

Putnam County

Community Health Assessment Report 2025

Release Date: January 2, 2026

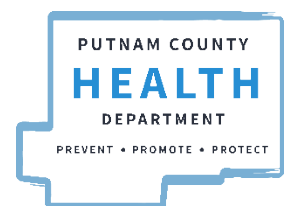


Table of Contents

Executive Summary	3
Process and Partnership	5
Methodology	6
Mobilizing for Action through Planning & Partnership (MAPP) Process Overview.....	6
Community Partner Assessment	7
Community Context Assessment	10
Forces of Change.....	10
Focus Groups	11
Key Informant Interviews	12
Community Status Assessment	13
Understanding Census Tracts and How Health Data Are Presented in This Report.....	15
Demographics of Putnam County	16
Access and Infrastructure	20
Access to Health Care Providers.....	21
Access to Insurance Coverage	26
Built Environment.....	30
Health Behaviors and Lifestyles	33
Preventive Health Screenings.....	34
Diet Related Behaviors	39
Physical Activity Related Behaviors	41
Abuse.....	43
Safety.....	44
Health Outcomes	45
General Health Status (Population-Level Indicators)	46
Mental Health and Substance Misuse	53
Mental Health Status.....	54
Substance Misuse and Risk Behaviors.....	59
Socio-Economic Factors	63
Economic Stability	64
Education Access & Attainment	69
Employment & Workforce.....	72
Community Vulnerability & Resilience	74
CHA Comparison Table (2016, 2021, & 2025)	75
References	78
Appendix A: Acknowledgements - Participating Partners	80
Appendix B: Community Partner Assessment Report (CPA)	81
Appendix C: Survey Respondent Demographics	123

Executive Summary

The Putnam County Health Department has long served—and continues to serve—as the lead agency in conducting comprehensive assessments of community health in collaboration with Partners for a Healthy Putnam County. This coalition of local organizations, agencies, businesses, and community members works collectively toward a shared equity vision: *Residents have access to fair and just opportunities to be as healthy, independent, and fulfilled as possible. Achieving this vision requires intentional collaboration to remove barriers to optimal health and to reduce stigma and its associated consequences.*

In early 2025, Partners for a Healthy Putnam County initiated planning efforts for the next Community Health Assessment (CHA). The Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework was presented to the Partners and selected as the guiding process to ensure the collection of comprehensive, high-quality data and meaningful community engagement. The use of MAPP 2.0 supports a structured, inclusive approach to assessing community health and identifying priorities. A detailed overview of the MAPP 2.0 process is provided on *Page 6* of this report.

The Partners group represents a broad cross-section of the community, including representatives from diverse organizations, sectors, and local institutions, as well as interested residents. A complete list of participating partners is included in *Appendix A*. Partners receive annual updates on progress toward the goals and strategies outlined in the current Community Health Improvement Plan (CHIP), shared through meetings and written reports. The full Partners group convenes as needed to guide assessment efforts and review emerging data, while subcommittees meet more frequently to implement and monitor CHIP strategies.

The 2025 Putnam County Community Health Assessment integrates secondary data, community survey results, and resident input to provide a comprehensive understanding of the county’s health status, strengths, and challenges. Findings are organized across five priority domains—Access and Infrastructure; Health Behaviors and Lifestyles; Health Outcomes; Mental Health and Substance Misuse; and Socioeconomic Factors—each illustrating the interconnected conditions that influence health and well-being throughout Putnam County.

Access and Infrastructure

Putnam County demonstrates strong engagement with preventive and routine healthcare despite notable gaps in provider availability. The county has fewer primary care physicians, dentists, and mental health providers per capita than state and national averages, contributing to long wait times and challenges accessing specialty care. While routine medical and dental visit rates remain comparable or higher than Ohio and national data, Medicaid coverage is low and transportation remains a frequently cited barrier—especially for low-income residents and those with mobility needs. Most residents report reliable transportation, but community feedback emphasizes gaps for vulnerable groups and the limited availability of public transit options. These access barriers highlight the need to strengthen provider capacity, address affordability concerns, and expand transportation support.

Health Behaviors and Lifestyles

Putnam County residents show strong adherence to many preventive health screenings, especially mammography, colorectal cancer screening, and blood pressure and cholesterol checks. However, nutrition and physical activity patterns reveal mixed results. Many residents consume insufficient fruits and vegetables, and survey findings show regular consumption of sugary drinks and frequent restaurant or takeout meals. While most adults engage in some physical activity, barriers such as motivation, time, and energy remain prominent. Lifestyle-related risks—including experiences of abuse, firearm accessibility, and social or environmental contributors—continue to influence residents’ health and sense of safety. Together, these findings highlight the importance of ongoing community education, improved access to healthy foods, and increased opportunities for safe and convenient physical activity.

Health Outcomes

Overall, Putnam County reports favorable self-rated physical health compared to Ohio and national averages. However, chronic conditions continue to pose substantial challenges within the community. Obesity affects 40% of adults, higher than state and national averages. High blood pressure, high cholesterol, arthritis, diabetes, and coronary heart disease remain common, with heart disease occurring at notably higher rates locally. Respiratory conditions—such as asthma and COPD—mirror state trends but remain above national levels. While stroke prevalence is lower than state and national averages, chronic disease burden overall remains a major driver of illness, reduced quality of life, and preventable healthcare costs. These patterns emphasize the need for sustained prevention strategies, chronic disease management, and policies that promote active living and healthy eating.

Mental Health and Substance Misuse

Mental health challenges and substance use behaviors represent growing areas of concern in Putnam County. Rates of depression, poor mental health days, and loneliness reflect significant emotional and psychological strain. At the same time, the county faces a severe shortage of mental health providers, limiting access to counseling, crisis support, and behavioral health services. Substance use patterns—particularly binge drinking, which is higher than Ohio and national averages—underscore cultural norms around alcohol that residents identified in focus groups. Suicide threats, attempts, and deaths have fluctuated in recent years, with threats and attempts indicating persistent need for early intervention, even as suicide death rates remain below state and national benchmarks. These findings highlight the importance of expanding mental health capacity, addressing stigma, bolstering crisis services, and promoting substance misuse prevention initiatives.

Socio-Economic Factors

Putnam County demonstrates strong economic stability relative to state and national benchmarks, with a higher median household income, lower poverty rate, and a smaller proportion of ALICE (Asset Limited, Income Constrained, Employed) households. Educational attainment is high at the high school level; however, post-secondary and college attainment lag state and national averages.

Despite overall economic strength, disparities persist across census tracts, with certain communities experiencing higher levels of poverty, transportation burden, and social vulnerability. Preschool enrollment rates are notably low, and while workforce participation is high, residents frequently report long work hours and limited time available for health, family, and well-being. These socio-economic conditions play a critical role in shaping access to resources, influencing health behaviors, and determining long-term community resilience.

Summary

Putnam County is a resilient and engaged community characterized by strong participation in preventive care, economic stability, and many favorable health indicators. At the same time, persistent challenges—including healthcare provider shortages, rising mental health needs, chronic disease burden, and barriers related to nutrition and physical activity—highlight the ongoing need for coordinated, data-driven action.

Addressing these priority areas will require sustained collaboration among healthcare systems, public health agencies, community organizations, schools, employers, and residents. Through shared commitment and strategic investment, Putnam County can continue to build an environment where all individuals have equitable access to the resources, support, and opportunities necessary to achieve optimal health and well-being.

Process and Partnership

CHA TIMELINE

Jan 10th, 2025 CPA ORIENTATION MEETING	Dec 18th, 2024 EMAIL INVITE SENT TO PARTNERS FOR CPA ORIENTATION MEETING
Feb 25th, 2025 CPA WORKSHOP MEETING #3	Feb 13th, 2025 CPA ORIENTATION MEETING #2
Apr 22nd, 2025 CCA SUBCOMMITTEE MEETING (FOCUS GROUP AND KEY INFORMANT QUESTIONS DETERMINED)	Mar 20th, 2025 CPA FINAL MEETING
Apr-May, 2025 METOPIO ORIENTATION FOR COMMUNITY PARTNERS	Apr 24th, 2025 FORCES OF CHANGE MEETING
Jun-Aug, 2025 PCHD HOSTED FOCUS GROUP SESSIONS	Jun, 4th 2025 COMMUNITY STATUS ASSESSMENT SUBCOMMITTEE MEETING - TO DETERMINE SURVEY QUESTIONS
Aug-Sept, 2025 COMMUNITY HEALTH SURVEY RELEASED & COMPLETED	Jul, 2025 KEY INFORMANT INTERVIEWS COMPLETED
Oct-Dec, 2025 CHA REPORT COMPILED & COMPLETED	Sept-Oct, 2025 SURVEY RESULTS ANALYZED

Partners for a Healthy Putnam County conducted and participated in the Community Health Assessment using the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. The Putnam County Health Department (PCHD) led and coordinated the process, recruiting 45 partners via email on November 6, 2024, to participate in an in-person planning meeting held on December 5, 2024, at the Putnam County Educational Service Center. Partner agencies and individuals were identified through a review of recommended participants outlined in the MAPP planning documents, as well as an assessment of existing community coalitions to identify gaps in representation related to community needs and health disparities.

During the initial meeting, Health Promotion staff from PCHD delivered an overview of the MAPP 2.0 framework, highlighted key differences from previous assessment processes, and outlined plans and expectations for the 2025 Community Health Assessment. A total of 22 participants representing 17 partner agencies attended the meeting. By its conclusion, participating partners formally committed to supporting and engaging in the three assessments included in the MAPP 2.0 process, with the Community Partner Assessment scheduled to begin in January 2025.

A preliminary timeline for completion of the Community Health Assessment was reviewed and discussed, and agency representatives volunteered to serve on steering committees for both the Community Context Assessment and the Community Health Status Assessment. These committees were established to guide assessment implementation,

support data review, and ensure that findings reflected both community priorities and local conditions.

Each assessment in the MAPP 2.0 process is outlined below.

Methodology

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

The 2025 Putnam County Community Health Assessment (CHA) was conducted using the National Association of County and City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. MAPP 2.0 is a community-driven approach to community health improvement that emphasizes partnership, data-informed decision-making, and continuous action to advance health equity.

MAPP 2.0 organizes community health improvement into three phases. This CHA represents completion of Phase 2: Tell the Community Story, which focuses on developing a comprehensive understanding of community health, system capacity, and the conditions that influence health and well-being. *Figure 1* provides an overview of the MAPP 2.0 phases and the assessment tools included in Phase 2.

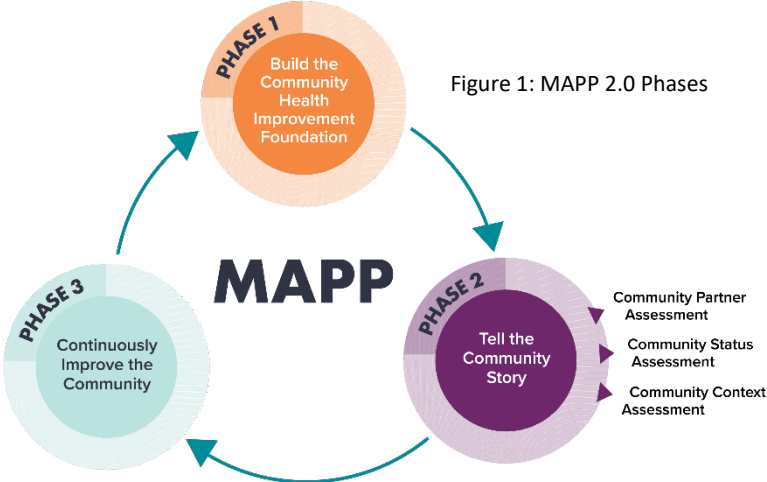


Figure 1: MAPP 2.0 Phases

Phase 2 integrates findings from three coordinated assessments to describe health from multiple perspectives. Together, these assessments examine community partnerships and capacity, population-level health status, and the broader social, economic, environmental, and systemic factors that shape health outcomes. This approach allows for a more complete understanding of health needs, strengths, and inequities within Putnam County.

The CHA incorporated both primary and secondary data. Primary data included community surveys, focus groups, and key informant input to capture resident perspectives and lived experience. Secondary data were obtained from established state, federal, and local sources, including the American Community Survey (ACS), Behavioral Risk Factor Surveillance System (BRFSS), Ohio Department of Health vital statistics, and other public health data systems. Most indicators reflect the most recent three to five years of available data.

Where available, data were reviewed by demographic and geographic characteristics to identify disparities and populations experiencing disproportionate health burdens. Findings were synthesized and reviewed by Putnam County Health Department staff and community partners to ensure accuracy, consistency, and relevance to local conditions.

Results from this assessment will inform the next phases of the MAPP 2.0 process, including priority identification and development of the Community Health Improvement Plan (CHIP). Implementation, monitoring, and ongoing evaluation will support continuous improvement and sustained action to improve health outcomes and advance health equity in Putnam County.

Community Partner Assessment

Overview

Between January and March 2025, the Putnam County Health Department (PCHD) led the Community Partner Assessment (CPA) as part of Phase II of the MAPP 2.0 framework developed by NACCHO. The CPA examined how organizations across sectors—healthcare, education, social services, local government, and business—work together to promote health equity and strengthen the Local Public Health System (LPHS).

All 45 partner agencies identified by the PCHD through the MAPP 2.0 planning process to participate in the CHA were sent an invitational email on December 18, 2024 to attend the CPA orientation meeting on January 10, 2025. During the orientation meeting, a monthly meeting schedule was agreed upon until the CPA was concluded. More than 30 community partners participated in four facilitated sessions and a 16-organization partner survey, producing a detailed picture of collaboration, resource sharing, and system capacity in Putnam County.

Purpose

The CPA evaluates how well the LPHS functions as a unified system by:

- Assessing organizational capacity, resources, and gaps.
- Identifying how partnerships, power, and data are shared.
- Determining the extent to which equity is embedded in policies and practices.
- Strengthening relationships and cross-sector collaboration.

In Putnam County, the CPA created a shared understanding of strengths, challenges, and readiness to advance equitable health improvement efforts.

Process Overview

CPA Meetings and Key Outcomes

Date	Meeting Focus	Key Outcomes
Jan 10, 2025 – Orientation Meeting #1	Introduced MAPP 2.0 framework, reviewed 2021 CHA & 2023–25 CHIP, discussed the importance of equity and partnership.	Established shared understanding of MAPP 2.0 and local process.
Feb 13, 2025 – Orientation Meeting #2	Reviewed CPA Survey results; introduced the “On the River” activity to explore upstream–downstream alignment.	Defined a shared health equity statement and connected partner activities to Social Determinants of Health.
Feb 25, 2025 – CPA Workshop Meeting #3	Conducted the Essential Public Health Services (EPHS) Sticky Note exercise; discussed system strengths and gaps.	Mapped partner contributions across the 10 EPHS; identified collaboration opportunities.
Mar 20, 2025 – CPA Final Meeting	Completed the Rich Picture Analysis and Spectrum of Community Engagement; transitioned into Community Context planning.	Synthesized CPA findings; identified key populations for qualitative focus groups.

Activities were intentionally aligned with NACCHO’s five CPA lenses:

1. *Community Strengths*
2. *Organizational Capacity*
3. *Systems of Power & Equity*
4. *Social Determinants of Health*
5. *Health Behaviors & Outcomes.*

Survey Highlights

Sixteen organizations completed the CPA Partner Survey (Fall 2024), representing health, education, social services, and government sectors.

Strengths

- Collaboration: 81% engage in community-led decision-making; 75% have participated in past health improvement efforts.
- Data Use: 70% conduct community health assessments; 63% use surveys for community feedback.
- Communication & Education: Most agencies identify outreach and education as their strongest strategies.

Areas for Growth

- Equity Integration: Only 6 of 16 organizations include equity in job descriptions; just 1 has a dedicated equity team.
- Resource Capacity: 7 organizations cite staffing shortages and 5 report limited funding.
- Upstream Engagement: Partners focus heavily on direct service (downstream) rather than policy or systems-level (upstream) change.

Overall Insight: Putnam County’s LPHS is highly collaborative yet must invest in equity structures, shared data systems, and policy coordination to achieve deeper systemic impact.

Key Partner Activity Findings

Essential Public Health Services (EPHS)

- Partners collectively address all 10 EPHS, with notable strengths in Assessment (EPHS 1) and Communication (EPHS 3) through data collection, outreach, and education.
- Emerging strengths were seen in Workforce Development (EPHS 8) and Quality Improvement (EPHS 9), while Policy Change (EPHS 5) and Data Integration (EPHS 9) remain limited.

“On the River” Activity

Partners mapped services along the upstream-midstream-downstream continuum:

- Upstream: policy, advocacy, systems change (limited presence).
- Midstream: access, prevention, workforce programs (strong).
- Downstream: direct clinical and support services (very strong).

Partners noted the importance of investing in “upstream” to prevent health inequities.

Rich Picture Analysis

Cross-sector groups illustrated interconnected root causes of local issues such as obesity, mental health, substance use, and access to care.

Findings Revealed:

- Shared determinants of health—poverty, transportation, housing, and stigma.
- Root causes—family stress, employment strain, and isolation.
- System needs—behavioral health expansion, early childhood support, and workforce development.

Community Engagement Spectrum

Most partners currently operate at the *consultation* and *collaboration* stages but aspire to move toward shared leadership and community ownership consistent with MAPP 2.0's emphasis on community power.

Themes Across All Activities

Theme	Insights
Collaboration & Partnership	Strong cross-sector partnerships with shared mission and high trust; long-standing coalitions form the backbone of health improvement efforts
Health Equity	Widely valued conceptually; partners committed to operationalizing it through staff training, policies, and inclusive decision-making
Systems Thinking	Increasing understanding of how social and environmental factors drive health outcomes; movement toward integrated planning
Data & Evaluation	Many organizations collect data independently; opportunity exists for unified, local data-sharing infrastructure
Workforce & Access	Staffing shortages, rural access, and transportation barriers persist as systemic challenges

Collective Health Equity Statement

This statement was developed by the partners during meeting #2 and reflects the shared values that will guide all future community health efforts.

“Residents have a choice to fair and just opportunities to be as happy, independent, and healthy as possible. To achieve this, we must collaborate to remove barriers and stigma to optimal health and their consequences.”

System Implications

- Strong Collaborative Infrastructure: Putnam County's LPHS is grounded in trusted relationships and cross-sector engagement.
- Need for Upstream Investment: Partners recognize the need to influence policy, systems, and environments to sustain impact.
- Commitment to Health Equity: Equity is a unifying value; implementation capacity must now match intent.
- Community Readiness: Partners exhibit motivation, maturity, and shared accountability to sustain equity-driven progress.

Conclusion

The Putnam County Community Partner Assessment captures the county's journey toward an equitable, data-driven, and collaborative public health system. It affirms that Putnam County's greatest asset is its people and partnerships, whose shared purpose and commitment to inclusion form the foundation for continued community health improvement. Full Community Partner Assessment is located in *Appendix B*.

Community Context Assessment

Partners were asked to brainstorm potential focus groups whose perspectives may not otherwise be represented and who could provide valuable insight into the experiences and needs of Putnam County residents, particularly those facing health disparities. The group also determined that the Forces of Change component would be most effectively conducted as an in-person meeting and scheduled this activity for April 24, 2025. In addition, it was agreed that a CCA subcommittee would oversee the development of methodology and implementation for the remaining CCA components.

On April 22, 2025, the CCA subcommittee met at the Putnam County Health Department to finalize focus group and key informant interview questions. Focus groups were conducted beginning in June 2025 and included senior citizens at the Council on Aging, law enforcement officers, members of the Family & Children First Council, a Continental community group, participants at the Leipsic Community Center, and elected officials. Key informant questionnaires were distributed via email to healthcare and mental health providers across the county, with 11 completed responses received.

Forces of Change

Completed on April 24, 2025

The Forces of Change is designed to help determine, through a health equity lens, what is occurring or might occur that affects the health of the community or the local public health system. Participants were asked to identify 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) and how these can contribute to inequities.

A worksheet was provided prior to the meeting for participants to gather their and others' thoughts on three topic areas:

- Social/Health
- Economic/Political
- Environmental/Technological

They were asked to think about forces of change that affect the local public health system or community.

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

The results are summarized below in each topic:

Social/Health:

- Aging population including more services needed, less family availability, more health issues will need care
- Food security includes access and affordability to healthy, nutritious food items
- Gaps in programming for all ages. Elderly with social isolation. Adults for healthy activities with no alcohol
- Childcare access and affordability
- Vaccine hesitancy
- Language barriers
- Housing and rent increases
- Mental health both adult and youth

Environmental/Technological:

- Natural disasters – flooding, tornado, severe weather, climate events
- Social media – older generation transitioning to apps, cyber bullying, parents not knowing social media apps
- Rural access for healthcare – telehealth, internet reliability, tech savvy enough for tele-visit
- Transportation – no public transportation, rural
- Artificial Intelligence (AI)
- More work from home
- Uncertainty of funding especially if government funded
- More places for outdoor activity such as nature walkways, kayaks, parks, keeping kids engaged

Economic/Political:

- Federal cuts including grants, senior benefits, public health, prevention services, food assistance
- Medicaid cuts
- Inflation
- Government negativity
- Housing costs and affordable rent
- Immigration policy
- Economic insecurity
- Healthcare shortage

Focus Groups

Completed June – August, 2025

Focus groups provide in-depth insight into the perceptions, opinions, and attitudes of community members through guided discussions. They are particularly useful for exploring complex issues and gathering detailed feedback on community health concerns and potential solutions. The focus group discussions in Putnam County covered various topics, including access to care, health behaviors, and overall health.

The focus group questions were determined by the CCA subcommittee and asked in every focus group conducted. The notes and/or transcript of each focus group were uploaded into Metopio AI software for summarization and theme prioritization.

Those questions were:

1. If you feel comfortable, close your eyes for a minute and picture what currently makes Putnam County healthy. Can you describe that to me?
2. What do you think are the most important Health issues in Putnam County?
3. What makes it hard for people in Putnam County to get the help they need?
4. What suggestions do you have to specifically help improve access to health-related services and programs?
5. What resources or activities would you like to see more of in our community that would impact health in a positive way?
6. Where do you currently get health related information?
7. How would you like to receive health information in the future?

There were eight focus groups conducted with a total of 61 participants. The key themes that emerged from these discussions included *access to care, mental health & substance abuse, and overall health*. Participants emphasized the importance of family, hard work, and community bonds while also highlighting significant health issues such as drinking, smoking, and exposure to farm chemicals. Access to healthcare emerged as a major concern, with long wait times for doctors and specialists, high costs of

care, and a lack of local services being frequently mentioned. These themes highlight the community's concerns and suggest areas for improvement in health services and infrastructure. Quotes from the focus group participants are scattered throughout the prioritized themes in the Community Status Assessment section of the report.

Notes from each focus group are available upon request.

Key Informant Interviews

Completed July 2025

Interviews offer a direct, one-on-one approach to gather detailed information on individuals' views, experiences, and knowledge regarding specific health topics. They are particularly effective for obtaining personal insights and understanding the depth of community health issues.

Key informant interview questions were determined by the CCA subcommittee and all health care provider offices and mental health facilities in the county were emailed the electronic survey for completion. There were 11 complete questionnaires. The completed summary of the survey monkey results was uploaded into Metopio for summarization and theme prioritization.

Those questions asked included:

1. Given your professional experience, describe the most important health issues in Putnam County?
2. What makes it hard for people in Putnam County to get the help they need?
3. What resources or activities would you like to see more of in the community that would impact health in a positive way?
4. What suggestions do you have to help improve access to health-related services and programs?

The responses focused on mental health, alcohol use, and diabetes as primary health concerns. The discussion underscored the challenges posed by social stigma, limited transportation, and inadequate funding in accessing necessary health services. Participants suggested increasing family-oriented events, promoting health education, and providing more affordable health resources to address these issues. These themes underscore the importance of addressing healthcare access and socioeconomic factors to improve community health. Quotes from the key informant interviews are scattered throughout the prioritized themes in the Community Status Assessment section of the report.

Key informant interviews are available upon request.

Community Status Assessment

The Community Status Assessment (CSA) was conducted by a self-selected subcommittee of Partners for a Healthy Putnam County. All community partners were invited to participate in the 2025 Community Health Assessment kick-off meeting, during which the methodology for the CSA was introduced. At this meeting, the use of an Artificial Intelligence (AI)–supported data platform endorsed by the National Association of County and City Health Officials (NACCHO) was proposed to enhance the assessment process.

Community partners interested in accessing the platform through a user license were asked to contribute financially. Once sufficient contributions were secured, the platform was purchased and a timeline for completion of the Community Status Assessment was established. Between April and May 2025, orientation sessions for the AI platform Metopio were provided to all contributing partners. Partners were encouraged to explore the platform independently to increase familiarity and identify opportunities for use within their respective organizations. Concurrently, Putnam County Health Promotion staff began meeting monthly with Metopio representatives to work through the Community Health Assessment module and support implementation.

Metopio is a comprehensive analytics platform that aggregates curated data from public and proprietary sources, providing population-level information on health behaviors, health risks, health outcomes, healthcare utilization, and community-level drivers of health. Where available, data are disaggregated by race, ethnicity, and gender, allowing for deeper examination of health patterns and disparities. In this assessment, Metopio data were used to supplement primary data and provide broader context for health indicators and conditions in Putnam County.

The Community Status Assessment subcommittee reconvened on June 4, 2025, to finalize the assessment methodology and begin selecting questions for the community resident survey. Community surveys are a critical tool for capturing information on health behaviors, mental health, perceptions of community conditions, and service needs. Survey topics included health behaviors, mental health, and questions related to living or working in the Putnam County service area.

The survey was distributed through multiple channels to maximize reach. Partner agencies were provided with flyers with a QR code and asked to share them with clients and staff living or working in Putnam County. Flyers were also posted in locations frequently accessed by lower-income residents, including laundromats, community centers, grocery stores, and service agencies. Additionally, paper surveys were distributed at the local free clinic. To achieve population-level representativeness, a minimum of 400 completed surveys was targeted; however, 269 responses were ultimately collected.

This lower-than-planned response rate necessitates cautious interpretation of the results.

Prior to analysis, survey data underwent a rigorous cleaning process. All incomplete responses, responses from individuals under the age of 18, and responses missing both age and sex were removed to ensure data integrity. The cleaned data were then weighted using post-stratification based on the most recent age and sex distribution of Putnam County. These weights were applied to calculate all final rates and percentages presented in this report.

Despite these methodological safeguards, several limitations remain. The lower number of completed surveys increases the margin of error and introduces the potential for non-response bias, whereby individuals who completed the survey may differ systematically from those who did not. Additionally, weighting adjustments were limited to age and sex and could not account for other demographic or social factors. As with all self-reported data, results may also be influenced by recall bias or social desirability bias. A comparison of survey respondent demographics to the overall population of Putnam County is provided in Appendix C.

Health Themes

Health themes included in the Community Status Assessment were informed by findings from focus groups, key informant interviews, and survey data. These themes reflect the primary health concerns and priority areas identified by community members and partners and provide a structured framework for presenting findings and guiding future action. The five health themes are outlined below.

1. Access and Infrastructure:

- Access to Healthcare Providers
- Access to Insurance Coverage
- Built Environment

2. Health Behaviors and Lifestyles:

- Preventative Health Screenings
- Diet Related Behaviors
- Physical Activity Related Behaviors
- Abuse
- Safety

3. Health Outcomes:

- General Health Status (Population-Level Indicators)
- Chronic Disease

4. Mental Health and Substance Misuse:

- Mental Health Status
- Substance Misuse and Risk Behaviors

5. Socio-Economic Factors:

- Economic Stability
- Education Access & Attainment
- Employment & Workforce
- Community Vulnerability & Resilience

Understanding Census Tracts and How Health Data Are Presented in This Report

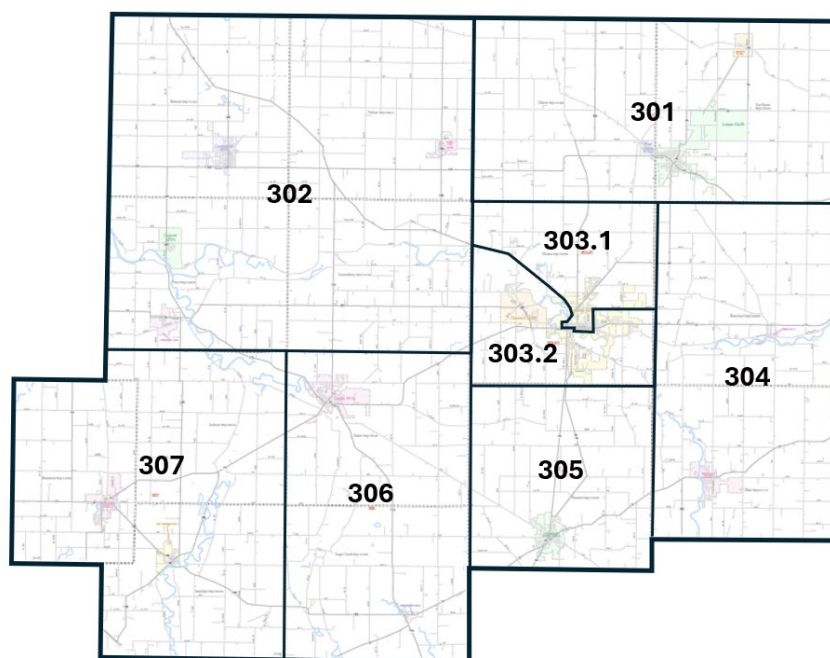
Census tracts are small geographic areas created by the U.S. Census Bureau to represent neighborhoods within a county. Each census tract includes a few thousand residents and is designed to remain mostly the same over time. Unlike villages, townships, or counties, census tracts are not political or service boundaries. They are used strictly for data collection and analysis.

Using census tracts allows health data to be examined at a more local, neighborhood level. Countywide averages can sometimes hide important differences across communities. Looking at data by census tract helps identify where health challenges, access barriers, or resource gaps may be more concentrated within the county.

Many state and federal health data sources—including the American Community Survey and CDC PLACES—are reported at the census tract level. Using census tracts allows data from different sources to be combined and compared consistently over time. In this assessment, census tract data are used to better understand neighborhood-level conditions, while county, state, and national data are also included for comparison to provide broader context.

Together, these geographic levels help paint a clearer picture of health across Putnam County—showing both overall trends and differences that exist within the county.

Below is a map of Putnam County with all eight Census Tracts and an accompanying table that identifies which villages are located in each one.



Census Tracts	Primary Villages Included
301	Leipsic, West Leipsic, Belmore
302	Miller City, Continental, Dupont, Cloverdale
303.01	Ottawa (Parts)
303.02	Ottawa (Parts), Glandorf
304	Pandora, Gilboa
305	Columbus Grove
306	Kalida, Vaughnsville
307	Ottoville, Fort Jennings

Demographics of Putnam County

Demographic characteristics provide the foundational context for understanding health needs, service utilization, and disparities within a community. Population structure influences demand for healthcare, education, workforce development, transportation, and social services, and shapes how residents experience health across the lifespan.

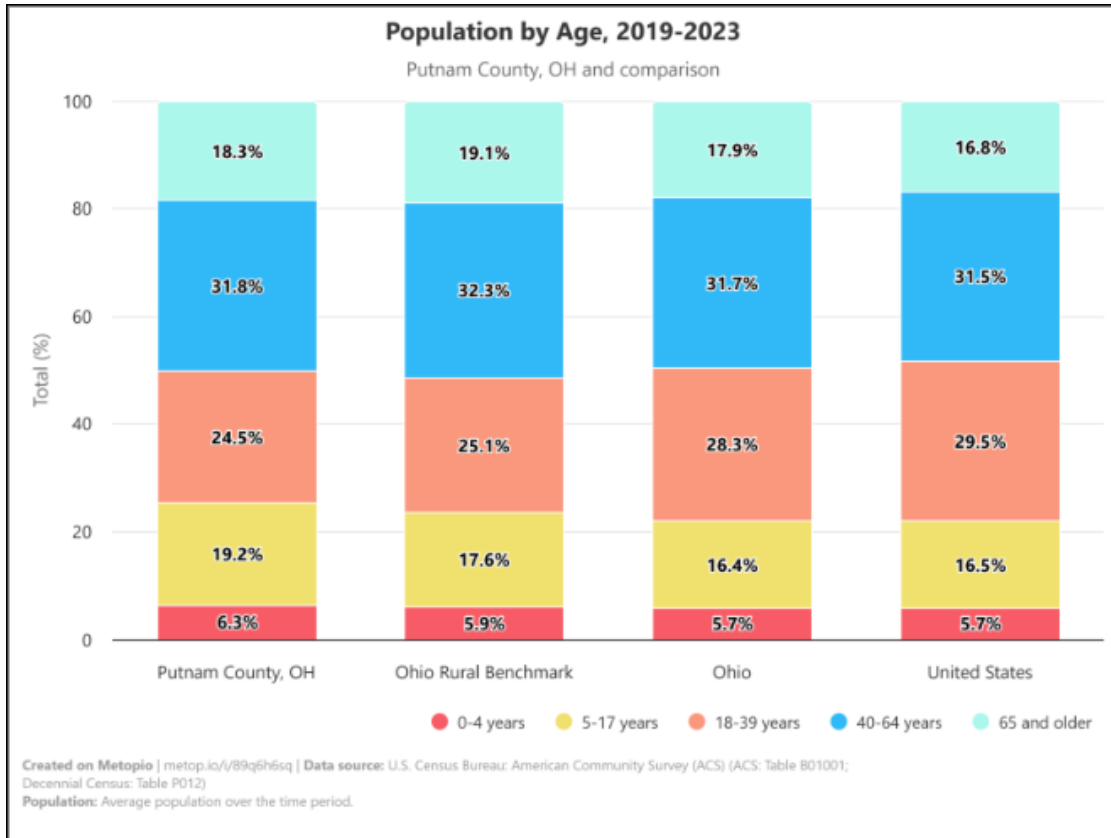
This section examines age distribution, gender composition, race and ethnicity, English proficiency, and disability status in Putnam County. The county's population reflects a strong working-age base alongside notable proportions of children and older adults, creating simultaneous demand for family supports, pediatric and school-based services, workforce stability, and aging-related healthcare and social services. These age dynamics have implications for both current service capacity and long-term planning.

Gender composition provides additional context for understanding patterns in preventive care utilization, chronic disease risk, and healthcare engagement. The county's racial and ethnic makeup, combined with generally low levels of limited English proficiency, suggests fewer widespread language barriers while still underscoring the need for culturally responsive services for smaller populations that may face disproportionate challenges. Disability patterns further highlight the importance of accessible healthcare facilities, transportation systems, housing, and employment opportunities to ensure that all residents can fully participate in community life.

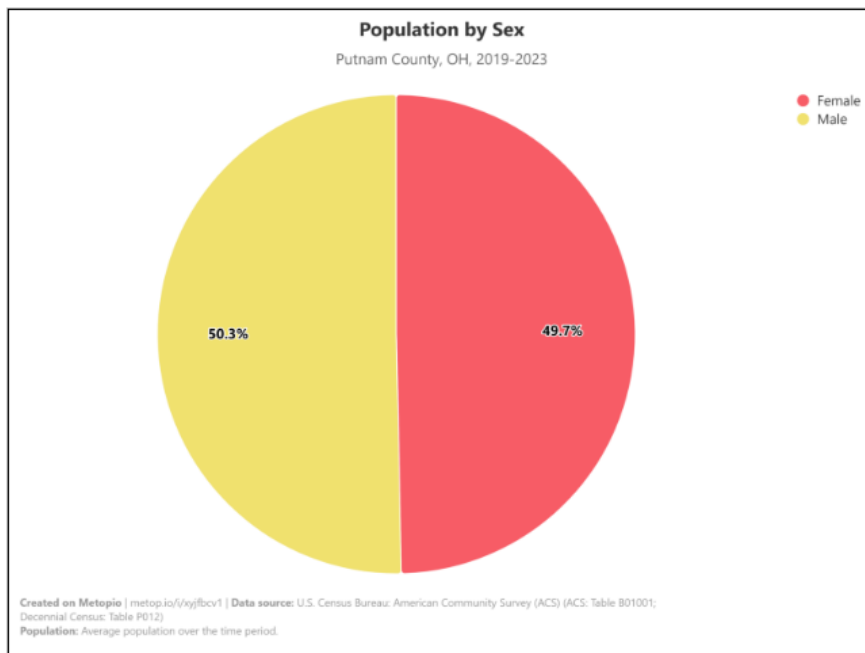
Together, these demographic characteristics establish essential context for interpreting patterns observed in access to care, health behaviors, and health outcomes throughout the assessment. Understanding who lives in Putnam County supports informed decision-making and ensures that programs, policies, and resources align with population needs.

Age

In Putnam County, the age distribution is balanced, with a significant proportion of the population falling within the 18-64 years age range. This is slightly lower than the state and national averages, indicating a marginally lower percentage of working-aged residents. The proportion of young children (0-4) and elderly (65+) individuals is higher than the state and national averages, suggesting a larger population of dependents and potentially impacting the demand for educational and elder care services.

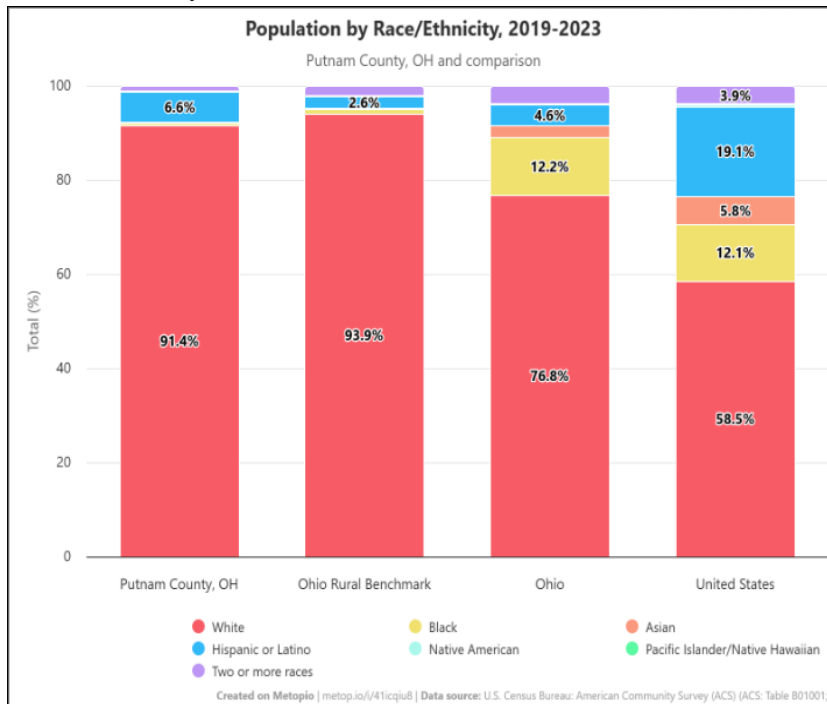


Gender



The gender distribution in Putnam County is almost equal, with a slight majority of males. Having a majority of male residents in Putnam County could have implications for healthcare needs, as certain health conditions and risks are more prevalent in males.

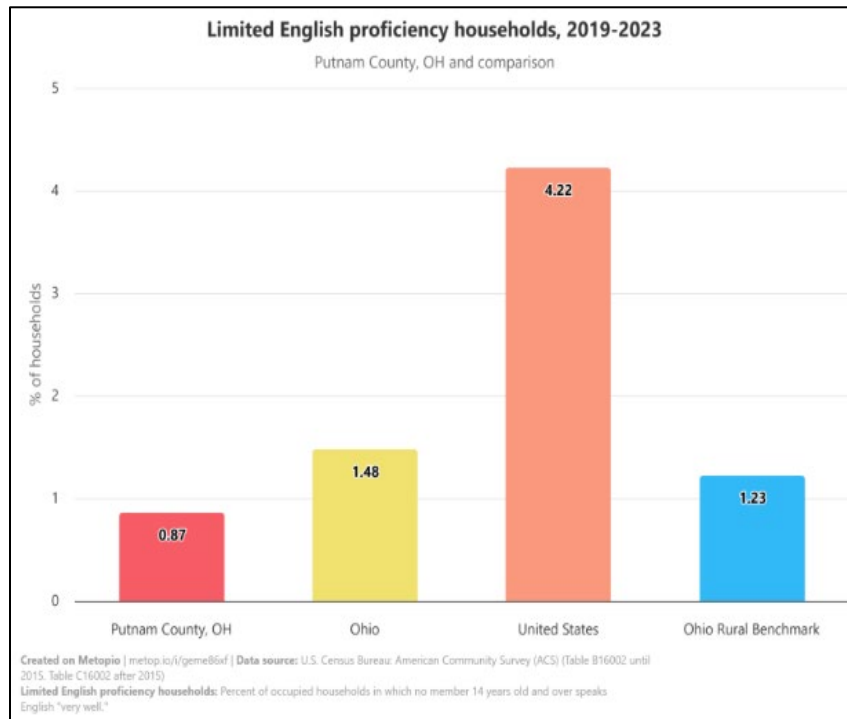
Race/Ethnicity



Putnam County’s population is predominantly White, with a smaller representation of Hispanic or Latino individuals. This demographic pattern aligns with the overall racial and ethnic distribution in rural Ohio but contrasts with national trends, where Hispanic or Latino populations and other racial groups make up a larger share of residents. The county’s comparatively lower diversity highlights potential implications for cultural competency in healthcare, underscoring the importance of ensuring providers are equipped to meet the needs of all residents, including access to language assistance services.

