2015 Annual Report
Report of Public Health Service in
Ashland County, Ohio

Ashland County Board of Health

Ashland City Board of Health

An Official Report Complied by the Ashland County-City Health Department

County Board of Health

Member	Term
Rebecca Cawrse, DVM	2018
Jeff Hardman	2016
Stan Kopp	2019
Ron Puglisi	2018
David Tomchak, MD, President	2018

City Board of Health

Member	Term
Glen Stewart, Mayor-Ex Officio-President	------
Janice Fridline	2017
Mike Huber, President Pro-Tem	2019
Charmaine Kaylor	2019
William Latham, Jr, DPM	2017
Larry Norris	2016

2015 Personnel-Ashland County-City Health Department

Jelayne Dray, RN, MSN	Health Commissioner
Daniel Daughtery, MD (thru 4-15)	Medical Director
David Tomchak, MD (4-15-present)	Interim Medical Director
Gayle Lantz, BS	Registrar of Vital Statistics
Lisa Burgess, RN, (thru 5-15)	Deputy Registrar
Jennifer Helbert (5-15 to present)	Deputy Registrar, EH PT Clerk
Pat Donaldson, BS,RS	Director of Environmental Health
A.J. Sturgis, BS, RS	PHS1
Ed Howard, BS, RS (thru 02-15)	PHS1
Thomas Cassell, BS, RS (05 -15 to present)	PHS1
Leslie Sexton (05-15 to present)	Environmental Health Clerk
Shirley Bixby, BSN, RN	Director of Nursing
Danielle Allen, RN	PHN
Lisa Burgess, RN	PHN
Lauren Jeffrey	Public Health Nurse Clerk
Linda McCarty, RN	PHN
Laurie McFarlin, RN	PHN
Ray Herbst, RS, REHS	Emergency Preparedness Director, MRC

The Ashland County-City Boards of Health, and its affiliates, comply with federal regulations in that no professionally qualified person will be discriminated against on account of race, color, religion, creed, sex, national origin, handicap, or political affiliation. Equal opportunity employer/provider of services.

CITY BOARD OF HEALTH

Mayor Glen Stewart

Larry Norris

Charmaine Kaylor

Janice Fridline

William Latham, DPM

Mike Huber

COUNTY BOARD OF HEALTH

Stan Kopp

David Tomchak, MD

Jeff Hardman

Rebecca Cawrse, DVM

Ron Puglisi

Ashland County, Ohio

District Advisory Council

" The Chief Executive of each municipal corporation not constituting a City Health District and the chairman of the Board of Township Trustees of each township in a General Health District shall meet annually at the county seat and shall organize by selecting a chairman and a secretary." " The Council shall meet annually for the purpose of electing its officers and a member of the Board of Health and shall also receive and consider the annual or special reports of such Board and make recommendations to it or to the Department of Health in regard to matters for the betterment of health and sanitation within the District or needed legislation." Section 3709.03-Ohio Revised Code.

TOWNSHIP	CHAIRMAN	ADDRESS
Clearcreek	David Shoup	1076 Township Road 1008, Ashland
Green	Rich Kline	2724 County Road 967, Perrysville
Hanover	John Burkhart	838 Valley View, Loudonville
Jackson	Kay Wright	115 US 42, West Salem
Lake	Robert Esselburn	77 County Road 2400, Lakeville
Mifflin	Tim Echelberger	1110 County Road 2075, Ashland
Milton	Rick Emmons	1566A Baney Road, Ashland
Mohican	Edward White	317 County Road 2000, Jeromesville
Montgomery	Richard Wesner	125 State Route 511, Ashland
Orange	George Parks	624 State Route 302, Ashland
Perry	Kent McGovern	1567 Township Road 355, Jeromesville
Ruggles	Matt Beattie	462 Township Road 1101, Nova
Sullivan	Douglas Campbell	361 US 224, Sullivan
Troy	Dennis Edwards	933 Township Road 350, Nova
Vermillion	William Helbert	1942 State Route 511, Ashland

VILLAGE	MAYOR
Bailey Lakes	John Benshoff
Hayesville	J. Emmett Justice
Jeromesville	Randy Spade
Loudonville	Stewart Zody
Mifflin	Freddie Craig
Perrysville	Duane Holland
Polk	James (Mick) Goon

County Commissioners

Denny Bittle	110 Cottage Street, Ashland
Barb Queer, Chairman	110 Cottage Street, Ashland
Mike Welch	110 Cottage Street, Ashland



Ashland City Council

Ward	Councilmen
Mayor	Glen Stewart
Ward 1	Duane Fishpaw
Ward 2	Robert M Valentine
Ward 3	Ruth Detrow
Ward 4	Sandra Tedlund-Tunnell
Councilman at Large	Matt Miller

2016 City Health Department
2015 Year End Report

Revenue

	2015 Permanent Budget	2015 Permanent Budget	MTD Revenue	YTD Revenue
State Tax Fees-Health	7,600.00	7,600.00	660.57	8,760.15
State Aid for Health	3,841.00	3,841.00	0.00	3,813.64
Vital Statistics-Health	40,000.00	40,000.00	2,630.93	35,674.24
Burial Permit Fee	175.00	175.00	21.00	144.00
ODH Automation Fee	24,000.00	24,000.00	2,043.00	27,090.00
Swim Pool License	5,100.00	5,100.00	0.00	4,490.00
Campground/Tattoo Fees			0.00	469.00
Misc Health	3,882.00	3,882.00	340.50	6,177.99
Revenues Total	**$84,598.00**	**$84,598.00**	**5,696.00**	**86,619.02**

