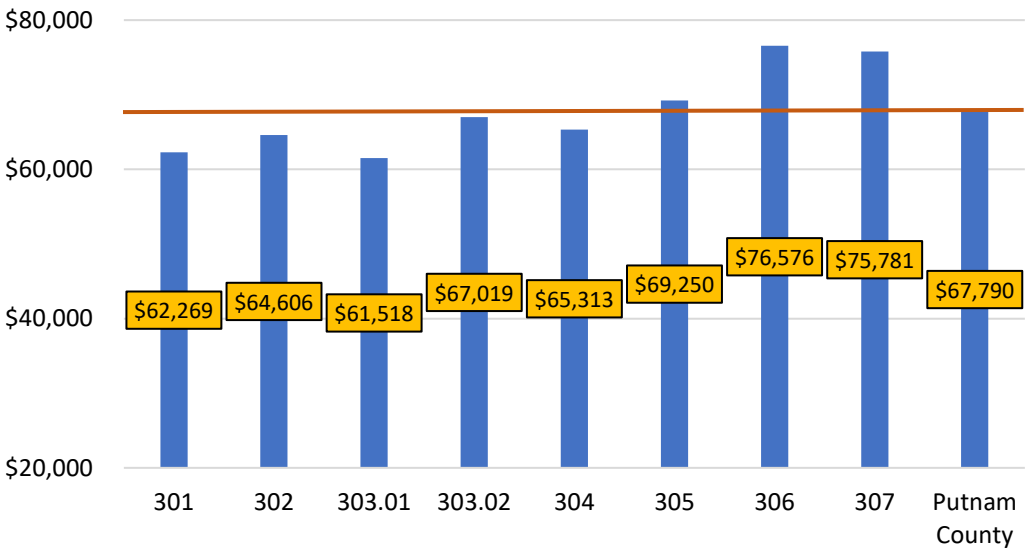


Figure. Overall, there are 561 unemployed individuals in Putnam County who are 16 years and over in the labor force. Census tracts 306 and 307 have the lowest number of unemployed individuals, while having the 1st and 3rd highest population sizes in Putnam County.

Source. Table S1701, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Income

Median Household Income by Census Tract, 2016-2020



Median Household Income

$67,790

Figure. Census tract 303.01 has the lowest median household income at $61,518. This is over $6,000 less than Putnam County as a whole. Census tract 306 has the highest median household income at $76,576.

Source. Table S1901, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Median Family Income by Census Tract, 2016-2020

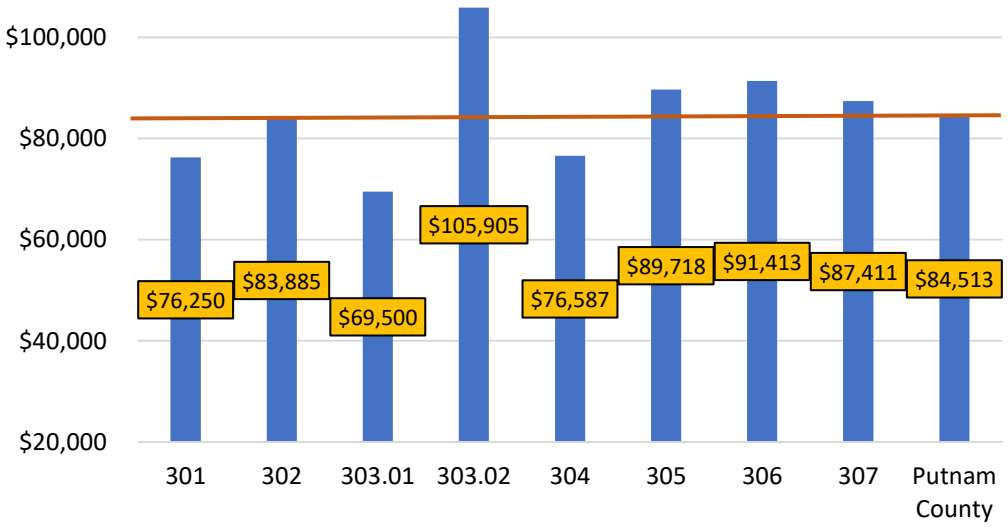


Figure. Census tract 303.01 has the lowest median family income in Putnam County at $69,500. 303.02 has the highest median family income at $105,905, which is roughly $21,000 above the Putnam County median.

Source. Table S1901, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Median Income of Non-Family Households, 2016-2020

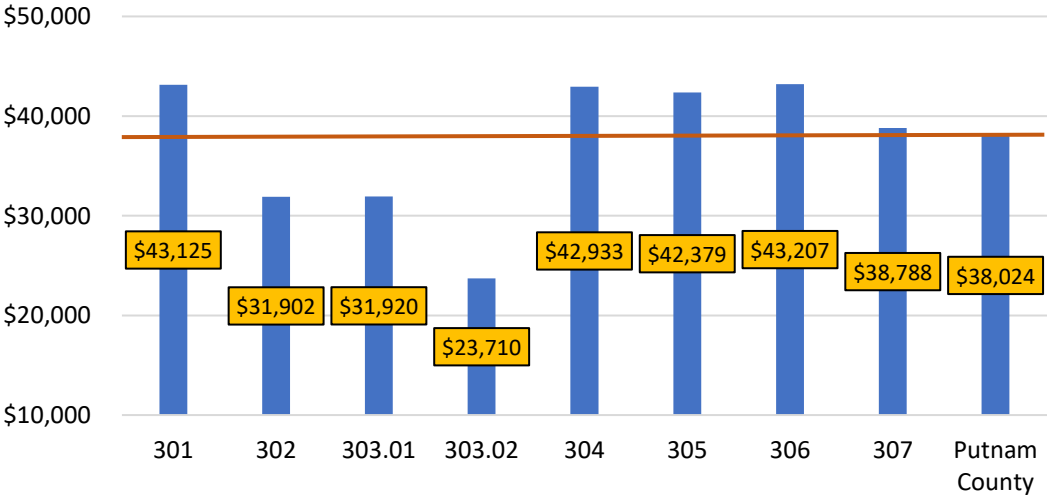


Figure. Census tract 303.02 has the lowest median income of non-family households at $23,710, despite having the highest median family income in Putnam County.

Source. Table S1901, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Educational Attainment

Bachelor's Degree or Higher by Census Tract, 2016-2020

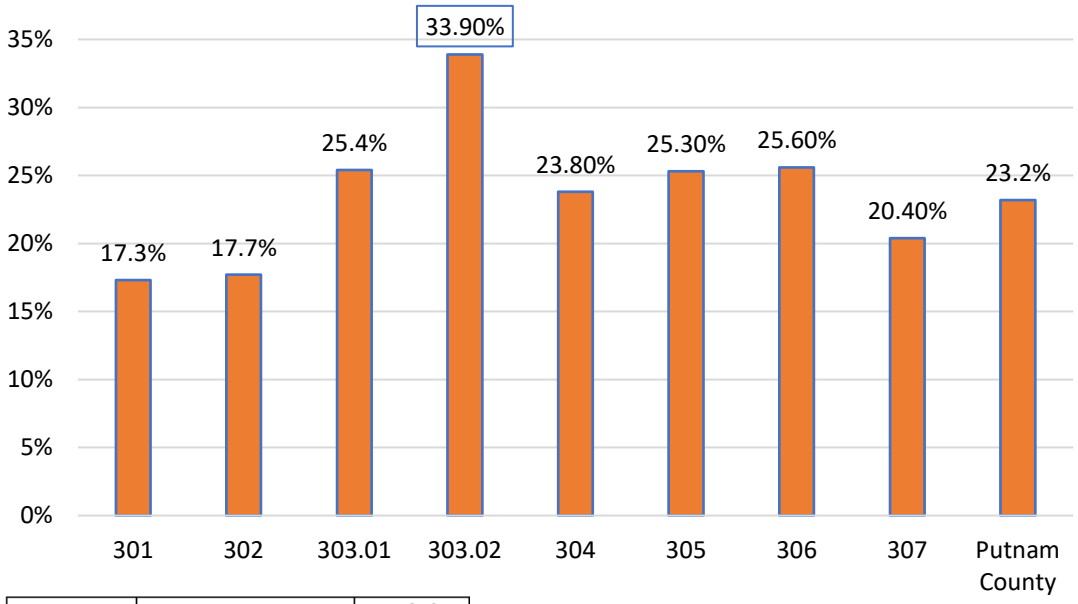


Figure. Census tract 303.02 has the highest percent population with a bachelor's degree or higher, while 301 and 302 have the lowest percent at 17.3% and 17.7% respectively.