English Proficiency

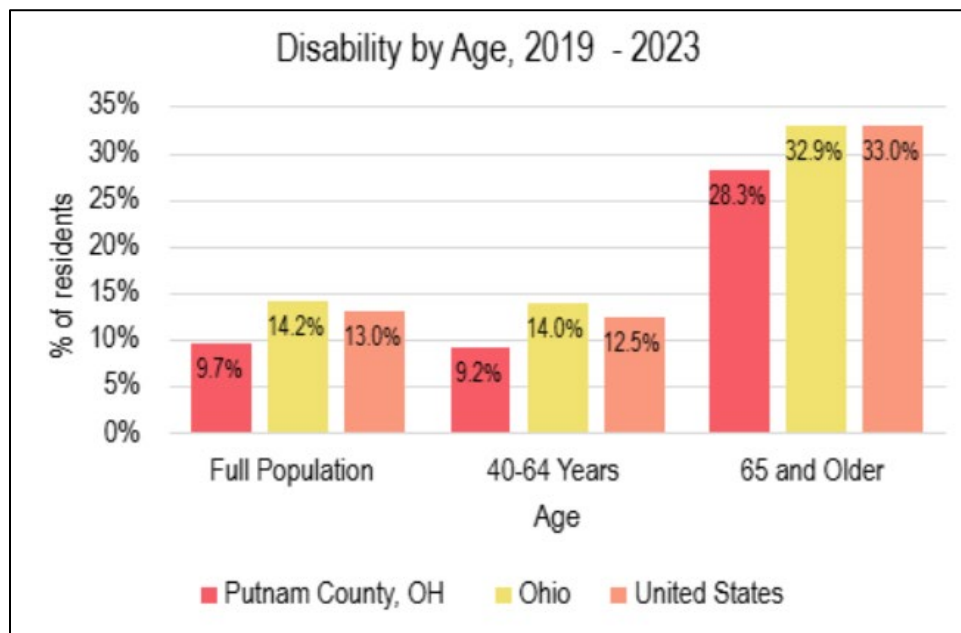
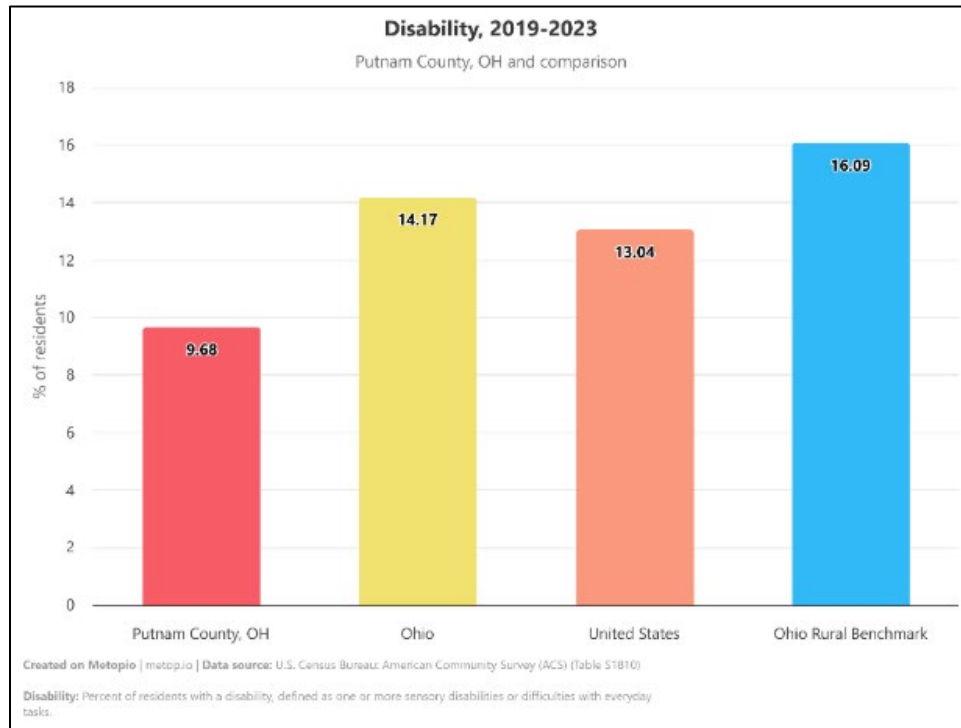
Putnam County has a low percentage of limited English proficiency households compared to the state and national averages. This could mean fewer language barriers in healthcare settings, potentially improving access to and quality of care for the community.



Disability

In Putnam County, the percentage of disabled residents is lower than the state and national averages, which could be due to various factors such as lifestyle, healthcare access, and community support systems.

Despite the lower prevalence of disability in all age groups, it is important to maintain and improve services for disabled individuals to ensure they receive the support needed to lead fulfilling lives. This includes accessible healthcare, transportation, and employment opportunities tailored to their needs.



Access and Infrastructure

Access and infrastructure encompass the systems, services, and physical environments that determine whether residents can obtain timely, affordable, and appropriate healthcare and meet essential needs. Provider availability, insurance coverage, and transportation are central to prevention, treatment, and ongoing health management.

This section examines access to healthcare providers, access to insurance coverage, and built environment factors such as transportation availability and vehicle access. The availability of primary care, dental, and mental health providers plays a critical role in shaping appointment availability, continuity of care, and access to specialty services. While many residents routinely engage in preventive and primary care, limited provider supply—particularly for behavioral health—contributes to longer wait times and challenges accessing timely services.

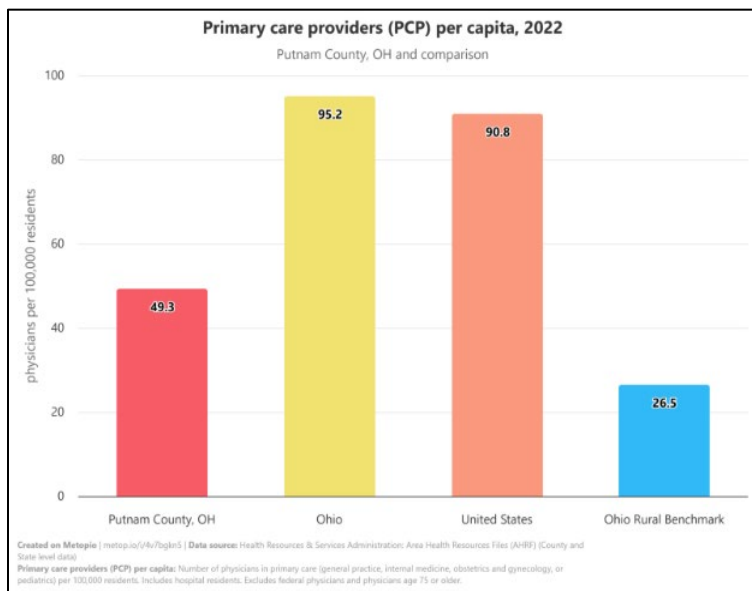
Insurance coverage patterns reflect broad coverage overall, with many residents relying on private insurance. At the same time, lower participation in public insurance programs raises considerations related to affordability and access for residents who may not qualify for or be able to afford private coverage. Built environment factors further influence access by affecting residents' ability to physically reach healthcare, employment, and essential services. Although most households report access to a vehicle, cost and limited alternatives continue to affect certain populations, particularly individuals with lower incomes, disabilities, or mobility challenges.

Together, these conditions illustrate how access barriers in Putnam County are shaped more by system capacity and infrastructure than by lack of engagement. Understanding these factors helps identify opportunities to strengthen provider availability, improve affordability, and reduce transportation-related barriers across the county.

Access to Health Care Providers

Primary Care Providers (PCP) Per Capita

Number of physicians in primary care (general practice, internal medicine, obstetrics and gynecology, or pediatrics) per 100,000 residents. Includes hospital residents.



Putnam County has substantially fewer primary care providers per capita than state and national levels. In 2022, Putnam County had 49.3 primary care providers per 100,000 residents, compared to 95.2 in Ohio and 90.8 nationally. Although provider availability in Putnam County is higher than the Ohio rural benchmark of 26.5, the county’s rate remains well below broader state and national levels. This gap in primary care capacity may contribute to longer wait times for appointments, challenges accessing routine and preventive care, and increased reliance on providers outside the county.

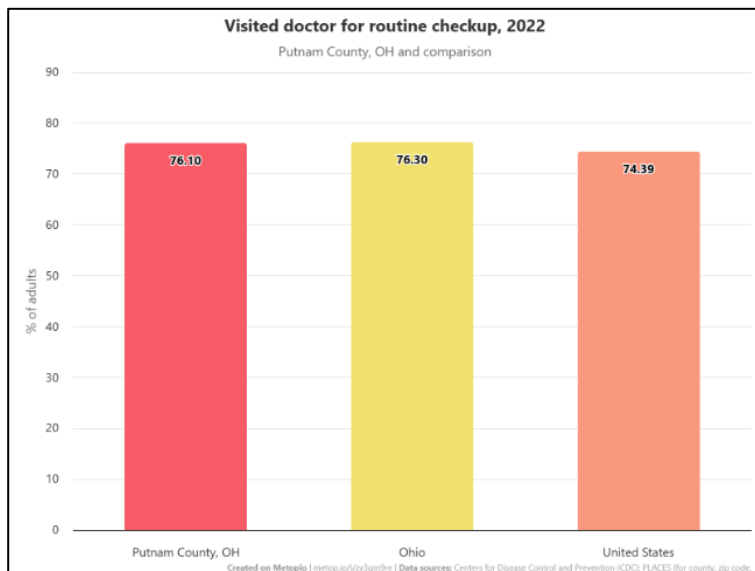
Data Sources: Health Resources & Services Administration: Area Health Resources Files (AHRF) (County and State level data)

Limited access to medical services, including a shortage of primary care physicians and urgent care facilities, is a significant barrier to health

Community resident perspectives in focus groups

Visited Doctor for Routine Checkup

Percent of resident adults aged 18 and older who report having been to a doctor for a routine checkup (e.g., a general physical exam, not an exam for a specific injury, illness, condition) in the previous year.

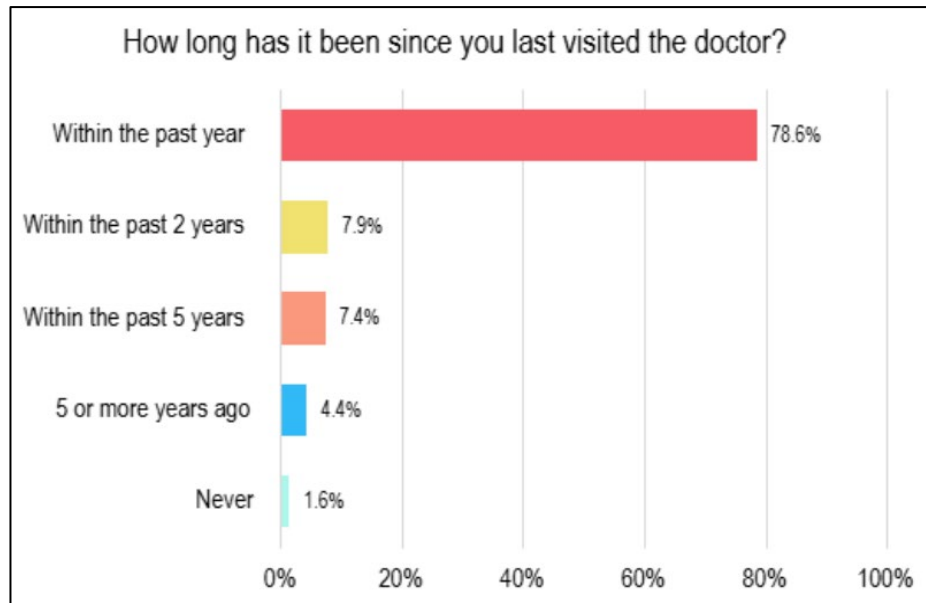


Putnam County residents regularly engage in routine medical care despite limited primary care capacity. In 2022, 76.1% of adults in Putnam County reported visiting a doctor for a routine checkup within the past year. This rate is nearly identical to the Ohio average of 76.3% and exceeds the national average of 74.4%. These findings suggest strong engagement in preventive and routine healthcare among Putnam County residents, even in the context of fewer available primary care providers.

Data Sources: Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract), Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA)

The 2025 Putnam County Community Health Assessment Survey asked respondents “About how long has it been since you last visited a doctor for a routine checkup?”

In the 2025 survey, over 78% of Putnam County residents said they had been to the doctor in the past year. While the majority has visited the doctor in the past year, 6% of survey respondents said that they have never been to the doctor or hadn’t been within the last 5+ years.

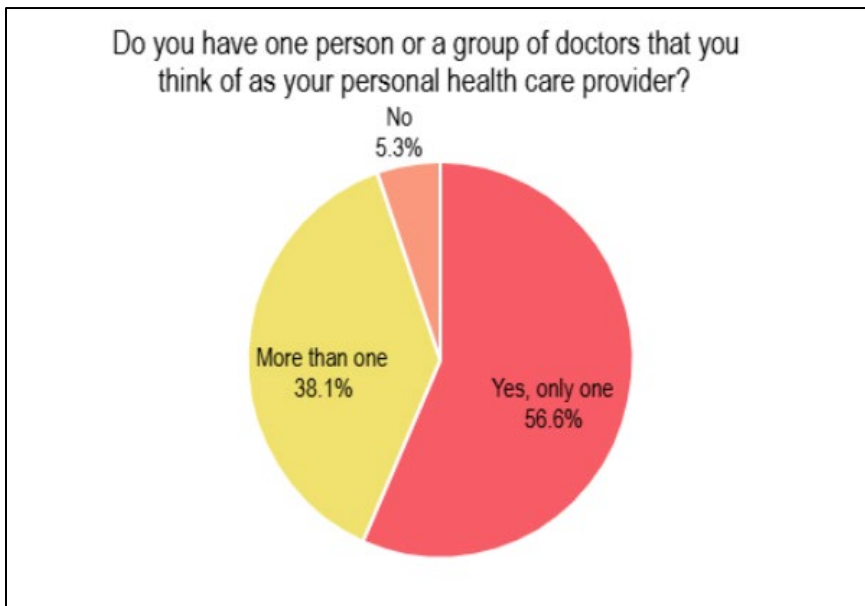


"The cost of health care such as hearing aid, you know you need one, but too much money."

Community resident perspective in focus groups

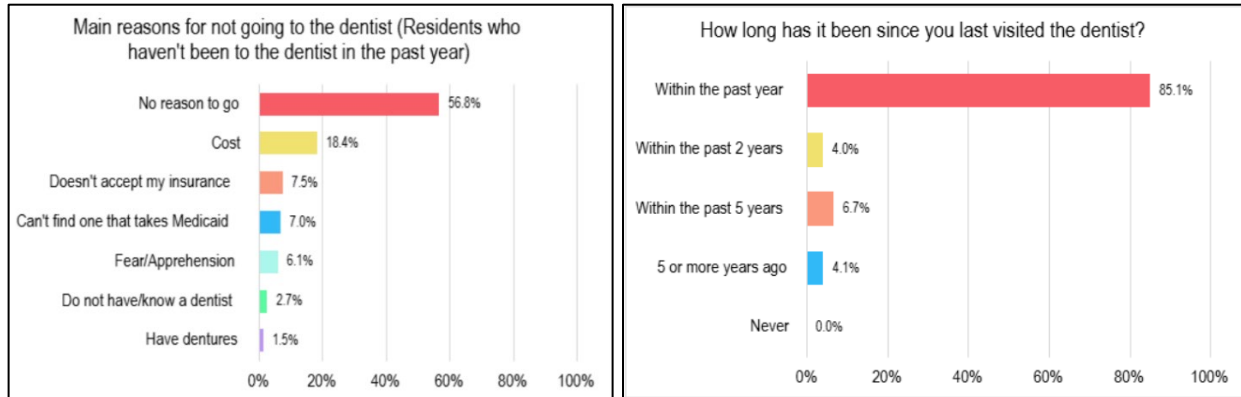
"When you call a doctor it takes about 3 weeks to get in - Too long of a wait to see doctor and specialists."

The 2025 Putnam County Community Health Assessment Survey asked respondents “Do you have one person or a group of doctors that you think of as your personal health care provider?”



Results indicate that most residents have an identified personal health care provider. Over half of respondents (56.6%) reported having one specific provider they consider their primary source of care, while 38.1% reported having more than one provider. Only 5.3% of respondents indicated they do not have a personal health care provider. These findings suggest that the large majority of residents have an established point of contact for their health care needs.

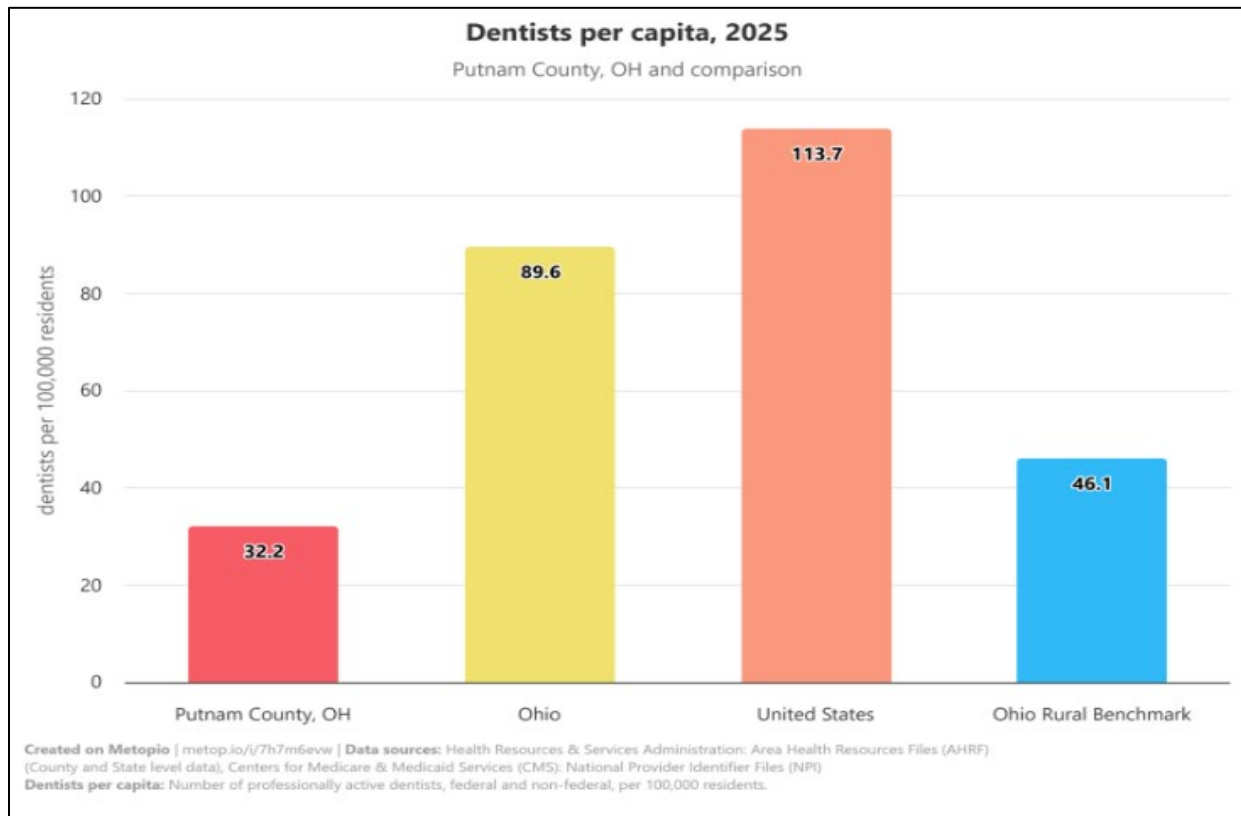
The 2025 Putnam County Community Health Assessment Survey had 85% of respondents stating they had visited a dentist in the past year. They were also asked if you have not visited a dentist in the last year, why not? Besides seeing no reason to go, residents identified cost as the main reason.



Dentists Per Capita

Number of professionally active dentists, federal and non-federal, per 100,000 residents.

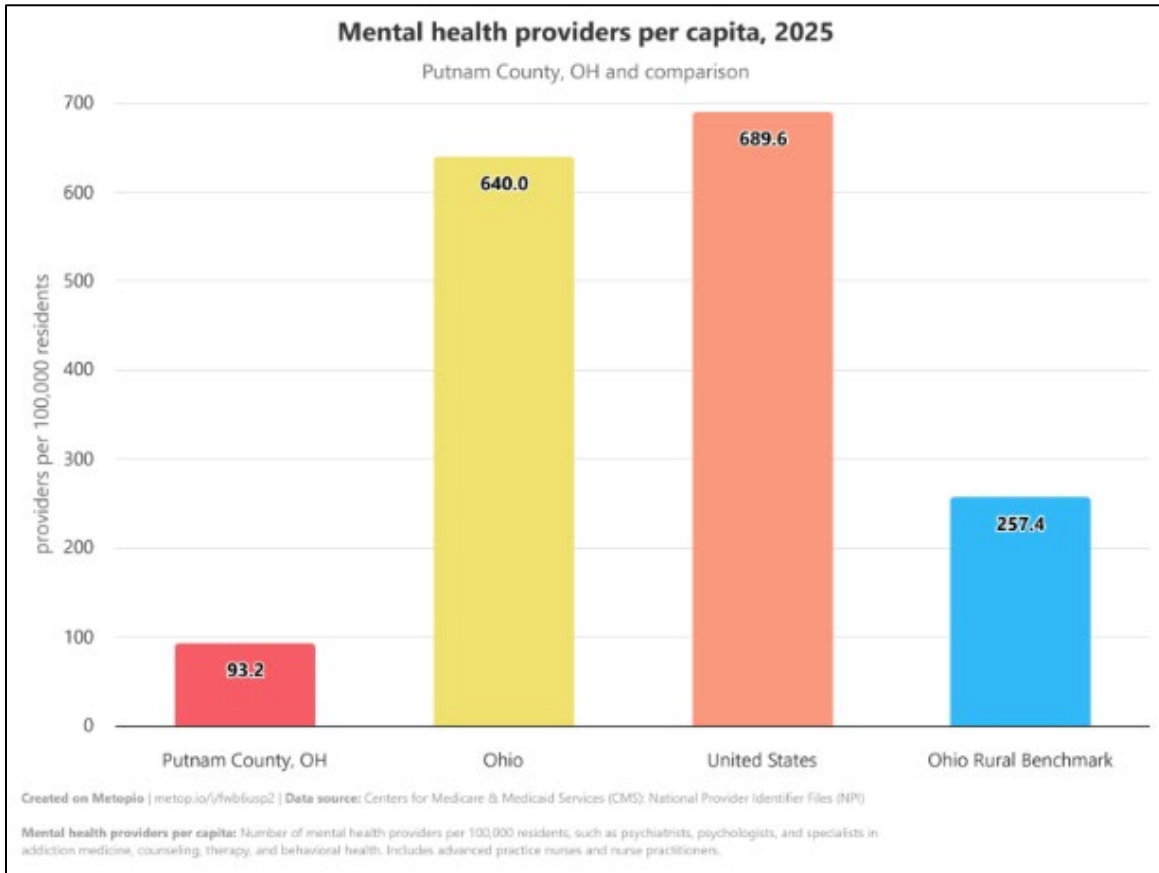
The United States has an average of 113.73 dentists per capita, while Ohio has a lower average of 89.63. Rural areas in Ohio, represented by the Ohio Rural Benchmark, have an even lower average of 46.07 dentists per capita. Putnam County has the lowest average of 32.2 dentists per capita.



Data Sources: Health Resources & Services Administration: Area Health Resources Files (AHRF) (County and State level data), Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

Mental Health Providers Per Capita

Number of mental health providers per 100,000 residents, such as psychiatrists, psychologists, and specialists in addiction medicine, counseling, therapy, and behavioral health. Includes advanced practice nurses and nurse practitioners.



Data Sources: Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

The United States has 689.6 mental health providers per capita. Ohio has a lower rate of 639.97 providers per capita, and its rural benchmark is even lower at 257.42. Putnam County has the lowest rate among the data points, with only 93.21 mental health providers per capita.

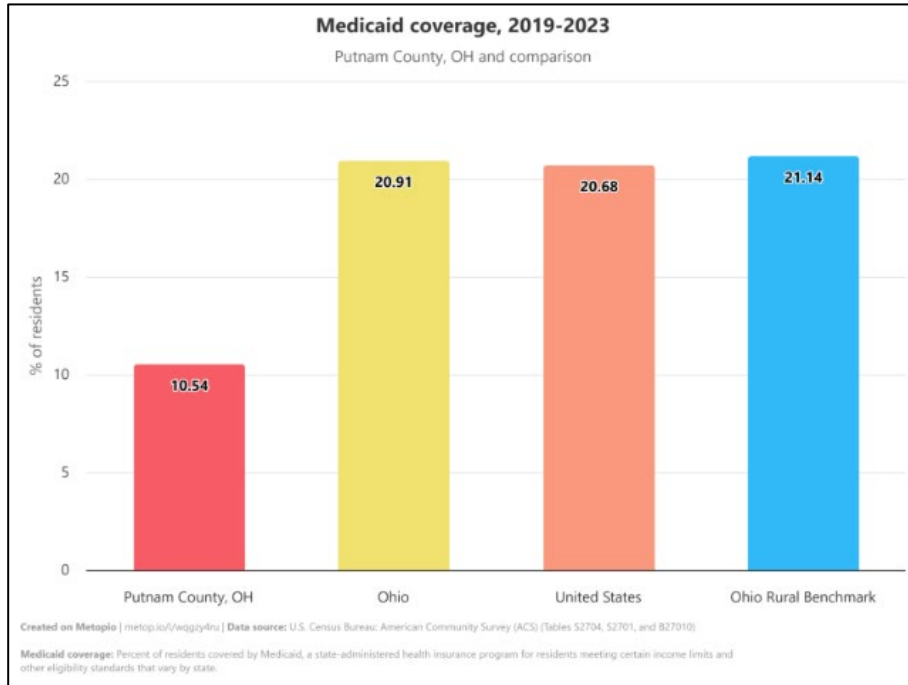
“Another thing I notice is Autism and we don't have the facility here to take care of them. It took 8 months to get a kid in to somewhere further away. There was nothing here in this town. Autism and not enough local services.”

Community resident perspective from focus group

Access to Insurance Coverage

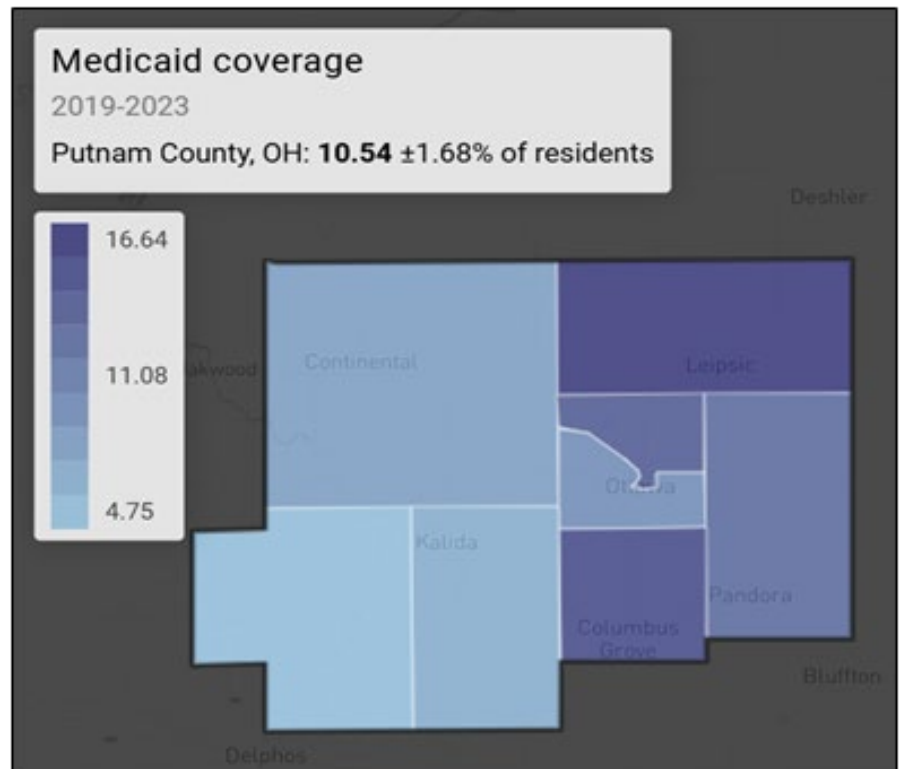
Medicaid Coverage

Percent of residents covered by Medicaid, a state-administered health insurance program for residents meeting certain income limits and other eligibility standards that vary by state.



Medicaid coverage in Ohio is slightly higher than the national average, with a rate of 20.91% compared to the United States' 20.68%. However, Ohio's rural benchmark is even higher at 21.14%. In contrast, Putnam County has a significantly lower Medicaid coverage rate of 10.54%.

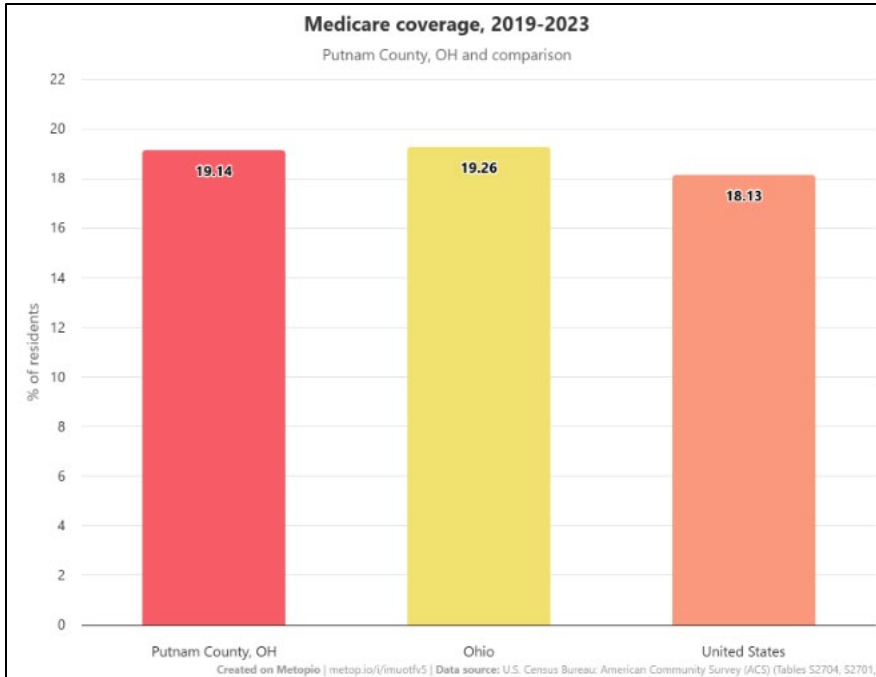
Medicaid coverage in Putnam County varied across different tracts between 2019 and 2023. Tract 301 had the highest coverage at 16.64%, while Tract 307 had the lowest at 4.75%. The data highlights the disparities in Medicaid coverage within the county, reflecting varying levels of income and eligibility among residents. These differences underscore the importance of tailored healthcare policies to address the specific needs of each tract. Please refer to the census tract map and corresponding table on page 15.



Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Tables S2704, S2701, and B27010)

Medicare Coverage

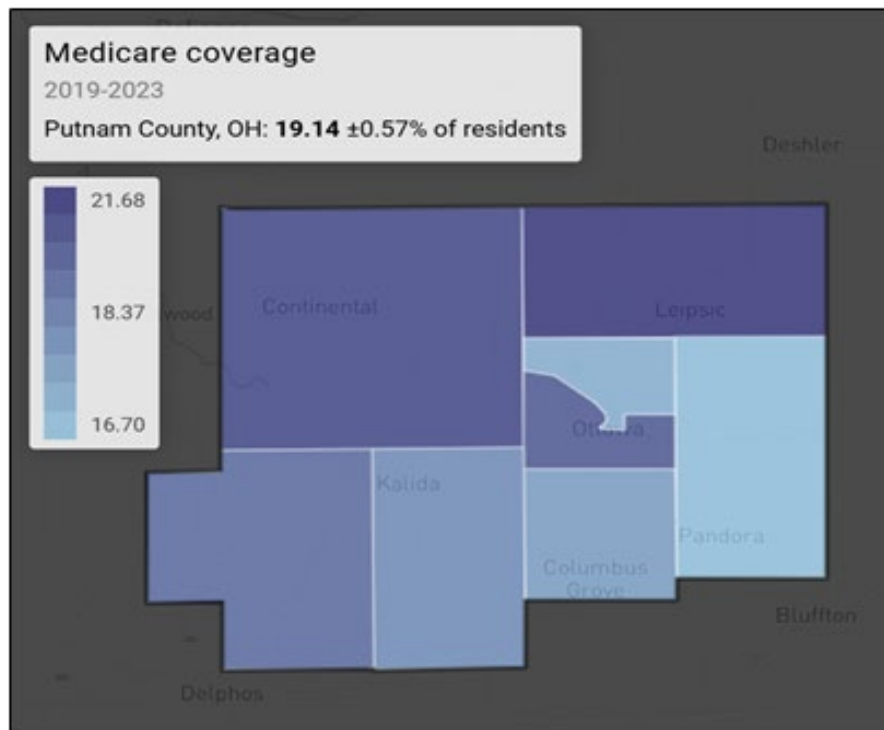
Percent of residents covered by Medicare, the federal health insurance system for seniors and some people with disabilities.



The data reveals Medicare coverage rates across various regions, with Ohio having a higher rate of 19.26% compared to the national average of 18.13%. Within Ohio, Putnam County specifically shows a slightly lower coverage rate of 19.14%. This indicates that Ohio and Putnam County are generally very similar to the nation.

Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Tables S2704, S2701, and B27010)

Map of Medicare Coverage



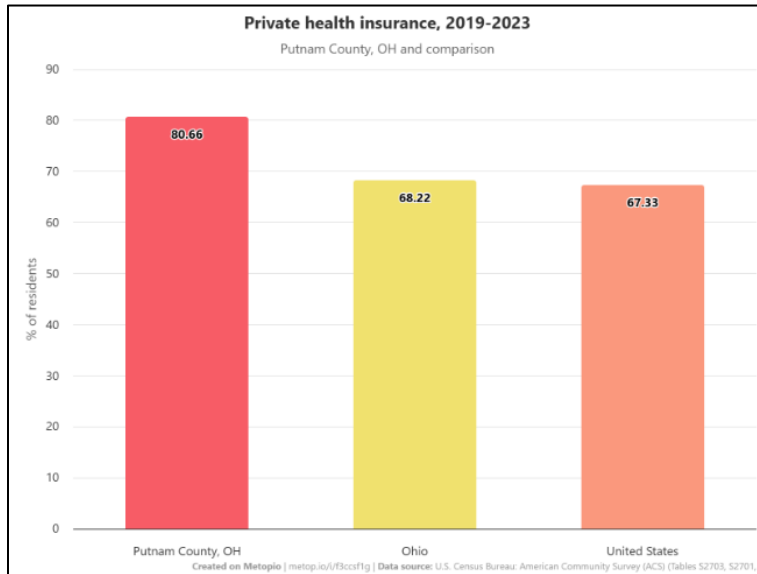
Medicare coverage in Putnam County varies across different tracts, with percentages ranging from 16.7% to 21.7%. The highest coverage is in Tract 301, while Tract 304 has the lowest. Overall, the Medicare coverage in this county is relatively consistent, reflecting a moderate level of health insurance among seniors and some disabled residents. Please refer to the census tract map and corresponding table on page 15.

Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Tables S2704, S2701, and B27010) Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Tables S2704, S2701, and B27010)

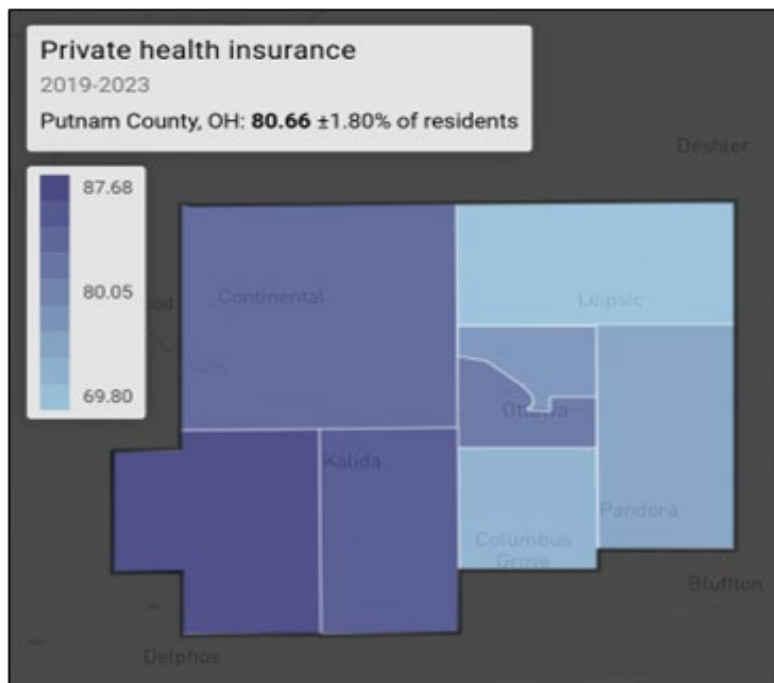
Private Health Insurance

Percent of residents covered by private health insurance, such as employer-provided health insurance, direct-purchase (ACA exchanges), or TriCare.

Private health insurance coverage in Putnam County is notably higher than both the state and national averages. In Ohio, 68.22% of the population has private health insurance, while the United States average stands at 67.33%. Putnam County's coverage rate of 80.66% highlights a significant local emphasis on private health insurance.

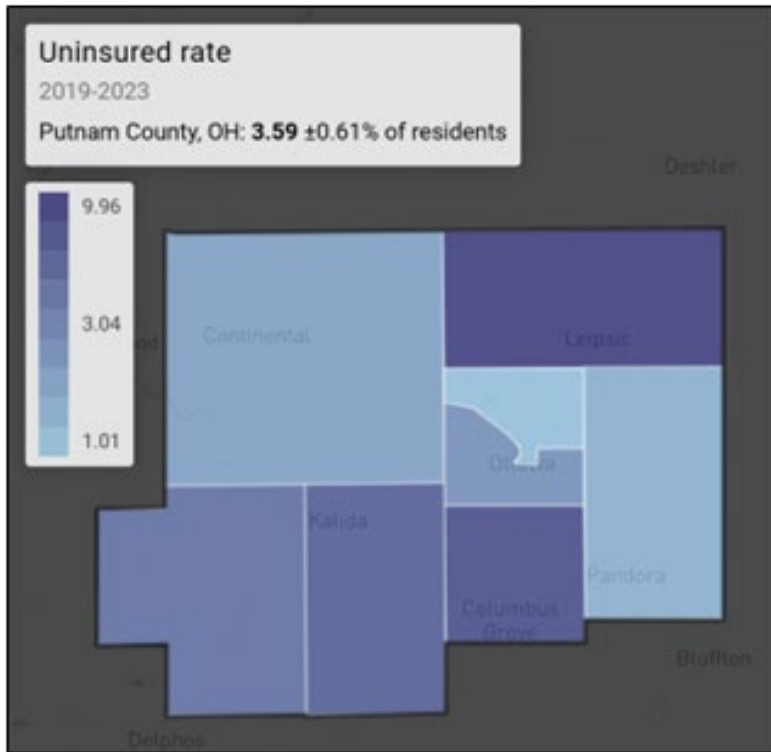


Private health insurance coverage in Putnam County varies across different tracts. Tract 307 has the highest coverage at 87.68%, while Tract 301 has the lowest at 69.8%. Overall, the county exhibits a relatively high percentage of residents with private health insurance. Please refer to the census tract map and corresponding table on page 15.

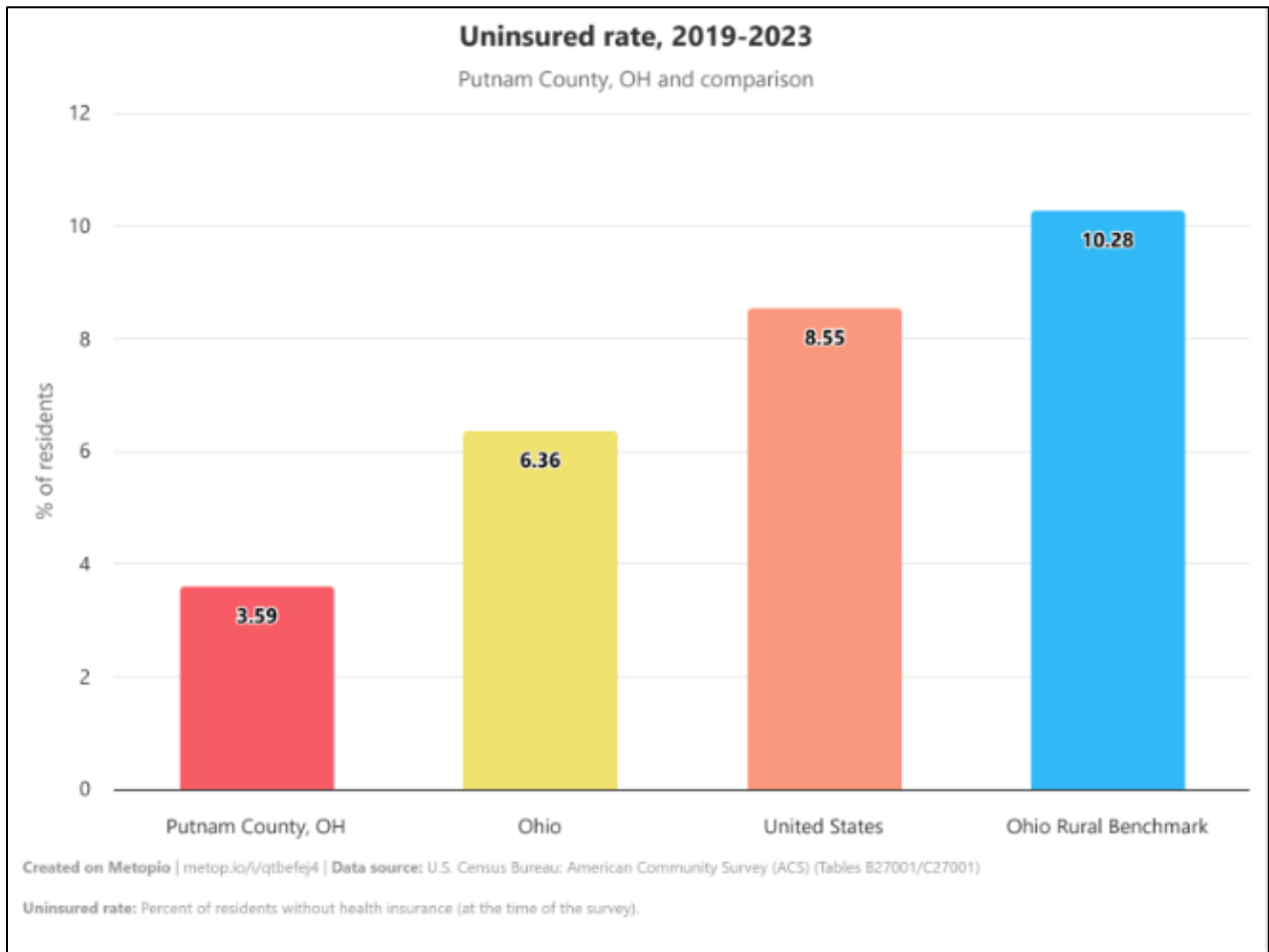


Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Tables S2703, S2701, and B27010)

No Medical Insurance



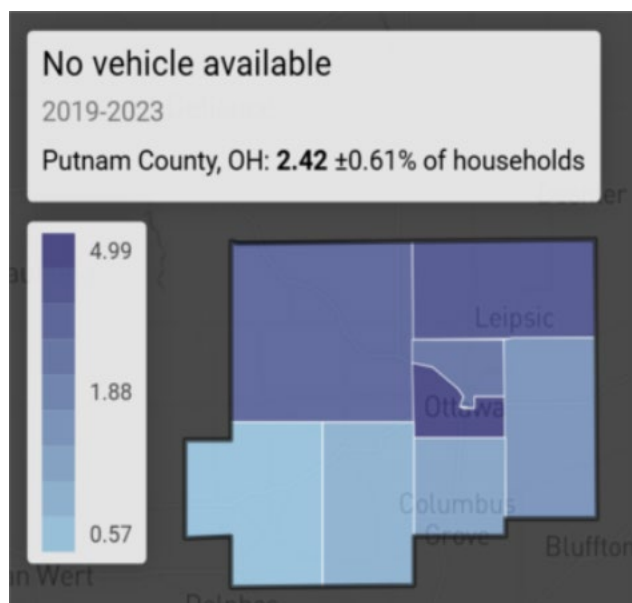
The uninsured rate in Putnam County varies significantly across different tracts. The highest rate is in Tract 301, at nearly 10%, while Tract 303.01 has the lowest rate at just 1%. The overall uninsured rate in the county is relatively low, with most tracts having rates below 5%. Please refer to the census tract map and corresponding table on page 15.



Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Built Environment

No Reliable Vehicle Available



Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Table B25044)

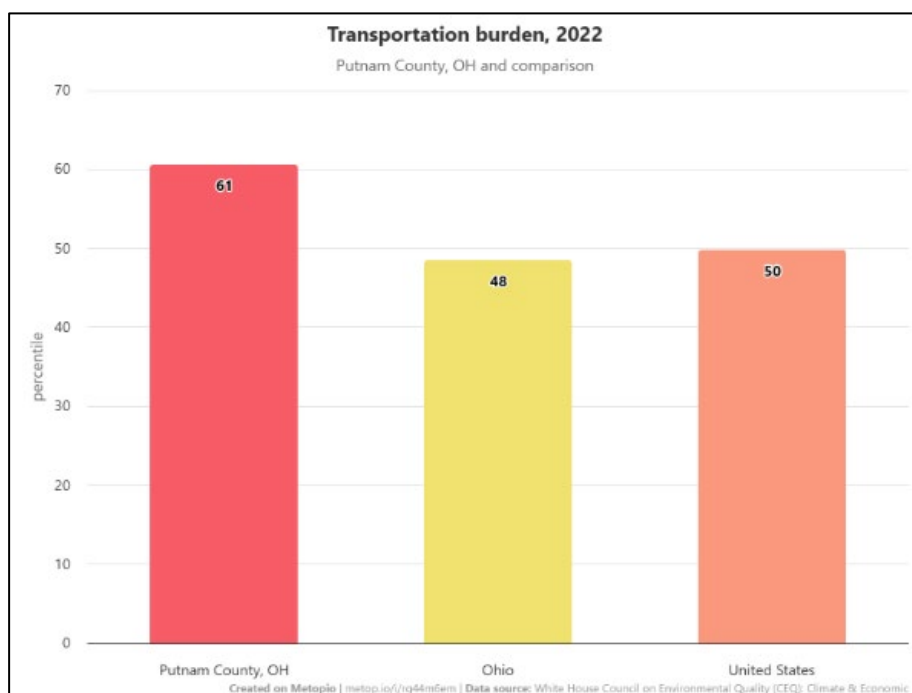
The percentage of households with no vehicle available in Putnam County varies across different tracts. Tract 307 has the lowest percentage at 0.57%, while Tract 303.02 has the highest at 4.99%. Overall, the percentages are relatively low across all tracts, indicating that most households in Putnam County have access to at least one vehicle. Please refer to the census tract map and corresponding table on page 15.

Public Transportation: Participants noted the challenges posed by inadequate public transportation, which affects residents' ability to access health services and other essential resources.

Community resident perspectives from focus groups

Transportation Burden

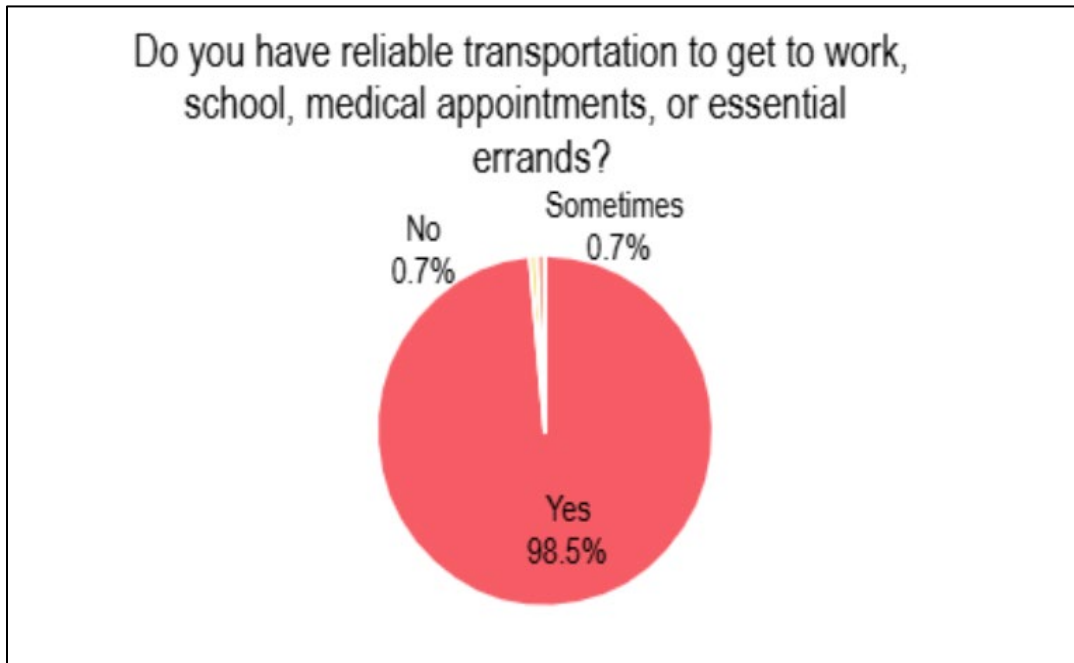
Transportation burden indicates that transportation costs are a significant financial strain in Putnam County. The data reveals the transportation burden across various regions, with Putnam County experiencing the highest burden at 60.64%. The United States has a national average of 49.85%, while Ohio's state average is slightly lower at 48.48%.



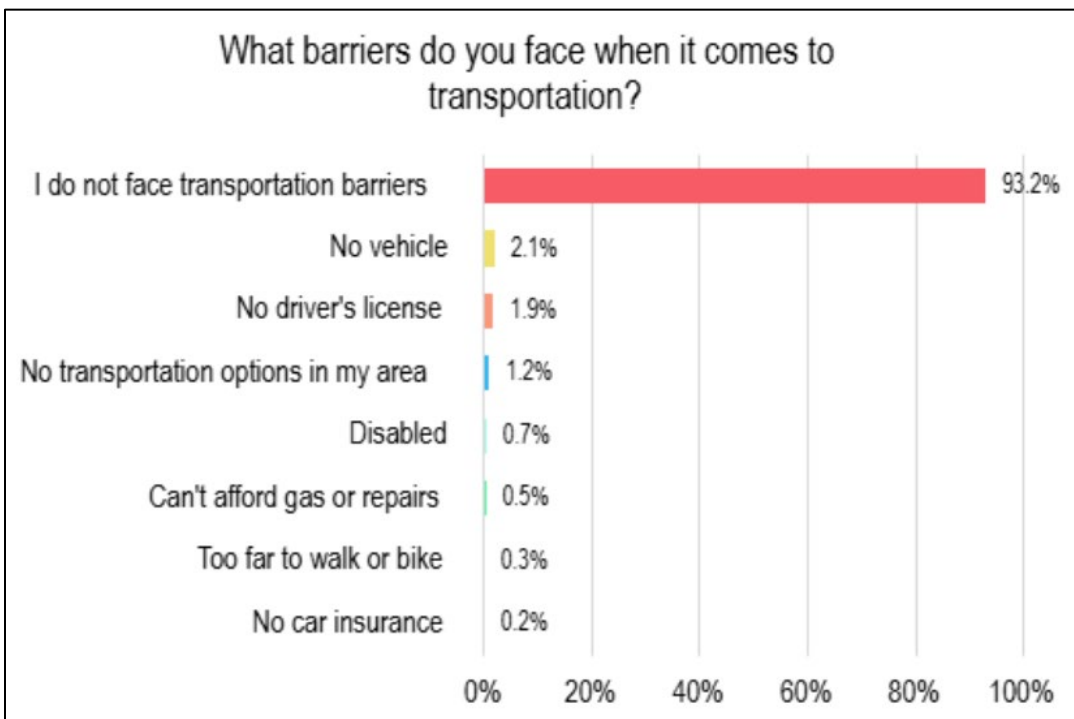
“Not enough transportation help or housing for low-income”

Community resident perspectives from focus groups

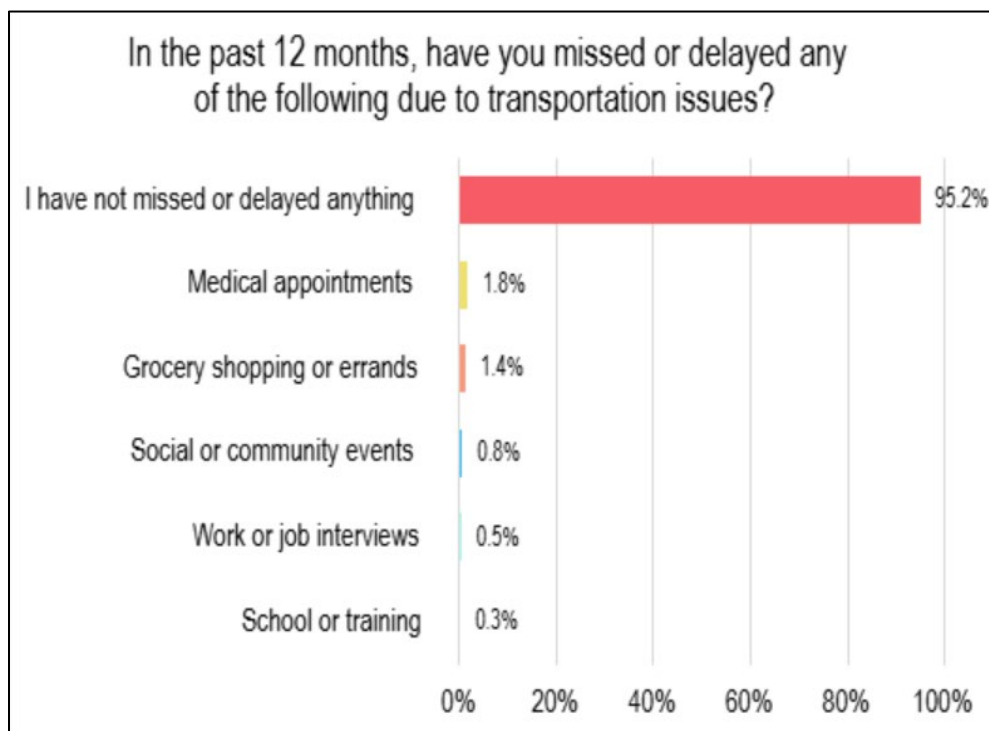
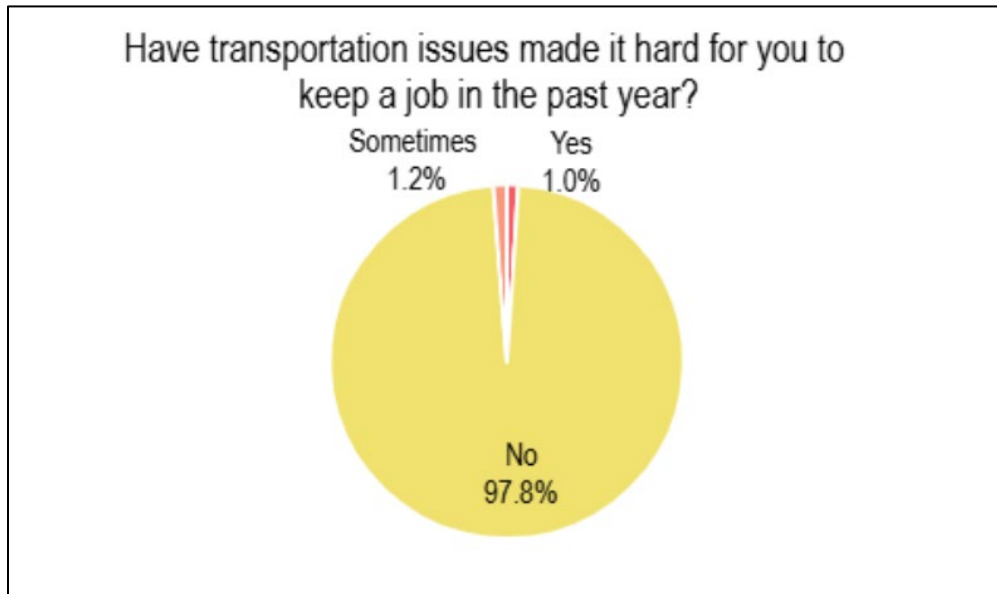
The 2025 Putnam County Community Health Assessment Survey had 98.5% of respondents stating they had reliable transportation and 95.2% have not missed anything due to transportation issues.



When asked about transportation barriers, 93.2% of respondents stated they do not face any barriers; however, that leaves 7% experiencing a variety of transportation issues.



98% of survey respondents replied *No* when asked if transportation issues made it hard for them to keep a job in the past year.



Health Behaviors and Lifestyles

Health behaviors and lifestyles reflect the everyday actions and habits that influence physical, mental, and social well-being. These behaviors are shaped by individual choices as well as the environments, resources, and social norms that support or constrain healthy living.

This section examines preventive health screenings, women’s and men’s health screenings, diet-related behaviors, physical activity patterns, experiences of abuse, and safety-related factors. Participation in preventive screenings remains strong across multiple areas, indicating awareness of early detection and routine health maintenance. These behaviors reflect engagement with the healthcare system and a general emphasis on prevention.

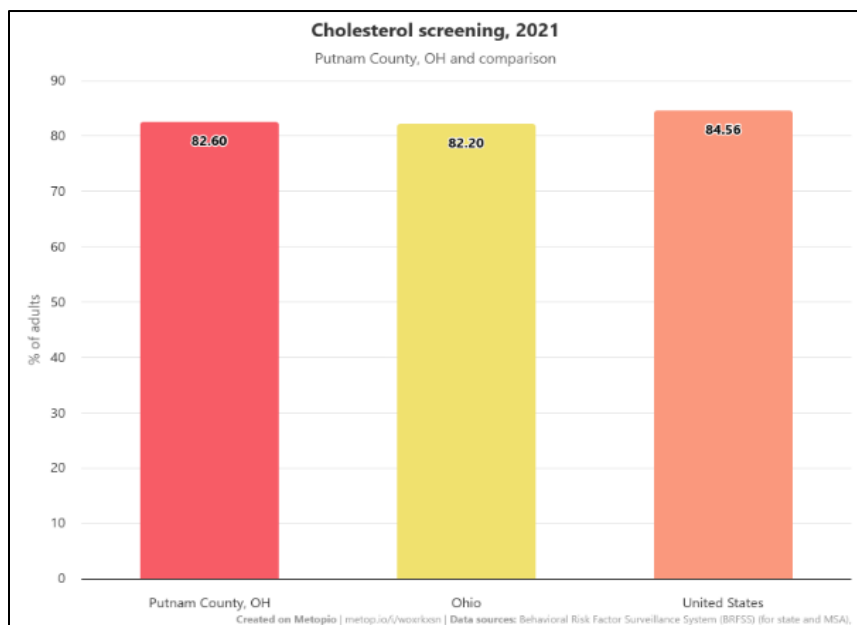
In contrast, diet-related behaviors reveal ongoing challenges related to cost, access, and preferences, with many residents reporting limited consumption of fruits and vegetables and regular reliance on restaurant or convenience foods. Physical activity patterns suggest that while most residents engage in some form of activity, barriers such as time constraints, motivation, energy, and access to safe or convenient spaces remain common. Safety-related topics, including experiences of abuse, firearm accessibility, and perceptions of personal and community safety, provide important context for understanding both physical injury risk and emotional well-being.

Taken together, these behaviors highlight areas of strength—particularly preventive care engagement—alongside opportunities to improve nutrition, physical activity, and safety through supportive environments, education, and community-based strategies.

Preventive Health Screenings

Cholesterol Screening

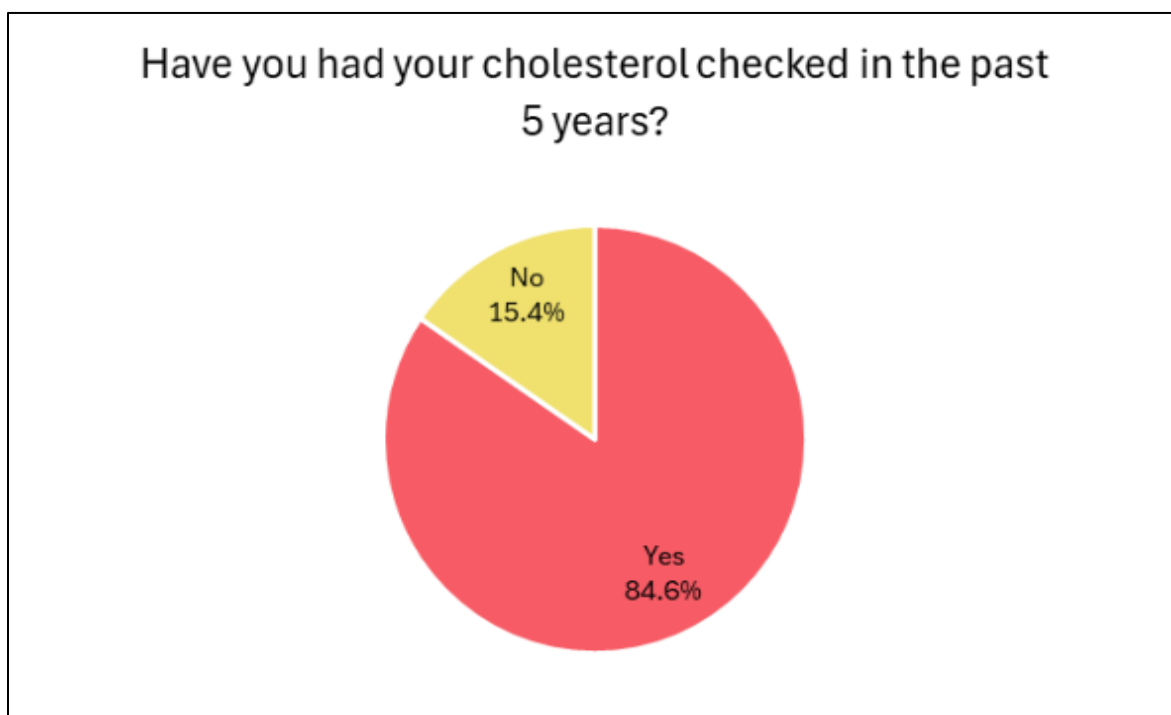
Percent of resident adults aged 18 and older who report having their cholesterol checked within the previous 5 years.



Cholesterol screening appears to be consistent between national, state, and local rates. Nationally, the screening rate stands at 84.56%. Putnam County has a slightly lower rate of 82.6%, and Ohio reports an even lower rate of 82.2%.

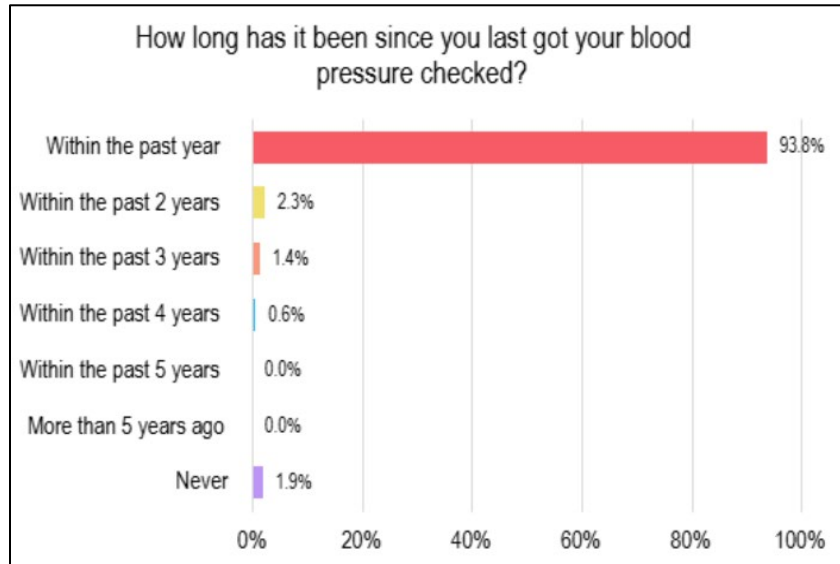
Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

When residents were asked in the 2025 Putnam County Community Health Assessment Survey, the vast majority responded that they had been screened in the past 5 years, supporting the 2021 national data source.



Blood Pressure Screening

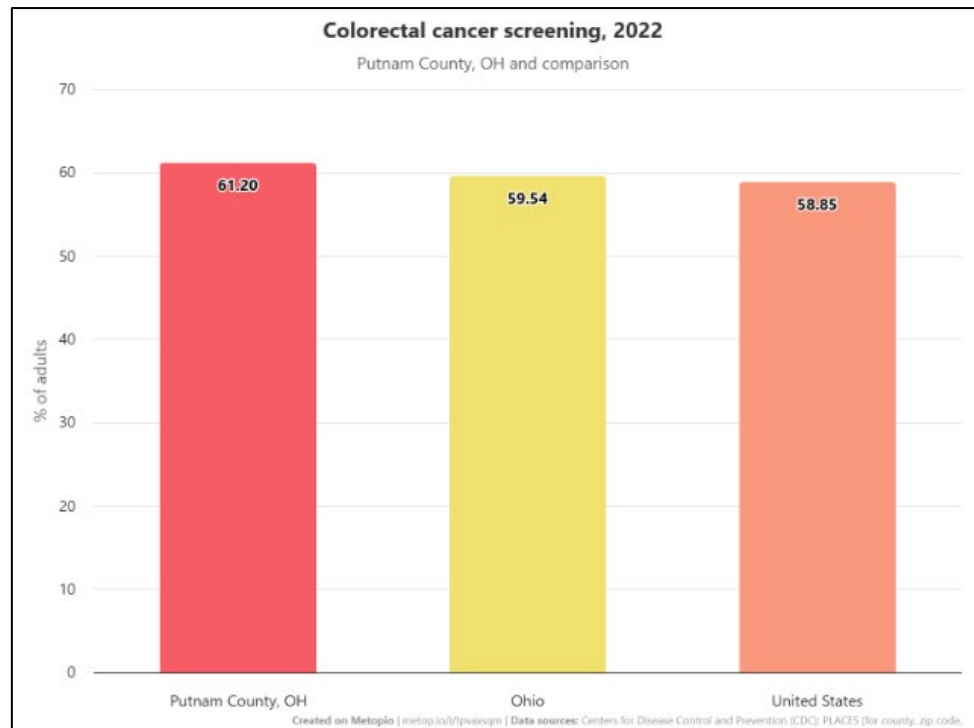
When residents were asked in the 2025 Putnam County Community Health Assessment Survey about having their blood pressure checked, the vast majority responded that their BP was checked in the past year.

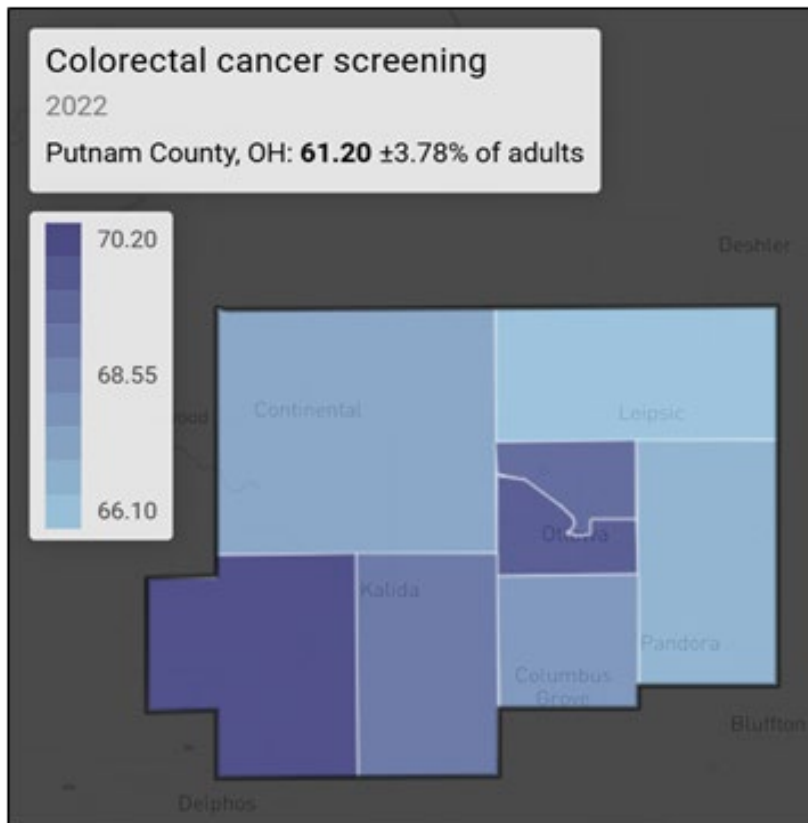


Colorectal Cancer Screening

Percent of resident adults aged 50-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

Colorectal cancer screening appears to be consistent between national, state, and local rates. Putnam County has the highest rate at 61.2%. Ohio's statewide rate is slightly lower at 59.54%, while the national average is 58.85%.

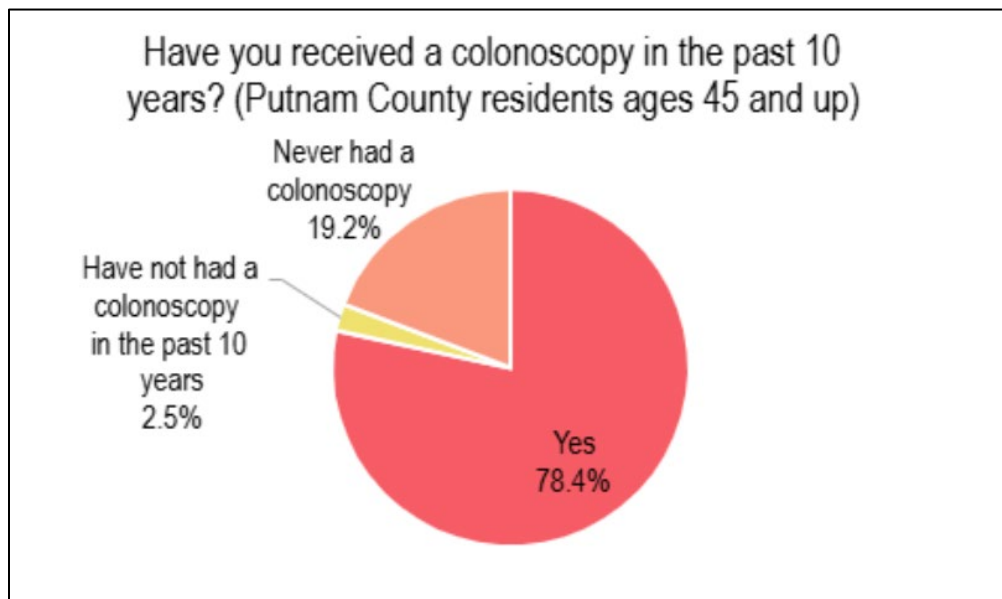




The data represents the percentage of adults aged 50-75 who have undergone colorectal cancer screening in various tracts of Putnam County. The screening rates range from 66.1% to 70.2%, indicating a relatively high level of screening within the county. This suggests a strong awareness and adherence to colorectal cancer screening guidelines among the adult population in Putnam County. Please refer to the census tract map and corresponding table on page 15.

Data Sources: Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract), Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA)

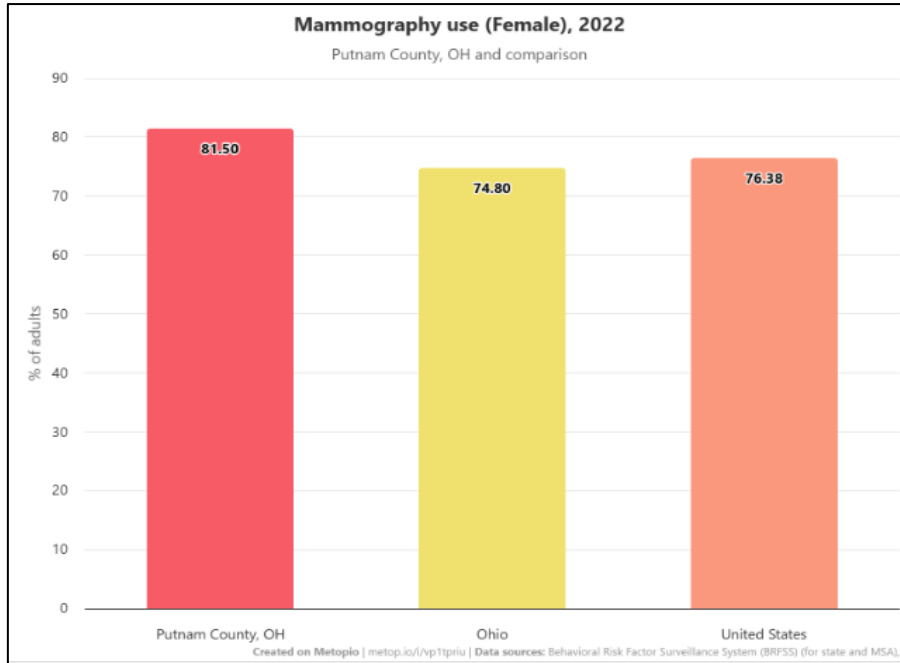
For the 2025 Putnam County Community Health Assessment Survey, resident responses were filtered according to age because the recommendation for receiving a colonoscopy is age 45 years and older. Most respondents older than 45 years of age responded that they had a colonoscopy in the past 10 years, which is even higher than the CDC data reporting for Putnam County and far exceeds the state and national rate.



Women's Health Screening

Mammography Use

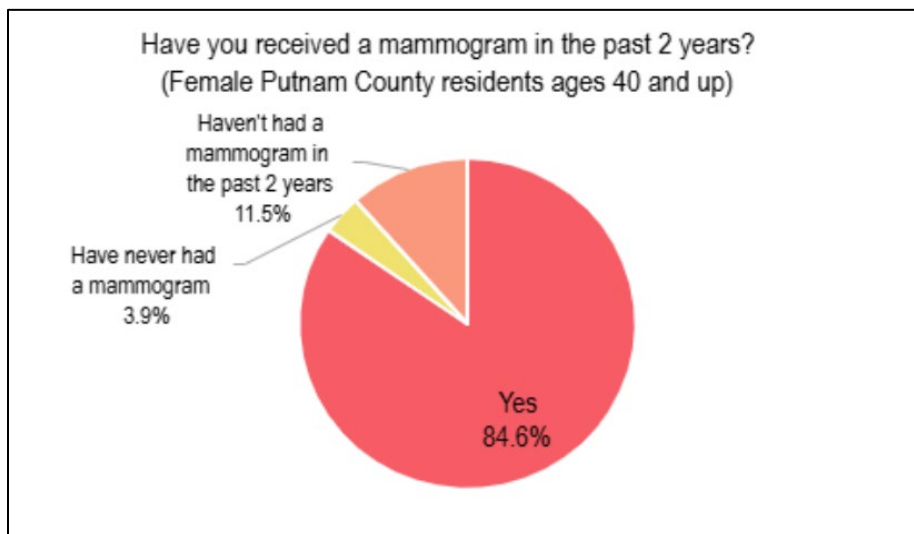
Percent of resident female adults aged 50-74 years who report having had a mammogram within the previous 2 years.



Putnam County mammography use rates (81.5%) are higher than Ohio (74.8%) and the United States (76.38%). This data highlights that Putnam County is performing better in this health metric compared to the national and state averages and places a high priority on screening.

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

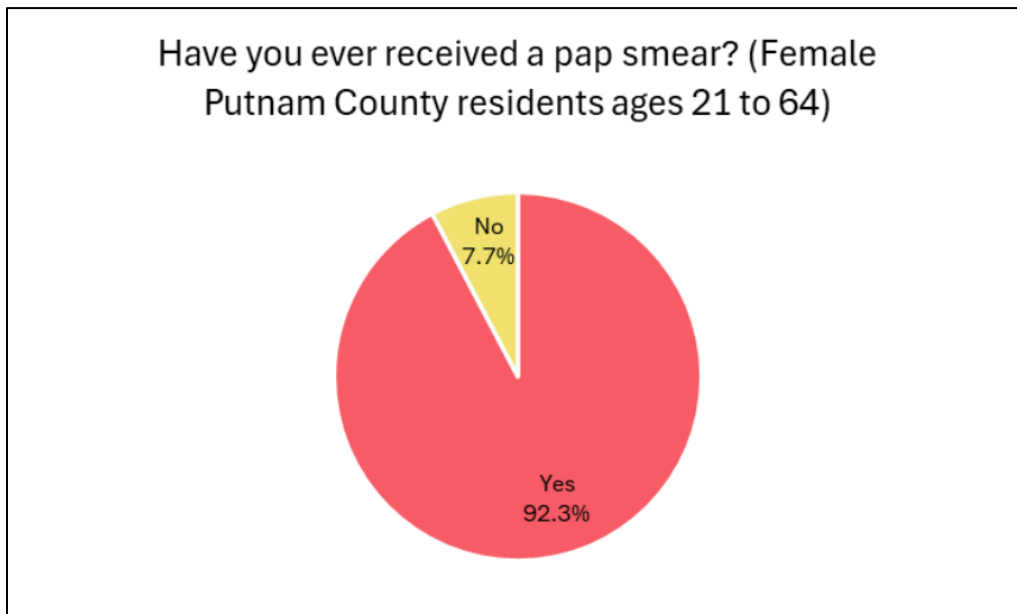
For the 2025 Putnam County Community Health Assessment Survey, resident responses were filtered according to age and gender because the recommendation for screening is for females age 40 years and older.



Most female respondents older than 40 years of age responded that they had a mammogram in the past 2 years, which is even higher than the CDC data reporting for Putnam County and far exceeds the state and national rate.

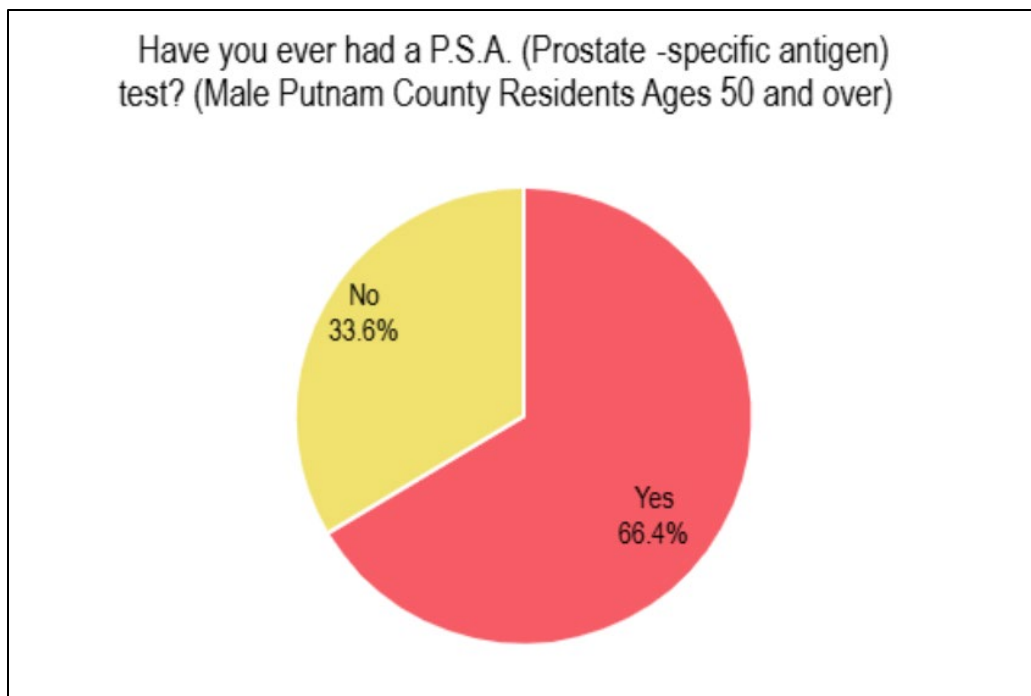
PAP Smear

For the 2025 Putnam County Community Health Assessment Survey, resident responses were filtered according to age and gender because the recommendation for screening is for females between the ages of 21 to 64 years of age. Most female respondents in this age category responded that they had a PAP smear for cervical cancer screening at some time in their past.



Men's Health Screening

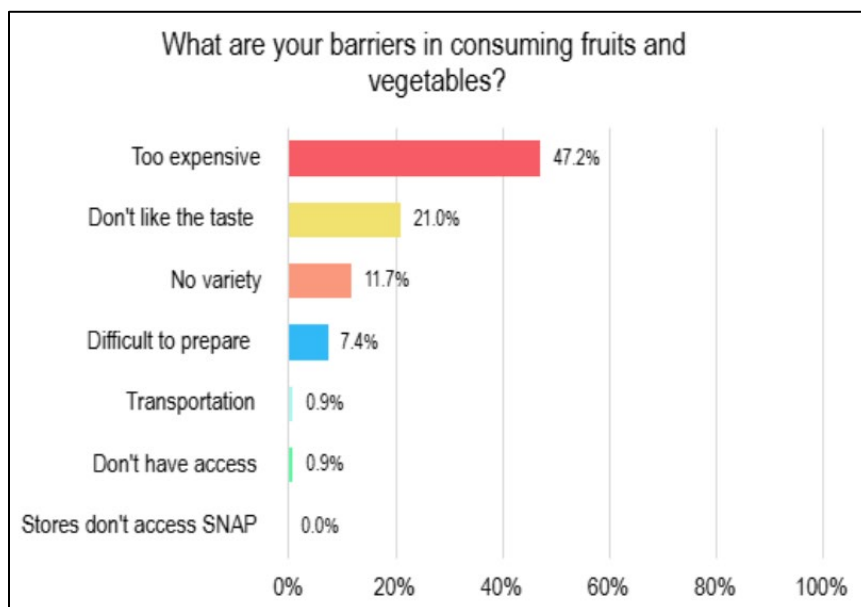
For the 2025 Putnam County Community Health Assessment Survey, resident responses were filtered according to age and gender because the recommendation for PSA screening is for males age 50 years and older. Many of male respondents older than 50 years of age responded that they had a PSA test at some time in their past, but there is work to do to improve these numbers.



Diet Related Behaviors

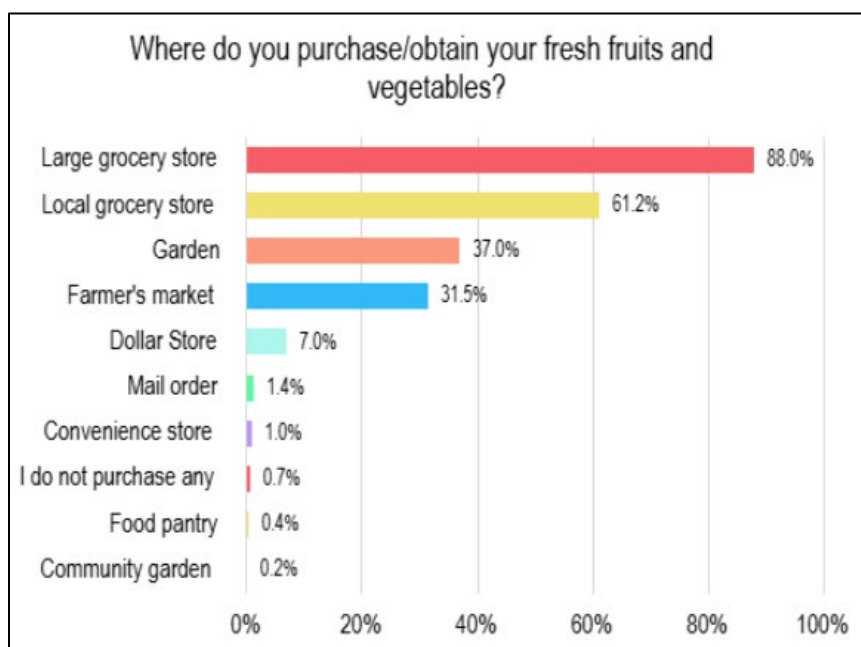
Barriers to Consuming Fruits and Vegetables

Data from the 2025 Community Health Assessment Survey highlight several key barriers that prevent Putnam County residents from eating recommended amounts of fruits and vegetables. Nearly half of respondents (47.2%) reported that fruits and vegetables are “too expensive,” making cost the most significant barrier. Additional barriers include not liking the taste (21.0%), lack of variety (11.7%), and difficulty preparing produce (7.4%).