Expenses

	2015 Permanent Budget	2015 Appropriation	Current Monthly Expenses	2015 YTD Expenses	2015 Unencumbered Balance
Division Director	35,000.00	35,000.00	3,888.80	35,000.00	
Dept Salaries	125,583.00	135,882.00	14,648.15	135,881.30	.70
Retirement-PERS	22,400.00	22,400.00	1,809.21	22,207.98	192.02
Medicare	2,400.00	2,400.00	268.81	2,203.92	196.08
City Share Ins.	34,000.00	25,340.00	2,124.10	25,339.23	.77
Office Supplies	8,700.00	4,650.00	522.18	1,923.28	2,726.72
Medical Supplies	8,950.00	8,950.00	385.80	6,488.65	2,461.35
Telephone	2,402.00	2,444.00	188.05	2,443.26	.74
Equipment	3,500.00	5,340.00	0.00	5,336.86	3.14
Rent	16,122.00	16,122.00	0.00	16,122.44	-.44
Service Contracts	4,400.00	5,470.00	359.67	5,468.75	1.25
Conference	650.00	1,030.00	0.00	650.00	380.00
Mileage	2,300.00	2,300.00	71.68	1,862.82	437.18
State fees/BD	25,000.00	40,360.00	0.00	40,667.32	-307.32
Burial Permit Fee	250.00	250.00	5.00	105.00	145.00
Contingencies	4,327.00	6,927.00	340.50	4,022.24	2,904.76
ODH Auto fee	2,700.00	0.00	0.00	0.00	0.00
Gen Liab Ins.	3,000.00	3,000.00	0.00	3,000.00	0.00
Expenses Total	**$301,684.00**	**$317,865.00**	**$24,611.95**	**$308,723.05**	**$9,141.95**

2016 County Health Department
2015 Year End Report

Revenue

Fund 9	Certified Budget	Amended Budget	MTD Actual	YTD Actual	Current Budget Balance
Real Property Taxes	157,000.00	161,000.00	0.00	160,730.70	269.30
Subdivision Levy	22,000.00	22,000.00	0.00	22,000.00	0.00
Mobile Home Tax	500.00	500.00	0.00	470.23	29.77
Health Permits	30,000.00	33,000.00	2,876.00	33,811.00	-811.00
Health Licenses	25,000.00	28,000.00	9,040.00	33,213.39	-5213.39
All State Revenue/Grants	6,800.00	8,800.00	0.00	8,798.30	1.70
2 Half Rollback Homestead/STA	23,000.00	23,000.00	0.00	22,639.24	360.76
BCMH Nursing Fees	00.00	57,000.00	3,270.00	56,890.00	110.00
Health Birth/Death Fees	22,000.00	25,300.00	2,600.00	25,525.00	-225.00
Environmental Health Fees	12,000.00	21,000.00	1,112.00	21,306.03	-306.03
Vaccine Nursing Fees	80,000.00	103,500.00	25,609.94	102,942.18	557.82
Misc. Revenue	46,836.00	19,036.00	3,985.00	19,141.53	-105.53
Other Reimbursement	2,000.00	2,000.00	0.00	1,198.04	801.96
Gifts & Donations	00.00	0.00	0.00	500.00	-500.00
Revenue Totals	**$427,136.00**	**$504,136.00**	**$48,492.94**	**$509,165.64**	**$-5029.64**
Fund 16					
All State Revenue/Grants	69,255.00	75,255.00	0.00	61,888.00	13,367.00
MRC Grant Awards	23,500.00	23,500.00	0.00	0.00	23,500.00
Advances	0.00	0.00	0.00	33,341.33	-33,341.33
All Other Reimbursements	0.00	0.00	0.00	3,500.00	-3,500.00
Revenue Totals	**$92,755.00**	**$98,755.00**	**0.00**	**$98,729.33**	**$25.67**
Fund 23					
Food Service License	105,000.00	105,000.00	812.00	102,483.35	2,516.65
Food Service License Late Fee	2,100.00	2,100.00	0.00	954.11	1,145.89
Food Service Review Fee	3,100.00	3,100.00	226.10	1,016.84	2,083.16
All Other Misc Revenue	3,500.00	3,500.00	0.00	502.05	2,997.95
Revenue Total	**$113,700.00**	**$113,700.00**	**$1,038.10**	**$104,956.35**	**$8,743.65**