Source. Table S1501, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Census Tract Number	Census Tract Name/Area	Population Size
301	Belmore & Leipsic	4,496
302	Miller City, Continental, Dupont, Cloverdale	5,619
303.01	Ottawa & Glandorf	3,608
303.02	Ottawa & Glandorf	4,442
304	Gilboa & Pandora	3,466
305	Columbus Grove	3,794
306	Kalida & Vaughnsville	4,126
307	Ottoville & Fort Jennings	4,916

Putnam County Educational Attainment, 2016-2020

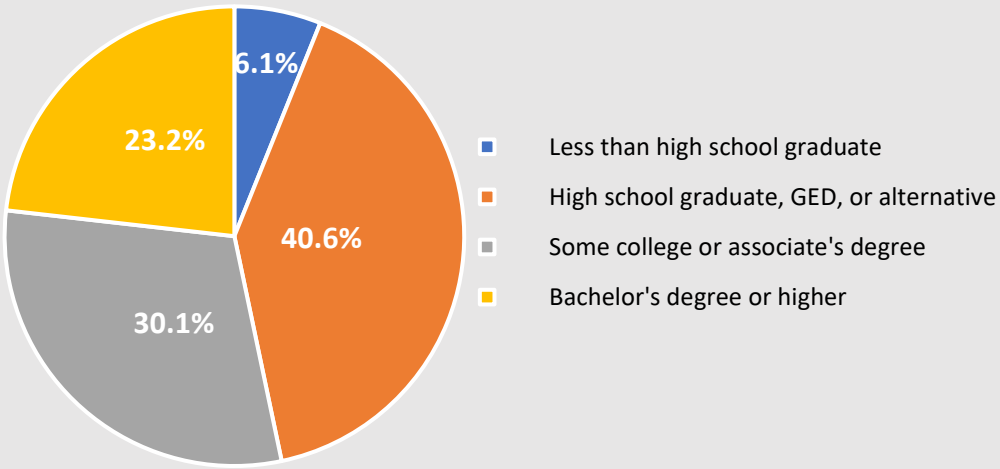


Figure. 6.1% of the Putnam County population has an education level less than a high school graduate. Over 40% of the population is a high school graduate or obtains a GED only. 30% of the population has some college education or an associate's degree, in addition to graduating high school. 23.2% of the population has a bachelor's degree or higher, in addition to graduating high school.

Source. Table S0102, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Housing

Percent of Occupied Housing Units Without an Available Vehicle, 2016-2020

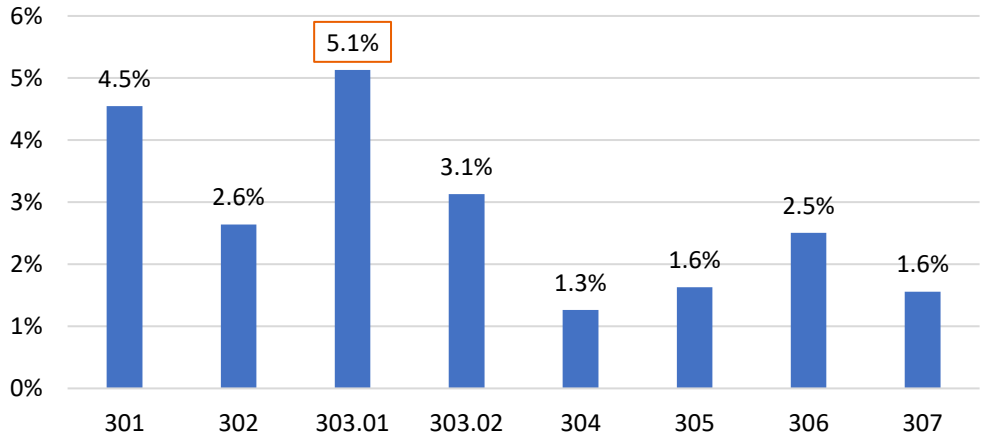


Figure. Census Tract 303.01 has the highest percent of housing units without a vehicle. Census tract 304 has the lowest percent of households without vehicles, meaning that more vehicles are available in 304 than 303.01.

Source. Table DP04, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Median Gross Rent by Census Tract, 2016-2020

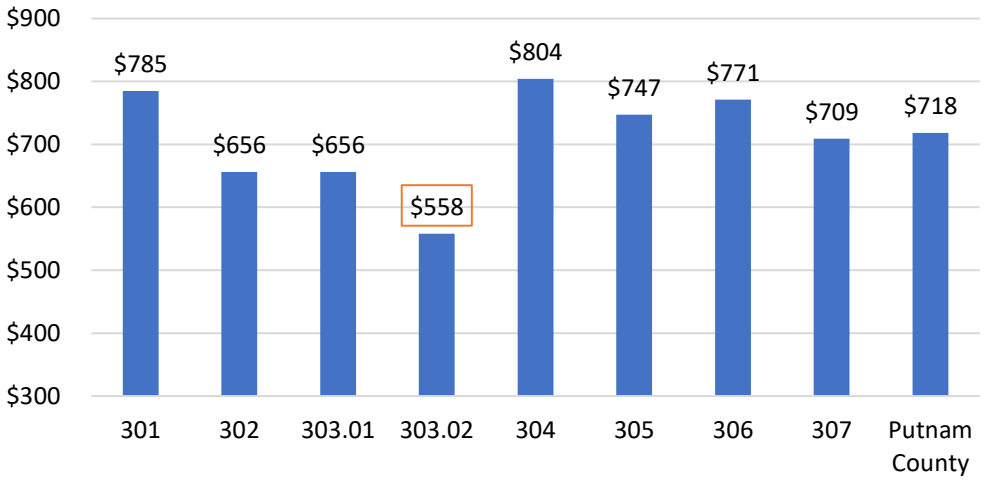


Figure. The median rent is lowest in census tract 303.02 at $558 per month. The median rent is highest in 304 at $804 per month.

Source. Table DP04, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Homeownership Rate by Census Tract, 2016-2020

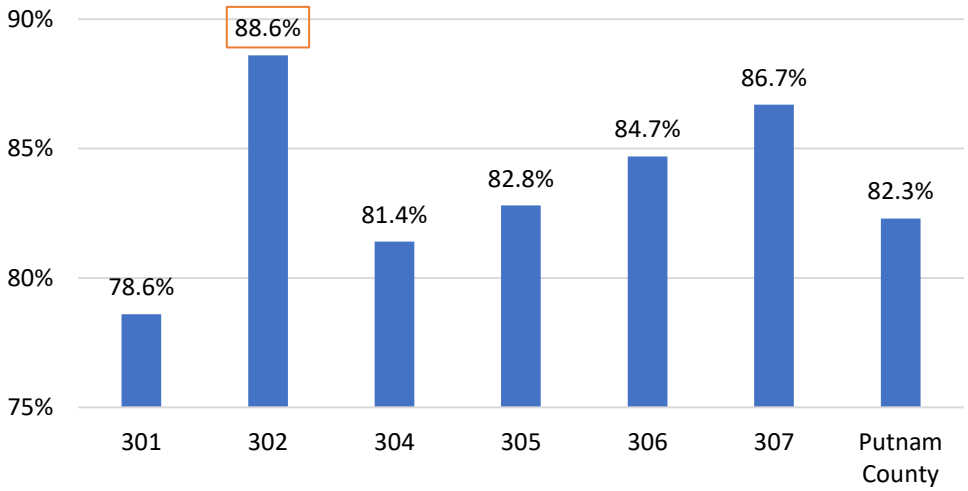
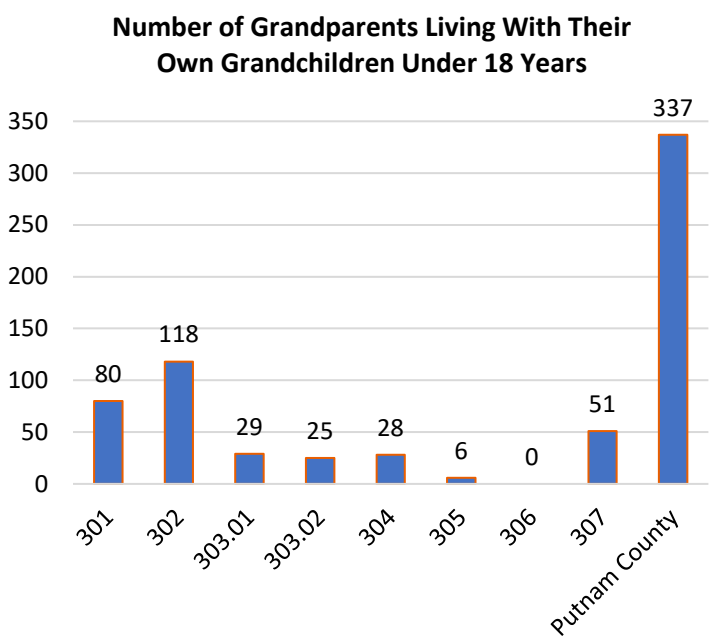