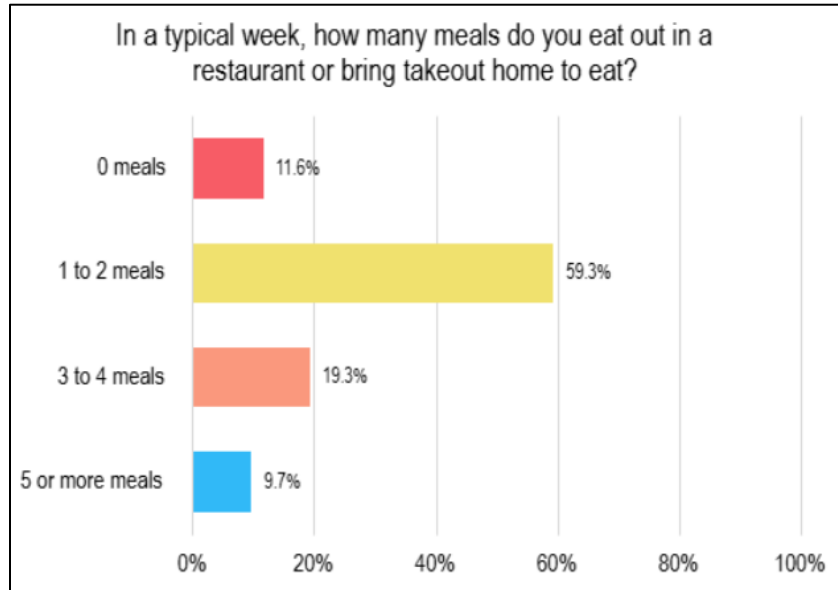
Where Residents Obtain Fresh Fruits and Vegetables

Survey results show that most Putnam County residents rely on traditional grocery stores to access fresh produce. Large grocery stores were selected by 88.0% of respondents, followed by local grocery stores (61.2%). Many residents also reported obtaining fruits and vegetables from home gardens (37.0%) and farmers' markets (31.5%), indicating strong community use of local food sources. Only a small percentage of residents rely on dollar stores, convenience stores, or food pantries for produce.



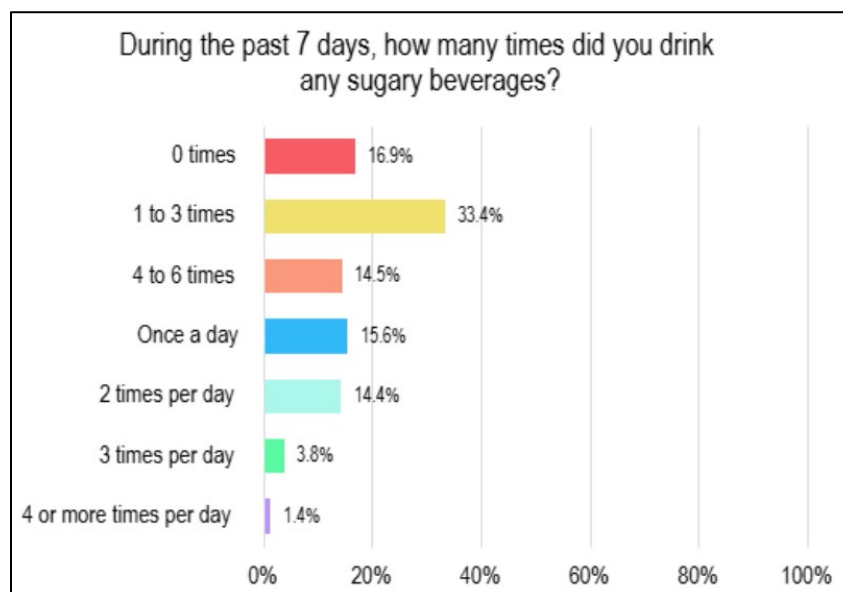
Weekly Frequency of Eating Out or Takeout Meals

When asked about weekly eating habits, most respondents (59.3%) reported eating out or purchasing takeout meals one to two times per week. Another 19.3% reported doing so three to four times weekly, while 9.7% reported five or more meals eaten out per week. Only 11.6% of residents stated that they do not eat out at all during a typical week. These patterns suggest that restaurants and takeout foods are a regular part of many residents' weekly routines, which may influence dietary choices and overall nutrition.



Sugary Beverage Consumption in the Past 7 Days

Sugary beverage intake varies widely among Putnam County residents. One-third of respondents (33.4%) consumed sugary drinks one to three times in the past week, while 16.9% reported no consumption. Daily intake is also common: 15.6% consumed sugary beverages once per day, and 14.4% consumed them twice per day. A smaller percentage reported drinking sugary beverages three or more times per day. These results indicate that while some residents limit sugary drink intake, many consume them regularly, which may contribute to chronic health risks such as obesity and diabetes.

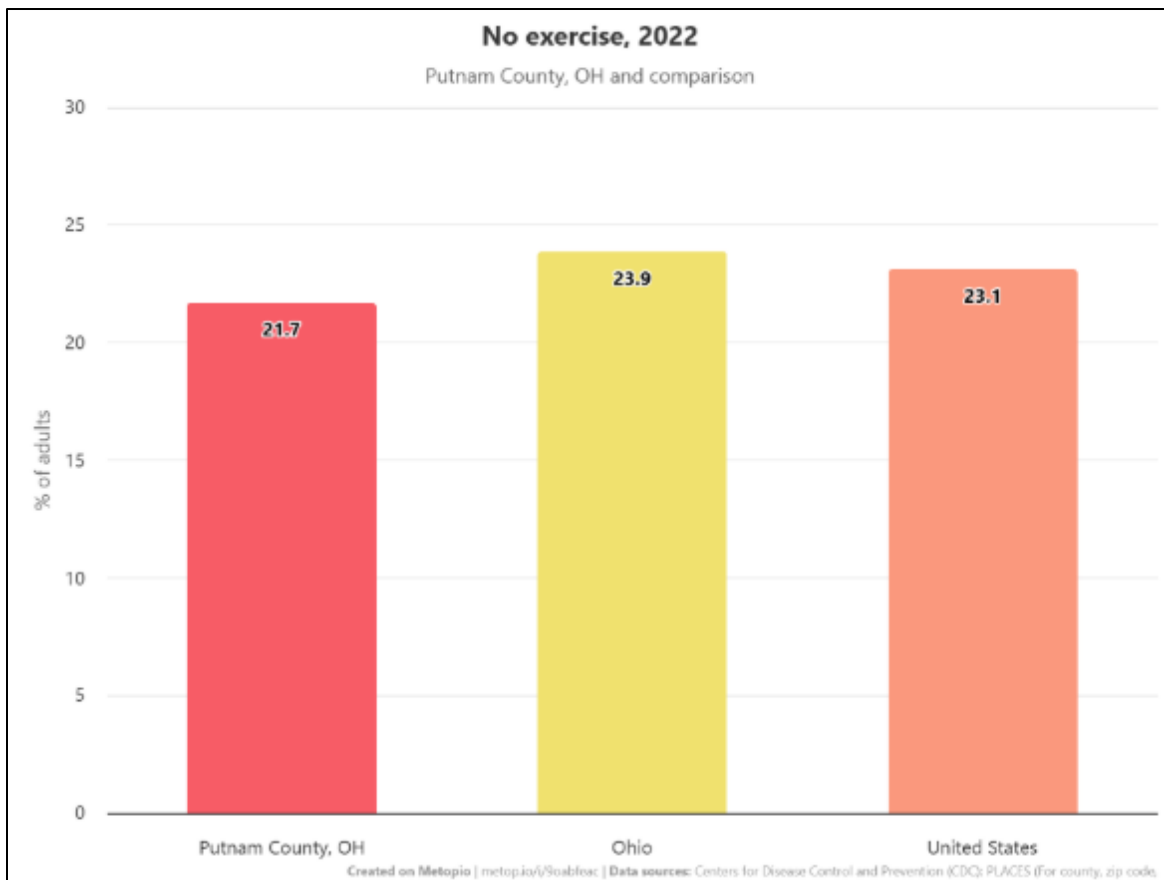


Physical Activity Related Behaviors

No Exercise

Percent of resident adults aged 18 and older who answered “No” to the following question: “During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?”

The data indicates that Ohio has a higher percentage of individuals who do not exercise compared to the national average, with Putnam County having a slightly lower percentage than the state average. The national average for no exercise is 23.1%, while Ohio's average is 23.9%. Putnam County has no exercise rate of 21.7%. This suggests that Ohio, and particularly Putnam County, may have unique factors influencing physical activity levels.

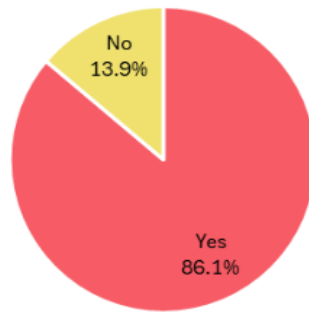


"Youth activities, healthy youth activities -Get them off their phones. Get them outdoors. And activities where they can come together and be friends and don't have to drink."

Community resident perspective from focus group

Exercise Habits

During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?



Results from the 2025 Putnam County Community Health Assessment Survey indicate that 13.9% of respondents did not participate in any exercise or physical activity in the past month, outside of their regular work responsibilities. Although most residents (86.1%) reported some level of physical activity, the share of individuals who remain inactive highlights the need

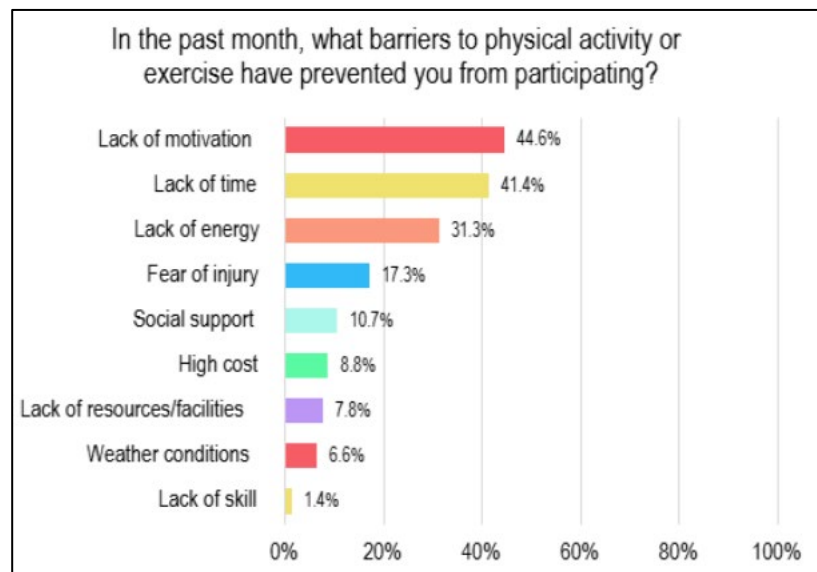
for continued efforts to promote and sustain exercise opportunities across the county.

"To me, it's the amount of people that focus on their health, their physical health whether it's going to work out at gyms, getting outside, being active, utilizing the parks. It seems like a majority of people in this county that I've seen put a primary focus on their health to live a longer life."

Community resident perspective from focus group

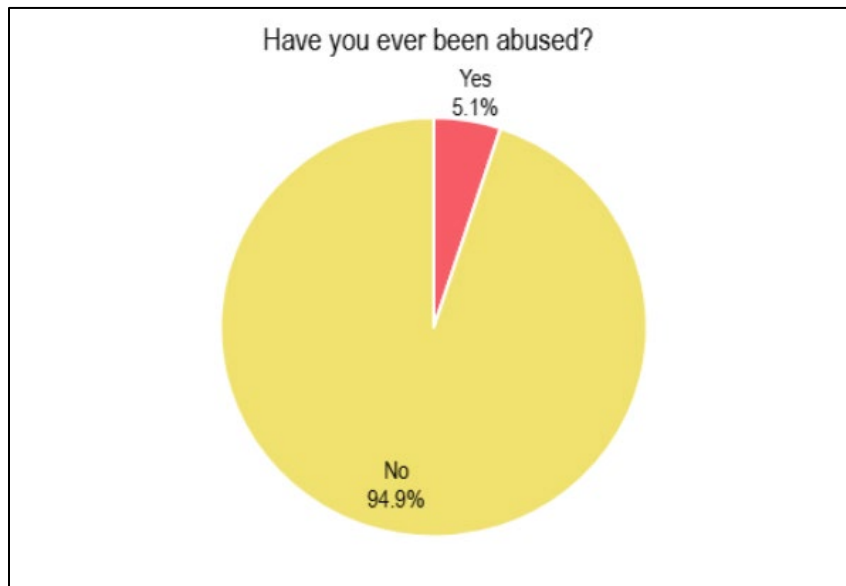
Barriers to Physical Activity

Residents identified several barriers that prevent them from engaging in regular physical activity. The most frequently reported obstacles include lack of motivation (44.6%), lack of time (41.6%), and low energy (37.3%). Other factors such as fear of injury, limited social support, high costs, and lack of available facilities further contribute to inactivity. These findings highlight both personal and environmental challenges that impact residents' ability to exercise consistently.



Abuse

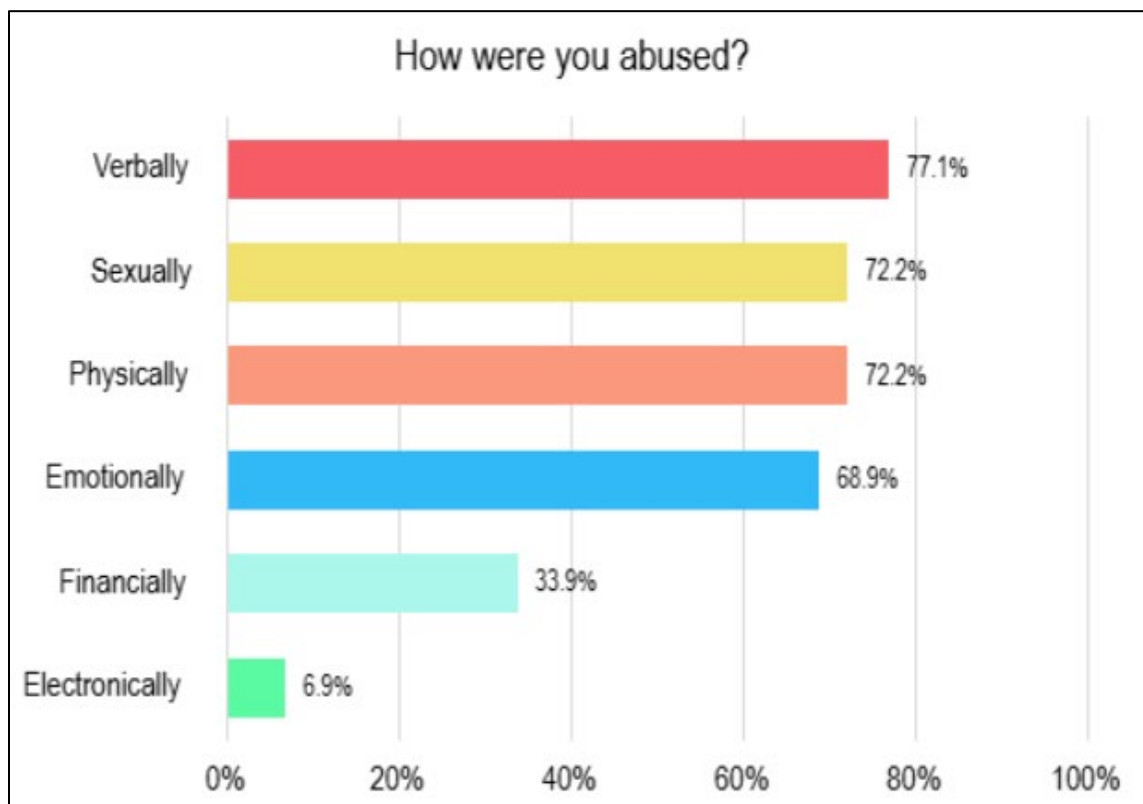
Experienced Abuse



Data from the 2025 Community Health Assessment Survey show that 5.1% of Putnam County respondents reported having experienced some form of abuse in their lifetime. While the majority (94.9%) indicated they had not been abused, the percentage who have experienced abuse represents an important public health concern, as even small proportions reflect real individuals impacted by violence or harm within the community.

Type of Abuse Experienced

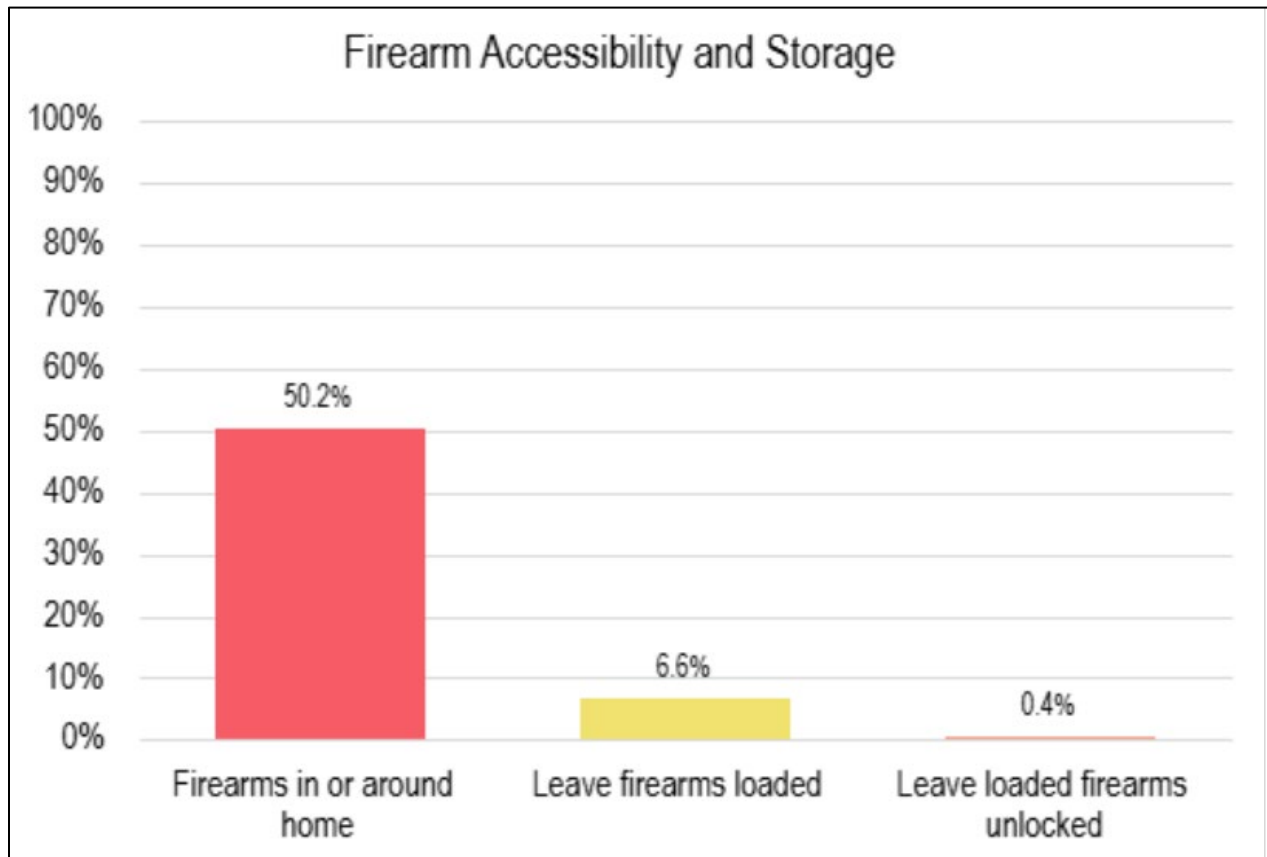
Among respondents who reported experiencing abuse, multiple forms of harm were identified. Verbal abuse was the most reported (77.1%), followed closely by sexual abuse (72.2%) and physical abuse (72.2%). Emotional abuse was also highly prevalent (68.9%). Financial abuse (33.9%) and electronic abuse (6.9%) were reported less frequently but still represent meaningful concerns. These findings illustrate that those who experience abuse often encounter more than one form, underscoring the need for comprehensive prevention and support services within Putnam County.



Safety

Firearm Accessibility and Storage

Survey findings show that half of respondents (50.2%) reported having firearms in or around their home. While only 6.6% stated that firearms were kept loaded, and just 0.4% indicated that loaded firearms were stored unlocked, these behaviors still represent potential safety risks—particularly for children, teens, and individuals experiencing a mental health crisis. These data highlight the importance of promoting safe firearm storage practices to reduce the risk of unintentional injury, suicide, and other firearm-related harms.



Health Outcomes

Health outcomes describe the overall health status of a population and the conditions that most affect quality of life, daily functioning, and longevity. Examining outcomes provides insight into how access to care, health behaviors, and broader social and environmental conditions translate into measurable health status over time.

This section focuses on general health status and chronic conditions, including obesity, heart disease, high blood pressure, high cholesterol, diabetes, respiratory disease, stroke, and cancer. Many residents report positive perceptions of their overall health; however, chronic conditions remain common and continue to influence daily life for a substantial portion of the population.

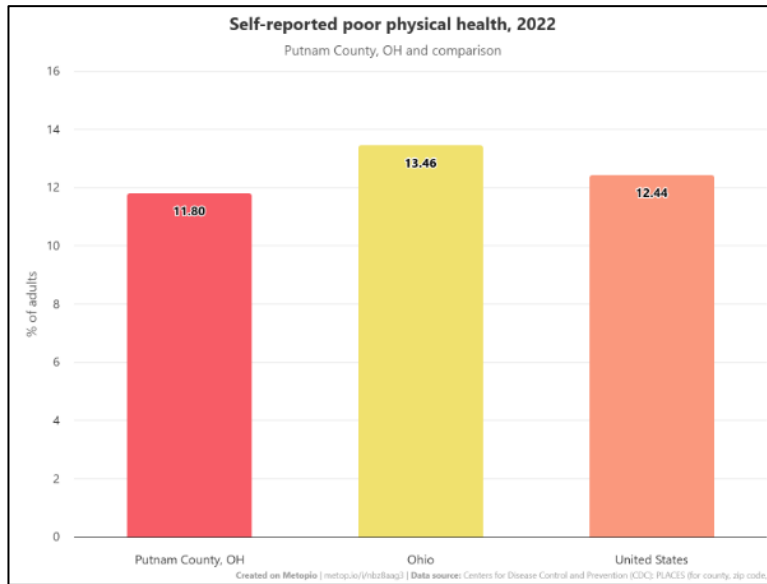
Conditions related to cardiovascular and metabolic health are particularly prominent, reflecting long-term patterns associated with diet, physical activity, and preventive care. Respiratory conditions and cancer further contribute to the overall burden of disease, even when prevalence aligns with broader trends. These conditions often require ongoing management and place sustained demand on healthcare services.

Understanding these outcomes provides clarity on where health challenges are concentrated and supports identification of prevention, early detection, and disease management efforts that can improve long-term health and reduce avoidable burden on individuals and the healthcare system.

General Health Status (Population-Level Indicators)

Self-Reported Poor Physical Health

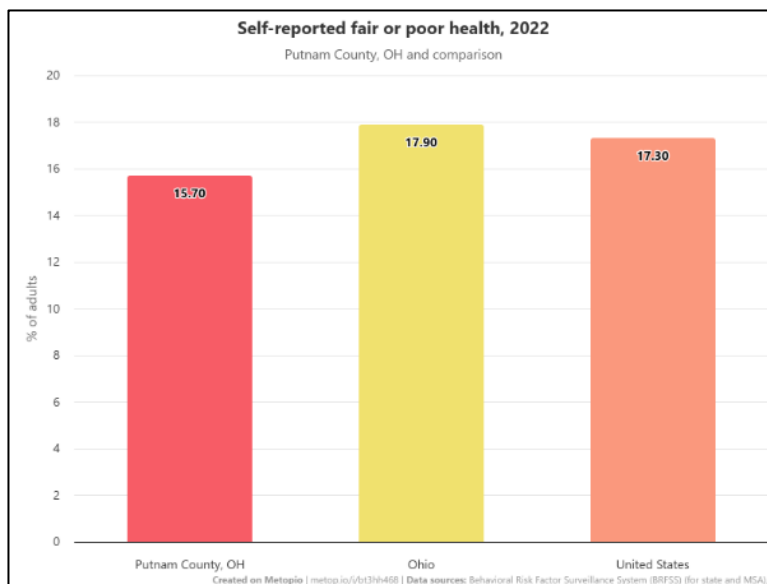
Percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their physical health was not good.



Putnam County data shows that 11.8% of adults reported experiencing 14 or more days of poor physical health in the past month. While this rate is lower than Ohio's overall rate of 13.46% and the national average of 12.44%, it still highlights a notable portion of residents facing ongoing physical health challenges. Continued local efforts to promote active living, preventive care, and healthy lifestyle choices are important to further improve physical health across the county.

Self-Reported Fair or Poor Health

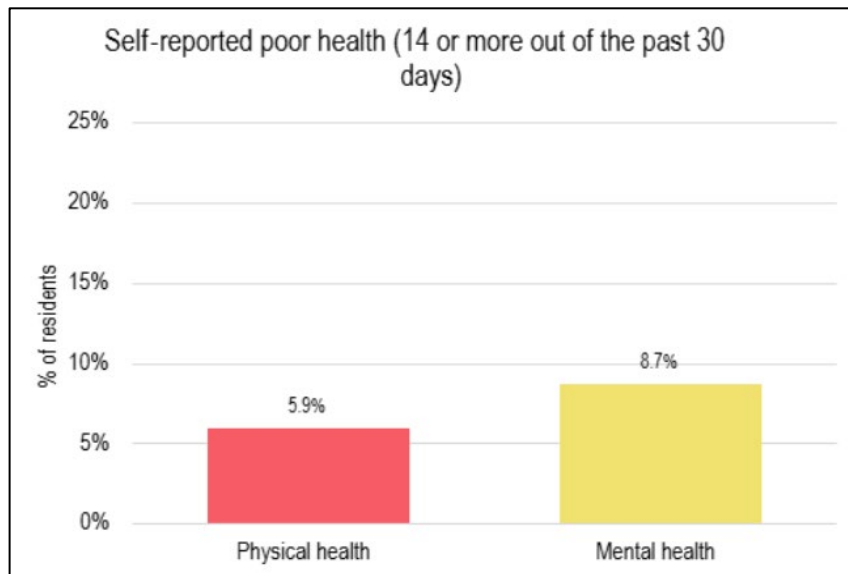
Percentage of resident adults aged 18 and older with self-reported fair or poor health status. This refers to an individual's overall perception of their health status



In Putnam County, 15.7% of adults reported their health as fair or poor—lower than both the Ohio rate of 17.9% and the national rate of 17.3%. This suggests that many residents perceive their overall health more positively compared to the broader state and nation. However, the data also show that a portion of the community continues to face health challenges. Ongoing local initiatives that promote preventive care, active living, and access to healthy food can help further improve overall well-being for Putnam County residents.

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), University of Wisconsin Population Health Institute: County Health Rankings (Calculated using data from BRFSS and UW Population Institute), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

Mental & Physical Health – Community Survey Results



The 2025 Community Health Assessment Survey asked residents to report “experiencing poor physical or mental health for 14 or more days out of the past 30 days”. Approximately 6% of respondents reported poor physical health for 14 or more days of the previous month, while about 9% reported poor mental health for the same duration. These findings suggest that mental health challenges are more commonly reported than physical health concerns

among residents, highlighting the importance of continued attention to mental health resources, support systems, and community wellness initiatives in Putnam County.

Chronic Disease

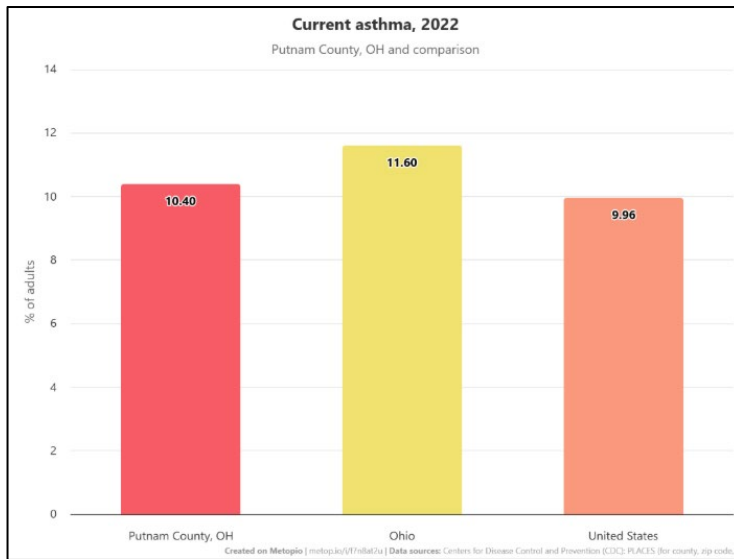
The following chart displays the prevalence of chronic health conditions diagnosed by a healthcare provider among respondents of the 2025 Putnam County Community Health Assessment Survey.

Survey participants from across Putnam County were asked whether they had ever been diagnosed with specific chronic conditions. The most reported condition was high blood pressure, affecting roughly one in three respondents. High cholesterol and arthritis were also frequently reported, followed by diabetes and asthma. Less commonly reported conditions included cancer, angina, kidney disease, heart attack, COPD, and stroke.



Asthma

Percent of adults (civilian, non-institutionalized population) who answer “yes” to both of the following questions: “Have you ever been told by a doctor, nurse, or other health professional that you have asthma?” and the question “Do you still have asthma?”

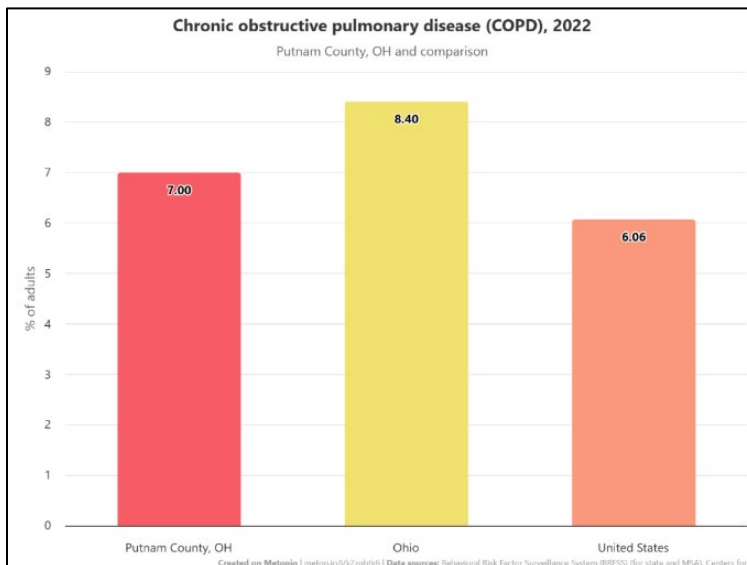


The data indicates that the prevalence of current asthma is higher in Ohio compared to the national average. Specifically, Putnam County has a slightly lower rate of current asthma compared to the state average. Overall, Ohio's current asthma rate is 11.6%, which is above the national average of 9.96%.

Data Sources: Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract), Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA)

Chronic Obstructive Pulmonary Disease (COPD)

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis.

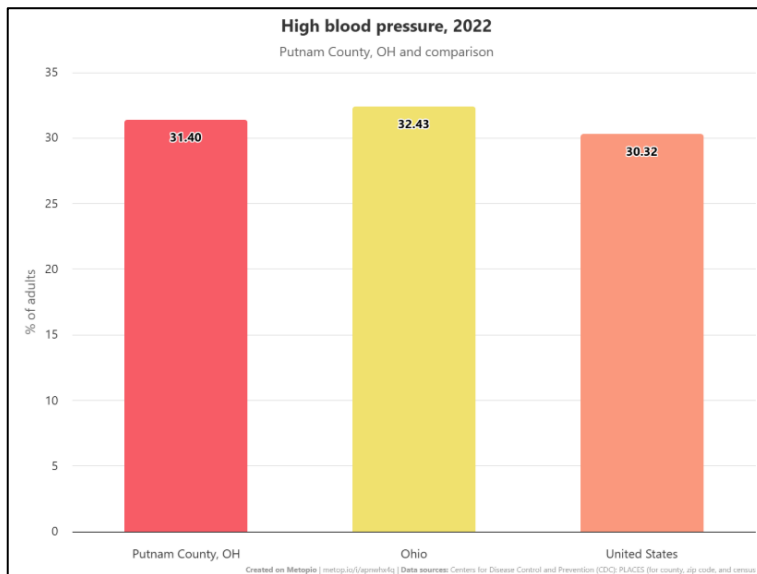


Chronic obstructive pulmonary disease (COPD) is a significant health issue in the United States. In Ohio, the prevalence of COPD is notably higher than the national average, with a rate of 8.4%. Putnam County has a slightly lower prevalence at 7.0% but still exceeds the national rate of 6.06%. This data highlights the need for targeted healthcare interventions in these areas to address the higher incidence of COPD.

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

High Blood Pressure

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure (hypertension). Women who were told they had high blood pressure during pregnancy and those who were told they had borderline hypertension were not included.

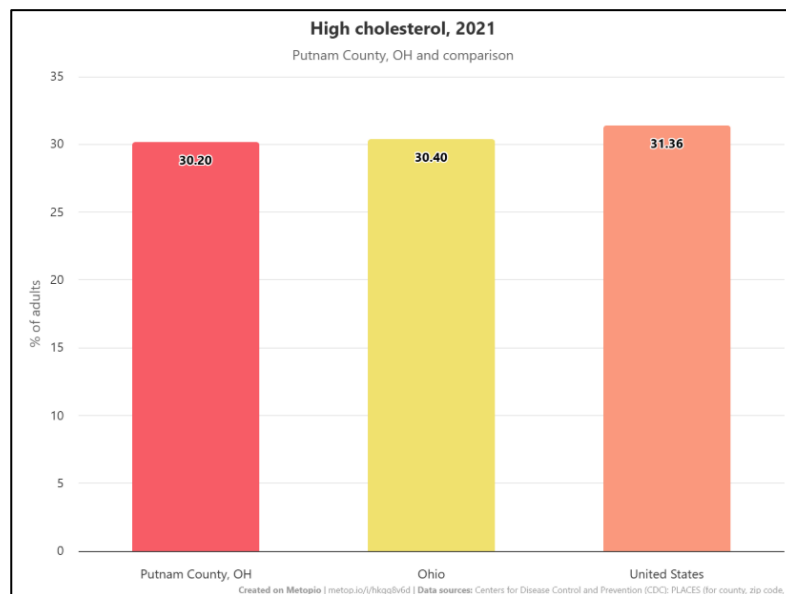


The data highlights high blood pressure rates. Ohio has the highest rate at 32.43%, followed by Putnam County at 31.4%. The national average is 30.32%.

High Cholesterol

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have high cholesterol.

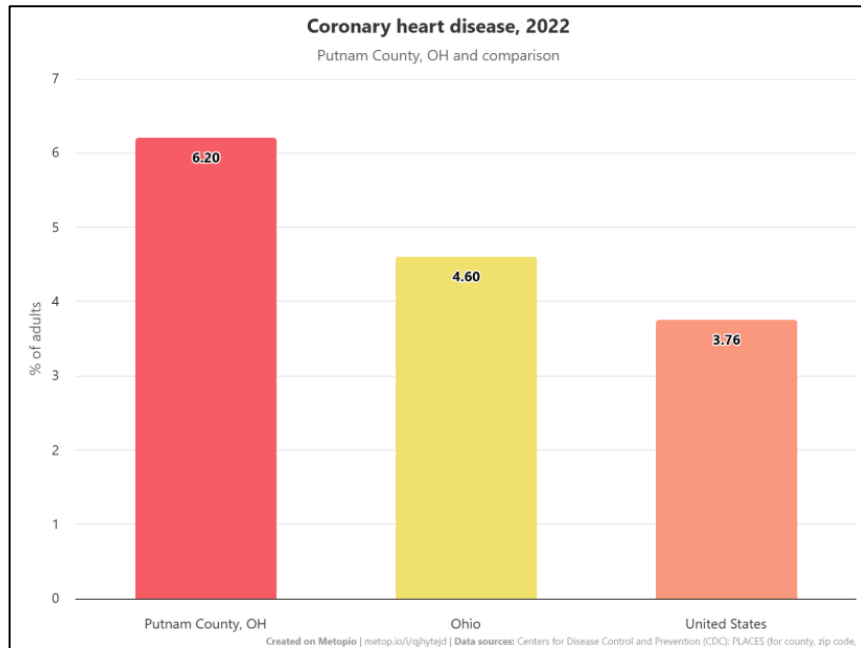
The following chart highlights that high cholesterol is a prevalent health concern across the United States, with a national prevalence rate of 31.36%. Ohio has a slightly lower prevalence rate of 30.4%. Putnam County has a cholesterol prevalence rate of 30.2%, indicating a consistent health issue. This health issue impacts a substantial portion of the adult population, highlighting the need for health interventions and awareness campaigns.



Data Sources: Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract), Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA)

Coronary Heart Disease

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have angina or coronary heart disease.



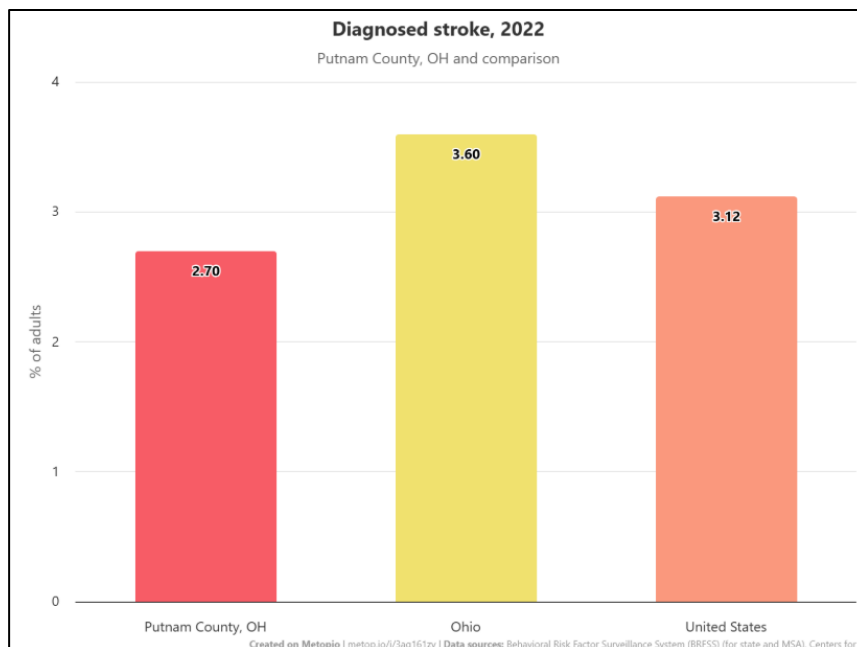
Coronary heart disease rates are the highest in Putnam County with a rate of 6.2%, while Ohio's overall rate is 4.6%. The United States has an average rate of 3.76%, with Putnam County having a notably higher prevalence of the disease.

“Limited access to medical services, including a shortage of primary care physicians and urgent care facilities, is a significant barrier to health.”

Community resident perspective from focus group

Diagnosed Stroke

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have had a stroke.

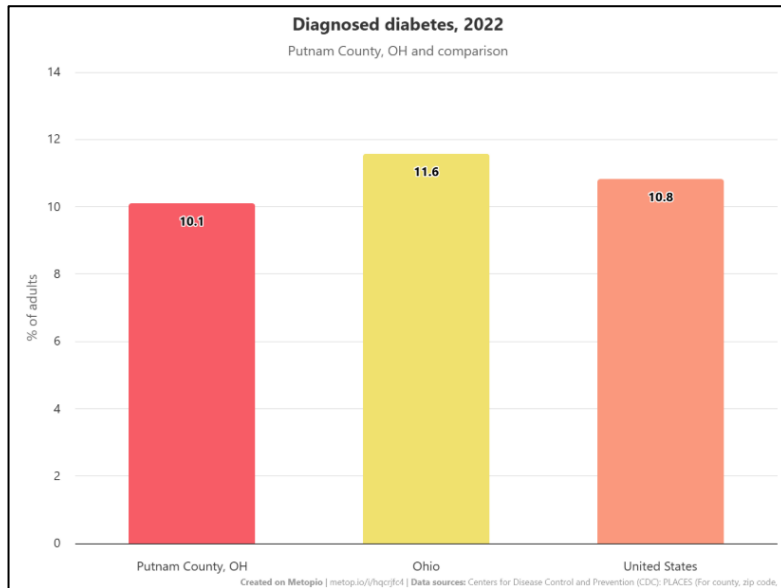


Putnam County reports a lower percentage of adults diagnosed with stroke (2.7%) compared to both Ohio (3.6%) and the United States (3.12%). This suggests that residents of Putnam County experience fewer stroke diagnoses than the state and national averages, indicating relatively better cardiovascular health outcomes locally. Continued prevention efforts can help sustain and further improve these favorable trends.

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

Diagnosed Diabetes

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have diabetes, other than diabetes during pregnancy. Data for counties and states are age-adjusted. Data for zip codes, census tracts and smaller layers are raw.



Putnam County reports a lower rate of diagnosed diabetes (10.1%) compared to both Ohio (11.6%) and the United States (10.8%). This indicates that the prevalence of diabetes among adults in Putnam County is below but very similar to both the state and national averages.

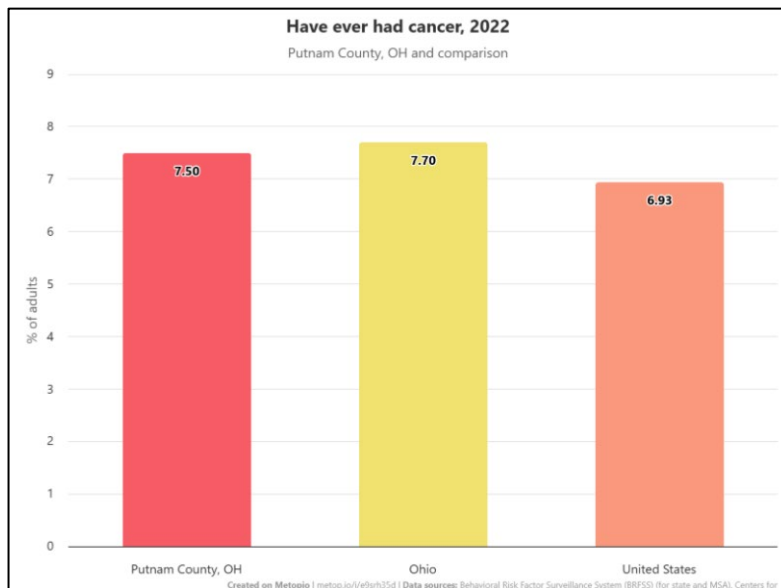
“Local diabetic classes for management and diet would be helpful.”