Expenses

Fund 9	2015 Appropriations	2015 Amended Budget	Current Monthly Expenses	2015 YTD Expenses	2015 Available Budget
Employee Wages	235,975.00	260,975.00	17,951.39	258,882.44	2,092.56
PERS/STRS	33,040.00	35,540.00	2,500.87	35,098.92	441.08
Workers Compensation	4,660.00	4,660.00	0.00	3,492.87	1,167.13
Medicare Employer Share	2,860.00	3,310.00	230.88	3,268.43	41.57
Insurance Premium	43,025.00	43,025.00	2,918.43	37,123.06	5,901.94
Ashland Co. Health Contract	8,500.00	8,500.00	537.93	7,475.79	1,024.21
Ashland Co Health Supplies	58,000.00	78,000.00	546.61	73,426.86	4,573.14
Postage	1,573.00	1,573.00	354.62	1,101.66	471.34
Equipment	7,000.00	7,000.00	2,998.35	2,998.35	4,001.65
Advances Out	5,000.00	33,341.33	0.00	33,341.33	00.00
County State Reimbursement	25,000.00	28,500.00	52.50	19,066.46	9,433.54
Tax Settlement Fees	7,700.00	7,700.00	00.00	3,577.36	4,122.64
Travel	14,000.00	14,000.00	798.62	10,652.47	3,347.53
Advertisement	200.00	200.00	00.00	200.00	00.00
County Other Expenses	30,000.00	40,050.00	565.21	31,500.15	8,549.85
Total Expenses	**476,533.00**	**566,374.33**	**29,455.41**	**521,206.15**	**45,168.18**
Fund 16					
Employee Wages	17,348.16	37,495.06	2,647.86	33,522.70	3,972.36
PERS/STRS	2,428.98	5,270.47	370.70	4,693.18	577.29
Workers Compensation	433.74	433.74	00.00	433.74	00.00
Medicare Employer Share	251.58	545.87	38.40	486.14	59.73
Insurance Premium	7,436.70	15,810.85	1,076.36	13,030.39	2,780.46
Ashland Co. Health Contract	5,000.02	12,500.02	2,500.00	12,500.00	0.02
Supplies	00.00	1,984.38	988.81	1,758.81	225.57
Travel	150.00	300.00	0.00	220.00	80.00
Other Expenses	8,357.78	19,290.57	126.29	18,108.76	1,181.81
County State Reimbursement	00.00	1,200.00	00.00	1,121.53	78.47
Expenses Total	**41,406.96**	**94,830.96**	**7,748.42**	**85,875.25**	**8,955.71**
2014-09200 Projects	3,355.23	6,855.23	00.00	3,355.23	3,500.00
2014-09240 Special Project	17,181.18	**17,181.18**	**00.00**	**8,133.76**	**9,047.42**
Special Projects Total	**20,536.41**	24,036.41	00.00	11,488.99	12,547.42
2015-09200 Ebola Supplement	00.00	16,679.33	2089.80	16,527.64	151.69
Ebola Supplement Total	**00.00**	**16,679.33**	**2089.80**	**16,527.64**	**151.69**
Total Expenses	$61,943.37	$135,546.70	$9838.22	$113,891.88	$21,654.82

Fund 23	2015 Appropriations	2015 Amended Budget	Current Monthly Expenses	2015 YTD Expenses	2015 Available Budget
Employee Wages	54,495.00	54,495.00	2,646.00	36,974.44	17,520.56
PERS/STRS	7,858.00	7,858.00	370.44	4,081.40	3,776.60
Workers Compensation	1,150.00	1,150.00	00.00	659.23	490.77
Medicare Employer Share	812.00	812.00	38.36	536.07	275.93
Insurance Premium	18,618.00	16,484.00	1,140.19	8,193.07	8,290.93
Supplies	100.00	100.00	00.00	100.00	00.00
Postage	100.00	100.00	00.00	100.00	00.00
AHD State Reimbursement	9,500.00	11,634.00	00.00	9,310.00	2,324.00
Travel	4,200.00	4,200.00	230.16	3,273.20	926.80
Other Expenses	2,666.00	2,666.00	634.17	2,408.87	257.13
Expenses Total	**99,499.00**	**99,499.00**	**5,059.32**	**65,636.28**	**33,862.72**

Fund 9
General Fund

Beginning/Adjusted Balance Carryover 2014	$149,865.61
Plus YTD Revenues	$509,165.64
Less TYD Expenses	-$521,206.15
Current Fund Balance	**$137,825.10**

Fund 16
PHEP Grant

Beginning/Adjusted Balance Carryover 2014	$45,475.63
Plus YTD Revenues	$98,729.33
Less TYD Expenses	-$113,891.88
Current Fund Balance	**$30,313.08**

Fund 23
Food Program

Beginning/Adjusted Balance Carryover 2014	$1,431.51
Plus YTD Revenues	$104,956.35
Less TYD Expenses	-$65,636.28
Current Fund Balance	**$40,751.58**

ENVIRONMENTAL HEALTH SERVICES

The Environmental Health Division's mission is to prevent and control the spread of communicable disease by maintaining a safe and healthy environment through education and enforcement of state and local laws and regulations.

Many changes occurred in our division in 2015. We lost a valued member of staff with the loss of Ed Howard in February. In May we welcomed a new food program sanitarian, Thomas Cassell and two new clerks, Leslie Sexton and Jennifer Helbert

The staff of Environmental Health Services includes:

Pat Donaldson, R.S., Director of Environmental Health. Pat's responsibilities include supervision of the Environmental Health Staff, management of the solid waste program, investigation of all animal bites and vector control issues, as well as nuisance complaint investigations and resolutions. Pat is also responsible for the inspection of all public swimming pools and manufactured home parks in the Ashland Health Departments' jurisdiction. She also monitors the septage program and conducts household sewage/private water system inspections.

A.J. Sturgis, R.S. A.J. is responsible for site evaluations, permitting, and inspection of household sewage and water system installations. He also investigates sewage nuisance complaints, collects water samples and monitors the sewage maintenance/inspection program for "conditionally approved" systems. A.J. also conducts the inspections of the campgrounds, schools, and institutional facilities in the Ashland Health district.

Thomas Cassell, R.S. Tom joined our staff in May, 2015. As program manager for the food protection program, Tom is responsible for the inspection of all licensed food operations and food establishments, including mobile, temporary, and vending, to ensure compliance with the food safety code and protection of the public from food-borne illness. He provides food handler education and plan review for new and altered food service operations.

Leslie Sexton joined the environmental health division as clerk in May, 2015. She processes all licenses and permits, directs clients to the appropriate staff, and answers general questions pertaining to the Environmental Health division. She is also responsible for providing licensing and transmittal reports to the Ohio Department of Health and Ohio EPA. Jennifer Helbert also joined our staff, assisting our division one day a week.