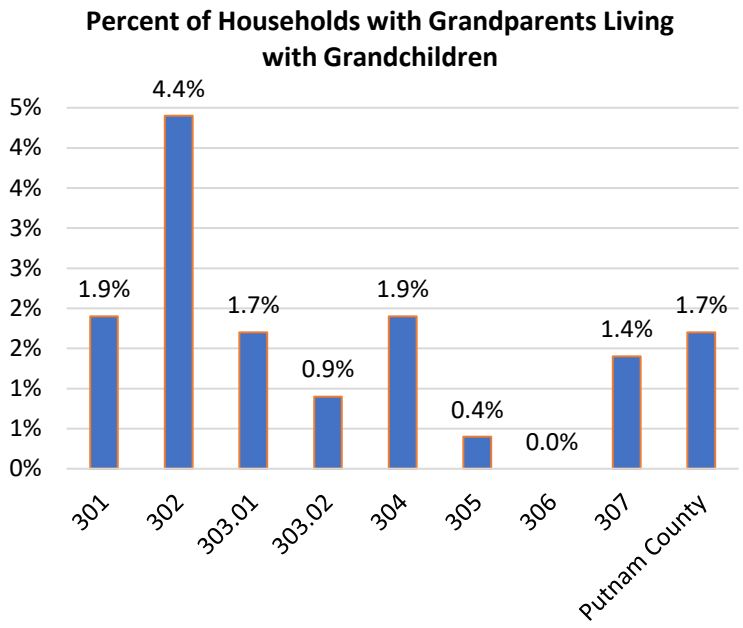
Figure. Census tract 302 has the highest percent of homeowners at 88.6%. Census tract 301 has the lowest percent of homeowners at 78.6%. Overall, Putnam County has a homeownership rate of 82.3%.

Source. Table DP04, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

*No data for Census Tract 303

Grandparents and Seniors





Figures. In Putnam County, 337 total grandparents live with grandchildren under 18. Census tract 302 has the highest percent of households with grandparents living with grandchildren.

Source. Table S1002, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

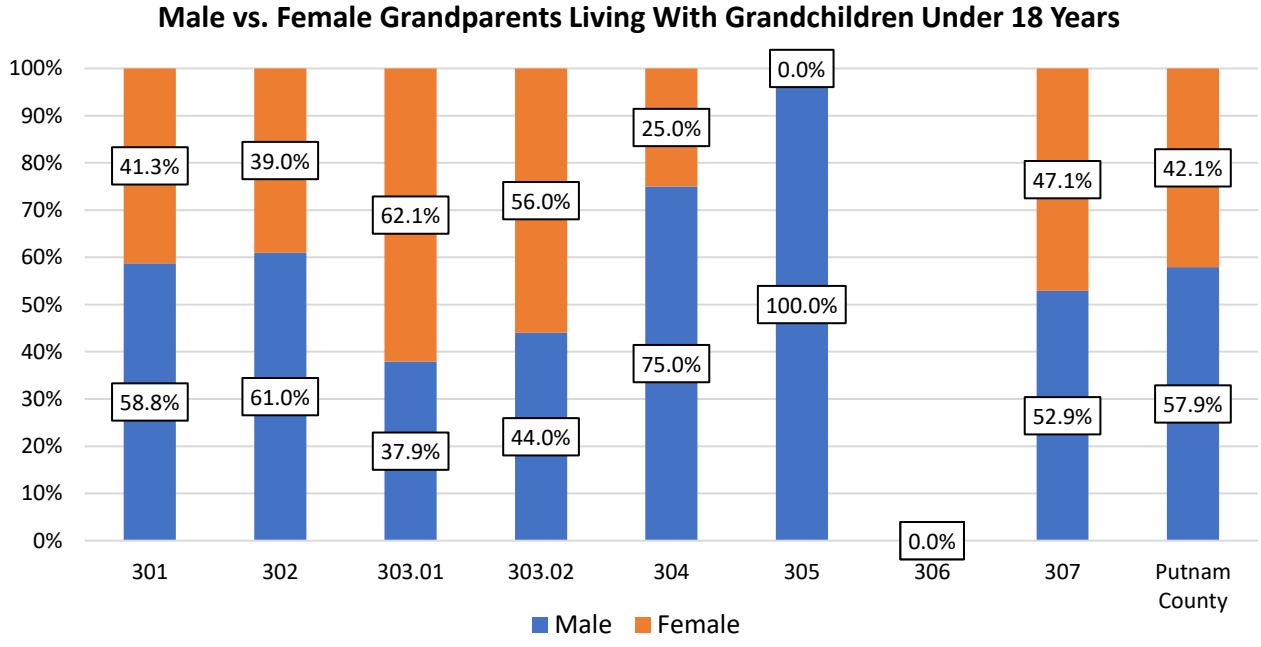


Figure. Overall, there are more male grandparents (57.9%) living with grandchildren under 18 than female grandparents (42.1%). There are no grandparents living with grandchildren in census tract 306.

Source. Table S1002, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Grandparents Responsible for Grandchildren by Age Range

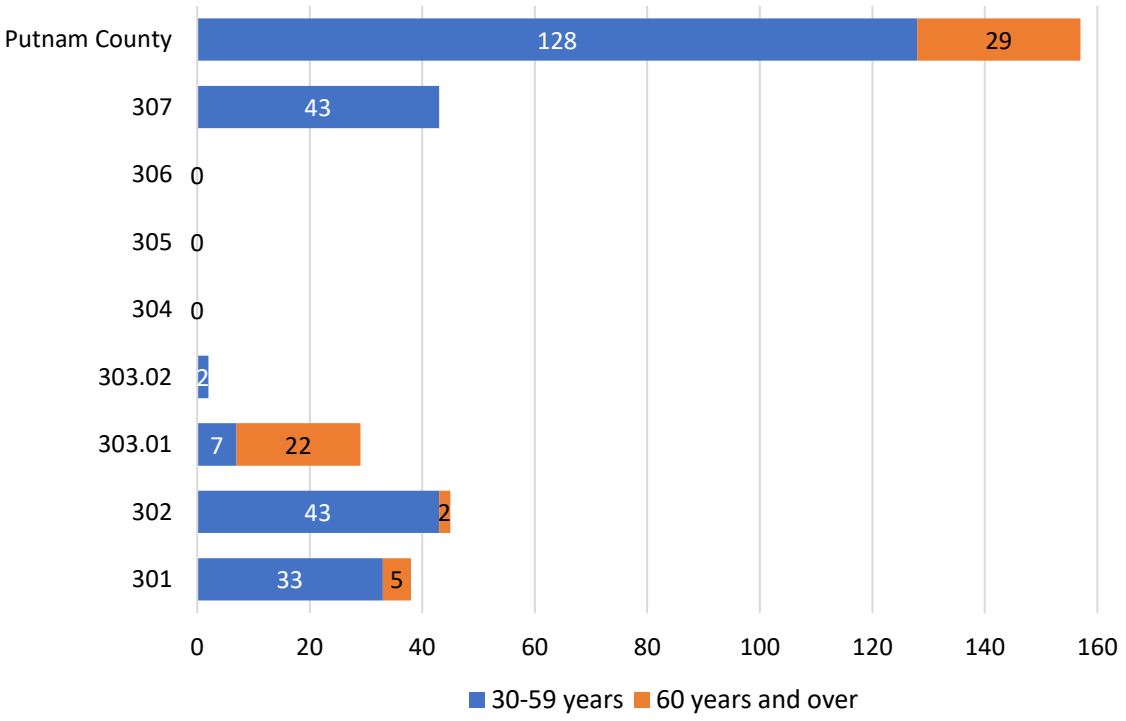


Figure. Census tracts 302 and 307 have the highest number of grandparents responsible for their grandchildren. Most grandparents responsible for grandchildren are between the ages of 30 and 59. In total, roughly 47% of grandparents living with their grandchildren are responsible for the grandchildren.