Community resident perspective from focus group

Data Sources: Centers for Disease Control and Prevention (CDC): PLACES (For county, zip code, and census tract), Centers for Disease Control and Prevention (CDC): United States Diabetes Surveillance System (County and state level data before 2017)

Cancer

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have cancer (other than skin cancer).



The chart data indicates the prevalence of individuals who have ever had cancer in Ohio, Putnam County and the United States. In Ohio, 7.7% of individuals have had cancer, while in Putnam County the rate is slightly lower at 7.5%. Nationwide, the prevalence is 6.93%.

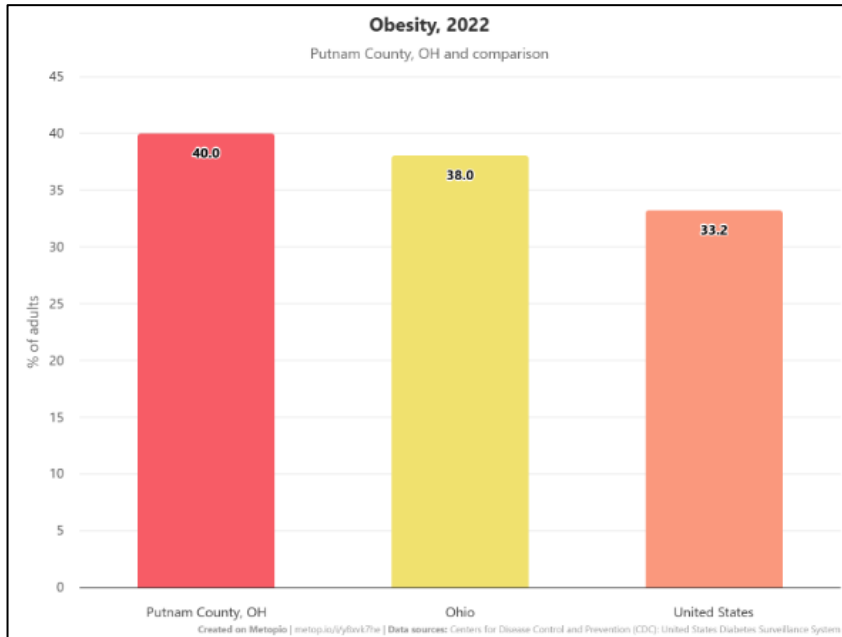
“Cancer – seems younger people are getting it more.”

Community resident perspective from focus group

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

Obesity

Percent of resident adults aged 18 and older who are obese (have a body mass index (BMI) ≥ 30.0 kg/m² calculated from self-reported weight and height). Excludes those with abnormal height or weight and pregnant women.

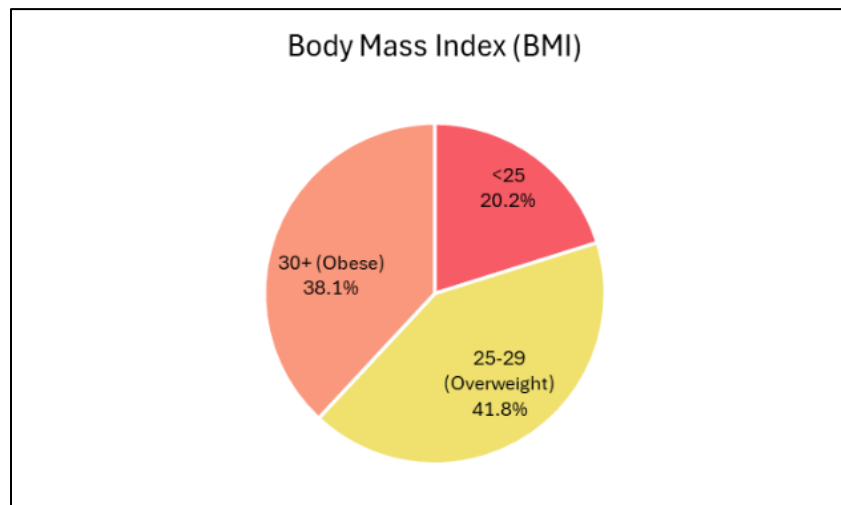


Obesity rates in Putnam County are higher than both the state and national averages. In Ohio, the obesity rate is 38.0%, while the United States has an obesity rate of 33.2%. Putnam County's obesity rate stands at 40.0%, indicating significant health concern for the area. These figures highlight the need for targeted health interventions to address obesity in Putnam County.

Data Sources: Centers for Disease Control and Prevention (CDC): United States Diabetes Surveillance System (County level data before 2018), Behavioral Risk Factor Surveillance System (BRFSS) (For state and MSA), Centers for Disease Control and Prevention (CDC): PLACES (For county, zip code, and census tract)

Body Mass Index

Data from the 2025 Community Health Assessment Survey confirms that overweight and obesity are significant chronic health conditions negatively impacting the health of Putnam County residents at even higher rates than CDC data indicates above in 2022 data.



Mental Health and Substance Misuse

Mental health and substance misuse affect emotional well-being, physical health, safety, and social stability. These factors influence individuals and families while also shaping community resilience, workforce participation, and demand for healthcare and social services.

This section examines mental health status, depression, emotional well-being, substance misuse and risk behaviors, alcohol use, tobacco and nicotine use, suicide-related indicators, and access to mental health providers. Emotional distress, loneliness, and depression are present across the community, often alongside barriers to accessing behavioral health services. Alcohol use patterns reflect social norms that contribute to risk, while tobacco and nicotine use remains relatively limited overall.

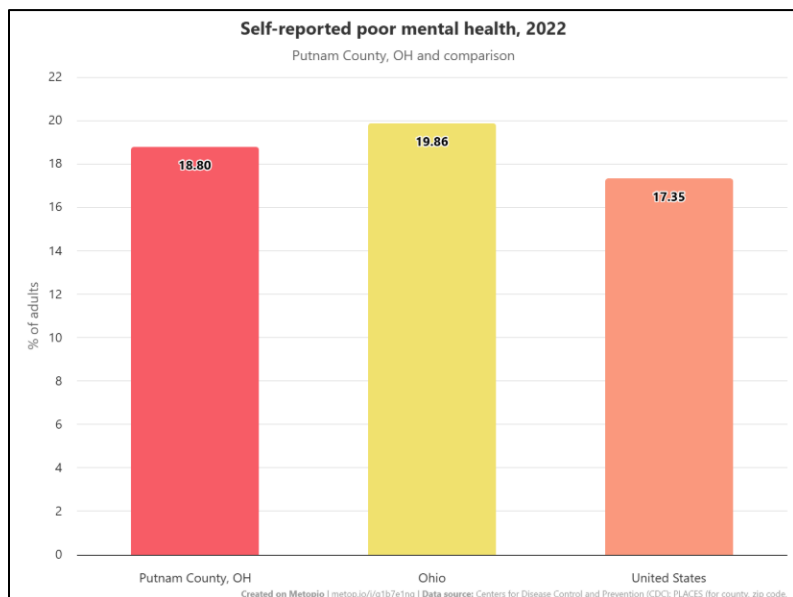
Access to mental health services is constrained by provider shortages, cost, stigma, and limited availability of local resources. Indicators related to suicide threats and attempts point to ongoing need for prevention, early intervention, and crisis response, even when mortality rates remain comparatively low.

Together, these findings underscore the importance of strengthening behavioral health capacity, expanding prevention and early support efforts, and reducing barriers to care to support emotional well-being and community safety.

Mental Health Status

Self-Reported Poor Mental Health

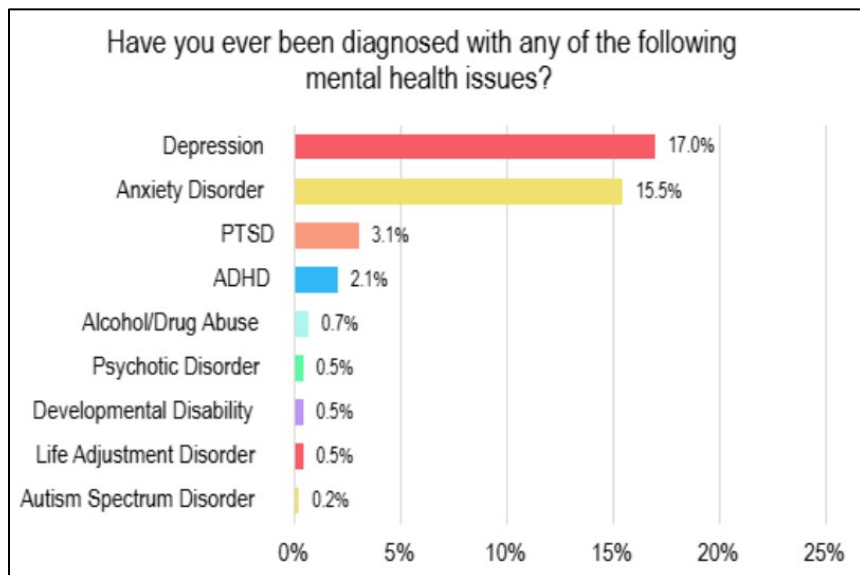
Percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.



Self-reported poor mental health is a significant issue in Ohio, with a rate of 19.86%, which is higher than the national average of 17.35%. Putnam County reports a slightly lower rate of 18.8%. This data highlights the need for targeted mental health interventions in the area.

Data Sources: Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

According to the 2025 Community Health Assessment Survey, 7.6% of respondents reported experiencing poor mental health for 14 or more days within the past 30 days, and 6.37% of respondents reported 14 or more days where poor physical or mental health kept them from doing their usual activities, highlighting ongoing challenges related to emotional well-being across the county.



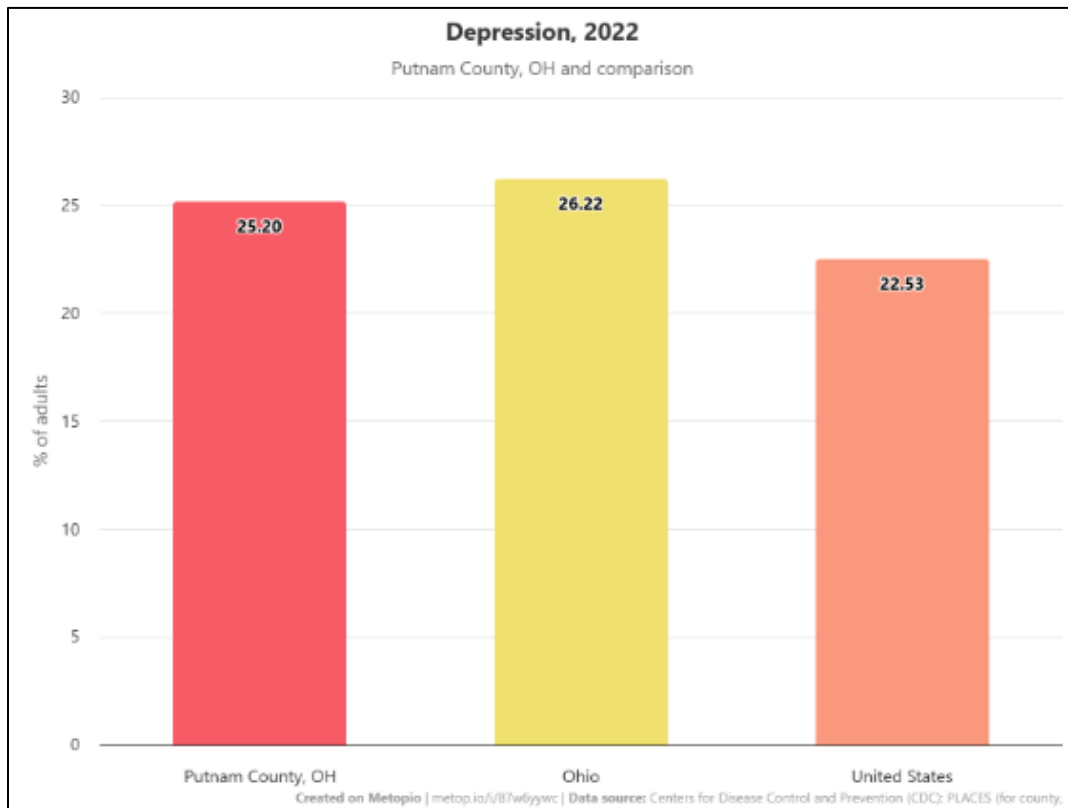
Complementing this measure, the survey also asked respondents whether they had ever been diagnosed with a mental health condition. The most reported diagnoses were depression (17%) and anxiety disorder (15.5%), followed by PTSD (3.1%) and ADHD (2.1%). Fewer residents reported diagnoses such as alcohol or drug abuse (0.7%), psychotic disorder (0.5%), developmental disability (0.5%), life adjustment disorder (0.5%), or autism spectrum disorder (0.2%).

Together, these findings suggest that while a significant portion of Putnam County residents have been diagnosed with a mental health condition, others may experience frequent poor mental health days even without a formal diagnosis. This underscores the importance of increasing access to mental health services, early intervention, and community education to support overall mental well-being.

Depression

Prevalence of depression among adults 18 years and older.

Depression rates in Ohio are notably higher than the national average, with the state experiencing a rate of 26.22% compared to the United States' 22.53%. Putnam County also reports a significant rate of 25.2%.

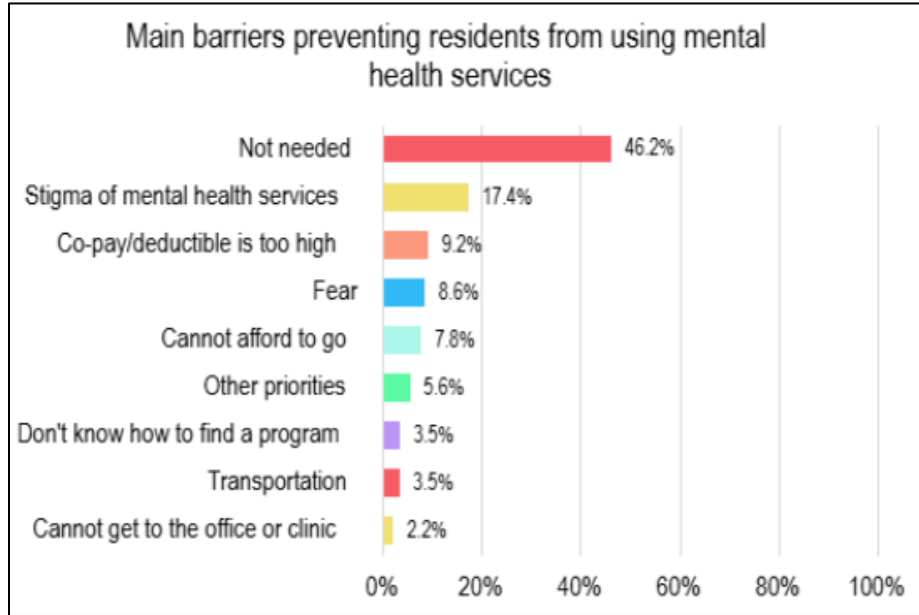


Data Sources: Centers for Disease Control and Prevention (CDC): PLACES (for county, zip code, and census tract)

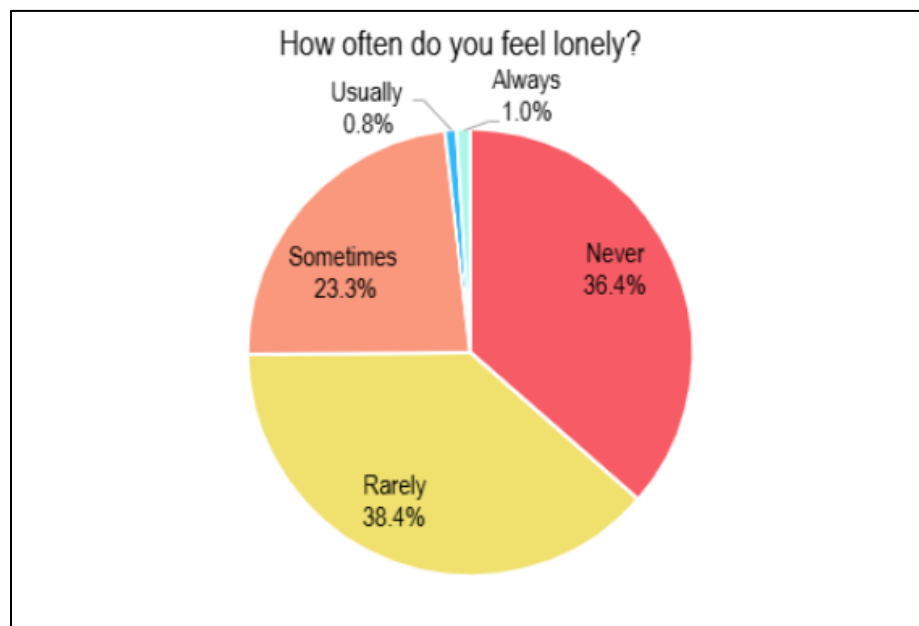
Many calls involve situations that stem from mental health concerns rather than criminal activity. The number of people showing signs or symptoms of mental health conditions, or receiving diagnoses, appears to be increasing. Law enforcement is frequently called to respond to individuals who are experiencing mental health crises—such as being overwhelmed, unable to cope with pressure, or having a breakdown. Calls related to suicide attempts and suicides are also occurring more often.

Law enforcement perspective from focus group

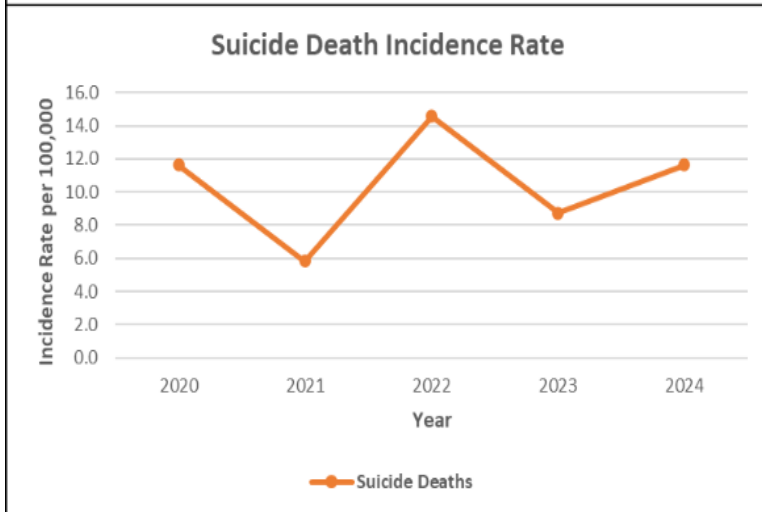
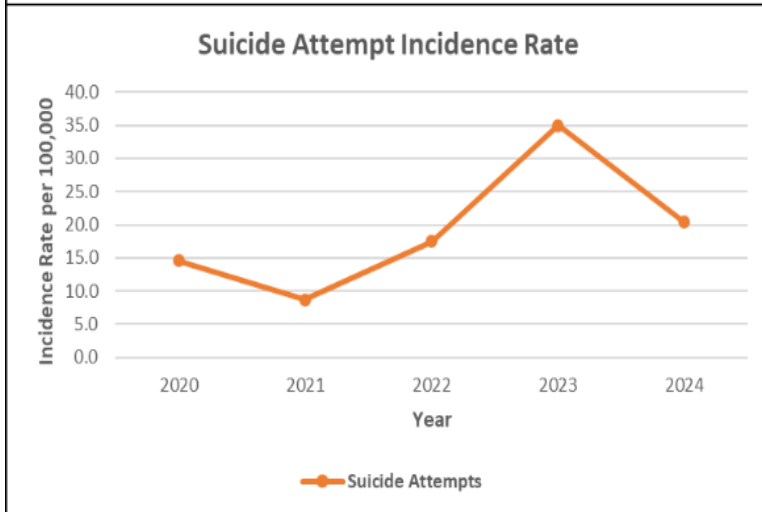
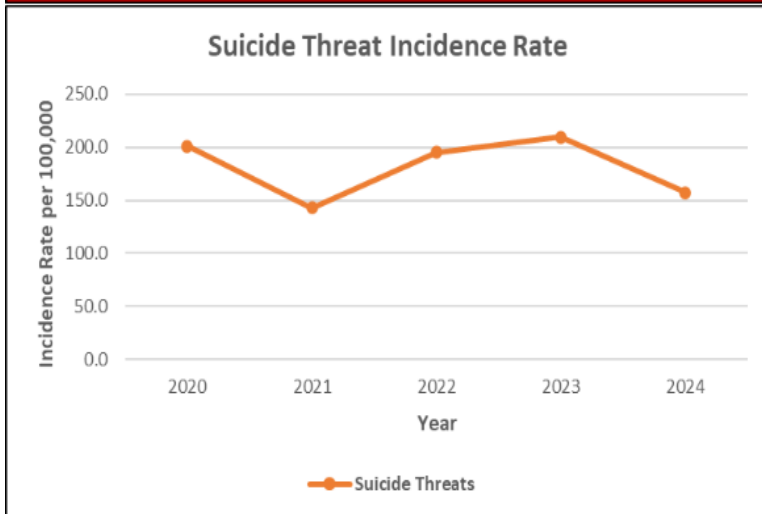
According to the 2025 Putnam County Community Health Assessment Survey, the most common barriers preventing residents from using mental health services were believing care wasn't needed, followed by cost concerns and the stigma of seeking help. Fewer respondents cited issues such as lack of time, transportation, or not knowing where to go. Additionally, 2.2% of survey respondents indicated they had seriously considered attempting suicide in the past 12 months, highlighting the need to increase access to mental health providers as well as address the main barriers preventing residents from seeking help.



This chart is comprised of data from the 2025 Putnam County Community Health Assessment Survey where residents were asked how often they feel lonely. While 36.4% reported never feeling lonely, nearly two-thirds experienced loneliness to some extent: 38.4% rarely, 23.3% sometimes, and a small portion usually or always. Combined with high rates of depression (25.2%) and poor mental health days (7.6%), these findings emphasize the link between social connection and mental well-being in Putnam County.



Suicide Threats, Attempts, & Deaths (2020-2024)



Suicide Trends

The figures to the left illustrate trends in suicide threats, attempts, and deaths in Putnam County over the past five years. These indicators help show the level of mental health distress in the community and can be useful for identifying where prevention and intervention resources are most needed.

Suicide Threats

Suicide threat incidence rates in Putnam County fluctuated between 2020 and 2024, ranging from approximately 150 to 210 threats per 100,000 residents. Rates peaked in 2023 before declining in 2024. Although annual variations are expected, these numbers indicate a continued level of emotional distress among some residents. This underscores the importance of early identification, crisis intervention services, and ongoing community education around recognizing warning signs.

Suicide Attempts

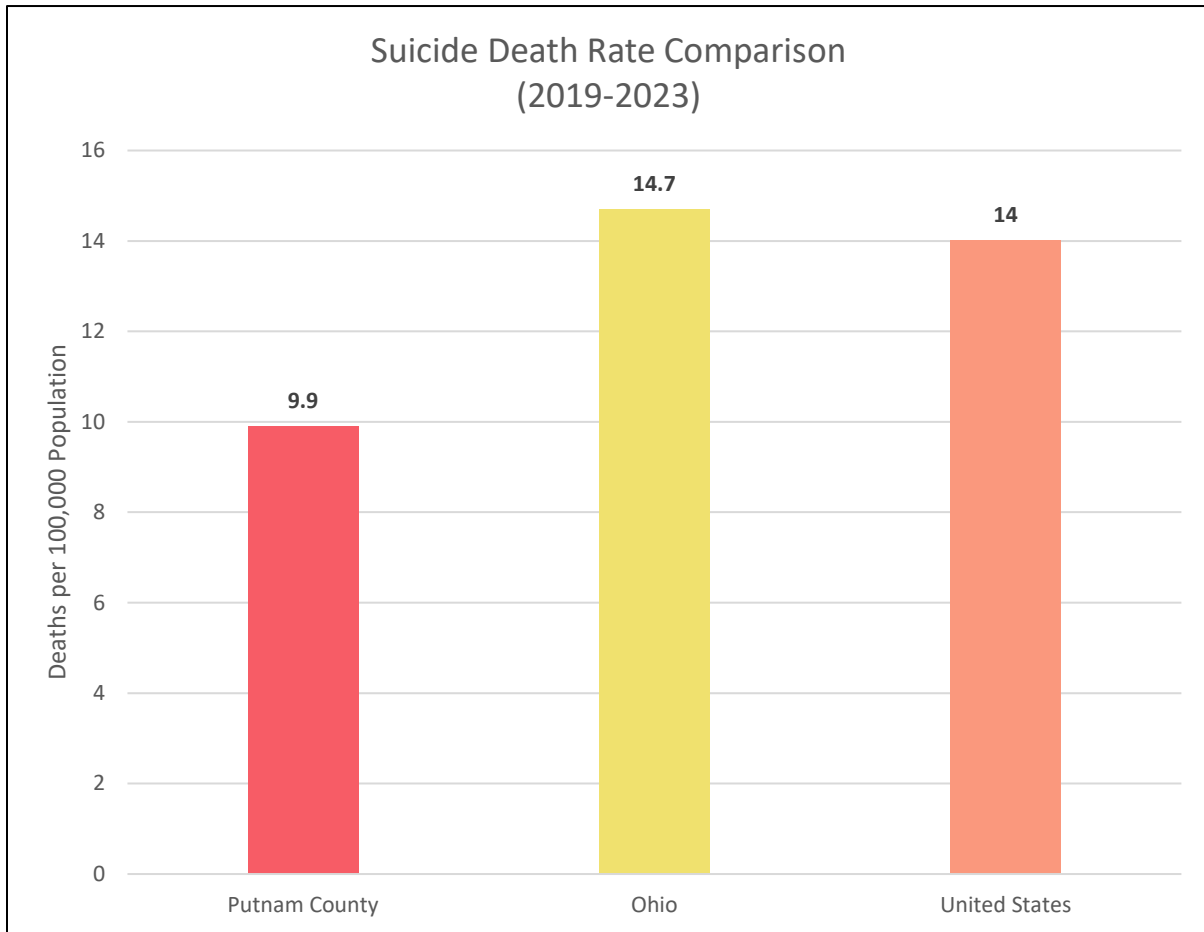
Suicide attempt rates show a similar fluctuating pattern. After decreasing in 2021, rates rose sharply in 2022 and reached their highest level in 2023 at nearly 35 attempts per 100,000. The rate declined again in 2024 but remains higher than earlier years. Attempt data are particularly important for planning clinical follow-up care, ensuring access to behavioral health professionals, and strengthening post-crisis supports.

Suicide Deaths

Suicide death incidence rates remained relatively stable from 2020 to 2024, with small yearly changes. Rates ranged

from about 8 to 15 deaths per 100,000, with a peak in 2022. While suicide deaths occur at much lower rates than threats or attempts, each case represents a significant loss to families and the community and highlights the need for coordinated prevention strategies.

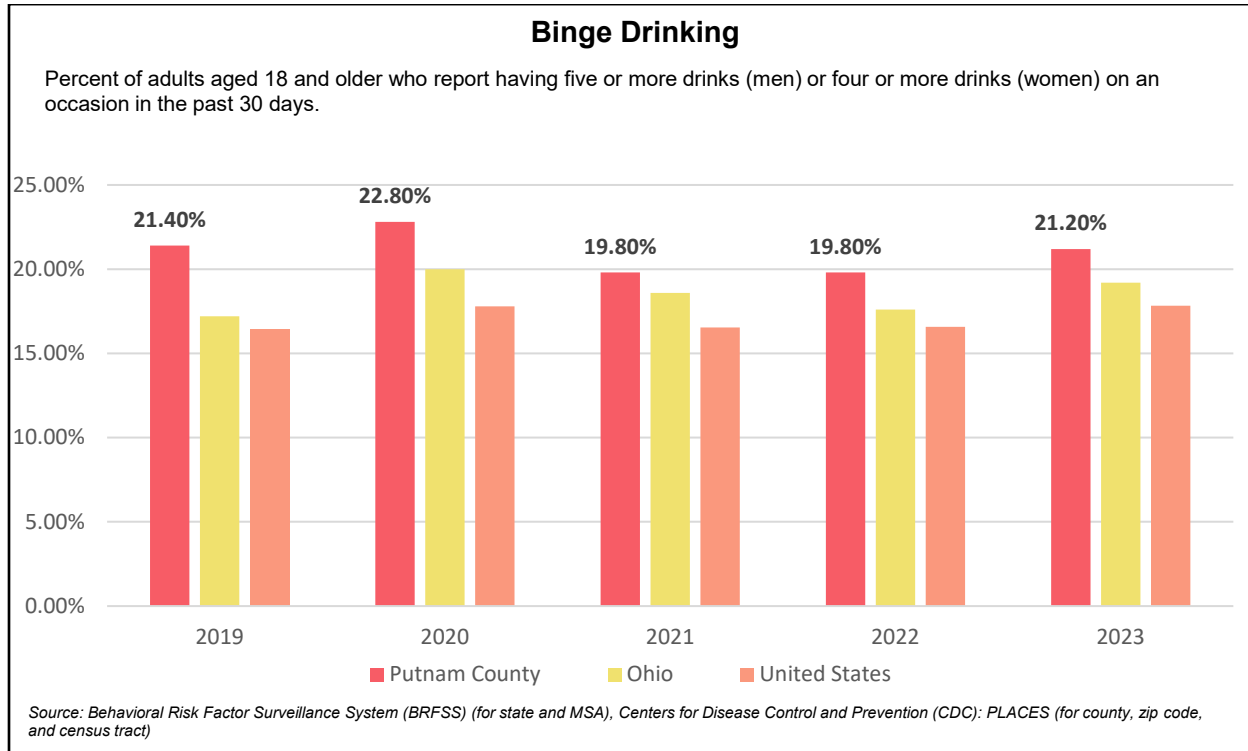
When compared to Ohio and national averages, Putnam County’s suicide death rate is lower. From 2019–2023, Putnam County recorded 9.9 deaths per 100,000, compared to 14.7 in Ohio and 14.0 nationally. Although this is a positive indicator for the county, suicide remains a critical public health issue, and even small numbers can have wide-ranging impacts in rural communities.



Substance Misuse and Risk Behaviors

Binge Drinking

Percent of adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Alcohol use is likely seriously underreported, so these estimates are an extreme lower bound on actual binge drinking prevalence.

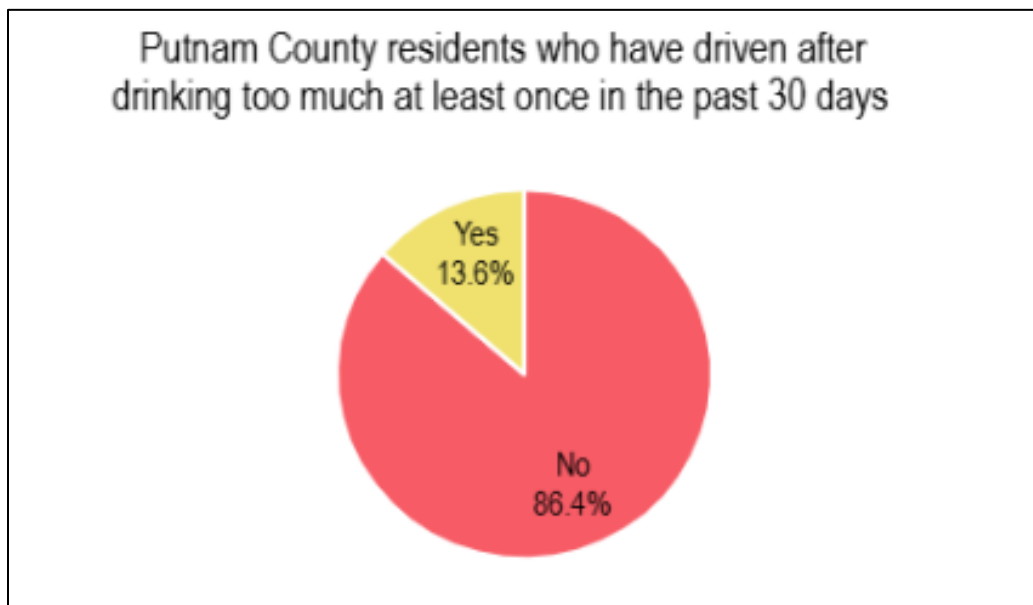
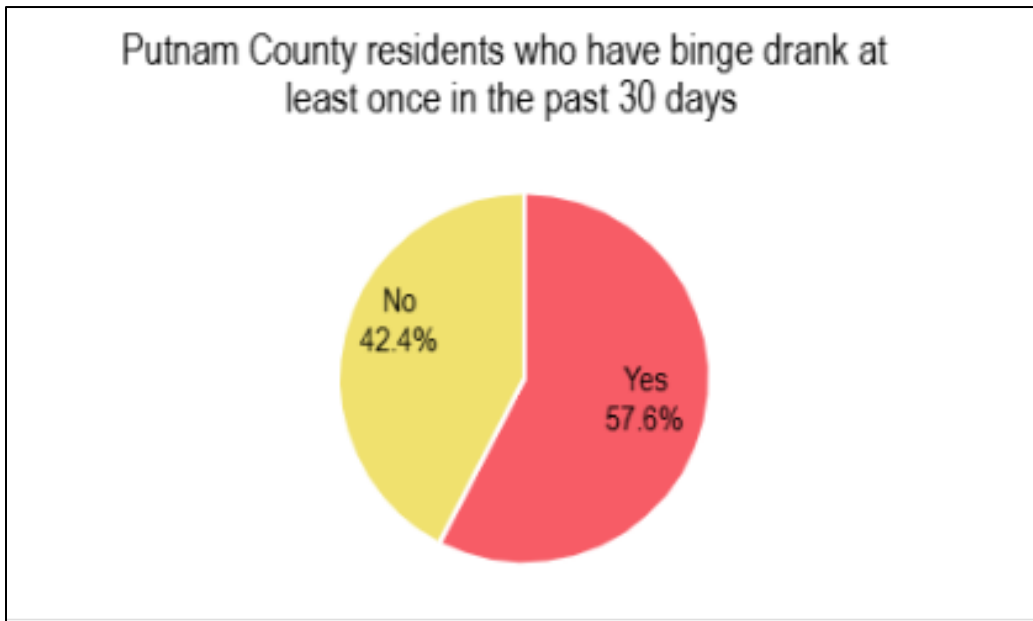


The chart illustrates trends in binge drinking among adults aged 18 and older in Putnam County from 2019 to 2023, compared with Ohio and the United States. Across the five-year period, Putnam County consistently reports higher rates of binge drinking than both the state and national averages. While all three geographies experienced a peak around 2020, rates declined in 2021 and 2022 before increasing again in 2023. This pattern suggests that binge drinking remains a persistent behavior in Putnam County, with levels that remain elevated relative to broader benchmarks.

The increase observed around 2020 aligns with broader social and economic disruptions during that time, followed by a temporary decline in subsequent years. However, the rebound in 2023 suggests that reductions were not sustained and that binge drinking remains an ongoing concern rather than a short-term fluctuation.

Higher levels of binge drinking have implications for both physical and mental health, including increased risk for injury, chronic disease, and behavioral health challenges. When viewed alongside other findings in the assessment—such as mental health stressors and law enforcement responses to alcohol-related incidents—this trend highlights the importance of continued prevention, education, and access to supportive services aimed at reducing harmful alcohol use.

The 2025 Putnam County Community Health Assessment Survey asked respondents about binge drinking frequency and drinking and driving. This data shows that residents report a much higher frequency of binge drinking in the past 30 days than CDC data demonstrates. However, most residents have not driven after drinking.



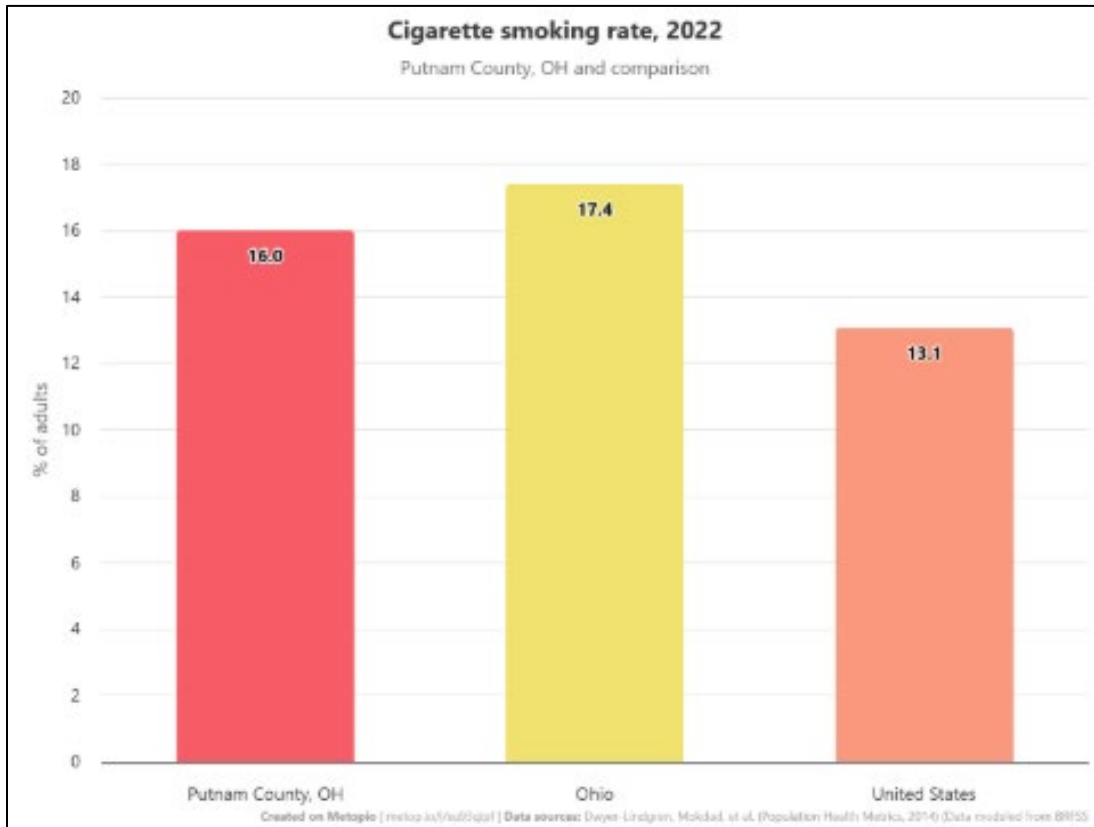
“Alcohol use is an issue in Putnam County. Especially the social acceptance of drinking and then driving home. Also, the acceptance of teenage drinking.”

Community resident perspective from focus group

Cigarette Smoking Rate

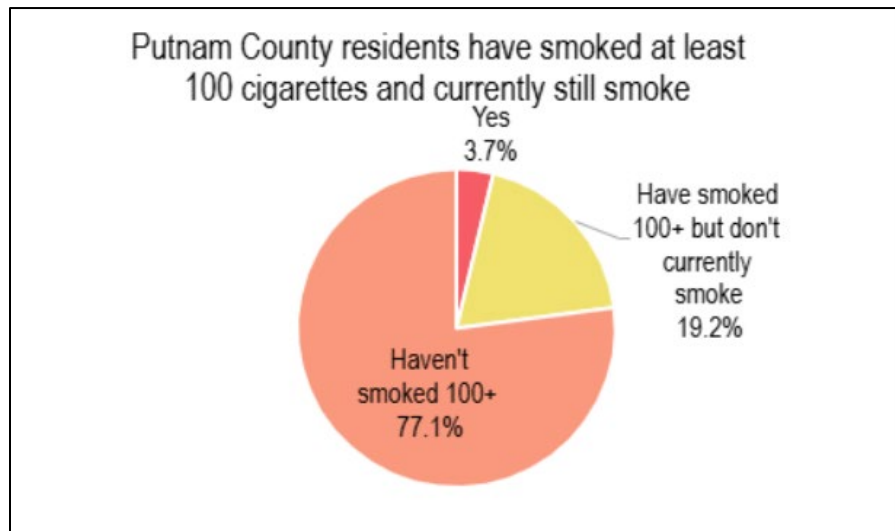
Percent of resident adults aged 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

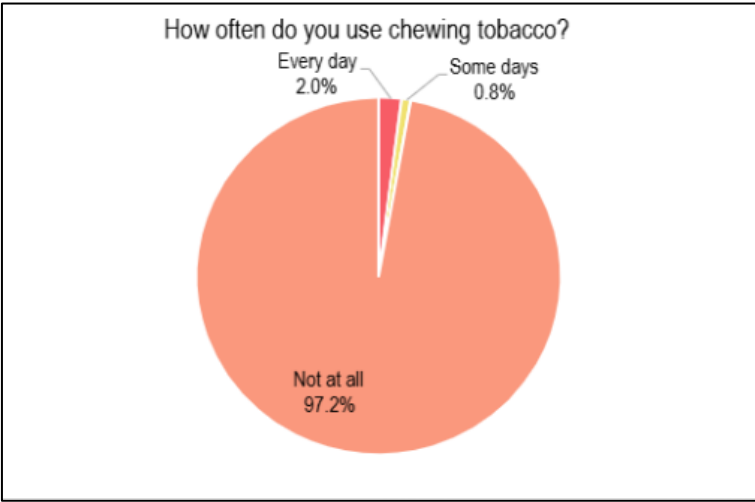
The data presents that the cigarette smoking rate in Ohio is higher at 17.4%, while Putnam County has a slightly lower rate of 16.0%. The national average for cigarette smoking in the United States is 13.06%.