Jenny is also the coordinator of the health department web site: www.ashlandhealth.com

Environmental Health Division:

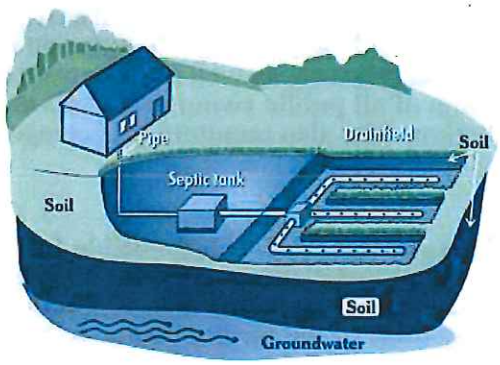
Pat Donaldson, R.S., Director,
A.J. Sturgis, R.S, Jennifer Helbert,
Leslie Sexton, Secretary, and
Thomas Cassell

Household Sewage and Water Systems

The Environmental Health division is responsible for site review, permitting, inspection and monitoring of household sewage and water systems. The division is also responsible for the prevention / correction of sewage nuisances.

Sewage: 2015 permits issued: **69** including **47** new, **15** replacement, & **7** alteration

	County	City	Total
Inspections	238	0	238
Consultations	1419	3	1422
Final Inspections	56	0	56
System Evaluations	9	0	9
Septage Site Inspections	5	0	5
Septage Consultations	16	0	16
Sewage Sludge Consults	0	0	0
Complaint Investigations	17	0	17
Complaint Consultations	54	5	59
Commercial Sewage Consults	5	0	5



Subdivisions:

	County	City	Total
Type 1 Plat Reviews	51	0	51
Plat Consultations	4	0	4

Water: **55** permits including **32** new water systems, **17** replacement systems, and **4** alterations, and **2** sealing.

	County	City	Total
Inspections	55	0	55
Consultations(private)	549	2	551
Consultations(commercial)	8	5	13
Final Inspections	41	0	41
System Evaluations	7	0	7
Water Samples(private)	173	0	173
Water Samples(commercial)	18	0	18
Water Hauler Inspections	5	1	6
Water Hauler Consultations	4	0	4

Food Protection

A total of **180** food service, **84** retail food establishments, **65** mobile, **16** temporary, and **50** vending licenses were issued in 2015. The Food Protection Division conducted the following food service / retail food inspections and consultations.

Inspections:

	County	City	Total
Food Service	215	154	369
Retail Food	80	57	137
Critical Control Point	49	52	101
Process Review	8	5	13
Mobile(local)	59	28	87
Mobile(out-of-county)	55	57	112
Retail Mobile	0	0	0
Temporary	6	8	14
Vending	0	0	0
Food Service Complaint	4	7	11
Food- Borne Complaint	1	0	1
Retail Food Complaint	3	2	5
Retail Food- Borne Compl.	0	0	0

Consultations:

	County	City	Total
Food Service	122	107	229
Retail Food	72	34	106
Mobile	64	17	81
Temporary Food Service	17	9	26
Mobile Base	0	1	1
Mobile Retail Food	5	0	5
Vending	0	0	0
Food Service Complaint	2	4	6
Retail Food Complaint	1	3	4
Food- Borne Complaint	0	1	1
Retail Food-Borne Complaint	0	0	0

Plan Review:

	County	City	Total
Food Service	0	0	0
Mobile	0	0	0
Retail Food	0	1	1
Retail Mobile	0	0	0

Solid and Infectious Waste

Compliance inspections are conducted at **one (1)** Construction and Demolition Debris Facility (C&DD) which is now in closure, **two (2)** Composting Facilities, and **one (1)** Large Infectious Waste Generator. The closed Ashland County Landfill and Mansfield Plumbing Products Captive Residual Landfill are monitored annually.

The Environmental Health Division, in cooperation with the Ohio E.P.A., investigates and attempts to abate all solid waste complaints.

	County	City	Total
Solid Waste/ Landfill Inspections	2	0	2
Solid Waste/Landfill Consultations	8	0	8
C&DD Inspection	5	0	5
C&DD Consultations	17	0	17
Composting Facility Inspection	2	0	2
Composting Facility Consultation	1	0	1
Infectious Waste Inspection	1	0	1
Infectious Waste Consultation	0	0	0
Complaint Investigation	8	3	11
Complaint Consultations	17	2	19

Campgrounds and Public Swimming Pools

The Environmental Health Division licensed and inspected; **14** campgrounds, **two (2)** residence camps; and **32** public swimming pools. Manufactured home parks are inspected thru a contract with the Ohio Manufactured Housing Commission; parks are no longer licensed by the department.

Inspections:

	County	City	Total
Manufactured Home Parks	7	7	14
Campground	6	1	7
Resident Camps	1	0	1
Temporary Camps	0	0	0
Swimming Pool, Spa, Special Use	30	20	50

Consultations:

	County	City	Total
Manufactured Home Parks	4	3	8
Campground	16	1	17
Residential Camp	3	0	3
Temporary Camp	0	0	0
Swimming pool, Spa, Special Use	26	16	42

Institutions

All public school buildings are inspected to ensure the public health and safety of the school environments.

In addition to these inspections, the Environmental Health Division cooperates to conduct sanitation / maintenance inspections at the Ashland County Jail.

	County	City	Total
Jail Inspections	0	1	1
Jail Consultations	1	2	3
School Inspections	1	2	3
School Consultations	4	4	8

Animal Bites, Complaints, and Vector Control

Investigations were conducted on **110** mammal bites or other exposures reported to this department for the control of rabies.