Source. Table S1002, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

33.9% of households with grandparents living with grandchildren in census tract 302 had an income below poverty level in the past 12 months.

Census Tract Number	Census Tract Name/Area	Population Size
301	Belmore & Leipsic	4,496
302	Miller City, Continental, Dupont, Cloverdale	5,619
303.01	Ottawa & Glandorf	3,608
303.02	Ottawa & Glandorf	4,442
304	Gilboa & Pandora	3,466
305	Columbus Grove	3,794
306	Kalida & Vaughnsville	4,126
307	Ottoville & Fort Jennings	4,916

Seniors Living in Putnam County

	301	302	303.01	303.02	304	305	306	307	Putnam County
65-69 years	241	414	228	213	175	217	273	226	1,987
70-74 years	257	202	121	177	68	181	139	138	1,283
75-79 years	135	110	183	198	111	105	69	154	1,065
80-84 years	177	104	15	72	92	42	47	101	650
85+ years	109	180	29	203	62	58	144	101	886
Total Seniors	919	1010	576	863	508	603	672	720	5,871

Source. Table S0101, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Poverty

Percent of People Living in Poverty in Putnam County, 2016-2020

301	302	303.01	303.02	304	305	306	307	Putnam County	Ohio
10.7%	13.0%	11.6%	6.2%	6.9%	6.7%	3.7%	1.8%	7.8%	13.6%

Source. Table S1701, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Percent of Children Living in Poverty, 2016-2020

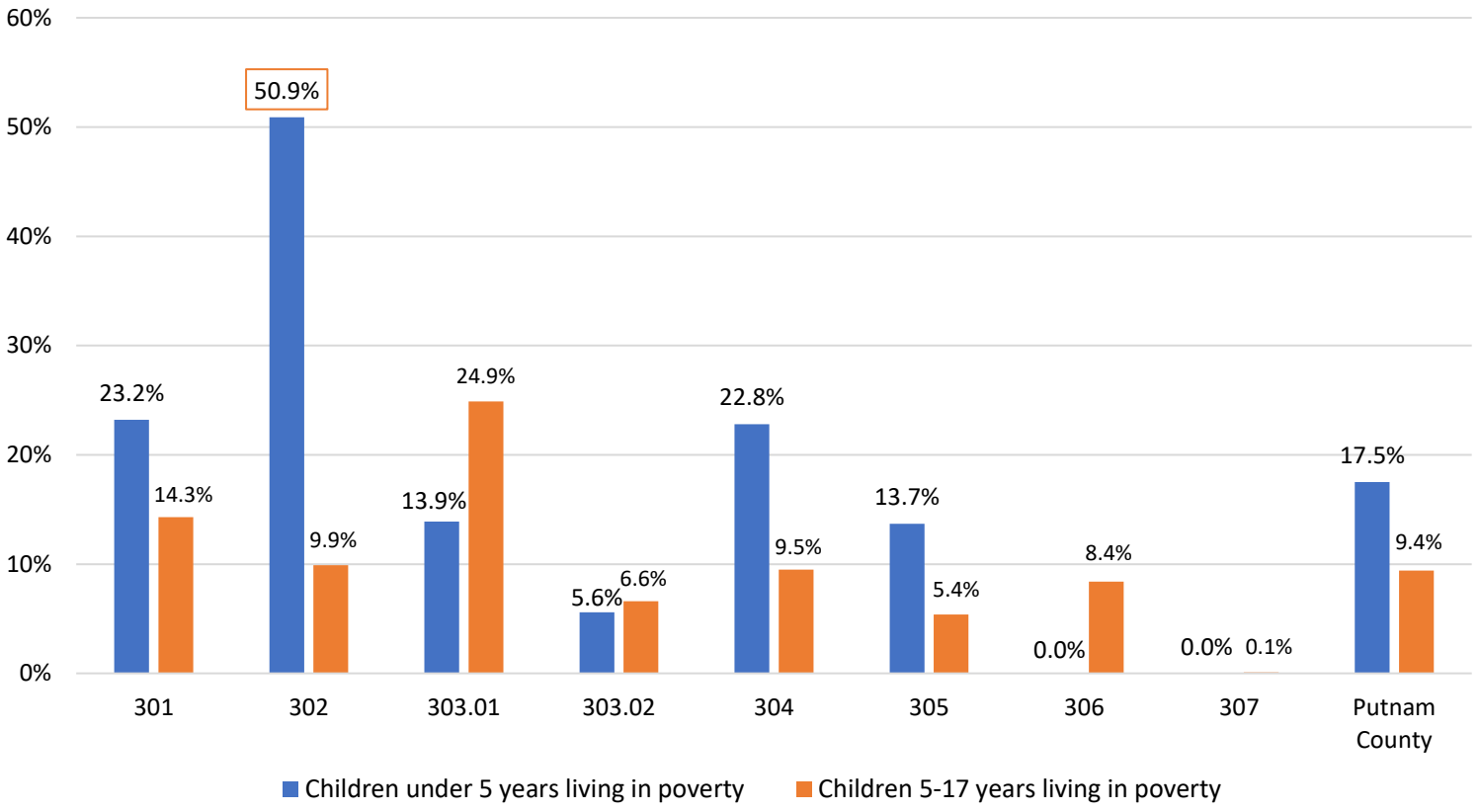


Figure. In census tract 302, 50.9% of children 5 years and younger are living in poverty. In 303.01, 24.9% of children between 5 and 17 years are living in poverty. Almost no children are living in poverty in 307.

Source. Table S1701, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

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301	Belmore & Leipsic	4,496
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Health

Disabled Population by Census Tract, 2016-2020

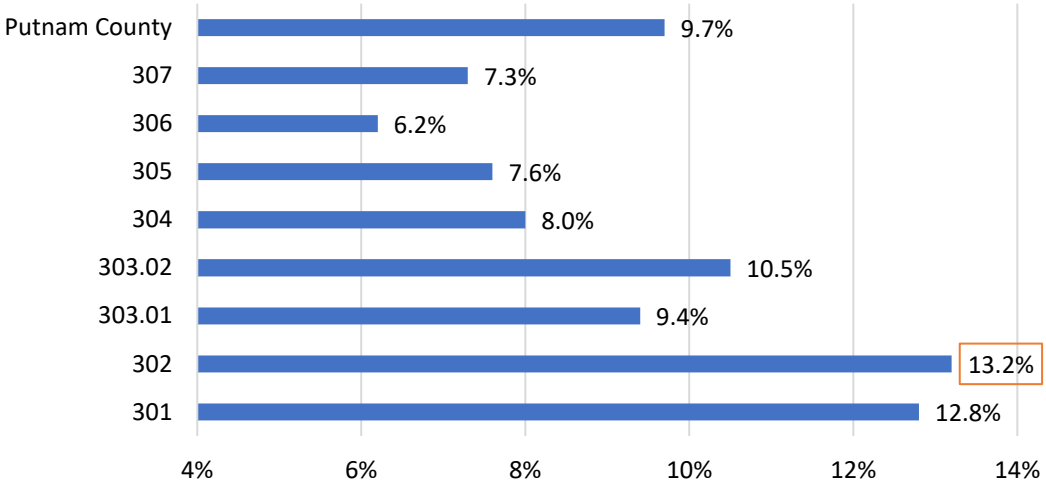


Figure. In Putnam County as a whole, 9.7% of the population is disabled. Census tract 302, has the highest disabled population at 13.2%. Census tract 306 has the lowest disabled population at 6.2%.