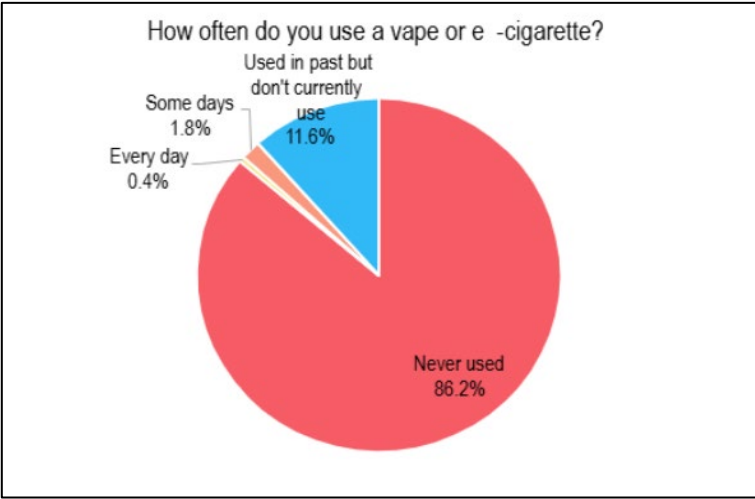
Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA)

According to the 2025 Putnam County Community Health Assessment Survey, 3.7% of respondents reported having smoked at least 100 cigarettes in their lifetime and currently still smoke. An additional 19.2% reported having smoked in the past but no longer do, while 77.1% indicated they have never smoked 100 or more cigarettes.



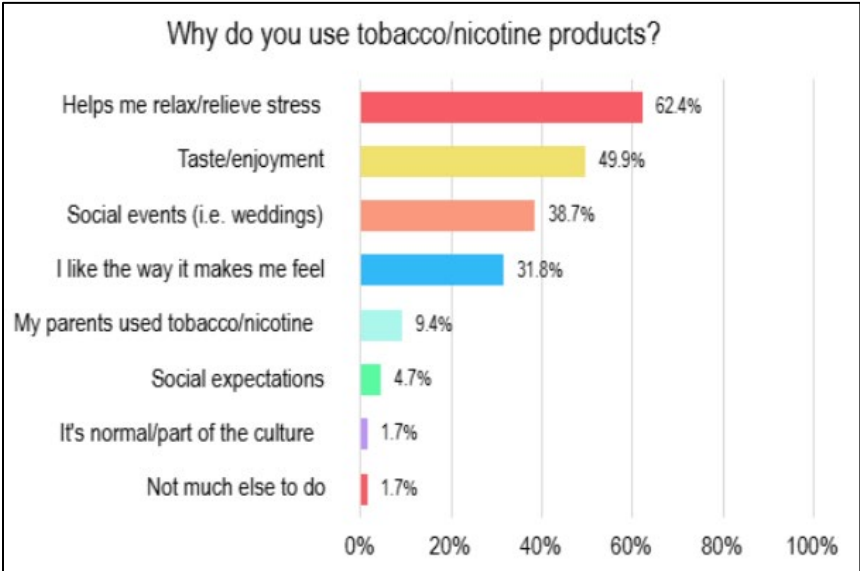


The Survey also indicates that most respondents (97.2%) do not use chewing tobacco. Only 2.0% reported using chewing tobacco every day, and 0.8% reported using it on some days.



86.2% of survey respondents reported never using a vape or e-cigarette. Another 11.6% indicated they had used one in the past but no longer do, while a small proportion reported current use—1.8% on some days and 0.4% every day.

Among Putnam County residents who reported using tobacco or nicotine products in the 2025 Putnam County Community Health Assessment Survey, the most common reason was to help relax or relieve stress (62.4%), followed by taste or enjoyment (49.9%) and participation in social events (38.7%). Other reasons included liking the way it makes them feel (31.8%) and parental use of tobacco or nicotine (9.4%). Fewer respondents cited social expectations (4.7%), cultural norms (1.7%), or lack of other activities (1.7%).



Socio-Economic Factors

Socio-economic conditions shape health by influencing access to resources, exposure to stress, and opportunities for stability and growth. Income, education, employment, and community resilience play a foundational role in determining health behaviors and outcomes.

This section examines economic stability, education access and attainment, employment and workforce conditions, and measures of community vulnerability and resilience. Overall economic conditions reflect relative stability and strong workforce participation; however, these conditions vary across geographic areas and populations. Educational attainment beyond high school lags broader benchmarks, which can influence employment opportunities and long-term economic mobility.

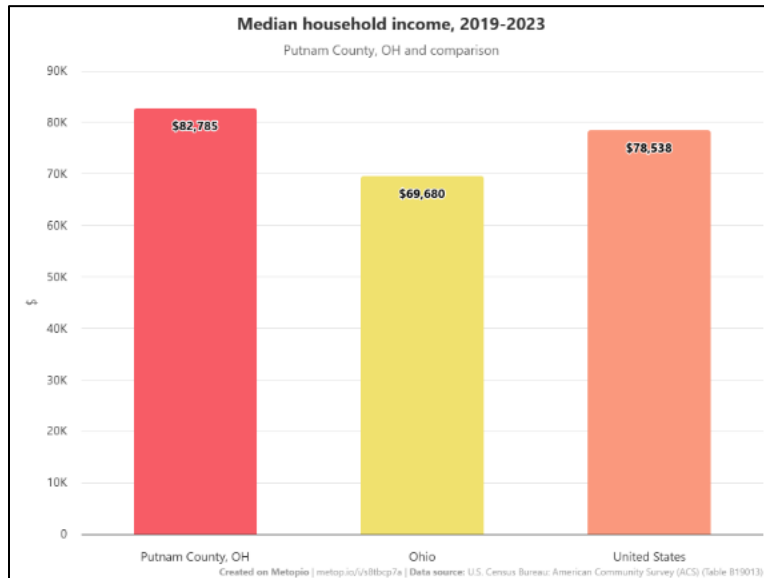
Employment patterns often involve long work hours and limited time availability, affecting residents' ability to prioritize health, family, and self-care. Childcare access and transportation costs further influence household stability and daily decision-making. Measures of vulnerability and resilience highlight differences in how communities experience and respond to economic and social pressures.

Understanding these socio-economic conditions provides essential context for interpreting disparities in health behaviors and outcomes and supports identification of strategies that strengthen resilience, reduce inequities, and promote long-term community well-being.

Economic Stability

Median Household Income

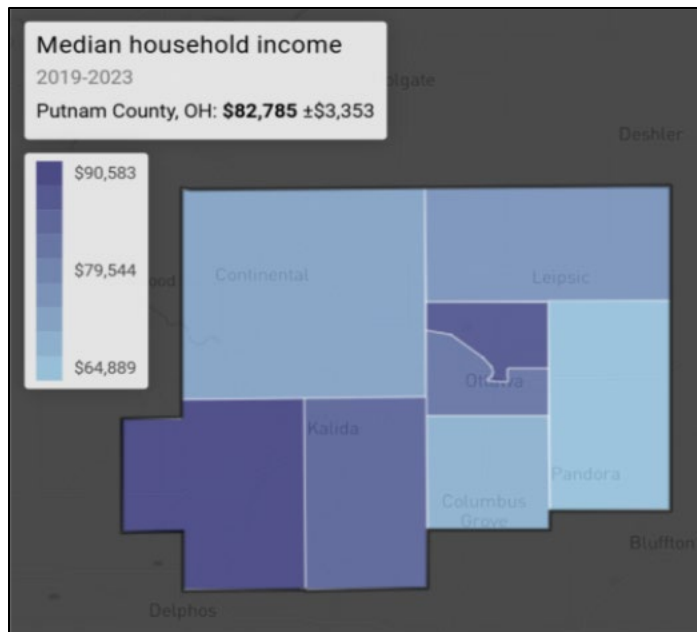
Income in the past 12 months.



The median household income in Putnam County is \$82,785, which is higher than the national median of \$78,538 and the state median of \$69,680. This indicates that Putnam County has a relatively higher income level compared to both the nation and the state. The data suggests that Putnam County may have a stronger economic base or higher-paying job opportunities.

“Cost of living - expenses > income.”

Community resident perspective from focus group



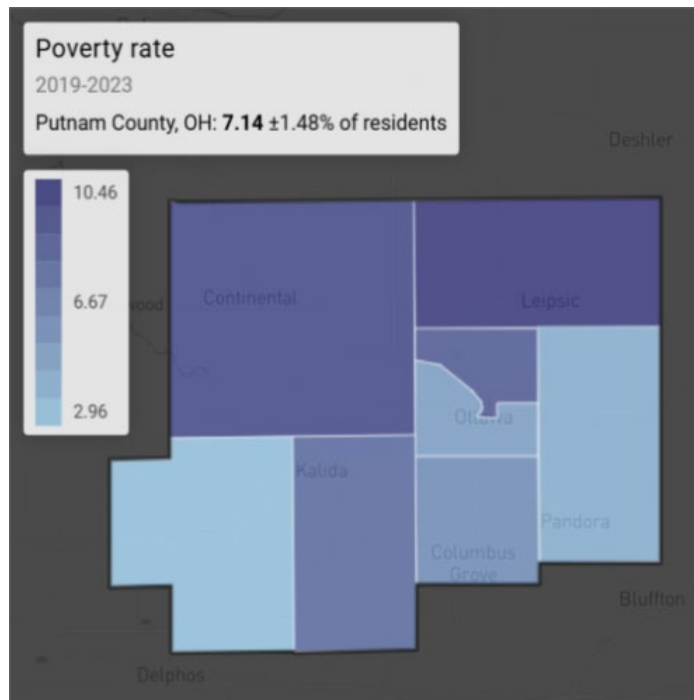
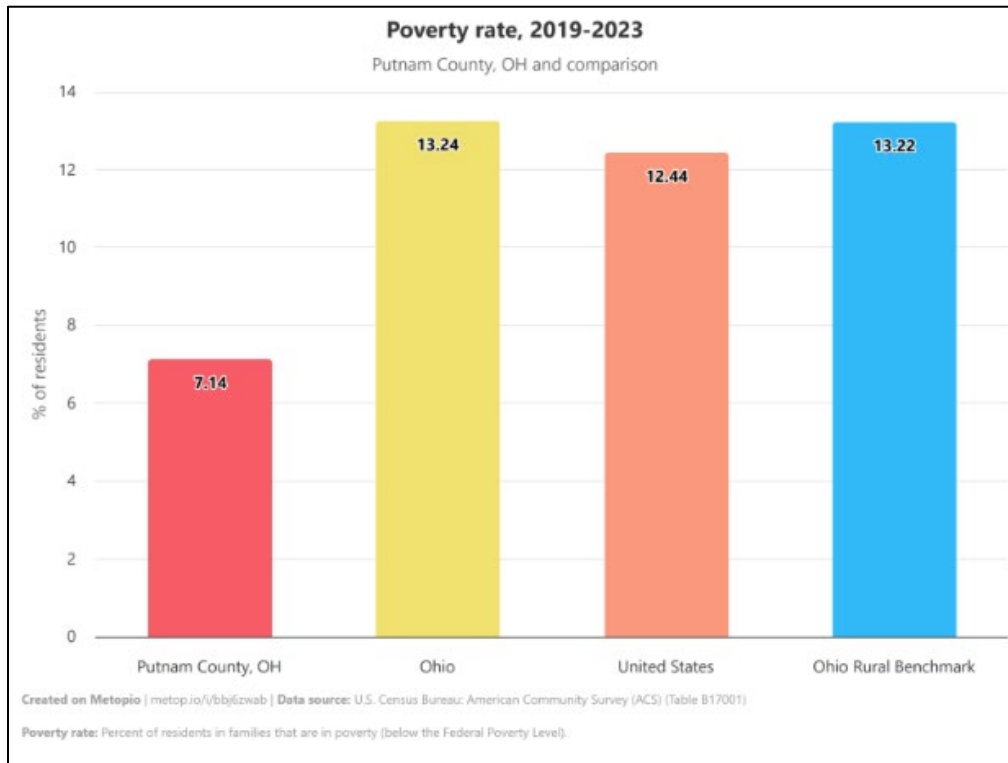
The median household income in Putnam County ranges from \$64,889 to \$90,583 across various tracts. The highest income is found in Tract 307, while Tract 304 has the lowest. Overall, the county exhibits relatively high median household incomes, indicating a generally affluent population. Please refer to the census tract map and corresponding table on page 15.

Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Table B19013)

Poverty Rate

Percent of residents in families that are in poverty (below the Federal Poverty Level).

The poverty rate in Ohio is 13.24%, which is slightly higher than the national average of 12.44%. The rural benchmark for Ohio also reflects a similar poverty rate of 13.22%. However, Putnam County has a significantly lower poverty rate of 7.14%, indicating a more prosperous local economy compared to the rest of the state and the nation.

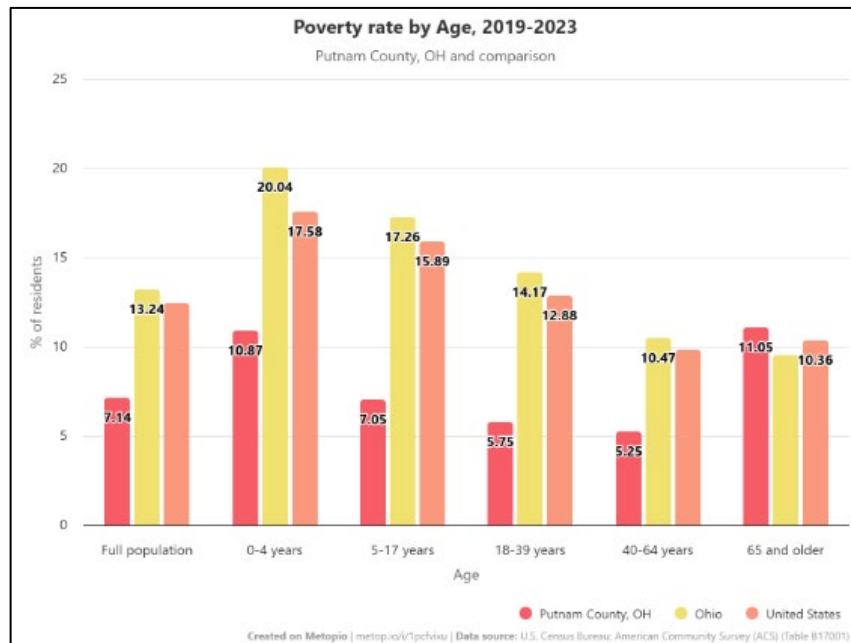


Despite Putnam County having a lower poverty rate than state and national levels, it varies across different tracts. The highest poverty rate is found in Tract 301 at 10.46%, while the lowest is in Tract 304 at 5.52%. Overall, the poverty rates in Putnam County are relatively low, with most rates below 10.5%.

Data Sources: U.S. Census Bureau; American Community Survey (ACS) (Table B17001)

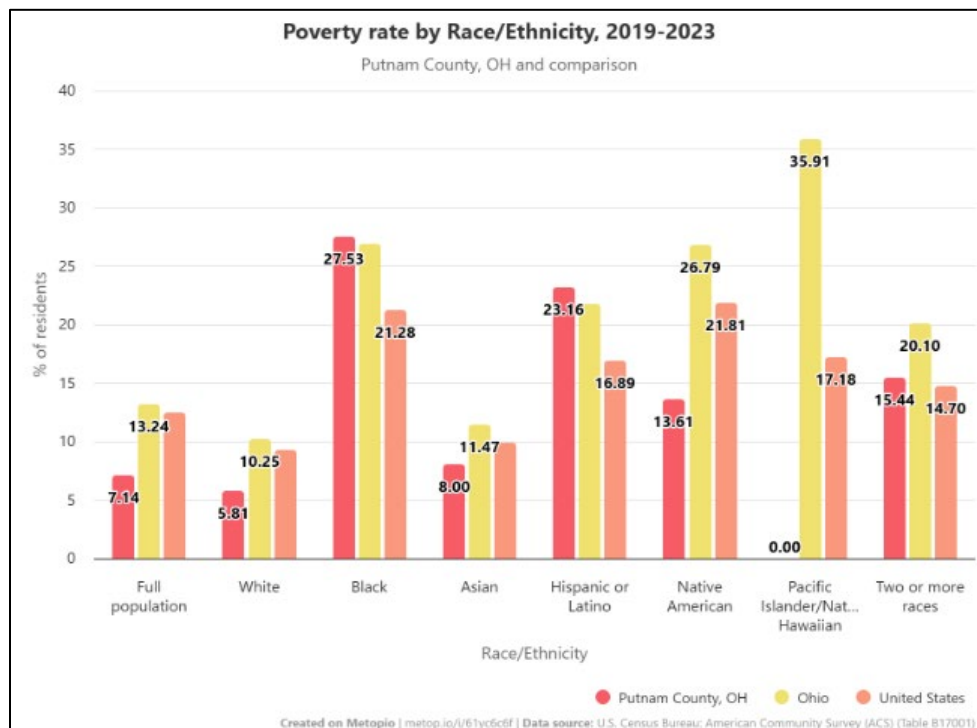
Poverty Rate by Age

The poverty rate in Putnam County is generally lower than both the state and national averages across all age groups. The highest disparity is observed in the 0-4 years age group, where the county's rate is significantly lower than Ohio's and the United States' rates. Overall, Putnam County exhibits a lower poverty rate compared to both Ohio and the United States, with the full population rate at 7.14%, contrasting with Ohio's 13.24% and the nation's 12.44%.



Poverty Rate by Race/Ethnicity

The poverty rate varies significantly across different racial and ethnic groups in Putnam County and the United States. In Putnam County, the poverty rate for Black individuals is 27.53%, which is higher than the state and national averages. The poverty rate for the full population in Putnam County is 7.14%, lower than both the state and national rates.



Data Sources U.S. Census Bureau: American Community Survey (ACS) (Table B17001)

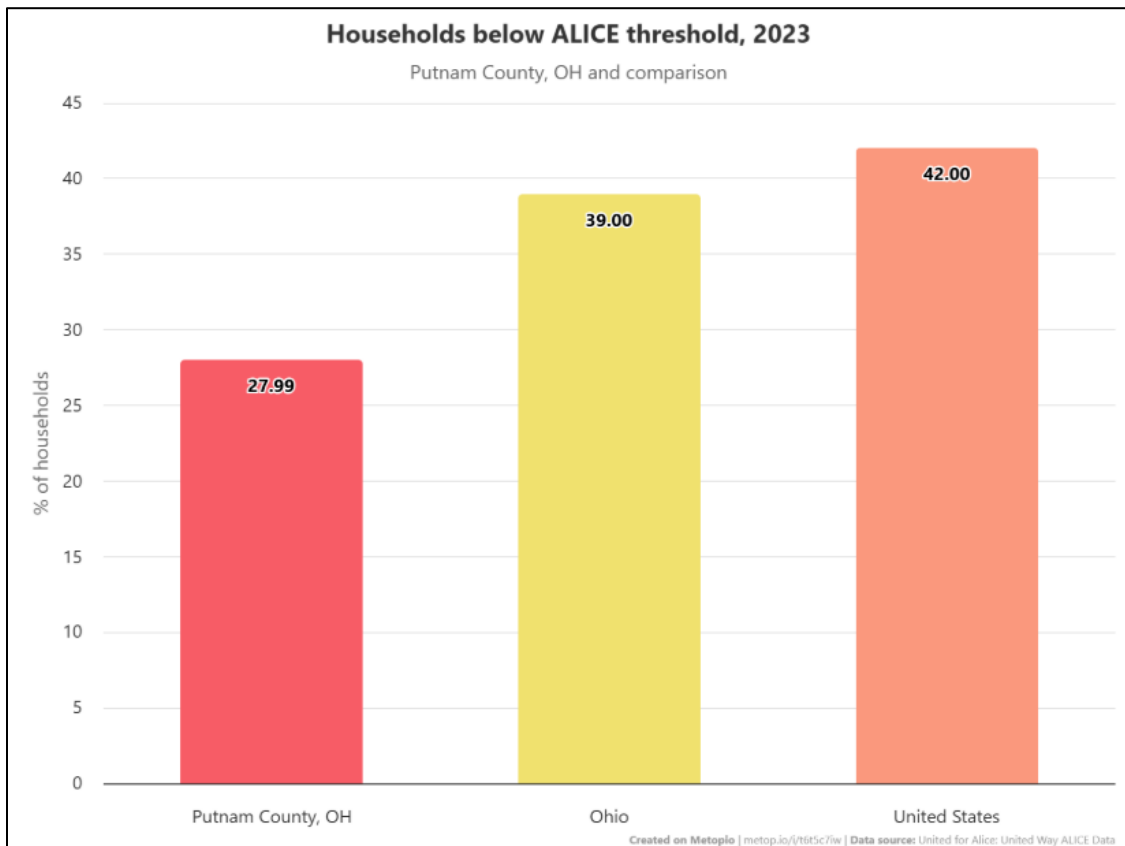
Households Below ALICE Threshold

The percentage of households below the ALICE threshold are those that don't meet the minimum income level necessary to afford the Household Survival Budget for each county in the United States. ALICE households earn above the Federal Poverty Level (FPL) but are unable to afford the basics of housing, child care, food, transportation, health care, and technology in the communities where they live

“The only way you can improve the access to those services and programs is make it way cheaper financially for people to afford it. But you're not going to be able to do that on a local level. But there's nothing else you can do locally.”

Community resident perspective from focus group

The data highlights the percentage of households below the ALICE threshold across various regions in the United States. Nationally, 42% of households fall below this threshold, indicating a significant portion of the population struggling to afford basic necessities. In Ohio, this figure is slightly lower at 39%, suggesting a somewhat better economic situation compared to the national average. Specifically, in Putnam County the percentage is notably lower at 27.99%, indicating a more favorable economic condition for households in this area.

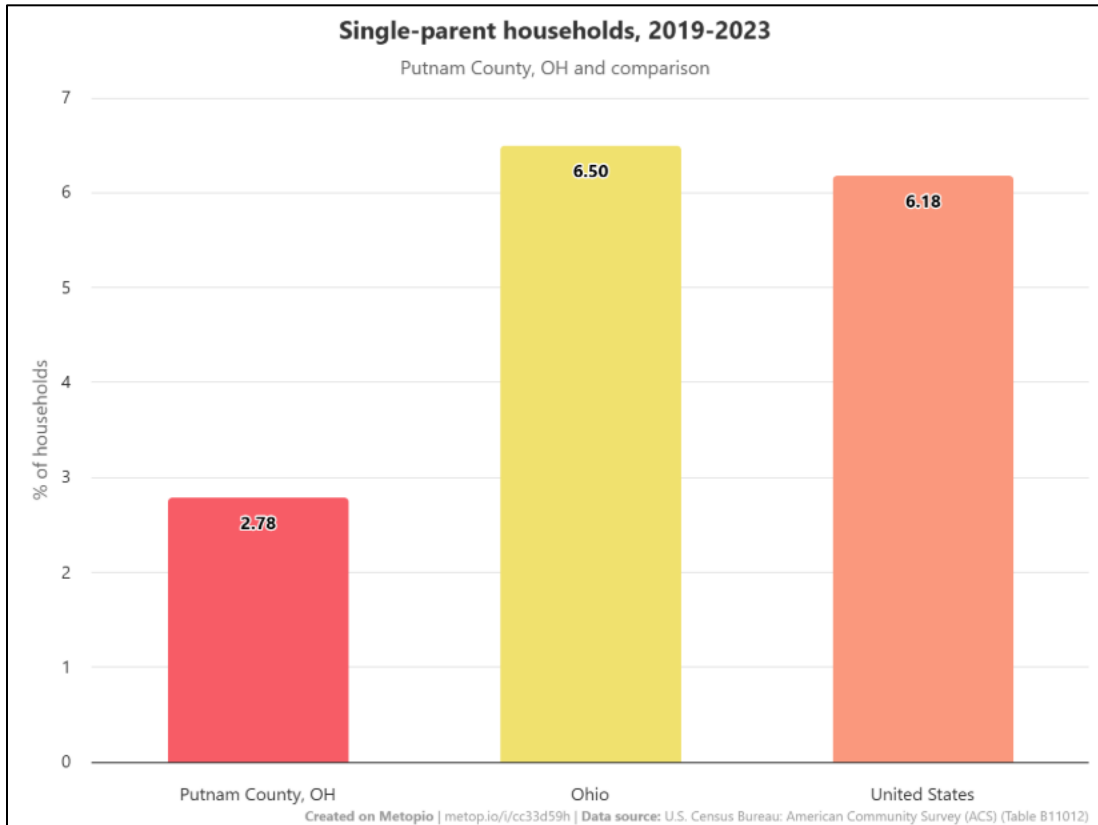


Data Sources: United for Alice: United Way ALICE Data

Single-parent households

Percentage of households that have children present and are headed by a single parent (mother or father), with no partner present.

The data highlights the prevalence of single-parent households across Ohio, the United States, and specifically in Putnam County. The highest rate is observed in Ohio at 6.5%, slightly above the national average of 6.18%. Putnam County has a notably lower rate of 2.78%, indicating a significant regional variation within the state. These differences underscore the importance of examining local contexts when addressing issues related to single-parent households.



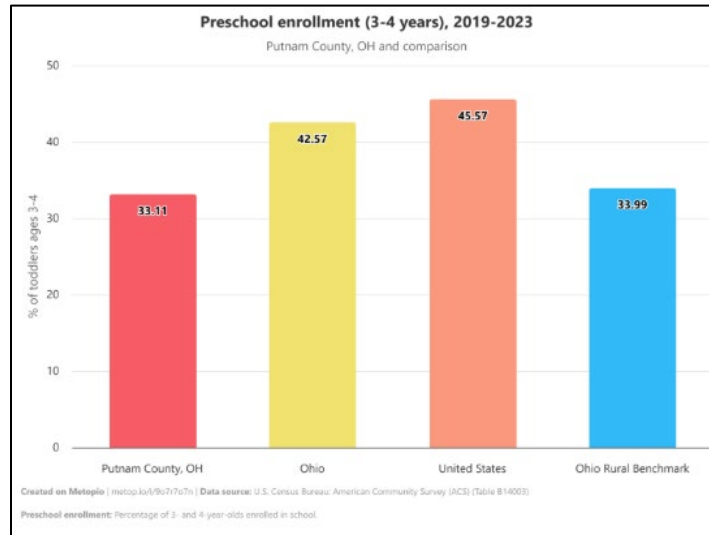
Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Table B11012)

Education Access & Attainment

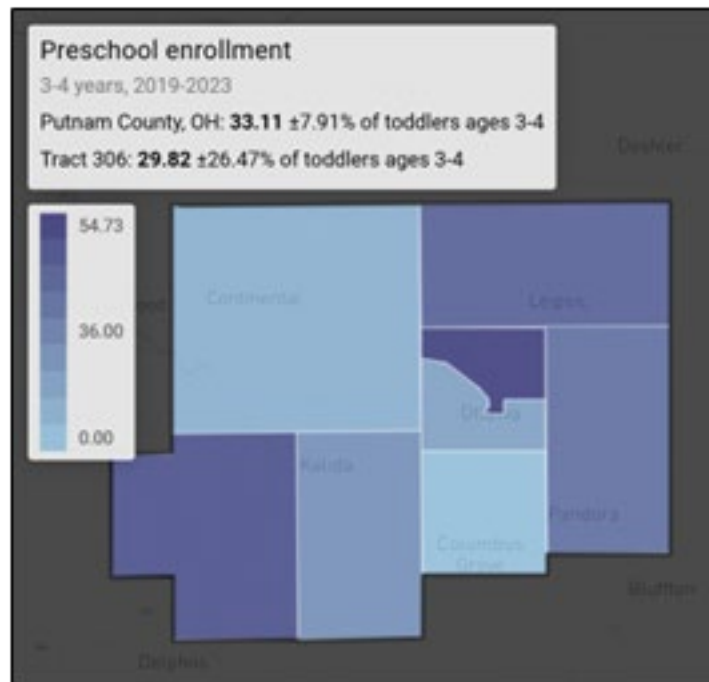
Preschool Enrollment

Percentage of 3- and 4-year-olds enrolled in school.

Preschool enrollment in the United States stands at 45.57%, with Ohio slightly below the national average at 42.57%. The Ohio Rural Benchmark is even lower at 33.99%, indicating a significant disparity in rural areas. Putnam County has one of the lowest enrollment rates at 33.11%, highlighting the challenges faced by rural communities in providing early childhood education.



Preschool enrollment rates for 3- and 4-year-olds in Putnam County varied significantly between 2019 and 2023 throughout the eight census tracts. Tract 303.01 had the highest enrollment rate at 54.73%, while Tract 305 had no enrollment. The overall enrollment rates in the county ranged from 0% to 54.73%, indicating diverse access to preschool education across different areas. Please refer to the census tract map and corresponding table on page 15.

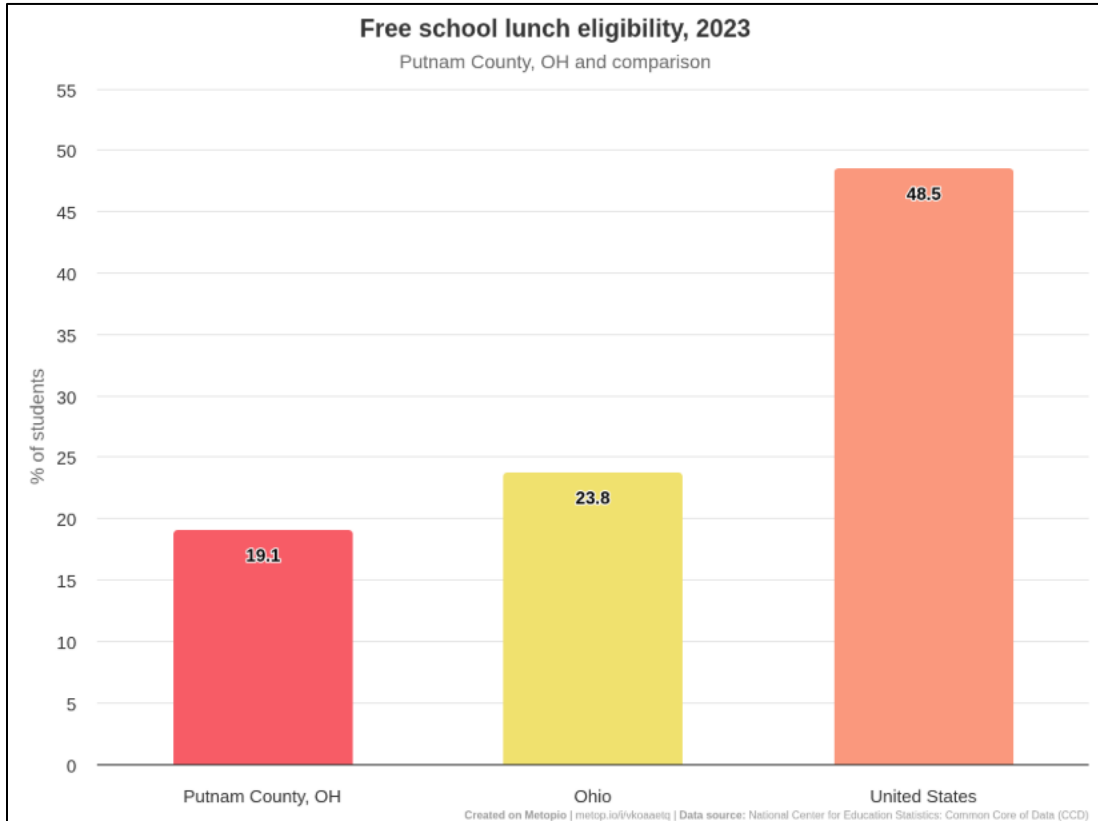


Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Table B14003)

Free School Lunch Eligibility

Percentage of students in public schools who are eligible for free lunch. The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential childcare institutions, providing nutritionally balanced, low-cost or free lunches to children each school day. Data is based on the date of the start of the school year.

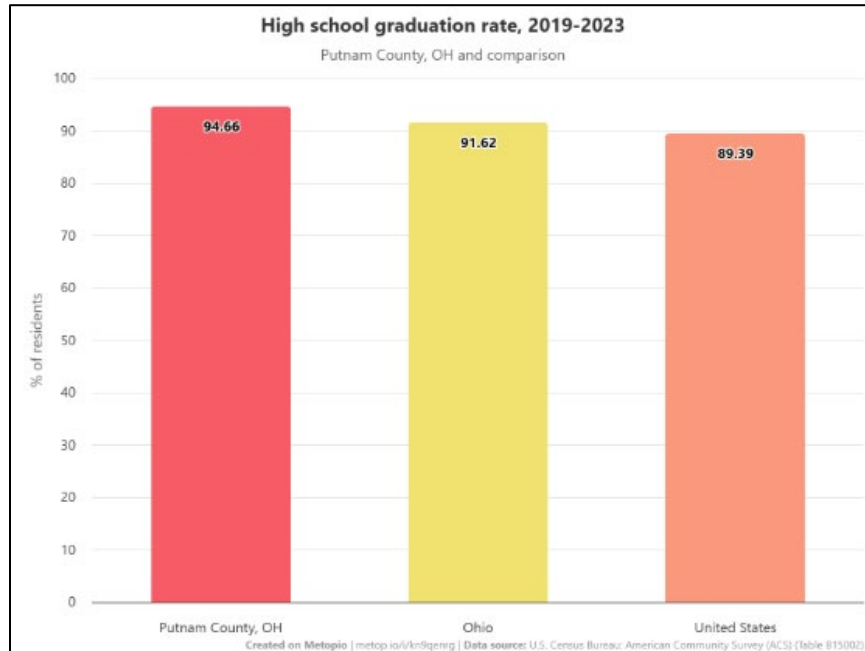
Free school lunch eligibility is a critical metric for understanding the economic needs of students across the United States. Nationally, 48.52% of students are eligible for free school lunches. In Ohio, this figure drops to 23.79%, indicating a lower level of economic need compared to the national average. Specifically, in Putnam County only 19.1% of students qualify for free school lunches, suggesting a relatively lower economic need in this area.



Data Sources: National Center for Education Statistics: Common Core of Data (CCD)

High School Graduation Rate

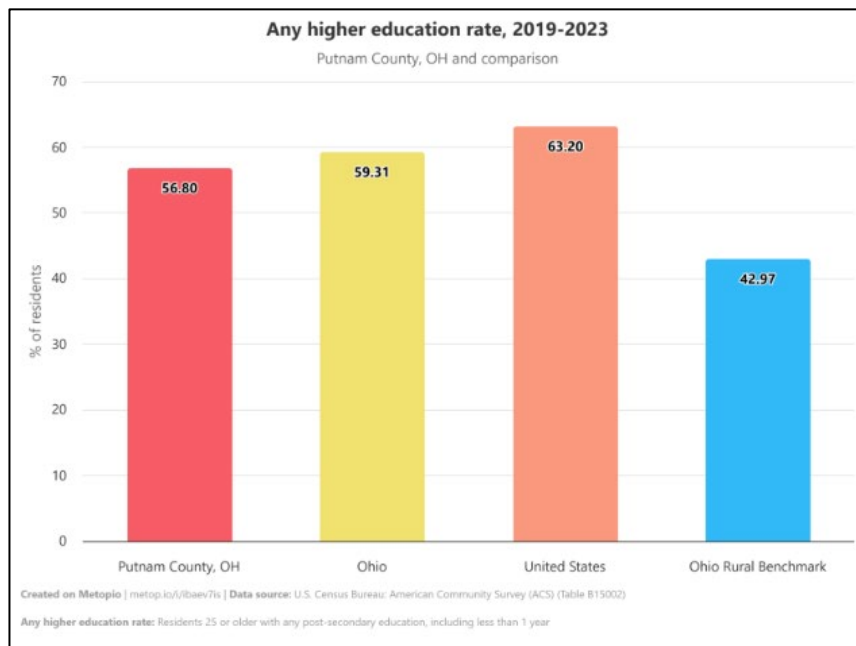
Residents 25 or older with at least a high school degree: including GED and any higher education.



The high school graduation rate in Putnam County is notably higher than both the state of Ohio and the United States as a whole. Putnam County boasts a graduation rate of 94.66%, while Ohio's rate is 91.62%, and the national rate is 89.39%. This indicates that Putnam County is performing exceptionally well in terms of high school completion.

Any Higher Education Rate

Residents 25 or older with any post-secondary education, including less than 1 year



The data illustrates the rate of individuals with any higher education across various regions in the United States. The national rate stands at 63.2%, while Ohio's rate is slightly lower at 59.31%. Putnam County has a rate of 56.8%, and the Ohio Rural Benchmark is significantly lower at 42.97%. This indicates a noticeable disparity in higher education attainment between urban and rural areas within Ohio.

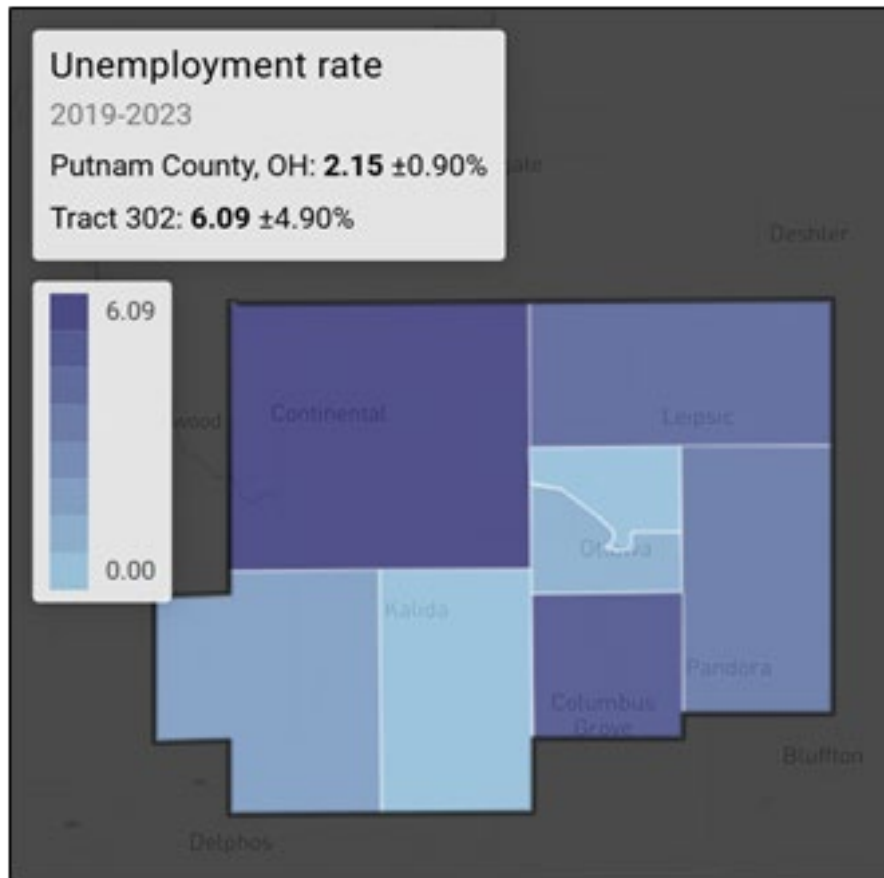
Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Table B15002)

Employment & Workforce

Unemployment Rate

Percent of residents 16 and older in the civilian labor force who are actively seeking employment.

The data represents the unemployment rate in various census tracts of Putnam County from 2019 to 2023. The unemployment rates range from 0.0% in Tract 303.01 and Tract 306 to 6.09% in Tract 302. This variation indicates differing economic conditions within the county. Please refer to the census tract map and corresponding table on page 15.

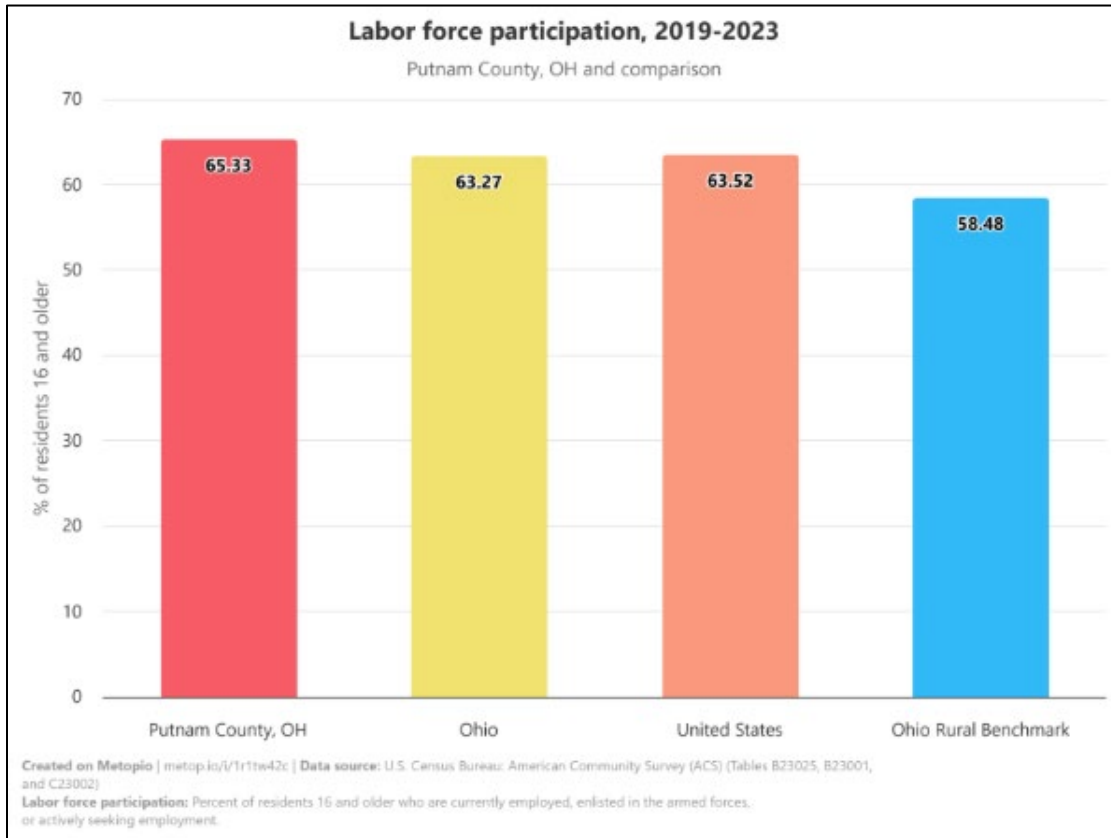


Labor Force Participation

Percent of residents 16 and older who are currently employed, enlisted in the armed forces, or actively seeking employment.