	Couny	City	Total
Dog Bite Investigations	35	19	54
Dog Specimens Sent	0	0	0
Cat Bite Investigations	7	6	13
Cat Specimens Sent	0	1	1
Domesticated Bite Investigations	1	0	1
Domesticated Specimens Sent	0	0	0
Wild Bite Investigations	0	0	0
Wild Specimens Sent	2	5	7
Animal Complaint Investigations	0	1	1
Animal Complaint Consultations	9	1	10
Insect And Rodent Investigations	1	3	4
Insect and Rodent Consultations	5	18	23
Animal Bite Consultations	114	57	171

Public Health Nuisance Complaints: Investigate and attempt to abate all Public Health nuisances

	County	City	Total
Housing Investigations	0	2	2
Housing Consultations	9	14	23
Air and Water Investigations	0	0	0
Air and Water Consultations	9	0	9
Mold Complaint Investigations	0	0	0
Mold Complaint Consultations	5	3	8
Other Investigations	0	1	1
Other Consultations	8	9	17

Miscellaneous Environmental Health Activities:

	County	City	Total
Tattoo Establishment Inspections	0	2	2
Tattoo Establishment Consultations	1	6	7
Microwave Oven Inspections	1	0	1
Microwave Oven Consultations	1	0	1
E.P.A. Co-op Site Inspections	6	0	6
O.D.H. Co-op Site Inspections	1	0	1
O.D.A. Co-op Site Inspections	0	0	0
Other Consultations	43	19	62
Administrative activities	36	32	68
Lab- sample deliveries	48	5	53
Non- Form Letters Written	19	0	19
Meetings Attended	50	8	58

Division Summary:

	County	City	Total
Inspections	1,079	439	1,518
Consultations	2,643	347	2,990
Other activities	346	52	398
Mileage	20,757	766	21,523

PUBLIC HEALTH NURSING SERVICES 2015

Lauren Jeffery- Clerk, Danielle Allen, RN, Linda McCarty RN, Jean Neel, RN, Laurie McFarlin, RN Lisa Burgess, RN, Shirley Bixby RN, BSN- Nursing Director

Sunny Riffle RN- Retired July, 2015

Nursing Clinic Hours

1763 State Route 60
Ashland, Ohio 44805
Phone: 419-282-4357
Fax: 419-282-4271

IMMUNIZATION CLINIC

Every Tuesday 8:30 a.m. – 3:30 p.m. (by appointment)
4th Monday of every month 1pm - 5 pm (walk-in)
(Excluding Holidays)
August and September: 2nd *and* 4th Mondays 1 pm – 5 pm (walk-in)

TUBERCULOSIS CLINIC

Every Tuesday 2 p.m.– 3:30 p.m.
Readings Every Thursday 2 p.m. – 3:30 p.m.

HYPERTENSION CLINIC

Every Tuesday 8 a.m. – noon (by appointment)

ACCHD Nursing Division Immunizations for 2015

Immunizations produce active immunity in individuals and herd immunity in communities against vaccine-preventable diseases. The Ashland County-City Health Department has an active Immunization Program which seeks to increase immunization rates in the community. The goal is reduction and elimination of vaccine-preventable diseases in the community.

Childhood Vaccines

In 2015, the following vaccines were available to infants and children age 6 weeks -18 years through the federal Vaccine for Children (VFC) program, as qualified, and through the state-funded ODH Immunization Program:

- Diphtheria, Tetanus, acellular Pertussis (DTaP)
- Hepatitis A
- Hepatitis B
- Haemophilus Influenza B (Hib)
- Human Papilloma Virus (HPV)
- Influenza
- Kinrix (combination Dtap, Polio)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (Menactra)
- Polio
- Pneumococcal (Prevnar13)
- Pentacel (combination DTaP, polio, Hib)
- Proquad (combination MMR, Varicella)
- Rotavirus (Rotateq)
- Tetanus, diphtheria (Td)
- Tetanus, diphtheria, acellular pertussis (Tdap)
- Varicella (chickenpox)

ACCHD participates in the VFC Delegation of Authority program through the Tuscarawas County Health Department allowing us to administer certain restricted VFC vaccine to children and adolescents who are Medicaid-eligible, uninsured, *under*insured, and American Indian/Alaskan Native.

Of all children seen in 2015, 53% fell into the categories of Medicaid-eligible, uninsured, or underinsured, making them "VFC Eligible". This was slightly more than the 50% figure last year. None were American Indian/Alaskan Native. 47% were privately insured. *See table below for figures*.

ACCHD is contracted with CPP Buying Group for purchase of private vaccines for privately-insured clients. ACCHD continues to be contracted with Medical Mutual and Anthem and added United HealthCare in 2015, allowing billing of those 3 private insurances. Clients with other private insurances are asked to pay and receipts given to them for submission for reimbursement. Private baby vaccines were purchased in 2015 for the first time. ODH continued to allow the use of state-funded vaccines for insured babies and children who had insurance that we could not bill.

Fewer uninsured children and fewer privately-insured children were seen in 2015 - the total # of clients for age 6 weeks through 18 years was 400 in 2015 as compared to 553 in 2014.

Fees for private vaccine were adjusted in January of 2015 and approved by the Board, based on our cost of purchase and cost of administration. Cash discount amounts are approved for those who pay by cash or check on day of service.

The charges for ODH-provided vaccine remained unchanged in 2015 with a basic administration fee of $10 for a single vaccine and a $5 fee for each additional vaccine needed at the same visit. No child is turned away for inability to pay for VFC or state-provided vaccine.

ODH requires certain vaccines for kindergarten as well as 7th grade students. To help meet this requirement, additional immunization clinics were held in August 2015.