Source. Table S2701, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

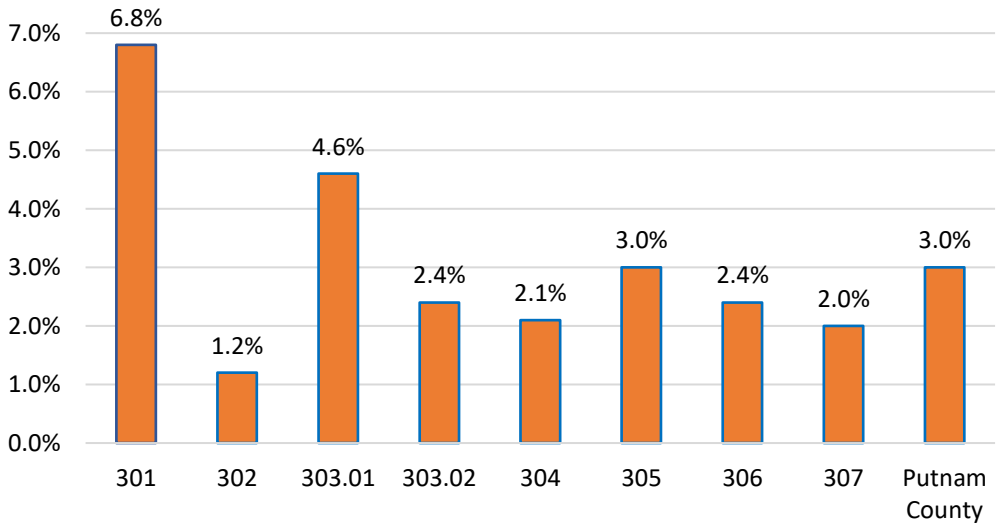
Census Tract Name/Area	Disability % Ranking	No Healthcare Coverage %
(301) Belmore & Leipsic	#2	#1
(302) Miller City, Continental, Dupont, Cloverdale	#1	#8
(**303.01)** Ottawa & Glandorf	#4	#2
(303.02) Ottawa & Glandorf	#3	#4/5
(304) Gilboa & Pandora	#5	#6
(305) Columbus Grove	#6	#3
(306) Kalida & Vaughnsville	#8	#4/5
(307) Ottoville & Fort Jennings	#7	#7

*#1=higher, #8=lowest

Percent of the Population without Healthcare Coverage, 2016-2020

Figure. In Putnam County as a whole, 3% of the population does not have healthcare coverage. In census tract 302, only 1.2% of the population is without healthcare coverage, while 301 has almost 7% of the population without healthcare coverage.

Source. Table S2701, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.



Food Assistance Programs

Percent of Households Receiving Food Stamps by Income

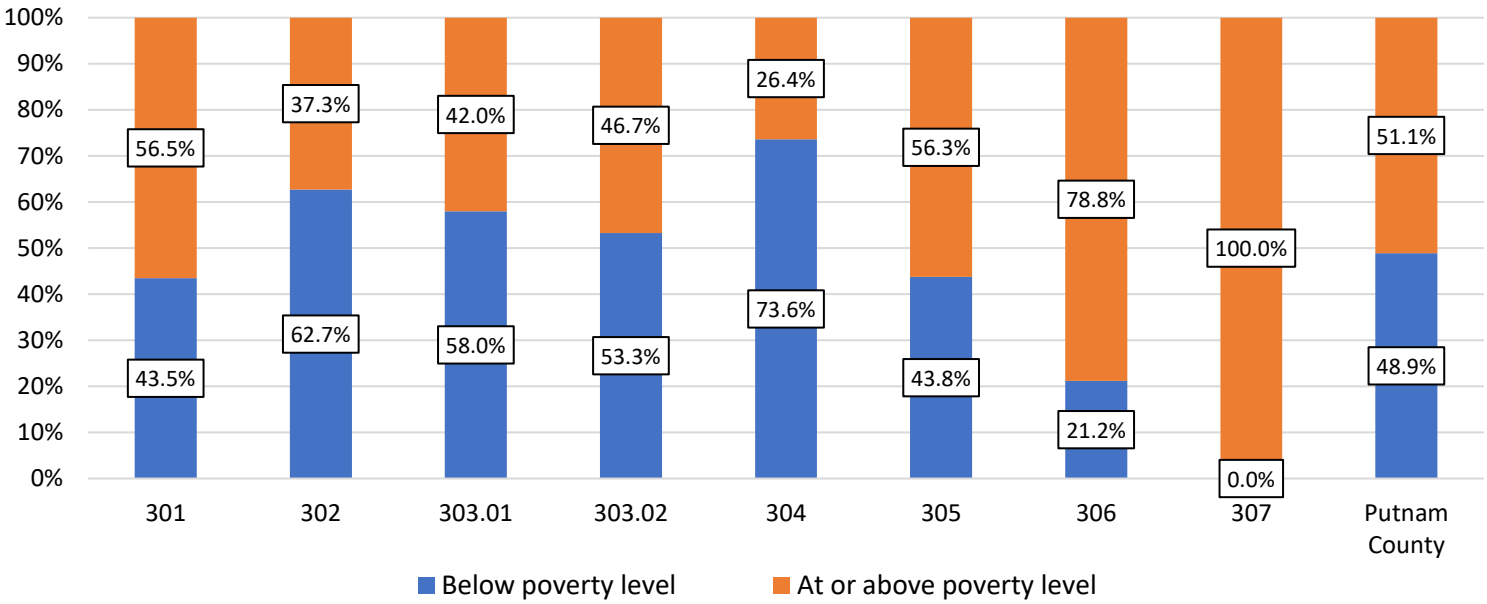
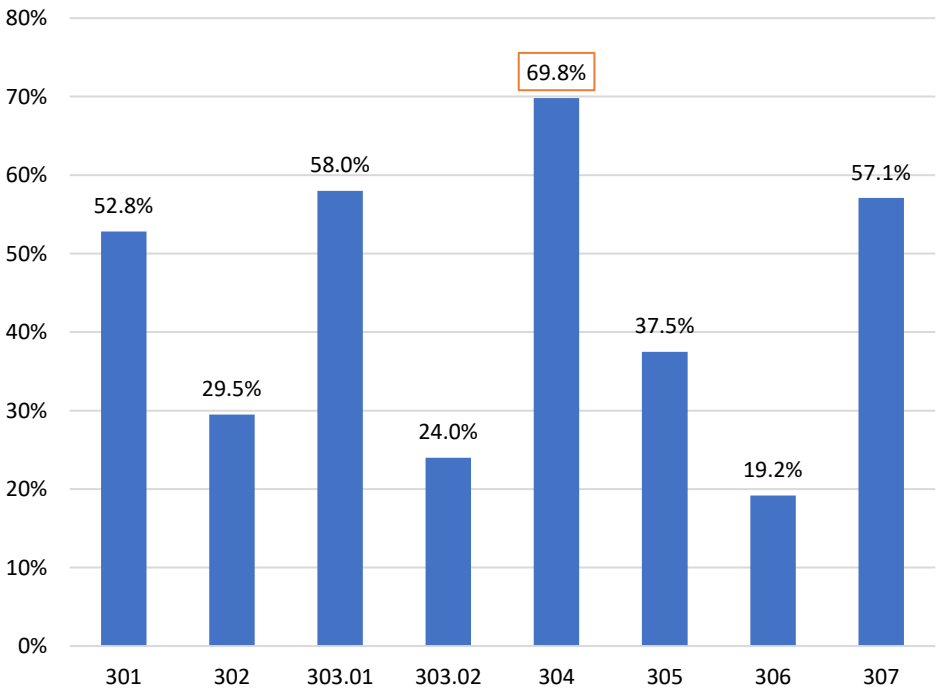


Figure. In Putnam County, 51.1% of households receiving food stamps had an income at or above poverty level. In census tract 304, 73.6% of households receiving food stamps had an income below poverty level.

Source. Table S2201, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Percent of Total Households Receiving Food Stamps with Children Under 18



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307	Ottoville & Fort Jennings	4,916

Figure. In Putnam County, 908 households, out of 13,301, receive food stamps. 408 of the 908 households (44.9%) have children under 18 years. In census tract 304, 69.8% of households receiving food stamps have children under 18.

Source. Table S2201, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Mortality

Putnam County Number of Resident Deaths, 2016-2020

Year	Male	Female	Total
2016	161	146	307
2017	164	170	334
2018	170	151	321
2019	151	174	325
2020	207	205	412

Source. Ohio Public Health Information Warehouse-Public. 2016-2020 Mortality Data.