“They are working all the time and do not have time for other things and resources to help them.”

Community resident perspective from focus group



Data Sources: U.S. Census Bureau: American Community Survey (ACS) (Tables B23025, B23001, and C2

Labor force participation rates vary across different regions. Putnam County has a notably high rate of 65.33%, surpassing both the national average of 63.52% and Ohio's average of 63.27%.

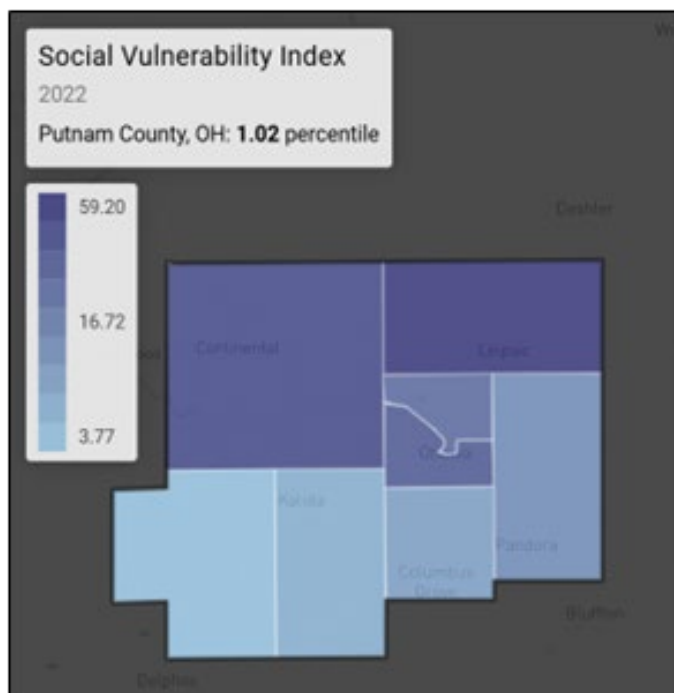
Community Vulnerability & Resilience

Social Vulnerability Index

The Social Vulnerability Index (SVI) was created to help public health officials and emergency response planners identify and map communities that may need additional support before, during, and after hazardous events, such as natural disasters, disease outbreaks, or public health emergencies. The SVI measures relative vulnerability by combining 15 social factors—including income, employment, education, household composition, disability, and minority status—into a single percentile ranking, with lower percentiles indicating less vulnerability and higher percentiles indicating greater vulnerability.

In Putnam County, overall social vulnerability remains low compared to broader benchmarks; however, meaningful variation exists across census tracts. In 2022, Census Tract 307 exhibited the lowest level of vulnerability, with an SVI percentile of 3.77, indicating relatively strong social and economic conditions. In contrast, Census Tract 301 had the highest vulnerability in the county, with an SVI percentile of 59.2. While this value does not reflect extreme vulnerability at the national level, it signals comparatively greater challenges within the local context.

The differences observed across census tracts suggest that certain areas of Putnam County may face higher barriers related to income stability, housing, transportation access, or population characteristics that can affect resilience during emergencies and access to services. These variations are important for planning purposes, as communities with higher social vulnerability may require additional outreach, resources, or coordination to ensure equitable access to health services, emergency preparedness, and recovery efforts. Please refer to the census tract map and corresponding table on page 15.



Data Sources: Centers for Disease Control and Prevention (CDC): Agency for Toxic Substances and Disease Registry - SVI Data

CHA Comparison Table (2016, 2021, & 2025)

Community Needs				
		2016	2021	2025
Sought assistance in past year for . . .	Food	4.0%	5.7%	1.8%
	Prescription assistance	4.0%	3.8%	1.8%
	Employment	2.0%	3.5%	<1.0%
	Utilities	4.0%	3.0%	1.4%
	Legal aid services	1.0%	2.1%	<1.0%
	Clothing	<1.0%	1.8%	<1.0%
	Affordable childcare	<1.0%	1.4%	<1.0%
	Rent/mortgage	1.0%	1.4%	<1.0%
Personal Health Status				
		2016	2021	2025
Number of days in past month that PHYSICAL health was not good	Average number of days not well	3.0	3.5	3.6
	None	50.0%	57.5%	55.0%
	1 or more	50.0%	42.6%	44.9%
Number of days in past month that MENTAL health was not good	Average number of days not well	4.1	4.8	4.6
	None	49.0%	52.0%	52.4%
	1 or more	51%	48.0%	47.6%
Insurance Coverage				
		2016	2021	2025
Insurance coverage	Not insured	5.0%	2.0%	1.9%
	Private insurance-employer paid	54.0%	52.2%	69.7%
	Private insurance- self paid	4.0%	11.2%	3.6%
	Medicare	18.0%	27.9%	21.4%
	Medicaid	6.0%	8.7%	1.7%
Access to Health Care				
		2016	2021	2025
Have primary care provider	Yes	70.0%	89.4%	94.7%
	No	30.0%	10.6%	5.3%
Had routine check-up in past year		63.0%	77.5%	78.6%

Mental Health				
		2016	2021	2025
During past 12 months...	Ever seriously consider suicide	3.0%	2.2%	2.2%
Resident/Immediate Family Member Diagnosed by Medical Professional	Depression	34.0%	21.7%	17.0%
	Anxiety disorder such as OCD or panic	19.0%	11.2%	15.5%
	ADD/ADHD	13.0%	8.9%	2.1%
	Posttraumatic stress disorder	6.0%	5.4%	3.1%
	Alcohol/Substance Abuse/Dependence	13.0%	4.3%	0.7%
	Bipolar	9.0%	3.8%	-
	Developmental disability	6.0%	3.2%	0.5%
	Autism spectrum	4.0%	2.4%	0.2%
	Life adjustment disorder	3.0%	2.2%	0.5%
Access to Oral Health Care				
		2016	2021	2025
Last Dental Checkup	Within past year	80.0%	73.2%	85.1%
Smoking and Tobacco Use				
		2016	2021	2025
Smoked 100 or more cigarettes in life	Yes	33.0%	36.6%	22.9%
	No	67.0%	63.4%	77.1%
Alcohol and Substance Abuse				
		2016	2021	2025
Driven after drinking in past month	Yes	30%	11.6%	13.6%
	No	70%	88.4%	86.4%
During the last 6 months, anyone in household use. . .	Marijuana	3.0%	7.4%	5.7%
	Amphetamines, methamphetamines	<1%	0.4%	<1.0%
	Cocaine or crack	<1%	0.2%	<1.0%
	Heroin	<1%	0.2%	<1.0%
	LSD or other hallucinogen	<1%	0.2%	<1.0%
	Inhalants	<1%	0.2%	<1.0%
	Ecstasy or GHB	<1%	0.2%	<1.0%
	Bath salts used illegally	<1%	0.2%	<1.0%
In past year taken prescriptions	Not belong to them	5.0%	1.6%	<1.0%
How typically get rid of unused prescription medication	Take to Take Back Center	5.0%	34.9%	31.4%
	Keep them in case I need them	13.0%	26.1%	36.2%
	Throw them in trash	16.0%	16.4%	23.3%
	Flush down toilet	13.0%	13.2%	9.1%
	Give them to someone else	-	0.4%	0.0

Healthy Living				
		2016	2021	2025
BMI	Normal weight	25.0%	21.6%	20.2%
	Overweight	36.0%	33.4%	41.8%
	Obese	38.0%	44.3%	38.1%
How often do you eat fresh fruits and vegetables	0-1 times/week	-	10.1%	3.5%
	2-4 times/week	-	37.4%	29.7%
	Once a day	-	27.9%	31.1%
	2-4 times a day		21.4%	30.9%
	5 or more times a day	1.0%	3.2%	4.8%
Prevention, Testing and Screening				
		2016	2021	2025
Had test	Blood Cholesterol Check	88.0%	88.0%	84.6%
	Mammogram (women only)	77.0%	68.6%	84.6%
	PAP Smear (women only)	77.0%	91.9%	92.3%
	PSA test for prostate cancer	47.0%	40.1%	66.4%
	Colonoscopy	64.0%	52.3%	78.4%
Been Diagnosed with Chronic Disease				
		2016	2021	2025
Respondent diagnosed	High blood pressure	30.0%	36.3%	33.1%
	Arthritis	35.0%	27.9%	24.9%
	High cholesterol	33.0%	26.8%	27.0%
	Diabetes	9.0%	17.7%	12.1%
	Any form of cancer	12.0%	11.7%	7.7%
	Heart attack	3.0%	-	1.6%
	Asthma	10.0%	9.2%	9.4%
	Coronary heart disease	-	9.8%	4.3%
	Stroke	1.0%	2.5%	0.6%
Housing				
		2016	2021	2025
Percentage of household income goes to housing	Less than 30%	49.0%	63.1%	72.8%
	30%-50%	24.0%	25.9%	23.6%
	50% or higher	9.0%	11.0%	3.6%
Safety and Violence				
		2016	2021	2025
Firearms in home	Yes	55.0%	53.2%	50.2%
	No	45.0%	46.8%	49.8%
Ever been abused	Yes	20.0%	20.6%	5.1%
	No	80.0%	79.4%	94.9%

References

The following is a list of datasets used during the analysis of secondary data. All datasets were accessed via the Metopio platform. A URL for each dataset is available upon request.

Centers for Disease Control and Prevention (CDC): Agency for Toxic Substances and Disease Registry - SVI Data

The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 U.S. census variables to help local officials identify communities that may need support before, during, or after disasters.

U.S. Census Bureau: American Community Survey (ACS)

The American Community Survey (ACS) is an ongoing survey of U.S. households and residents that provides a wide variety of information. It replaces the long-form Census questionnaire and is administered to 1 in 38 U.S. households each year. Responses from multiple years can be aggregated to provide information about very small geographies.

Health Resources & Services Administration: Area Health Resources Files (AHRF)

This dataset provides current as well as historic data for more than 6,000 variables for each of the nation's counties, as well as state and national data. It contains information on health facilities, health professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics.

Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

Centers for Disease Control and Prevention (CDC)

White House Council on Environmental Quality (CEQ): Climate & Economic Justice Screening Tool (CEJST)

The tool has an interactive map and uses datasets that are indicators of burdens in eight categories: climate change, energy, health, housing, legacy pollution, transportation, water and wastewater, and workforce development. The tool uses this information to identify communities that are experiencing these burdens. These are the communities that are disadvantaged because they are marginalized by underinvestment and overburdened by pollution.

National Center for Education Statistics: Common Core of Data (CCD)

The Common Core of Data (CCD) is the Department of Education's primary database on public elementary and secondary education in the U.S. CCD is a comprehensive, annual, national statistical database of all public elementary and secondary schools and school districts, which contains data that are designed to be comparable across states. The objectives of CCD are (1) to provide an official listing of public elementary and secondary schools and school districts in the nation, which can be used to select samples for other National Center for Education Statistics (NCES) surveys, and (2) to provide basic information and descriptive statistics on public elementary and secondary schools and schooling in general.

University of Wisconsin Population Health Institute: County Health Rankings

County Health Rankings help us understand what influences how long and how well we live. They provide measures of the current overall health (health outcomes) of each county in all 50 states and the District of Columbia.

Dwyer-Lindgren, Mokdad, et al. (Population Health Metrics, 2014)

Cigarette smoking prevalence in US counties: 1996-2012. Population Health Metrics, 2014, Volume 12, Number 1, Page 1

Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

A National Provider Identifier is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI is the required identifier for Medicare services, and is also used by other payers, including commercial healthcare insurers. The NPI Registry provides information about all physicians in the country and their specialties.

Centers for Disease Control and Prevention (CDC): PLACES

The PLACES Project is a collaboration between CDC, the Robert Wood Johnson Foundation (RWJF), and the CDC Foundation (CDCF). PLACES will allow counties, places, and local health departments regardless of population size and urban-rural status to better understand the burden and geographic distribution of health-related outcomes in their jurisdictions and assist them in planning public health interventions. PLACES is an extension of the original 500 Cities Project that provided city and census tract estimates for chronic disease risk factors, health outcomes, and clinical preventive services use for the 500 largest US cities. The PLACES Project provides model-based population-level analysis and community estimates to all counties, cities, census tracts, and ZIP codes across the United States.

Centers for Disease Control and Prevention (CDC): United States Diabetes Surveillance System

The CDC's United States Diabetes Surveillance System contains data about diabetes, obesity, and physical activity. This data is modeled using data from the Behavioral Risk Factor Surveillance System (BRFSS).

United for Alice: United Way ALICE Data

Every two years, United For ALICE conducts a study of financial hardship at the national level in order to better understand economic disparity within and across states, to track changes over time, and to inform action that improves conditions for ALICE households nationwide.

Appendix A: Acknowledgements - Participating Partners

Putnam County Health Department

Kim Rieman, Health Commissioner
Sherri Recker
Sarah Nsiah
Andrew Burwell
Trae Gulgin

Blanchard Valley Health System

Chelsie Niese
Andrea Becker
Paige Frey

Mercy Health

Tyler Smith
Catherine Lusky

Putnam County Job and Family Services

Meg Schroeder

Putnam County Council on Aging

Jodi Warnecke
Mary Maas

Pathways Counseling Center

Donna Konst

Law Enforcement

Sheriff Brian Siefker
Jim Gulker
Scott Stant
Randy Weller

Area Agency on Aging

Leann Unverferth
Amber Jones

Putnam County Family and Children First

Beth Tobe

Putnam County Community Improvement Corp.

Amy Sealts

Putnam County YMCA

Aaron Baumgartner

Putnam County Soil & Water

Sarah Rieman

Go Ottawa

Jacqueline Langhals

Putnam County Commissioners

Tim Wehri

Putnam County Board of Developmental Disabilities

Beth Hempfling

Leipsic Community Center

Amanda Schroeder

Putnam County Educational Service Center

Dr. Jan Osborn

Alcohol, Drug and Mental Health Services Board

Jennifer Horstman

Putnam County EMA

Brian Hilvers

Putnam County United Way

Ashley Baumgartner

Crime Victim Services

Greg Recker
Erin Burkholder
Tammy Baumunk

HHWP Community Action

Sheila Elston
Christina Sowders

HHWP Head Start

Jeanne Wenzinger

Lima Memorial Hospital

Jeff Utz
Jacob Rigali

Ohio State Extension SNAP-Ed

Mona Lisa Hoffman

Ohio Department of Health

Nick Walters

Putnam County Home Care & Hospice

Shelby Cole
Jessica Schlosser

Appendix B: Community Partner Assessment Report (CPA)

Putnam County Community Partner Assessment Report (2025)

Phase II: Tell the Community Story – Mobilizing for Action through Planning and Partnerships (MAPP 2.0)

Table Of Contents

INTRODUCTION AND PURPOSE	83
Purpose of the CPA.....	83
OVERVIEW OF THE MAPP 2.0 PROCESS	84
CPA PROCESS OVERVIEW IN PUTNAM COUNTY	85
Timeline and Focus Areas	85
ALIGNMENT WITH NACCHO’S CPA FRAMEWORK	86
COMMUNITY PARTNER SURVEY HIGHLIGHTS	87
<i>Key Findings</i>	87
Strengths & Opportunities.....	87
Areas For Growth & Development	88
PARTNER ENGAGEMENT ACTIVITIES	89
RICH PICTURE ANALYSIS – EXPLORING ROOT CAUSES	91
SPECTRUM OF COMMUNITY ENGAGEMENT	92
THEMATIC SYNTHESIS ACROSS ACTIVITIES	92
COLLECTIVE HEALTH EQUITY STATEMENT	93
TRANSITION TO COMMUNITY CONTEXT ASSESSMENT	93
SYSTEM IMPLICATIONS	93
CONCLUSION	93
APPENDIX A: PARTNER SURVEY	94
APPENDIX B: RICH PICTURE ANALYSIS EXERCISE	114
APPENDIX C: ESSENTIAL PUBLIC HEALTH SERVICES (STICKY NOTES EXERCISE)	118

Executive Summary

Between January and March 2025, the Putnam County Health Department (PCHD) led the Community Partner Assessment (CPA) as part of Phase II of the MAPP 2.0 framework. Over 30 representatives from healthcare, education, social services, and community-based organizations participated in four meetings and a partner survey.

The CPA examined how Putnam County's Local Public Health System (LPHS) collaborates, shares resources, integrates equity, and uses data to advance community health. Findings reveal a deeply collaborative network with shared trust and mission, yet one that must strengthen its upstream strategies, workforce capacity, and equity infrastructure to drive systemic change.

Key Highlights:

- **Broad Collaboration:** 81% of partners engage in community-led decision-making; 75% have participated in health improvement processes.
- **Equity Integration:** Only 6 of 16 organizations include equity in job descriptions, and just one has a dedicated equity team.
- **Data Use:** 70% conduct community health assessments; 30% do not collect data at all.
- **Capacity Challenges:** Staffing and funding remain consistent barriers, particularly in smaller organizations.

System Implications: Putnam County's health network is united and action-oriented. The CPA solidifies its readiness to align resources, data, and equity-centered policies to sustain community well-being.

Introduction and Purpose

The Community Partner Assessment (CPA) is one of three key assessments in Phase II: Tell the Community Story of the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework developed by the National Association of County and City Health Officials (NACCHO).

It serves as a systems-level analysis of how organizations across sectors collaborate to promote community health and equity.

Purpose of the CPA

As outlined by NACCHO, the CPA aims to:

1. Identify and assess the strengths, gaps, and capacity of local organizations and the broader local public health system (LPHS).
2. Examine how partnerships, power, and resources are shared across sectors.
3. Explore how health equity is embedded in policies, programs, and practices.
4. Strengthen relationships and cross-sector collaboration to advance collective action.
5. Build a shared understanding of system readiness for community-driven change.

In Putnam County, this process was designed to uncover how organizations work together, how they use data and community input, and where equity gaps remain, while creating a foundation for the Community Context Assessment and 2026–2028 Community Health Improvement Plan (CHIP).



Overview of the MAPP 2.0 Process

MAPP 2.0, developed by NACCHO, is a community-driven framework that empowers local partners to achieve health equity through structured collaboration and shared accountability.

It unfolds through three iterative phases:

MAPP 2.0 Phase	Purpose	Key Outputs
Phase I – Build the Foundation	Establish partnerships, governance, and a shared vision for health equity	Vision, Leadership Team, Engagement Plan
Phase II – Tell the Community Story	Gather data through three assessments: <ul style="list-style-type: none"> • Community Partner Assessment (CPA) • Community Status Assessment (CSA) • Community Context 	Comprehensive Community Health Assessment

	Assessment (CCA)	
Phase III – Continuously Improve the Community	Prioritize issues, develop and implement CHIP, and evaluate progress	Community Health Improvement Plan

MAPP 2.0 is guided by nine core principles:

1. Equity
2. Inclusion
3. Community Power
4. Trusted Relationships
5. Shared Vision
6. Data for Decision-Making
7. Strategic Collaboration
8. Continuous Improvement
9. Systems Thinking

CPA Process Overview in Putnam County

Between January and March 2025, the Putnam County Health Department (PCHD) convened a four-meeting series to complete the Community Partner Assessment, engaging over 30 representatives from healthcare, education, social services, business, and community-based organizations.

Timeline and Focus Areas

Date	Meeting Focus	Key Outcomes
Jan 10, 2025 – Orientation Meeting #1	Introduced MAPP 2.0 framework, reviewed 2021 CHA & 2023–25 CHIP, discussed the importance of equity and partnership.	Established shared understanding of MAPP 2.0 and local process.
Feb 13, 2025 – Orientation Meeting #2	Reviewed CPA Survey results; introduced the “On the River” activity to explore upstream–downstream alignment.	Defined a shared health equity statement and connected partner activities to social determinants of health.
Feb 25, 2025 – CPA Workshop Meeting #3	Conducted the Essential Public Health Services (EPHS) Sticky Note exercise; discussed system strengths and gaps.	Mapped partner contributions across the 10 EPHS; identified collaboration opportunities.
Mar 20, 2025 – CPA Final Meeting	Completed the Rich Picture Analysis and Spectrum of Community Engagement; transitioned into Community Context planning.	Synthesized CPA findings; identified key populations for qualitative focus groups.

Alignment with NACCHO’s CPA Framework

According to national guidance, the CPA explores the LPHS through five lenses, each of which was intentionally incorporated into the Putnam County process:

NACCHO CPA Lens	Local Approach / Data Source
<i>Community Strengths</i>	Identified through the <i>Common Themes Activity</i> —partners described shared assets such as collaboration, strong local leadership, and commitment to service.
<i>Organizational Capacity</i>	Evaluated through the <i>EPHS Sticky Note Exercise</i> and <i>CPA Survey</i> , which mapped resources, workforce capacity, and service roles.
<i>Systems of Power & Equity</i>	Explored through the <i>Defining Health Equity</i> discussion and <i>On the River</i> activity, highlighting disparities in resource allocation and community influence.
<i>Social Determinants of Health (SDOH)</i>	Embedded in all activities, especially the <i>Rich Picture Analysis</i> , which examined how housing, income, education, and social support intersect.
<i>Health Behaviors & Outcomes</i>	Connected to system-level influences in the <i>Rich Picture</i> and <i>On the River</i> , revealing how programs and policies shape health outcomes.

This multi-layered approach ensured that the Putnam County CPA met both the intent and structure of NACCHO’s MAPP 2.0 guidance.

Community Partner Survey Highlights

The CPA Survey (Fall 2024) gathered input from 16 organizations across public health, healthcare, education, and social service sectors. Results provided a baseline of partner capacity, equity integration, and collaboration readiness.

Key Findings

Strengths & Opportunities

Community-Oriented (Figure 1)

- 3/4 organizations have participated in a community health improvement process.
- 81.3% of organizations have engaged in community-led decision-making, demonstrating a strong commitment to community engagement.

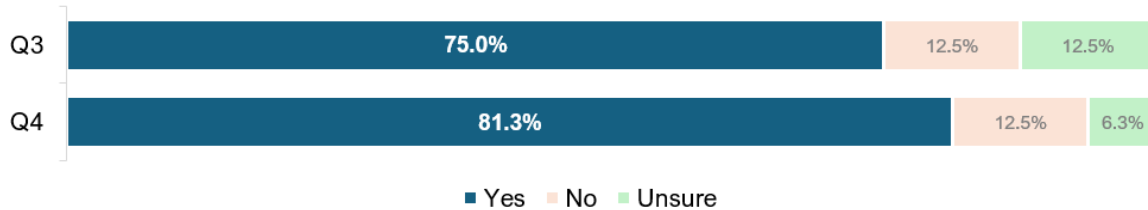


Figure 1

Diverse and Collaborative (Figure 2)

- Organizations represented a variety of sectors:
 - Primarily Social Services, Government/Public Agencies, and Healthcare.
- Over half of organizations selected 'collaborate' as one of their top 3 approaches to community engagement.

CPA Organization Breakdown

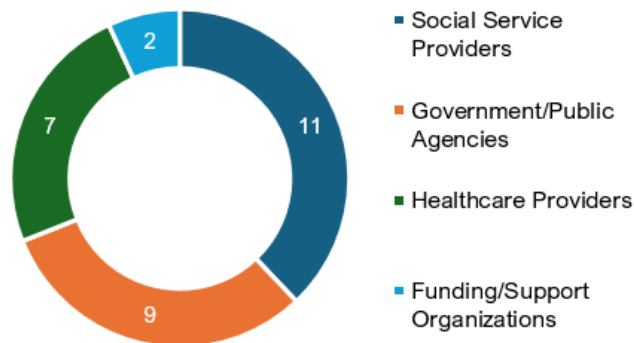


Figure 2

Communication and Education Focus (Figure 3)

- Communication and education were identified by most agencies as a core competency and key strategy for community impact.



Figure 3

Data-Driven (Figure 4)

- Almost 70% of organizations conduct community health needs assessments.
- 63% use surveys as a method for data collection, indicating a data-driven approach to understanding community needs.
- While data is heavily emphasized in some organizations, nearly 30% indicated they do not collect any form of data.

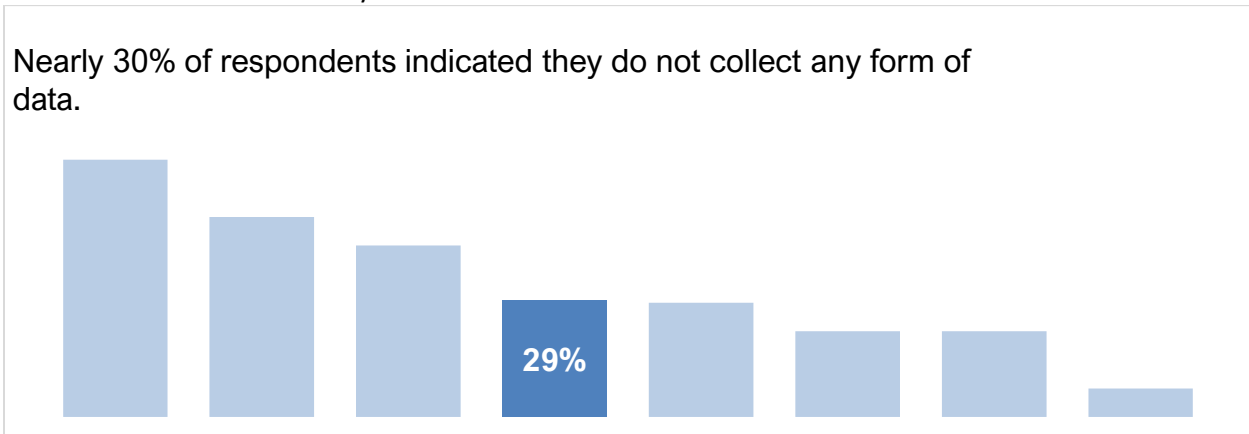


Figure 4

Areas For Growth & Development

Enhancing Equity (Figure 5)

- 6 out of 16 organizations include equity in job descriptions.
- Only 1 organization has a team dedicated to advancing equity, highlighting a need to further integrate equity considerations into internal practices and service delivery.

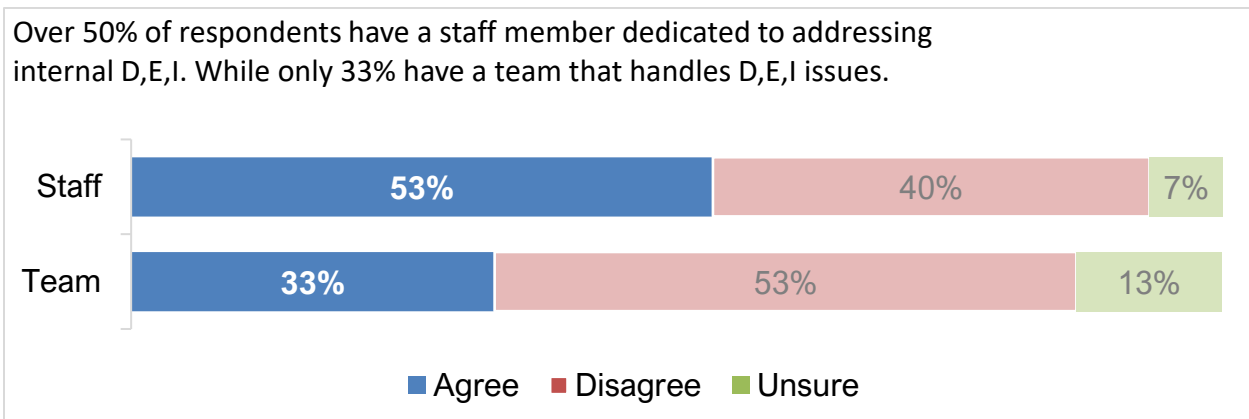


Figure 5

Deepening Community Engagement (Figure 6)

- Just about half of organizations use social media for community engagement

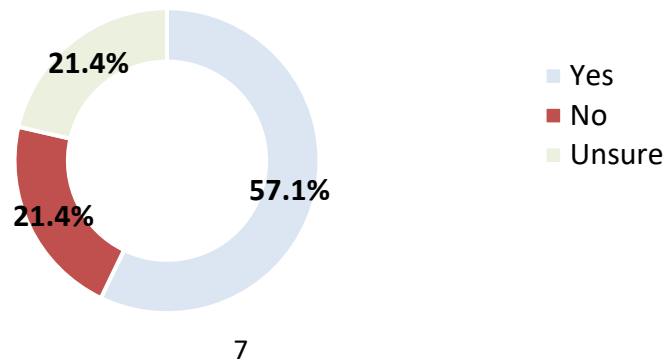


Figure 6

Resource Optimization (Figure 7)

- 7 out of 16 organizations identified insufficient staff as a challenge, and 5 identified insufficient funding as a barrier, suggesting a need to explore opportunities for resource sharing and collaboration

21.4% of respondents indicated they do not have sufficient capacity to meet the needs of their clients



Figure

Overall Implication

Putnam County's public health network is deeply collaborative but needs to strengthen equity infrastructure and shared data capacity to better target system-level barriers.

Partner Engagement Activities

The 10 Essential Public Health Services (EPHS):

1. Assess and monitor population health status, factors that influence health, and community needs and assets.
2. Investigate, diagnose, and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4. Strengthen, support, and mobilize communities and partnerships to improve health.
5. Create, champion, and implement policies, plans, and laws that impact health.
6. Utilize legal and regulatory actions to improve and protect the public's health.
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
10. Build and maintain a strong organizational infrastructure for public health.

1. Essential Public Health Services (EPHS) Sticky Note Exercise

- Partners mapped their activities to the 10 EPHS to visualize how their work contributes to population health.

Highlights include:

- Strong representation in Assessment (EPHS 1) and Communication (EPHS 3) through surveys, education, and outreach
- Emerging strengths in Workforce Development (EPHS 8) and Quality Improvement (EPHS 9).
- Opportunities to expand Policy & Systems Change (EPHS 5) and Equity-focused Access (EPHS 7).
 - Gaps were identified in Policy Development (EPHS 5) and Data Integration (EPHS 9)—areas targeted for future system strengthening.
 - This exercise confirmed that Putnam County’s LPHS is comprehensive and collaborative, with every EPHS represented by at least one active partner.

2. “On the River” Activity – Upstream, Midstream, Downstream Reflection

Partners categorized their services to understand how collective action spans:

- *Upstream (policy/system)* – e.g., childcare advocacy, transportation coordination, legislative engagement.
- *Midstream (access/programs)* – e.g., workforce education, prevention coalitions, outcome measurement.
- *Downstream (direct services)* – e.g., immunizations, communicable disease response, free clinics.
 - Partners concluded that while downstream and midstream efforts are strong, more work is needed upstream to shift systems and policies that drive inequities.

One participant summarized:

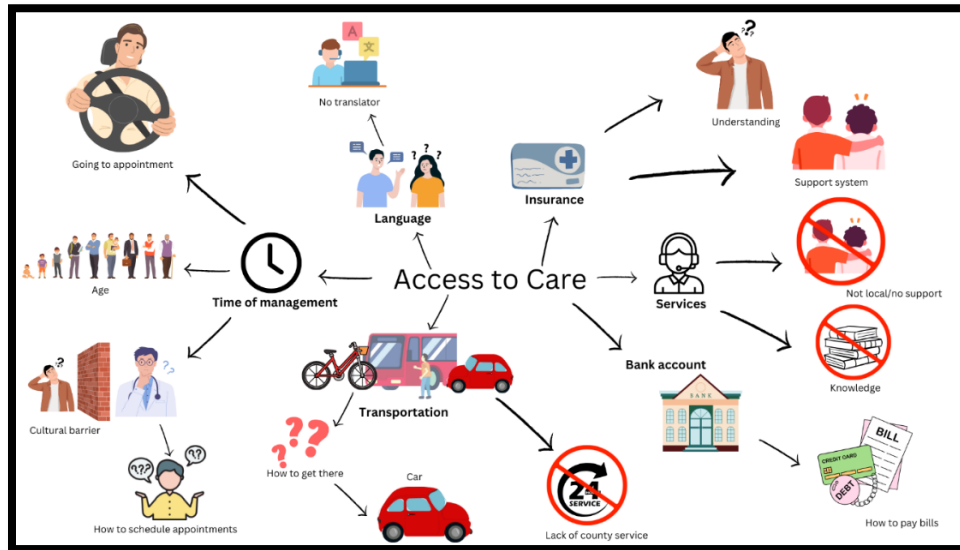
“Our goal is to turn the stream into a lazy river—making movement between levels seamless and sustainable.”



Rich Picture Analysis – Exploring Root Causes

During the final CPA meeting, partners drew Rich Picture Diagrams illustrating interconnected root causes across nine community issues: obesity, mental health, substance use, vaping, access to care, childcare, and domestic violence.

The following diagram highlights the root causes of barriers to “Access to Care.” There were five groups comprised of 3-5 individuals from different organizations. Each group was given a scenario with the underlying issue. From there, using words and illustrations, each group created a rich picture analysis.

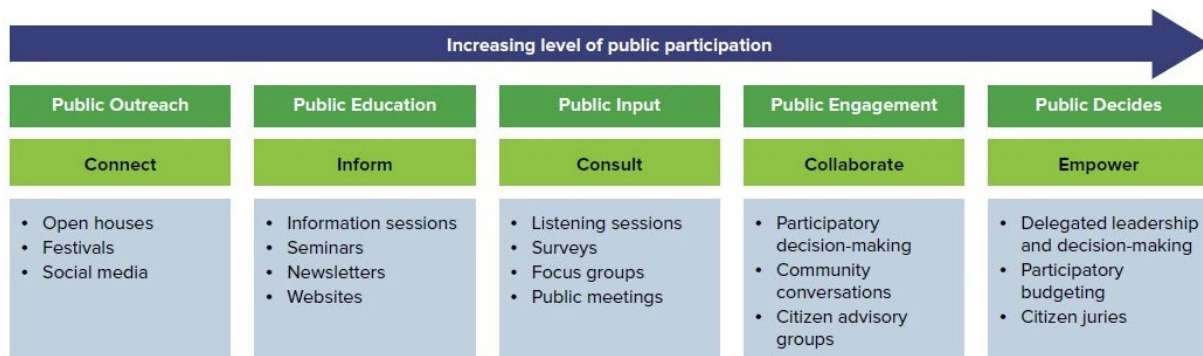


Findings revealed:

- Shared determinants: poverty, transportation, mental wellness, family instability, and cultural stigma.
- Common root causes: isolation, employment strain, and housing barriers.
- Systems-level needs: upstream investments in early childhood support, behavioral health, and workforce development.

Spectrum of Community Engagement

Partners reflected on their place within the Community Engagement Spectrum, recognizing that most organizations currently operate in consultation and collaboration stages. Partners expressed interest in moving toward shared leadership and community ownership in future CHIP planning—consistent with MAPP 2.0’s emphasis on community power



Thematic Synthesis Across Activities

+Across all CPA activities and survey results, several key themes emerged:

Theme	Insights
Collaboration & Partnership	Strong cross-sector partnerships with shared mission and high trust; long-standing coalitions form the backbone of health improvement efforts
Health Equity	Widely valued conceptually; partners committed to operationalizing it through staff training, policies, and inclusive decision-making
Systems Thinking	Increasing understanding of how social and environmental factors drive health outcomes; movement toward integrated planning
Data & Evaluation	Many organizations collect data independently; opportunity exists for unified, local data-sharing infrastructure
Workforce & Access	Staffing shortages, rural access, and transportation barriers persist as systemic challenges

Collective Health Equity Statement

This shared statement reflects the values of inclusion, fairness, and opportunity that partners agreed should guide all future community health work.

“Residents have a choice to fair and just opportunities to be as happy, independent, and healthy as possible. To achieve this, we must collaborate to remove barriers and stigma to optimal health and their consequences.”

Transition to Community Context Assessment

At the March 20 meeting, partners identified the following priority populations for focus groups and key informant interviews to ensure representative qualitative data collection:

- School administrators, counselors, and nurses
- Low-income and single-parent households
- Healthcare and behavioral health providers
- English as Second Language (ESL) and ethnic populations
- Older adults and caregivers
- Law enforcement
- Residents outside Ottawa villages
- Farmers
- Elected officials

These insights helped to guide the Community Context Assessment, ensuring diverse voices and lived experiences informed the next phase.

System Implications

Strong Collaborative Infrastructure – Putnam County’s network demonstrates exceptional coordination, shared purpose, and trusted relationships. These social assets form the foundation of a resilient local public health system.

Need for Upstream Investment – While programmatic collaboration is robust, limited policy engagement and system-level advocacy hinder long-term structural change.

Commitment to Health Equity – Partners uniformly value equity as a guiding principle, though many organizations are still developing the internal structures to embed it fully.

Community Readiness – Partners exhibit motivation, maturity, and trust, positioning Putnam County for continued system improvement and equity-driven progress.

Conclusion

The Community Partner Assessment reaffirmed that Putnam County’s greatest strength is its people and partnerships. Organizations across sectors are engaged, collaborative, and ready to evolve their systems to better promote health equity.

The insights, shared values, and relationships established through the CPA provided a solid foundation for the Community Context and Status Assessments, culminating in a data-informed, equity-driven Community Health Improvement Plan (CHIP).

Appendix A: Partner Survey

Community Partner Assessment

About Your Organization

* 1. What is the full name of your organization?

* 2. Which best describes your position or role in your organization?

- Administrative staff
- Front line staff
- Supervisor (not senior management)
- Senior management level/unit or program lead
- Community member
- Community leader
- Other (please specify)

* 3. Has your organization ever participated in a community health improvement process?

- Yes
- No
- Unsure

* 4. Has your organization ever participated in or facilitated community-led decision-making around policies, actions, or programs?

- Yes
- No
- Unsure

* 5. Which of the following best describe(s) your organization? (check all that apply)

- County health department
- Other village government agency
- Other county government agency
- Other state government agency
- Hospital
- Private clinic
- Public clinic
- Emergency response
- Schools/education (PK-12)
- College/university
- Library
- Non-profit organization
- Grassroots community organizing group/organization
- Social service provider
- Housing provider
- Mental health provider
- Foundation/philanthropy
- For-profit organization/private business
- Faith-based organization
- Other (please specify)

Community Partner Assessment

Organizational Interest in Participating in and Supporting MAPP

* 6. What are your organization's top-three interests in joining a community health improvement partnership: (only choose 3)

- To deliver programs effectively and efficiently and avoid duplicated efforts
- To pool resources
- To increase communication among groups
- To break down stereotypes
- To build networks and friendships
- To revitalize low energy of groups who are trying to do too much alone
- To plan and launch community-wide initiatives
- To develop and use political power to gain services or other benefits for the community
- To improve line of communication from communities to government decision-making
- To improve line of communication from government to communities
- To create long-term, permanent social change
- To obtain or provide services
- Other (please specify)

7. (Optional) What are your agency's 1-3 most valuable resources and strongest assets you would like other agencies to know? (i.e., what makes your organization great)?

* 8. What resources might your organization contribute to support MAPP activities? (check all that apply) Note: This question does not commit your organization to support; it only identifies ways your organization *might* be able to support.

- Funding to support assessment activities (e.g., data collection, analysis)
- Food for community meetings
- Childcare for community meetings
- Policy/advocacy skills
- Media connections
- Social media capacities
- Physical space to hold meetings
- Staff time to support the process (attend meetings and activities)
- Lending interpretation equipment for use during meetings
- Note-taking support during qualitative data collection
- I'm unsure
- Other (please specify)

Community Partner Assessment

Demographics and Characteristics of Clients/Members served/Engaged

* 9. What racial/ethnic populations does your organization work with? (check all that apply)

- Black/African American
- African
- Native American/Indigenous/Alaska Native
- Latinx/Hispanic
- Asian
- Asian American
- Pacific Islander/Native Hawaiian
- Middle Eastern/North African
- White/European
- Other (please specify)

* 10. Does your organization work with immigrants, refugees, asylum seekers, and other populations who speak English as a second language?

- Yes
- No
- Unsure

* 11. Does your organization offer services for transgender, nonbinary, and other members of the LGBTQIA+ community?

- Yes—we provide services specifically for the LGBTQIA+ community
- Somewhat—we provide general services and LGBTQIA+ individuals could use those services
- No—LGBTQIA+ populations are not welcome
- Unsure

* 12. Does your organization offer services specifically for people with disabilities?

- Yes—we provide services specifically for people with disabilities
- Somewhat—we are wheelchair accessible and compliant with the American Disabilities Act but are not specifically designed to serve people with disabilities
- No—our organization is not specifically designed to serve people with disabilities
- Unsure

* 13. Does your organization work with other populations or groups who are not addressed in the previous questions? For example, groups identifiable by gender, socioeconomic status, education, disability, immigration status, religion, insurance status, housing status, occupation, age, neighborhood, and involvement in the criminal legal system.

- No
- Unsure
- If yes, please list these groups:

* 14. Does your organization have access to interpretation and translation services?

- No
- Unsure
- Not applicable
- If yes, list what languages are offered?

15. (Optional) What do you do to reach/engage/work with your clientele or community? (check all that apply)

- We hire staff from specific racial/ethnic groups that mirror our target populations
- We hire staff/interpreters who speak the language/s of our target populations
- We support leadership development in our target populations
- We have leadership who speak the language/s of our target populations
- Our organization is physically located in neighborhood/s of our target populations
- We receive many clients from our target populations
- We receive many referrals from our target populations
- We work closely with community organizations from our target populations
- We have done extensive outreach to our target populations
- Other (please specify)

16. (Optional) Does the leadership of your organization reflect the demographics of the community you serve?

- Yes
- No
- Unsure
- Not applicable

17. (Optional) Do the administrative/frontline staff and others in your organization reflect the demographics of the community you serve?

- Yes
- No
- Unsure
- Not applicable

18. (Optional) What languages do staff at your organization speak? (check all that apply)

- English
- Spanish
- Chinese (Mandarin, Cantonese, Hokkien, etc.)
- Tagalog (Filipino)
- Vietnamese
- French and French Creole
- Arabic
- Sign language
- Other (please specify)

19. (Optional) In what language/s do you hold public meetings? (check all that apply)

- English
- Spanish
- Chinese (Mandarin, Cantonese, Hokkien, etc.)
- Tagalog (Filipino)
- Vietnamese
- French and French Creole
- Arabic
- Sign language
- Other (please specify)

Community Partner Assessment

Topic Area Focus

How much does your organization focus on each of these topics? For each one, select a) A lot, b) A little, c) Not at all, or d) Unsure

* 20. **Economic Stability:** The connection between people's financial resources- income, cost of living, and socioeconomic status- and their health. This includes issues such as poverty, employment, food security, and housing stability.