Adult Vaccines

The following privately-purchased vaccines continue to be available at ACCHD to anyone age 19 and older. These private vaccines were also used for teens covered by Medical Mutual or Anthem:

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, Rubella (MMR)
- Meningococcal (Menactra)
- Pneumococcal (Pneumovax)
- Pneumococcal (Prevnar 13)
- Tetanus, diphtheria, acellular pertussis (Tdap)
- Tetanus, diphtheria (Td)
- Varicella (Chickenpox)
- Zoster (Shingles)

ODH continued to provide local health departments with Td and Tdap vaccines for qualifying adults. The state adult Tdap is intended only for uninsured or *under*insured parents who are caregivers of infants and young children. *See table below for stats.* An administration fee of $10 was charged for each dose of state-provided adult vaccines.

ACCHD continued to participate in the ODH Hepatitis Vaccine Project on a limited basis in 2015, as time allowed for nurse visits to the Ashland County Jail. This enabled inmates to receive Hepatitis A and B vaccines at no cost. Qualifying uninsured high-risk clients seeking vaccination for Hepatitis A and B at the health department clinic were charged a $10 administration fee for each vaccine. *See table below for stats.*

ACCHD continued to participate in Vaccine Assistance Programs for adults through three pharmaceutical manufacturers – Merck, GSK, and Sanofi. Individual financial applications are submitted and if approved, qualifying clients are charged only an administration fee of $10 per vaccine. These vaccines are then replaced to us free by each manufacturer. *See table below for stats.*

Childhood Vaccines age 6 weeks – 18 years		**Adult Vaccines age 19 and older**	
VFC Eligible (Medicaid) -	84	Regular private vaccines -	207
VFC Eligible (Uninsured) -	92	ODH Hepatitis Project (including Ashland Co. Jail)	7
VFC Eligible (*Under*insured) -	35	ODH Tdap Project -	2
Privately Insured -	189	Patient Assistance Programs -	3
TOTAL -	**400**	**TOTAL -**	**219**

Immunizations are given at the ACCHD clinic by appointment on Tuesdays with walk-in clinics on the 4th Monday of each month. Additional walk-in clinics are available in August and September for required back-to-school vaccines. The Monday walk-in clinic hours remain 1pm – 5pm year round.

Seasonal Influenza Vaccines and Clinics

ACCHD gave Quadrivalent Influenza Vaccine in 2015 and for the first time gave High-Dose to those age 65 and older who wanted it. Fees were adjusted based on our cost to purchase - regular-dose private influenza vaccine was $25, FluMist was $30, baby doses were $30 and High-dose was $40. State-provided flu vaccine was used for qualifying children age 6 months – 18 years. This included FluMist as well as the injectable vaccine. An administration fee of $10 was charged for state vaccine. For those with Medicare Part B, Medicaid, United HealthCare Community, CareSource, Medical Mutual, Anthem, and United HealthCare private, the cost was billed to their insurance.

In the fall, two (2) mass clinics were held to administer seasonal influenza vaccine to the public – at the Loudonville Lions Club and at the Ashland Salvation Army Kroc Center. *See table below*. Volunteers and student nurses from Mount Vernon Nazarene University School of Nursing assisted in staffing these clinics. The Public Health trailer allowed us to transport all needed supplies and equipment for set-up and operations.

In 2015 ACCHD nurses held private on-site flu clinics at 7 companies, including Ashland City employees and Ashland County employees, and one (1) school. A few home flu shots were taken to private homes for those who were homebound. Additional flu vaccine was given at the ACCHD during regular clinic hours. *See table below for statistics*.

The following chart includes *2014*'s flu vaccine that was given *after 1-1-15* as well as the 2015 vaccine that was started in September of 2015:

ACCHD gave 315 *fewer* flu vaccines in 2015 than in 2014.

Influenza Vaccine given 1-1-15 through 12-31-15	
Mass clinic at Loudonville Lions Club	106
Mass clinic at Ashland Kroc Center	122
On-site at private companies	130
On-site at 1 local school	20
City & county employees	138
At ACCHD clinics	176
Home visits	3
Total flu vaccine given 695	
Billed to private insurance (all ages)	**415**
Billed to Medicare	**105**
Provided by ODH (VFC) – age 6 mo – 18 years	**35**

Vaccine area: Julie Leon- Insurance Navigator, Nurses- Margaret VanCamp, Dorothy Stitzlein, Danielle Allen and Laurie McFarlin

Registration table from left to right: Laura Driebelbis, Linda McCarty, Judy Weaver, Lauren Jeffery, Jenny Helbert, Leslie Sexton

Hypertension Program

Blood pressure monitoring continues to be available by appointment every Tuesday morning. A medical history is taken at the first visit and reviewed /updated at each subsequent visit. Clients are weighed and dietary needs discussed as needed.

A total of **five (5)** blood pressures were taken at the Ashland Clinic in 2015. Blood pressure screening was also provided for **86** clients at the Amish Health and Safety Day and the Ashland County Wellness Program.

Student Nurses

Student nurses from North Central State College of Nursing and Ashland University- Dwight Schar School of Nursing were frequent visitors in the Nursing Department. They were also able to spend several days in the clinics and home visiting with the BCMH nurses as well as going on Food inspections with the Environmental Health Division and helped with special nursing projects. A total of **5** individual students were welcomed to the clinical experience at the Health Department.

Senior Health Fair

The Senior Health Fair held at Ashland University on May 15, 2015 gave Linda McCarty RN and Shirley Bixby RN, BSN, an opportunity to man a booth and distribute information about adult vaccines and poison look-alikes.