Top 5 Leading Causes of Death, 2016-2020

1. Diseases of the Heart: 389
2. Malignant Neoplasms: 310
3. Not a Leading Cause: 269
4. Chronic Lower Respiratory Diseases: 104
5. COVID-19: 81

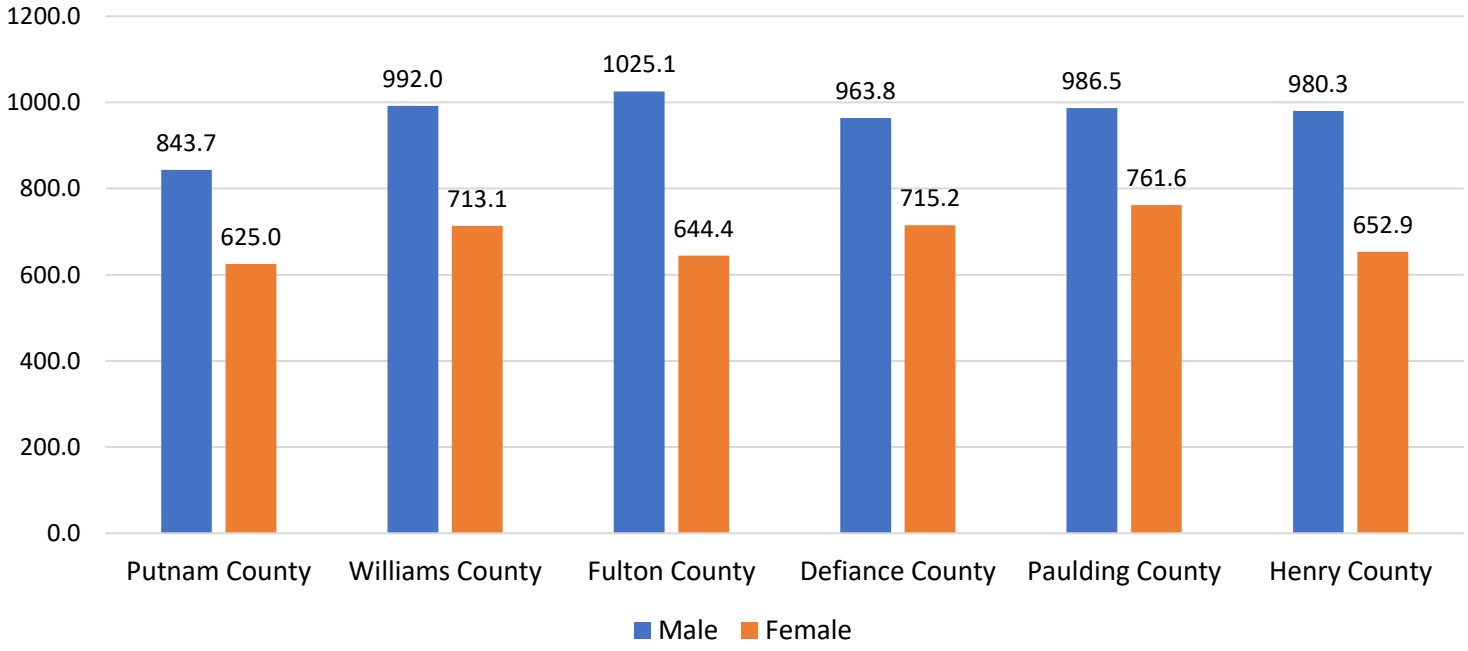
1,699 Total Deaths in Putnam County from 2016-2020

Putnam County Age-Adjusted Death Rate per 100,000, 2016-2020

Sex	2016	2017	2018	2019	2020
Male	816.9	816.5	840.3	718.6	1,022.9
Female	558.9	622.7	562.4	617.5	759.2
Overall	680.9	723.9	691.2	666.3	884.3

Source. Ohio Public Health Information Warehouse-Public. 2016-2020 Mortality Data.

Age-Adjusted Death Rates Comparison, 2016-2020



Source. Ohio Public Health Information Warehouse-Public. 2016-2020 Mortality Data.

Number of Deaths by Sex and Town/Zip-Code, 2016-2020

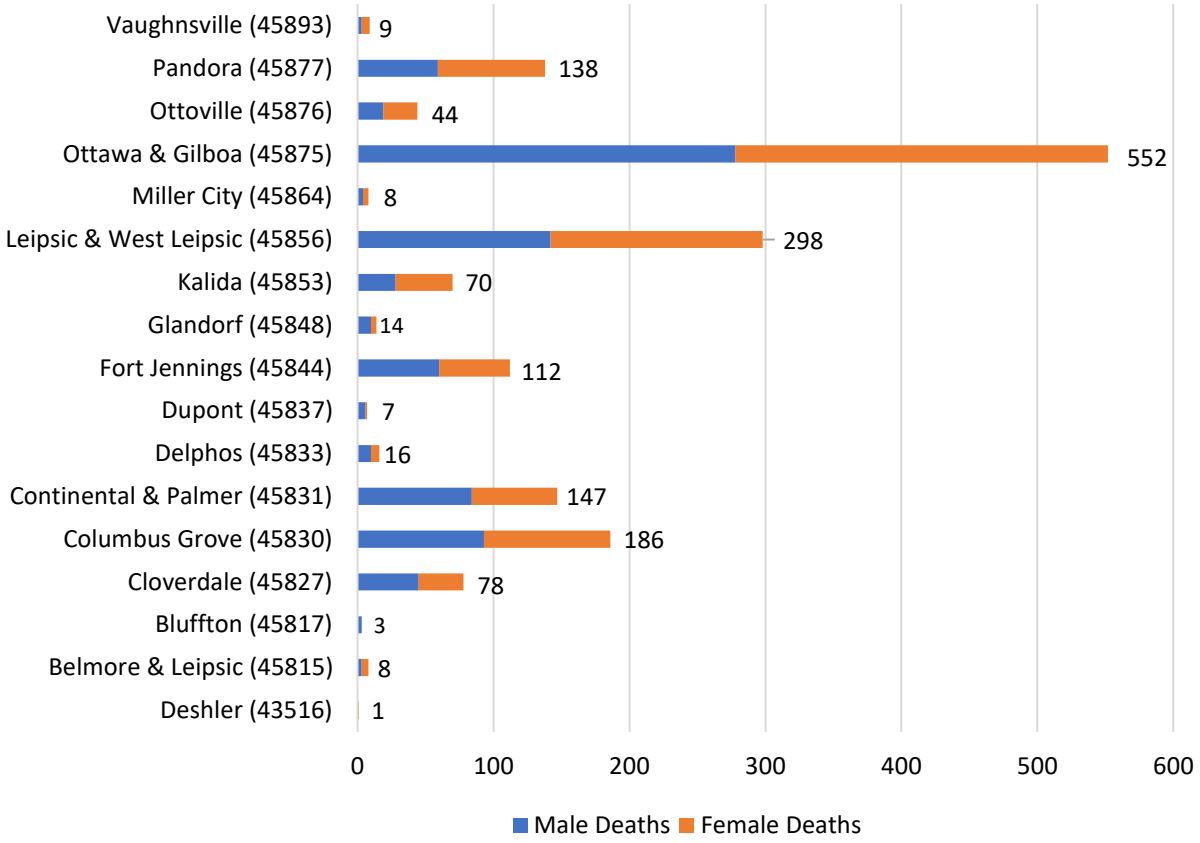


Figure. Ottawa and Gilboa had the highest number of deaths from 2016-2020, followed by Leipsic and West Leipsic at 298 deaths. In total, there were 1,699 deaths in Putnam County from 2016-2020.

Source. Ohio Public Health Information Warehouse-Secure. 2016-2020 Mortality Data. Ohio Department of Health.