- A lot
- A little
- Not at all
- Unsure

* 21. **Education Access and Services:** The connection of education to health and well-being. This includes issues such as graduating from high school, educational attainment in general language and literacy, and early childhood education and development.

- A lot
- A little
- Not at all
- Unsure

* 22. **Healthcare Access and Quality:** The connection between people's access to and understanding of health services and their own health. This includes issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.

- A lot
- A little
- Not at all
- Unsure

* 23. **Neighborhood and Built Environment:** The connection between where a person lives—housing, neighborhood, and environment— and their health and well-being. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety.

- A lot
- A little
- Not at all
- Unsure

* 24. **Social and Community Context:** The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, violence, and incarceration.

- A lot
- A little
- Not at all
- Unsure

* 25. Which of the following categories does your organization work on/with? (check all that apply)

- Arts and culture
- Businesses and for-profit organizations
- Criminal legal system
- Disability/independent living
- Early childhood development/childcare
- Education
- Community economic development
- Economic security
- Environmental justice/climate change
- Faith communities
- Family well-being
- Financial institutions (e.g., banks, credit unions)
- Food access and affordability (e.g., food bank)
- Food service/restaurants
- Gender discrimination/equity
- Government accountability
- Healthcare access/utilization
- Housing
- Human services
- Immigration
- Jobs/labor conditions/wages and income
- Land use planning/development
- LGBTQIA+ discrimination/equity
- Parks, recreation, and open space
- Public health
- Public safety/violence
- Racial justice
- Seniors/elder care
- Transportation
- Utilities
- Veterans' issues
- Violence
- Youth development and leadership
- Other (please specify)

* 26. Which of the following health topics does your organization work on? (check all that apply)

- Cancer
- Chronic disease (e.g., asthma, diabetes/obesity, cardiovascular disease)
- Family/maternal health
- Immunizations and screenings
- Infectious disease
- Injury and violence prevention
- HIV/STD prevention
- Healthcare access/utilization
- Health equity
- Health insurance/Medicare/Medicaid
- Mental or behavioral health (e.g., PTSD, anxiety, trauma)
- Physical activity
- Tobacco and substance use and prevention
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)/food stamps
- None of the above/Not applicable
- Other (please specify)

* 27. If your organization has a shared definition of equity or health equity, please copy and paste it below.

Community Partner Assessment

Organizational Commitment to Equity

Please review the following statements. For each one, select a) Agree, b) Disagree, or c) Unsure.

28. We have at least one person in our organization dedicated to addressing diversity, equity, and inclusion internally in our organization.

- Agree
 Disagree
 Unsure

* 29. We have at least one person in our organization dedicated to addressing inequities externally in our community.

- Agree
 Disagree
 Unsure

* 30. We have a team dedicated to advancing equity/addressing inequities in our organization.

- Agree
 Disagree
 Unsure

* 31. Advancing equity/addressing inequities is included in all or most staff job requirements.

- Agree
 Disagree
 Unsure

* 32. In 1-2 sentences, describe the people impacted by your organization and the work you are doing.

Community Partner Assessment

Organizational Accountability

* 33. Does your organization have an advisory board of community members, stakeholders, youth, or others who are impacted by your organization?

- Yes
 No
 Unsure

* 34. To whom is your organization accountable? By accountable we mean whom your organization must report to because they determine or oversee your funding as an organization, determine your priorities, etc. This could be who has power over your organization's decision-making—for example, city government agencies may be accountable to the mayor or city council; a business may be accountable to its shareholders; and an organizing group may be accountable to its members. (check all that apply)

- Mayor, governor, or other elected executive official
 City council, board of supervisors/commissioners, or other elected legislative officials
 State government
 Federal government
 Tribal government
 Foundation
 Community members
 Members of the organization/association
 Customers/clients
 Board of directors/trustees
 Shareholders
 Voters
 Voting members
 National/parent organization
 Other government agencies
 Other (please specify)

Community Partner Assessment

Organizational Capacities Related to the 10 Essential Public Health Services

One goal of this assessment is to help describe how each partner organization contributes to your local public health system. Your organization and you are vital to our community's local public health system, even if you do not work in public health or healthcare.

Public health is more than healthcare, and health outcomes are shaped by behaviors, ability to access care, living and working conditions, and the institutions, policies, systems, cultural norms, social inequalities, and environment that shape our community.

Organizations working to improve the well-being of individuals, families, and communities through improving housing, education, childcare, workforce development, or other conditions have an impact on the public's health.

One way to understand, assess, and improve our local public health system is to name how your organizational capacities and activities align with 10 Essential Public Health Services (EPHS).

The 10 statements below describe activities needed for the public health system (e.g., assessment, communication, community engagement).

* 35. Please select whether your organization regularly does the following activities. (check all that apply)

- Assessment: My organization conducts assessments of living and working conditions and community needs and assets.
- Investigation of Hazards: My organization investigates, diagnoses, and addresses health problems and hazards affecting the population.
- Communication and Education: My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being, and how to improve it.
- Community Engagement and Partnerships: My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being.
- Policies, Plans, Laws: My organization works to create, champion, and apply policies, plans, and laws that impact health and well-being.
- Legal and Regulatory Authority: My organization has legal or regulatory authority to protect health and well-being and uses legal and regulatory actions to improve and protect the public's health and well-being.
- Access to Care: My organization provides healthcare and social services to individuals or works to ensure equitable access and an effective system of care and services.
- Workforce: My organization supports workforce development and can help build and support a diverse, skilled workforce.
- Evaluation And Research: My organization conducts evaluation, research, and continuous quality improvement and can help improve or innovate functions.
- Organizational Infrastructure: My organization is helping build and maintain a strong organizational infrastructure for health and well-being.
- Unsure

* 36. Are there any other core competencies or strengths not included on the list above that your organization does?

- No
- If yes, please list these core competencies/strengths:

37. (Optional) Does your organization have sufficient capacity to meet the needs of your clients/ members? For example, do you have enough staff/funding/support to do your work?

- Yes
- No
- If unsure, please elaborate:

Community Partner Assessment

General Capacities and Strategies

* 38. Which of the following strategies does your organization use to do your work? (check all that apply)

- Research and Policy Analysis: Gathering and analyzing data to create credibility and inform policies, projects, programs, or coalitions.
- Social and Health Services: Providing services that reach clients and meet their needs (including clinical and healthcare services).
- Organizing: Involving people in efforts to change their circumstances by changing the underlying structures, decision-making processes, policies, and priorities that produce inequities.
- Communications: Messaging that resonates with communities, connects them to an issue, or inspires them to act.
- Leadership Development: Equipping leaders with the skills, knowledge, and experiences to play a greater role within their organization or movement.
- Litigation: Using legal resources to reach outcomes that further long-term goals.
- Advocacy and Grassroots Lobbying: Targeting public officials either by speaking to them or mobilizing constituents to influence legislative or executive policy decisions.
- Alliance and Coalition-Building: Building collaboration among groups with shared values and interest.
- Arts and Culture: Nurturing the multiple skills of an individual through the arts and encouraging connection through shared experiences.
- Campaigns: Using organized actions that address a specific purpose, policy, or change.
- Healing: Addressing personal and community trauma and how they connect to larger social and economic inequalities.
- Inside-Outside Strategies: Coordinating support from organizations on the "outside" with a team of like-minded policymakers on the "inside" to achieve common goals.
- Integrated Voter Engagement: Connecting organizing and voter-engagement strategies to build a strong base over multiple election cycles.
- Movement-Building: Scaling up from single organizations and issues to long-term initiatives, perspectives, and narratives that seek to change systems.
- Narrative Change: Harnessing arts and expression to replace dominant assumptions about a community or issue with dignified narratives and values.
- Other (please specify)

39. (Optional) One goal of MAPP is to help build the collective capacity of our network and connect partners to help build their capacities. What capacities would you like to grow as an organization, including any mentioned above?

Community Partner Assessment

Data Access and Systems

* 40. Does your organization conduct assessments (e.g., of basic needs, community health, neighborhood)?

- No
- Unsure
- If yes, please describe what they assess.

* 41. Can you share the assessments you described above with the MAPP collaborative?

- Yes
- No
- Unsure
- Not applicable—My organization does not conduct assessments.

* 42. What data does your organization collect? (check all that apply)

- Demographic information about clients or members
- Access and utilization data about services provided and to whom
- Evaluation, performance management, or quality improvement information about services and programs offered
- Data about health status
- Data about health behaviors
- Data about conditions and social determinants of health (e.g., housing, education, or other conditions)
- Data about systems of power, privilege, and oppression
- We don't collect data
- Other (please specify)

* 43. Can you share any of that data with the MAPP collaborative?

- Yes, already being shared
- Yes, can share
- No
- Unsure

* 44. How does your organization collect data? (check all that apply)

- Surveys
- Focus groups
- Interviews
- Feedback forms
- Photovoice or other participatory research
- Notes from community meetings
- Videos
- Secondary data sources
- Electronic health records
- Data tracking systems
- Other (please specify)

* 45. What data skills does your organization have? (check all that apply)

- Survey design and analysis
- Secondary data analysis
- Needs assessment
- Focus group facilitation
- Interviewing
- Detailed note-taking or transcription
- Participatory research
- Facilitators of community or town hall meetings
- Asset mapping
- Mapping/visualization skills
- Other quantitative or qualitative methods:

* 46. Does your organization analyze data with a health equity lens or health equity in mind?

If Yes, please describe:

- No
- Unsure
- If yes, please describe

47. (Optional) Please add comments about how your organization could support data collection and analysis in the MAPP process:

Community Partner Assessment

Community-Engagement Practices

48. (Optional) What type of community-engagement practices does your organization do most often (check one): Note: We will explore this more deeply in the CPA partner discussion.

- Inform: Provide the community with relevant information.
- Consult: Gather input from the community.
- Involve: Ensure community needs and assets are integrated into process and inform planning.
- Collaborate: Ensure community capacity to play a leadership role in implementation of decisions.
- Defer to: Foster democratic participation and equity through community-driven decision-making. Bridge divide between community and governance.
- Unsure

* 49. Which of the following methods of community engagement does your organization use most often? (check all that apply):

- Customer/patient satisfaction surveys
- Fact sheets
- Open houses
- Presentations
- Billboards
- Videos
- Public comment
- Focus groups
- Community forums/events
- Surveys
- Community organizing
- Advocacy
- House meetings
- Interactive workshops
- Polling
- Memorandums of understanding (MOUs) with community-based organizations
- Citizen advisory committees
- Open planning forums with citizen polling
- Community-driven planning
- Consensus building
- Participatory action research
- Participatory budgeting
- Social media
- Other (please specify)

* 50. When you host community meetings, do you offer: (check all that apply)

- Stipends or gift cards for participation
- Interpretation/translation to other languages including sign language
- Food/snacks
- Transportation vouchers if needed
- Childcare if needed
- Accessible materials for low literacy populations
- Virtual ways to participate
- Not applicable
- Other (please specify)

51. (Optional) Please add comments about how your organization could support community engagement in the MAPP process:

* 52. What policy/advocacy work does your organization do? (check all that apply)

- Develop close relationships with elected officials
- Educate decision-makers and respond to their questions
- Respond to requests from decision-makers
- Use relationships to access decision-makers
- Write or develop policy
- Advocate for policy change
- Build capacity of impacted individuals/communities to advocate for policy change
- Lobby for policy change
- Mobilize public opinion on policies via media/communications
- Contribute to political campaigns/political action committees (PACs)
- Voter outreach and education
- Legal advocacy
- Not applicable
- Unsure
- Other (please specify)

Community Partner Assessment

Policy, Advocacy, and Communications

Please review the following statements. For each one, select a) Strongly agree, b) Agree, c) Disagree, d) Strongly disagree, e) unsure

* 53. Our organization has a strong presence in local earned media (print/radio/TV).

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

* 54. Our organization has strong communications infrastructure and capacity.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

* 55. Our organization has a clear communications strategy.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

* 56. Our organization has good relationships with other organizations who can help share information.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

* 57. Our organization has a clear equity lens that we use for our external communications and engagement work.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

* 58. What communications work does your organization do most often? (check all that apply)

- Internal newsletters to staff
- External newsletters to members/the public
- Ongoing and active relationships with local journalists and earned media organizations
- Media contact list for press advisories/releases
- Social media outreach (e.g., on Facebook, Twitter, Instagram)
- Ethnicity-specific outreach in non-English language
- Press releases/press conferences
- Data dashboard
- Meet to discuss narrative and messaging to the public
- Other (please specify)

59. (Optional) If your organization has publicly available materials, are they translated into other languages?

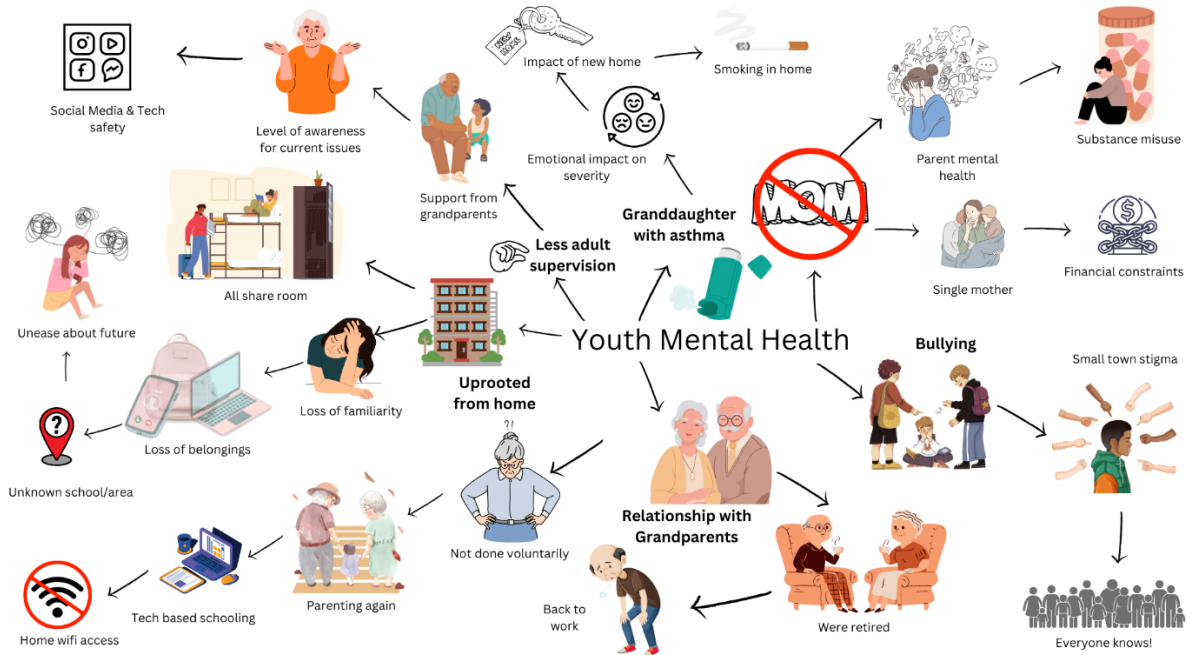
- All publicly available materials are translated into other languages
- Most publicly available materials are translated into other languages (e.g., when conducting outreach to various populations or when hosting events for various populations)
- Few publicly available materials are translated into other languages (e.g., only when requested)
- No publicly available materials are translated into other languages
- Not applicable (we do not have publicly available materials)

60. (Optional) Please add any questions, comments, or suggestions about the MAPP process and our next steps together to improve community health:

Appendix B: Rich Picture Analysis Exercise

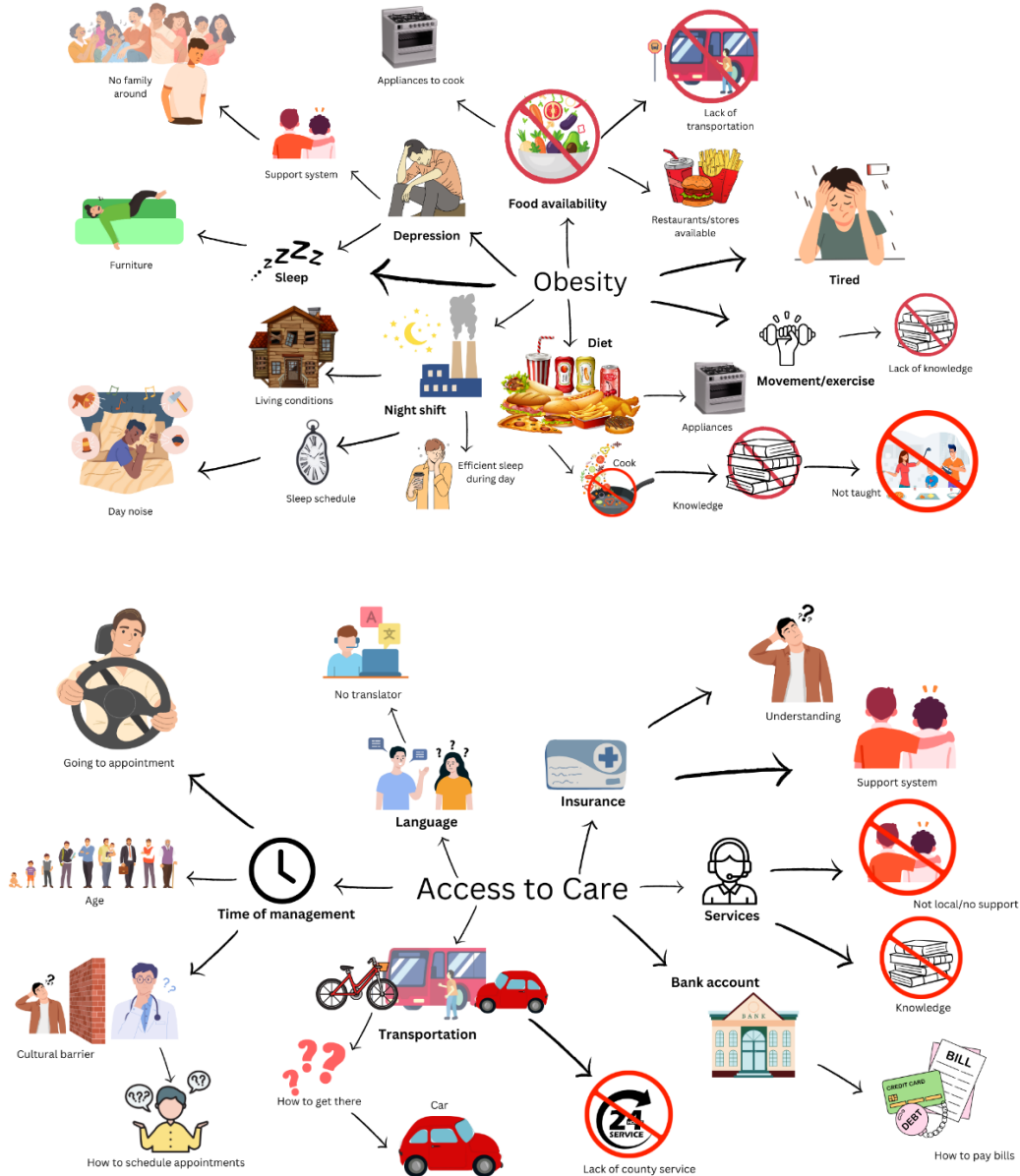
Scenario #1: Youth mental health and unsafe housing

A grandmother got a call from the school that one of granddaughters was acting out in her math class. The grandmother and her husband both live in Glandorf with their 4 grandchildren (ages 6 to 14). The grandparents (65 and 66) have been caring for their 4 granddaughters for the last 7 months since their mom dropped them off for a weekend and has not been back. Both previously retired grandparents needed to go back to working full time last month to help pay for the extra expenses of raising 4 kids. Their 2-bedroom home needs some repairs, but they can't afford it. It has started to impact the 8-year-old granddaughter's asthma. The kids got a call from their mom saying she would visit over the break, but the kids went back to school this week, and she never showed up.



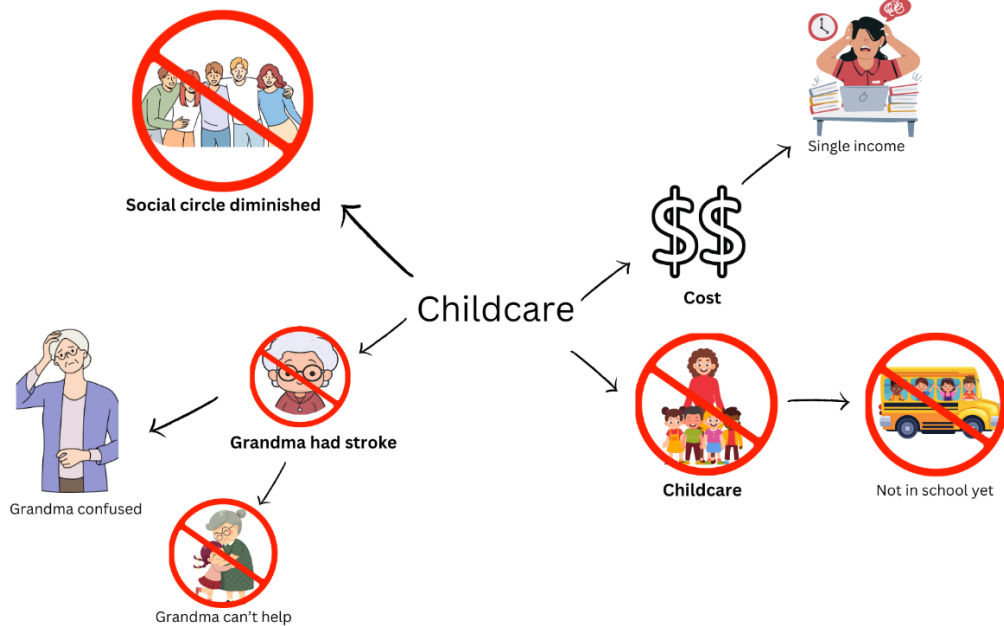
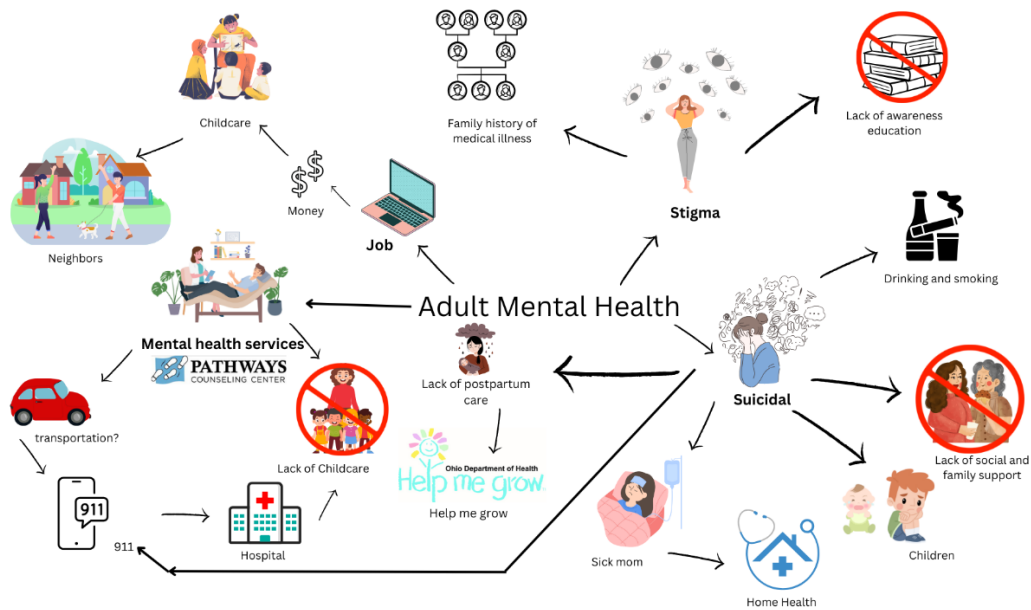
Scenario #2 Obesity and Access to care

A 19-year-old young man moves to Leipsic to start the night shift at a manufacturer facility. The job is taking a toll on his health. He sleeps most of the day and is exhausted when he gets up. He is only eating fast food and he has never cooked his own meals before. He is on his feet at work but does not exercise. He has gained 25lbs in the last 4 months which is a lot for his frame. He wants to get a doctor but the language barrier has made it hard to call to make an appointment. Work pays well and he has gotten support from his employer for translation to sign up for health insurance for the first time.



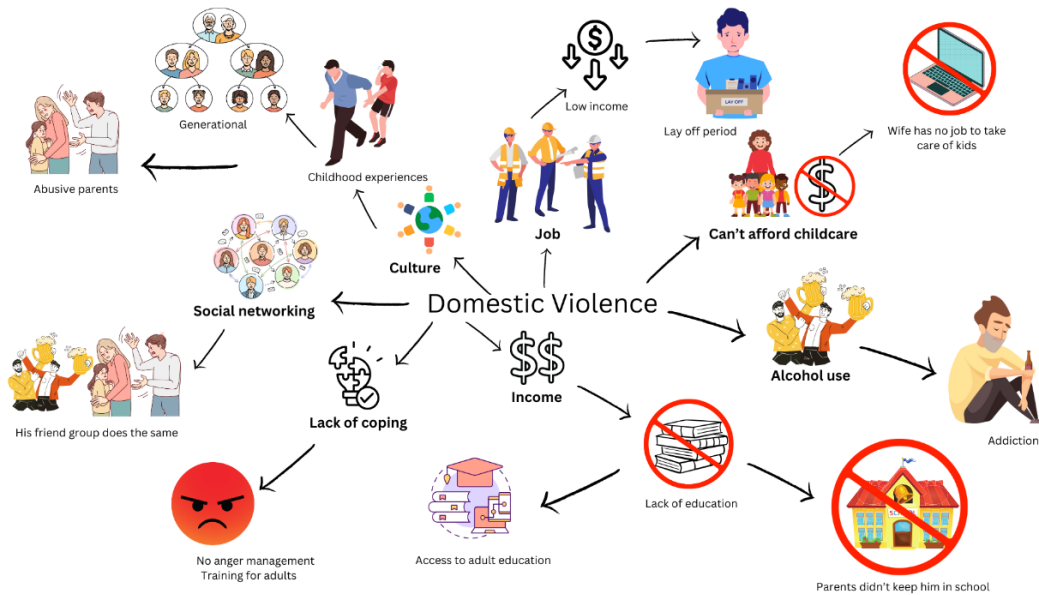
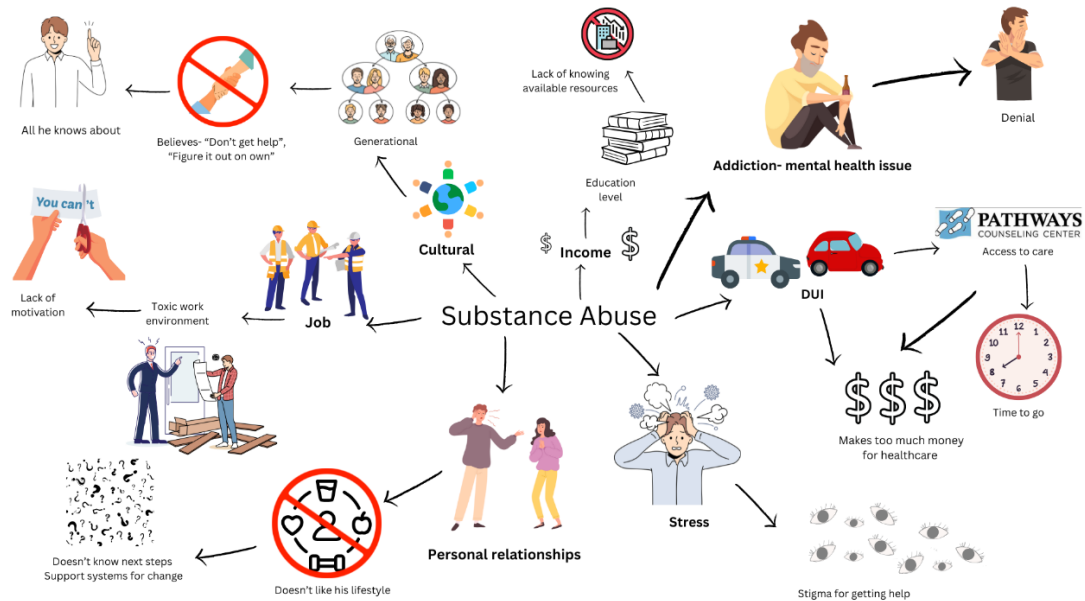
Scenario #3 Adult mental health and childcare

A single mom is raising her 2 children, both under 3 years old, on her own. For the last week she is back to work at an office doing billing in Ottawa, after being on paid maternity leave for 12 weeks. She still has postpartum depression. When her husband left 3 weeks ago, she became suicidal. She has family in the area, but her mom can't help the children any more due to her recent stroke 2 weeks ago.



Scenario #4 Substance abuse and domestic violence

A 42-year-old Fort Jennings man works in construction and is struggling to keep his job and his family. He often drinks 8 plus beers a night. As a result, he is late to work often. A week ago, his supervisor warned him that if he is late again, he will be terminated. He verbally abuses his wife and kids when he is drunk. Today, his wife threatened to leave him and take their kids if it happens again.



Appendix C: Essential Public Health Services (Sticky Notes Exercise)

Description: There were posters hung on the walls of the meeting room when this exercise took place. Everyone present from partner organizations wrote down sticky notes the services they provide that contribute to the health and well-being of Putnam County residents. The following list is the compiled results.

#1 Assess and monitor population health

- SDOH assessments completed
- Able to assess the patients' home environment. We look for ways to help keep patients in the home safety- Bridge HH & Hospice
- partners to develop CHIP collect local data collect data on SDOH(try patient)- BVHS
- Healthy eating and active living assessments CHC Grant- PCHD
- Holds focus groups- AAA3
- Community health assessment; surveyance for illness (passive and active)- PCHD
- CHA participate
- Coordinating PC CHA- PCHD
- Transportation surveys through coordinated transportation plan
- Bike Audits- Go Ottawa
- Developing new programs to serve a wider range pf patients (ex: private pay homecare new in 2025- PC Home care & Hospice
- Using existing data for reapplying for GRANT, a policy, system, and environmental changes- OSU SNAP-ED
- PRIDE survey- Putnam Co. Task Force
- Assess Behavioral Health Needs
- Offer to support health Atlas in Allen County
- Assist families with applications
- Conducting school climate surveys- CVS
- Conduct needs assessment to identify barriers to care
- Hold numerous focus groups/CHIP
- Community Tobacco survey -PCHD

#2 Investigate, diagnose, and address health hazards and root causes

- Follow up on reports of increased disease (communicable & chronic)- PCHD
- Partners with health department for reportable diseases and tracing (weekly infections disease webinar)- BVHS
- Cancer cluster investigations- PCHD
- Communicable Disease Investigations- PCHD
- Cancer report by epidemiologist
- Disaster partnering with community- lead facilitator
- Conducts Health/Environmental Assessments- AAA3
- Opioid report on overdoses and deaths last 8-10 years
- Communicable disease follow-up and contact tracing
- Providers updates on recalls for the public

#3 Communicate effectively to inform and educate

- Tobacco awareness programs
- Social media posts on health-related topics
- Have numerous programs and services to educate our students in many aspects of their life

- PCESC & 9 local school districts currently public schools
- Improving processes/embracing new systems to more efficiently serve patients- PC Homecare & Hospice
- Info available in Spanish and other formats- PCCOA
- Fall prevention through MOB; Aging in place Home Assessments; Social isolation through programs and activities- PCCOA
- Signs of suicide; fatal vision; girls circle/boys council
- PARTY- Pathways Prevention Service
- Translating patient education into multiple language
- Partnership with Community Health Partner to offer resources- TLCC
- Participate in health fairs and senior expo
- Access to local, healthy food through Farmers Market- Go Ottawa
- Monitoring preventative health compliance of patient population
- Network with other entities
- Red ribbon week; wellness week; safety city- Task Force
- Facebook page has healthy tips- AAA3
- Conducting a health eating assessment to create a plan to provide increased access to healthy foods and educate about health eating- CHC Grant PCHD
- Focus on education of wellness visits
- School tobacco education- PCHD
- Outreach or stroke CPR classes EMS training on Hazmat- EMA/EMS
- Resource/referral (promote services)
- Supply programming research based to SNAP (low-income) participants on nutrition and physical activity- OSU SNAP-ED
- Social media networks- LMH
- Violence prevention and healthy relationship education in schools- CVS
- Social marketing campaigns for healthy interpersonal relationships- CVS
- Community partnership- created websites and forms with task forces with CHIP plans- BVHS
- Educate on various topics; public informative; crisis communication- PCHD
- Medication education; disease education; safe living in the home education; through therapy- Bridge HH & Hospice

#4 Strengthen, support and mobilize communities and partnerships

- Prevention coalition
- Domestic violence task force elder abuse task force
- Fall prevention; transportation coalition; Programs and activities; senior expo, rocksteady boxing; Pathways counseling @ PCCOA- PCCOA
- OSU SNAP-ED
- Nine local school districts work with numerous county agencies in physical, mental & social emotional programs mental health, ALICE training safe schools. Task force for youth, FCFC, etc.- PCESC
- Family & Children first council
- Putnam Adolescent Response Team for Youth (PARTY)- pathways
- Putnam County Risk Force for Youth
- Free community meals monthly- TLCC
- Collaborate with other business and organizations to assess needs of community- TLCC
- PC Tobacco Coalition- Pathways/FCFC
- Organize task force focusing on domestic violence/sexual violence- CVS

- Educate public or medical emergencies- EMA/EMS
- Be healthy now partnership (Hancock)- BVHS
- Community organizing around different events- Go Ottawa
- Free/reduced cost for agencies to run information/prevention programs- TLCC
- Work closely with the school's education, awareness support
- Community Engage through Health fairs- LMH
- Violence prevention coalition- CVS
- Work closely with Health Dept. court system; Juvenile smoking and vaping programs
- Access to public pools; partner with 3 community to manage public pools- Putnam YMCA
- Various community coalition led and participate- PCHD
- Partnership with Mercy Health Rehab. Facility used for post-operation rehabilitation- Putnam YMCA
- Liaisons help educate the community about home health, hospice, palliative care, several different community partnerships to help with engagement and education- Bridge HH & Hospice
- Works with community organizations and coalitions- AAA3
- Gym and swim days. All services open to public free of charge to promote healthy activity- Putnam YMCA

#5 Create, champion and implement policies, plans and laws

- Provides Immunizations to low-income families
- Encourage local policy change on various topics; work with state and federal legislators- PCHD
- Commissioners Asso. Lobbies at the state for health policies- Commissioners
- The joint commission accreditation; patient advocacy; own bridge policies, procedures and best practices to meet quality metrics- Bridge HH & Hospice
- Advocates locally, statewide, and federally for policies & laws effecting older adults- AAA3
Village strategic planning- Go Ottawa
OSU SNAP-ED
Coordinates with Putnam COA on the coordinated transportation plan- AAA3
Lobbying for childcare strategies; through Ohio alliance of YMCAs- buildout -policies to support childcare strategies
Meet w/ state legislators to promote health such as vaccine requirements and reporting
Strategic planning
Legislative community committee (opioids and mental health)- BVHS
Strategic plan development based on needs assessment – LMH
Policy advocacy with local & state lawmakers & officials
Prevention activities- signs of suicide; fatal vision real time experience effects of drugs and alcohol
Evaluation and improve the Ottawa farmers market based on resident and vender feedback-
CHC Grant PCHD

#6 Utilize legal and regulatory actions

- Requesting compliance checks- PCHD
- Proper training to educate our agency and community
- Environmental health rules enforced; enforce rules to decrease the spread of communicable disease- PCHD
- Commissioners help fund different agencies to improve health- Commissioners
- Nuisance for septic- PCHD
- Collaboration with local govt. and commissioners
- Food licensing

#7 Enable equitable access

- Operates local indigent clinic and supports mobile clinic- BVHS
- Carport for vaccinations for disabled
- Services in the home or off- hours
- Free health clinic for community- TLCC
- Community health worker helping link people
- No wrong door- FCFC
- Wraparound/service coordination- FCFC
- Equity. Our schools and ESC thrive to provide specially designed instruction/individualize for students
- School consultation- Pathways
- Evaluate and provide evidence-based programs
- No wrong door resource
- Provide community services- CVS
- Help clients navigate barriers- PCJFS
- Social services- PCJFS
- Connection to behavioral and mental health services- PCJFS
- Help victims who speak languages other than English navigate court
- Connect clients to community resources- CVS
- Free STD testing
- Preventative services- PCJFS
- DEI trainings for community- CVS
- PCBDD
- Offer down payment assist and \$10k in forgivable loans for housing
- Access to care brings behavioral services to schools, council on aging, other off-site locations
- Offer DEI training on cultural competency to clinicians
- Provide free transportation to and from appointments within 50-mile radius
- Provide free screenings and preventive care via mobile clinic
- Provides social services through OHCW; vaccine clinics; contracted transportation- AAA3
- We provide medical directors, NPs, Nurses, STNAs, social workers, and chaplains for all our service lines- Bridge HH & Hospice
- Focus on fund- raising to help close the gap for pts. Whose services/supplies aren't covered at 100%- PC Homecare & Hospice
- Open door program- supports families through stipends used to access services regardless of ability to pay- Putnam YMCA
- Transportation; helping identify population with greatest needs- PCHD
- Assistance offered for Medicaid applications
- OSU SNAP-ED
- High focus on access to primary care services
- Transportation for seniors 60 and better; counseling through pathways at PCCOA- PCCOA
- Assistance with Medicare- PCCOA

#8 Build a diverse and skilled workforce

- Our schools and ESC are working and developing new workforce development pathways for ALL students (ex: credentials, certificates, job coaches)
- Vaccination education to provider offices
- We hire a large variety of different skilled level individuals to meet the needs of all patients.

- Provide job education, learning opportunities, and further education- Bridge HH & Hospice
- My organization funds employees to go to workshops to improve public health
- Continuing education opportunities for clinicians and support staff- PC Homecare & Hospice
- PCBDD
- Education and training, local schools, High schools and college reimbursement- LMH
- Training- fire on hazmat- EMA/EMS
- Educating young people- PCIFS
- Provide internship to develop pipeline development for healthcare minority
- Workforce development; focus on equity and bias; growing public health workforce- PCHD
- Anticipation on local task force to increase community health workers from CHIP data- BVHS
- Work force development; support staff to increase education level with tuition reimbursement
- Pay for continuing education for staff

#9 Improve and innovate through evaluation, research and quality improvement

- We have a 6-person quality team dedicated to ensuring we are meeting quality metrics and working to implement ways to improve- Bridge HH & Hospice
- Quality improvement projects in department and divisions- PCHD
- State & local data collection of Program Participants- OSU SNAP-ED
- Outcome measurement surveys- CVS
- Collect and analyze surveys/customer satisfaction to continuously improve care/communication and better serve pts.- PC Homecare & Hospice
- Established a local free diabetic monthly clinic now following +500 patients with research reporting
- Improving relationships with other counties

#10 Build and maintain a strong organizational infrastructure for public health

- Financial growth to maintain services- PCHD
- Board of Trustees educated by public health in needs and SDOH- focused on two areas of community for improvement- BVHS
- My organization helps fund infrastructure for Public Health
- CHA & CHIP pooling organizational resources to improve the health of the community- PCHD
- Bridge is part of a health system (BVHS) which provides organizational infrastructure. We have great resources, leadership, and plenty of system analysis to help enhance our quality of care- Bridge HH & Hospice

Appendix C: Survey Respondent Demographics

		CHA Survey Respondent Total	CHA Survey Respondent Percentage	Census Reported Percentage
Zip Code	45815	<5	<1%	<1%
	45827	9	3.5%	6.0%
	45830	26	10.1%	15.0%
	45831	9	3.5%	9.9%
	45837	<5	<1%	<1%
	45844	11	4.3%	8.1%
	45848	8	3.1%	<1%
	45853	13	5.1%	4.7%
	45856	28	10.9%	14.7%
	45864	<5	<1%	<1%
	45875	132	51.4%	30.2%
	45876	6	2.3%	2.5%
	45877	12	4.7%	6.8%
	45893	<5	<1%	<1%
Age Group	18-20	<5	1.1%	4.4%
	21-24	<5	1.5%	5.8%
	25-29	14	5.2%	7.1%
	30-34	21	7.8%	7.3%
	35-39	28	10.4%	8.3%
	40-44	18	6.7%	7.8%
	45-49	20	7.4%	7.5%
	50-54	23	8.5%	8.2%
	55-59	26	9.7%	8.6%
	60-64	25	9.3%	10.4%
65+	87	32.3%	24.5%	
Sex	Male	68	25.3%	50.2%
	Female	201	74.7%	49.8%
Race	White	262	99.24%	97.9%
	Black or African American	<5	<1%	<1%
	American Indian or Alaska Native	<5	<1%	<1%
	Asian	<5	<1%	<1%
	Pacific Islander	<5	<1%	<1%
	Multiracial	<5	<1%	1.2%
Ethnicity	Hispanic/Latino	7	2.6%	7.1%
	Non-Hispanic/Latino	262	97.4%	92.9%

Highest grade of school completed	Never attended school or only attended kindergarten	0	<1%	Unknown
	Grades 1 through 8	<5	1.1%	Unknown
	Grades 9 through 12	<5	<1%	5.3%
	Grade 12 or GED	40	14.9%	37.1%
	College 1 year to 3 years	67	25.0%	32.2%
	College 4 years or more	156	58.2%	25.5%
Annual household income	Less than \$10,000	7	2.8%	3.8%
	\$10,000 to less than \$15,000	<5	1.2%	3.2%
	\$15,000 to less than \$20,000	<5	<1%	4.8%
	\$20,000 to less than \$25,000	9	3.5%	
	\$25,000 to less than \$35,000	15	5.9%	4.7%
	\$35,000 to less than \$50,000	18	7.1%	11.4%
	\$50,000 to less than \$75,000	33	13.0%	17.3%
	\$75,000 to less than \$100,000	45	17.7%	16.2%
	\$100,000 to less than \$150,000	65	25.6%	21.9%
	\$150,000 to less than \$200,000	43	16.9%	8.3%
	\$200,000 or more	14	5.5%	8.4%