NECO Regional Drill and Tele-psychiatry demonstration

The Public Health Emergency Response and Preparedness program led by Ray Herbst held a regional drill on April 9, 2015. The nursing department employees and MRC volunteers were able to demonstrate their ability to respond to potential emergency situations at the Health Department.

A tele-psychiatry demonstration was held by Ray Herbst assisted by Hena Samdani and other volunteers. The nursing department was able to attend this training opportunity.

Amish Health and Safety Day

An Amish Health and Safety Day was held at Ashland County Hay Auction. The event was coordinated by the Nursing Division and local Emergency Management Director, Mark Rafeld, and numerous volunteers. The event was attended by approximately 600 Amish. Blood pressures, blood sugar checks and education about poison look-a-likes were provided by the Nursing division. Community CPR was demonstrated by the American Red Cross. Buggy lighting and safety were also discussed and demonstrated by Wayne Wengerd. School supplies were distributed by the United Way of Ashland. The event was held in August.

Ashland County Sheriff's Department Detective Lieutenant Scott Smart discusses water safety.

Communicable Disease Education Programs

Nursing services have been requested by Ashland County West Holmes Career Center for Communicable Disease Education. Laurie McFarlin was able to do this education for them. Shirley Bixby was able to provide an educational program regarding adult vaccines and cold and flu to the First United Methodist Church Members. A Blood Borne Pathogens training was completed for the Ashland County Department of Jobs and Family Services and the Ashland County Engineers by Shirley Bixby. Shirley Bixby attended the AOHC conference in Columbus in March. The main focus of the conference is to educate and support Local Health departments and prepare them for accreditation. The Ashland University class of Emerging Pathogens requested Shirley Bixby teach on two separate occasions regarding communicable disease surveillance and control and the Measles outbreak. Shirley and Mark Rafeld attended the Amish and Plain people nationwide conference held at the Mohican Lodge. They discussed "Lessons learned in the Measles Outbreak."

Tattoo Inspections and Trainings

The Environmental Health Division and the Nursing Division directors made their yearly inspection to **two** county **tattoo** establishments. Ken Gardner from the Ashland Fire Department provided the First aid training for the artists. Shirley Bixby RN, BSN, Director of Nurses provided the Blood-borne Pathogen training for the tattoo artists.

Communicable Disease Surveillance and Control

Ohio Administrative Code 3701-3-02 identifies diseases that are declared to be dangerous to public health and are reportable to the health department. A listing of the diseases which are reportable to the health department is available on the Ashland County-City Health Department or the Ohio Department of Health websites.

Reportable Infectious Diseases in Ashland County in 2015

Campylobacter …….....16
Chlamydia infection ……..149
E-Coli 0157 …….....1
Giardiasis ……...3
Gonococcal infection …….....14
Hepatitis A……..1
Hepatitis B (including delta) - chronic …….....5
Hepatitis B (Perinatal)……2
Hepatitis C - chronic ……..53
Latent TB Infection…….6
Influenza - associated hospitalization …….....16
Lyme Disease ……...…….....9
Mycobacterium other than TB (Mott)…….3
Pertussis …….....2
Salmonellosis ……..……7
Streptococcal pneumonia - invasive antibiotic resistant/intermediate ……...7
Syphilis……..…..1
Varicella …….5

Reportable Outbreak

Norovirus…….1

The Ashland County Service Center sign placed by the Lyme Disease Support Group.

Pediculosis (Lice) Screening

The policy of the Ashland County-City Boards of Health concerning head lice is a "**nit free head**" prior to school readmission. Responsibility for checking and clearing students for readmission has been given to the schools. All city and county schools have authorized personnel for clearance, in addition to the school nurses. Education is provided to the schools and day care centers on lice prevention and detection.

Adults and children who are not in a formal school program may be checked for lice at the ACCHD. Public Health Nurses performed **25** head checks in 2015 at the health department. ACCHD provides De-Bug shampoo and lotion for treatment of lice and nits at minimal cost. This is a non-toxic enzyme- based product that can be used multiple times safely. Those who cannot afford treatment may be referred to Associated Charities for assistance.

Tuberculosis Program

Tuberculosis screening and surveillance continues to be an important function of the health department. TB testing is done using the Mantoux method.

Walk-in TB testing clinic continues to be held every Tuesday from 2 – 3:30 p.m. with readings on Thursday of the same week 2 – 3:30 p.m. TB tests may also be done on Tuesday mornings by appointment.

A total of **226** TB skin tests were done by the health department in 2015. Of these, there were **5** positive skin tests (converters). Follow-up chest x-rays were done and all were negative for active TB. They were referred to their private physician for possible prophylaxis of latent TB infection. Referrals are made to Dr. Daugherty for those who do not have a private physician. Treatment for out- of county residents is arranged through their local TB control units.

TB testing and follow-up at the **Ashland County Jail** is performed by the Ashland County jail nurse. Positive readings are reported to the health department after a chest x-ray is done at the jail. Dr, Vore assesses the need for treatment of possible LTBI.

All children entering kindergarten and other students new to the school are required to be screened for TB by completion of a questionnaire with high-risk conditions. Children who have any yes answers are required to have a TB skin test.

The fee for TB testing in 2014 remained at $15 per test for Ashland County residents and $20 for out-of-county residents. No one was turned away for inability to pay. All contacts to an active case are tested at no charge.

The Ashland County Commissioners will cover the cost of the first chest x-ray for converters who cannot pay. They will also pay for tuberculosis drugs / INH for prophylaxis and/or treatment, if needed, of persons with active or latent TB who are unable to pay. The client must obtain the drugs from the pharmacy that submits the lowest bid.