Average Age of Death by Town/Zip-Code, 2016-2020

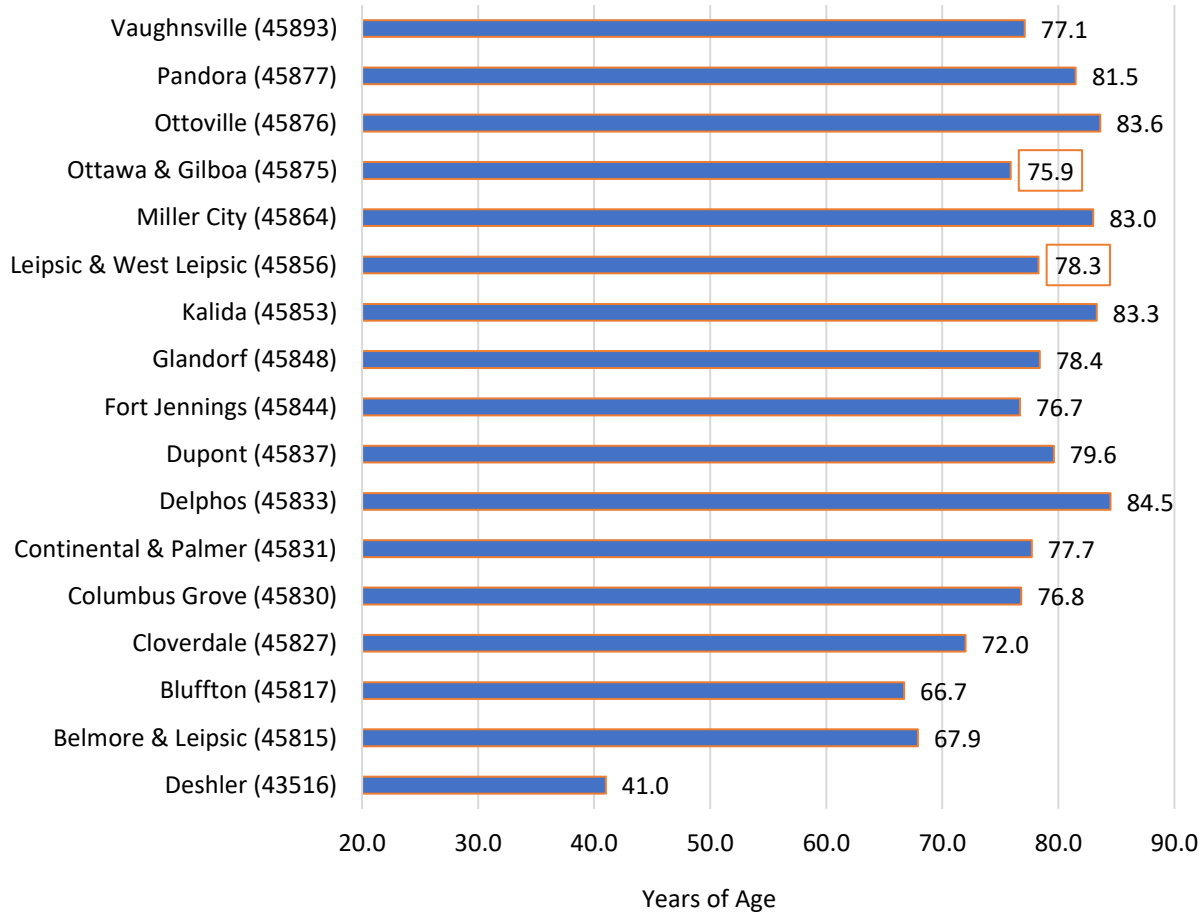


Figure. In Deshler, the average age of death was 41 years, however there was only one death from 2016-2020. Overall, towns with the highest number of deaths in total, have a slightly lower average age of death.

Source. Ohio Public Health Information Warehouse-Secure. 2016-2020 Mortality Data. Ohio Department of Health.

Cancer Incidence

Putnam County Cancer Diagnoses by Sex, 2016-2020

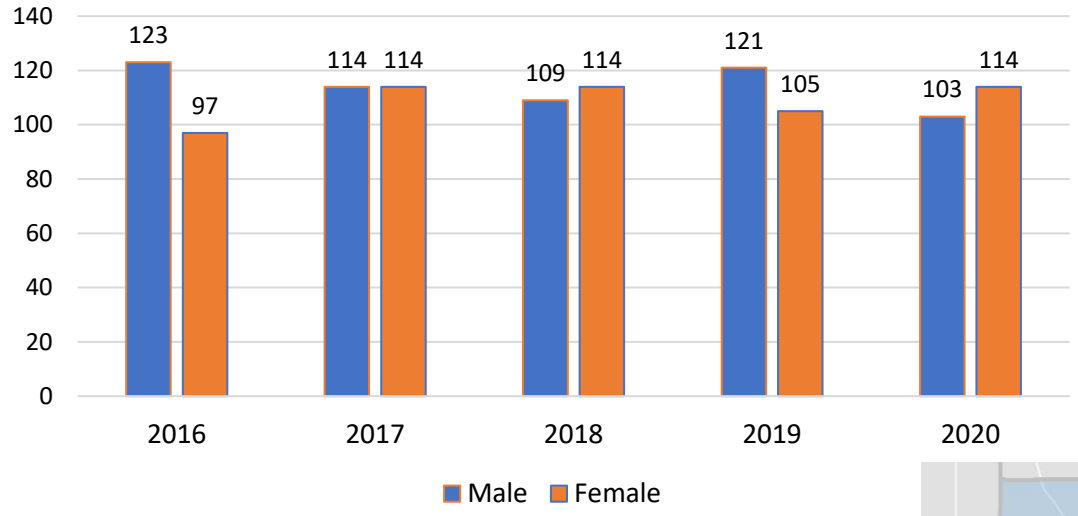
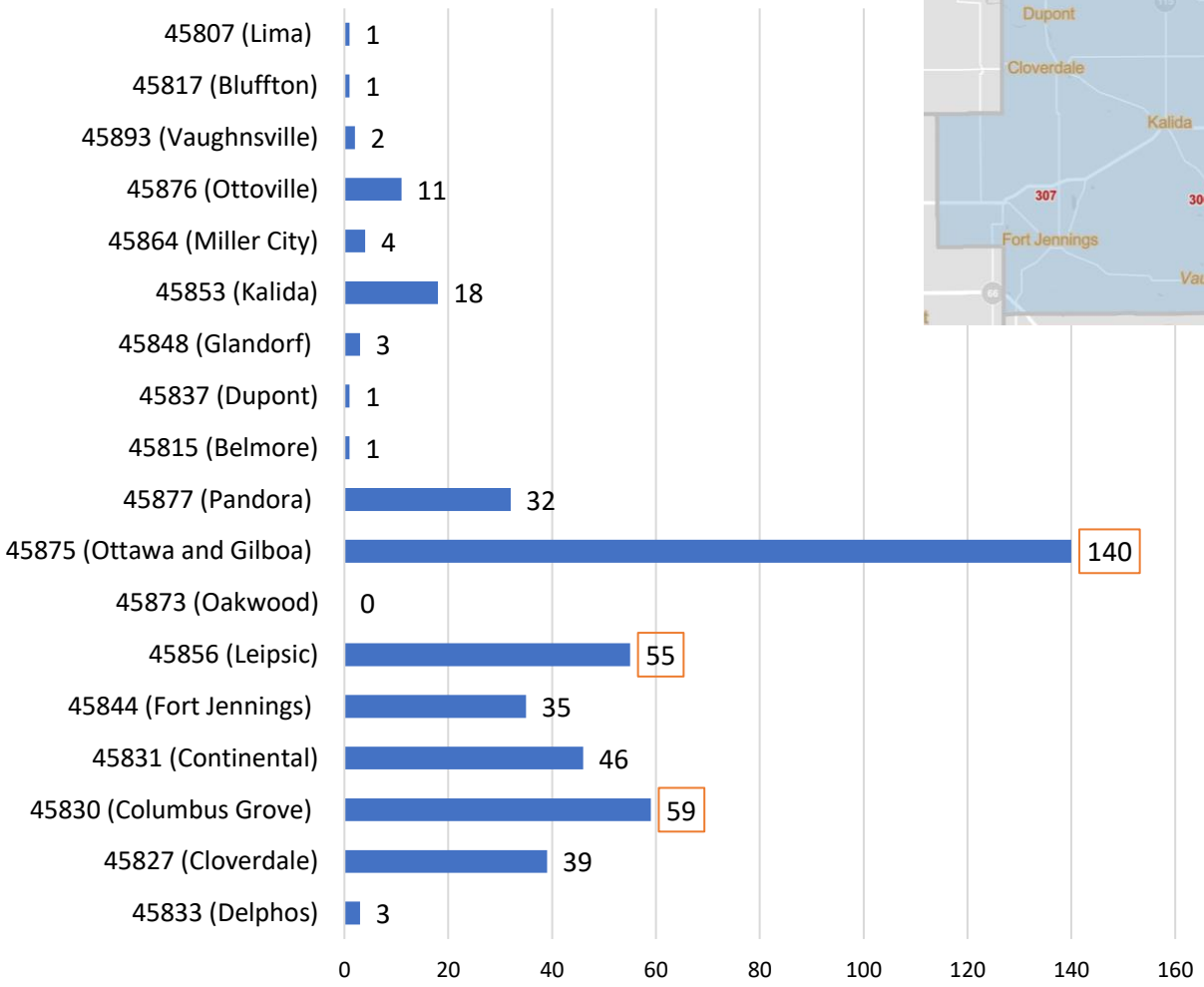


Figure. Overall, cancer diagnoses have remained consistent in Putnam County from 2016-2020.

Source: Ohio Public Health Information Warehouse-Secure. Cancer Identified Incidence Data (1996-Present). Ohio Department of Health.

Putnam County Cancer Diagnoses by Zip-Code, 2016-2020



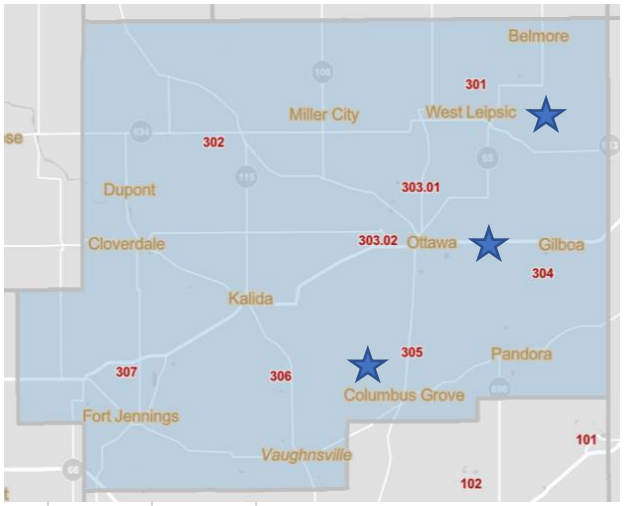


Figure. Zip-code 45875 had the highest number of cancer diagnoses from 2016-2020. 45830 and 45856 had the second and third highest number of diagnoses.

Source: Ohio Public Health Information Warehouse-Secure. Cancer Identified Incidence Data (1996-Present). Ohio Department of Health.

Summary

This report offers a detailed examination of disparities within Putnam County across various dimensions, such as population demographics, employment, income, educational attainment, housing, and more. By analyzing the data at the census tract level, several patterns of inequity and disparity emerge that can inform future public health interventions. The distribution of the Hispanic population in Putnam County shows a stark contrast, with census tract 301 having the highest concentration. This information can be vital in directing culturally tailored resources and services to meet the unique needs of this population. On the other hand, census tract 307, despite its significant population size, shows a notable absence of Hispanic residents, possible indicating areas of ethnic and cultural homogeneity.

Employment rates across census tracts reveal significant variation, with census tract 302 struggling with the lowest employment rate at 58.4%. This may reflect economic challenges in the area, requiring focused workforce development and support initiatives. Conversely, census tract 306 shows the highest employment rate at 73.1%, suggesting higher economic stability. This data underscores the need for targeted employment programs in underperforming tracts to address systemic inequalities. Income disparities are also pronounced, with census tract 303.01 falling behind in terms of median household and family incomes. In contrast, census tract 303.02 showcases a unique situation where non-family households struggle economically having a median income of $23,710, despite having the highest median family income of $105,905. These disparities suggest that income inequality is complex and may require multifaceted solutions.

Education is another area where disparities are evident. Census tract 301 and 302 lag in terms of higher education attainment, which may limit economic opportunities for residents. These tracts could benefit from educational programs and initiatives to increase college enrollment and completion rates. Meanwhile, census tract 303.02's higher educational attainment reflects a population with greater access to opportunities, correlating with higher income levels for families there. Housing data highlights both access and affordability issues. Census tract 303.01's had the highest percentage of housing units without a vehicle (5.1%), which could suggest transportation challenges, potentially limiting access to employment and essential services. Additionally, the disparity in median rent across census tracts reflects varying degrees of housing affordability. With census tract 304 having the highest median rent at $804, and census tract 303.02 with the lowest median at $558, there are clear gaps in housing costs and accessibility. Homeownership rates further accentuate these differences, with certain areas exhibiting higher rates of homeownership than others.

The data on grandparents living with grandchildren reveals social dynamics that may place additional strain on family resources. Census tract 302 stands out with a higher percentage of such households at 4.4%, indicating a need for supportive services targeting multi-generational families. There is also a gender disparity in these numbers, with 53 more male grandparents

taking on this responsibility than female grandparents. Poverty is also of concern, particularly for young children in census tract 302, where over half of children under five are living in poverty. This alarming statistic suggests the need for interventions, such as early childhood education, nutrition programs, and family support services. This is in contrast with census tract 307, where almost no children live in poverty, highlights the uneven distribution of resources and opportunities across the county.

Health data indicates disparities in both disability rates and healthcare coverage. Census tract 301, with the second highest disabled population and lowest healthcare coverage, may require targeted health interventions and improved access to medical services. Addressing these gaps could significantly enhance overall well-being in the area. The reliance on food assistance programs varies, with census tract 304 showing a link between food stamp usage and poverty levels. A large percentage of households receiving food stamps also have children under 18 (44.9%) highlights the importance of addressing food insecurity among vulnerable populations, particularly in census tracts 301, 303.01, 304, and 307 in which over 50% of households receiving food stamps have children under 18.

Mortality data provides insights into health outcomes across the county, with the leading causes of death reflecting common chronic conditions such as heart disease, respiratory disease, and cancer. The zip code (45875) for Ottawa and Gilboa, had the highest number of deaths across all Putnam County zip codes while also being the most populated in the county. Zip code 45875 could benefit from focused public health initiatives aimed at reducing mortality form these leading causes. The lower average age of death in areas with the highest number of deaths such as Ottawa and Leipsic suggest these areas may be experiencing health disparities that shorten their lifespans. The consistent cancer incidence across the county suggests that cancer remains a significant health concern. Like the number of deaths, Ottawa's zip code has the highest number of cancer diagnoses as well. This might indicate a need for enhanced cancer prevention, screenings, and treatment services in the area.

Analysis of the key points in this report reveals that census tracts 302, 303.01, and 307 are areas of concern in terms of health disparities. Census tract 302 consistently appears as an area facing multiple challenges, including low employment rates, high poverty levels, and a substantial percentage of disabled individuals. It also has the highest percentage of households with grandparents living with grandchildren, indicating potential social and economic strains. Census tract 303.01 struggles with low income and housing issues, such as limited access to vehicles, which could further compound economic difficulties. Census tract 307, while having a larger population and relatively better income statistics, reveals disparities in poverty rates among children and other social indicators. These areas, therefore, stand out as priority targets for focused public health interventions and resource allocation to mitigate health inequities across the county.

References

Kolmar, C. (2022, April 4). *Best Counties to Live in Ohio for 2022*. HomeSnacks. Retrieved September 12, 2022, from https://www.homesnacks.com/best-counties-in-ohio/.

Table P1, 2020 Decennial Census. United States Census Bureau.

Putnam County Ohio, Quick Facts. Census Bureau Maps. United States Census Bureau.

Table P1, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table P2, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S0101, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table DP03, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S1701, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S1901, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S1501, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S0102, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table DP04, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S1002, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S2701, 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Table S2201, Food Stamps/Supplemental Nutrition Assistance Program (SNAP). 2016-2020 American Community Survey 5-Year Estimates. United States Census Bureau.

Ohio Public Health Information Warehouse-Public. 2016-2020 Mortality Data. Ohio Department of Health.

Ohio Public Health Information Warehouse-Secure. 2016-2020 Mortality Data. Ohio Department of Health.

Ohio Public Health Information Warehouse-Secure. Cancer Identified Incidence Data (1996-Present). Ohio Department of Health.