World TB education day was attended by Laurie McFarlin, Linda McCarty and Shirley Bixby. The on-going efforts to eradicate TB in the work continues. The latest research and guidelines were received at this conference.

Lead Case Management

The Ohio Department of Health contracts yearly with the local health department to perform case management, community outreach and education to families that have a lead poisoned child. Ohio currently mandates all children have lead poisoning testing at ages one and two if they are on Ohio's Medicaid or live in a high risk zip code. The Ashland zip code, 44805, 44842, and 44851 are listed as a high-risk zip code. Several homes in the city and in the county have been mandated to have the lead hazards removed or "abated" because of compliance with testing. Children that have been affected by the lead poison are referred to services in the county that help children with learning disabilities. The current case load of lead poisoned children is **five.**

CMH- Children with Medical Handicaps Program

The Bureau for Children with Medical Handicaps is a tax-supported, state-administered program in the Ohio Department of Health. The Bureau receives funding for services from the Federal Maternal and Child Health Block Grant, state general revenue and county tax funds, third party reimbursements, donations and Early Intervention dollars. Its stated mission is to assure, through the development and support of high quality and coordinated systems, that children with special health care needs and their families obtain comprehensive care and services which are family-centered, community-based, and culturally competent.

The role of the local health department includes assisting families in applying for services for the diagnosis and treatment of medically-eligible conditions for children who are residents in Ohio, ages 0-21 years; collaborating with other agencies and assisting and facilitating access to quality care; supporting service coordination for children with selected diagnoses; and assisting families to access and utilize appropriate sources of payment for their child's needs.

In 2015, Ashland County CMH Program provided services for approximately **337** children in our community. The Diagnostic program assisted **55** families in obtaining or ruling out a medical diagnosis. That approval can assist families with a six month period of secondary insurance to offset the incurred cost of medical testing and care. The Treatment program has approximately **190** active clients that receive year to year coverage along with Public Health Nurse Services. The Service Coordination Program has served **68** children within the county ages 0-3 years of age and offers a year of assistance obtaining resources and coordination of care. An additional **24** families have been served by the PHN's in 2015 and are currently active in the enrollment process or failed to complete a needed component in the process preventing further involvement of the PHN. One (**1**) Adult with the diagnosis of Cystic Fibrosis was also served.

In 2015, CMH paid approximately $281,247.88 in medical claim benefits to Ashland County residents enrolled in the program.

Along with the update to the program name, our health department has faced many challenges providing uninterrupted services. The program is coordinated by Lisa Burgess, RN, with assistance in case management from Nursing Director, Shirley Bixby RN, BSN. Danielle Allen joined the ACCHD in October and is training to be the newest Public Health Nurse. Sunny Riffle, RN, retired in July. Teresa Browne, RN, worked until July also. There is an opening for an RN at this time.

The CMH staff attended many training offerings including "PHN Sharing Days", "Bridges out of Poverty", Attended trainings for the year 2015 for CMH PHN case managers include an Ashland conference on Animal Cruelty, Child Abuse, and Domestic Violence: The Toxic Triad by Dr. Barabra Boat, Ph.D in April. In May, Public Health Nurse Education Day Program in Columbus at the Ohio Department of Health. An all-day training presented by Jo Mascorro in Columbus sponsored by the Ohio Coalition for the Education of Children with Disabilities in November on Strategies to Assist in working with Individuals who Experience Special Needs from Mild, Severe, Profound, and/or Multiple Disabilities.

Shirley Bixby and Lisa Burgess were working with Help Me Grow on becoming part of their team to become service providers. They completed training in the Battelle Developmental Inventory, Second Edition in September in Cuyahoga County by ODH-Help Me Grow and an October training on IFSP outcome Practice by Ohio Department of Developmental Disabilities.

Public Health Nurse Lisa Burgess secured sponsorship from United Healthcare Community Plan to bring Rebecca Tolson, a Certified Academic Language Therapist, to the Ashland Public Library in November. A presentation on Dyslexia Basics for Parents had approximately 28 attendees.

Lisa also started a parent support group in January of 2015, Strength in Numbers, for caregivers of children with special needs meeting monthly. A presentation on "Parent's Rights in the Special Education Process," was given by Karen Lyke with the Ohio Coalition for the Education of Children with Disabilities in February and a presentation by Catholic Charities on Caregiver Stress in March. The group continues to meet and has a range of attendees from 3 to 14.

Newborn Genetic Screening

The Newborn Screening (NBS) Program for genetic, endocrine and metabolic disorders identifies newborn babies who may be at risk for one of several serious diseases. If left untreated, these diseases can lead to slow growth, blindness, mental retardation and possible death. Finding these problems early and providing appropriate treatment may prevent many serious complications from developing later. Ohio currently mandates testing of all newborns for 32 disorders.

If the baby is born at home, the medical attendant present at birth is required to collect the NBS. If no attendant is present at birth the local health department is responsible for collecting the specimen. The only reason for refusal recognized by the state is religious objection. In 2015, no specimens were collected by public health nurses.

Midwives delivering home births have added quite a few screens this year and have screened 116 newborns throughout the county. Newborn screening kits are distributed to the midwives for submission of the blood samples to the Ohio Department of Health.

Public Health School Screening Programs

Contracts for vision, hearing and scoliosis school screenings were not completed in 2014 in time to perform the screenings before the end of the year. Loudonville-Perrysville School District and Dale Roy School did sign late contracts for these services, which were done in early 2015 for the 2014-15 school year. Vision and hearing screenings were done for L-P Schools again in the fall of 2015. ACCHD nurses travel to each contracted school to re-test children who do not pass the initial screenings performed by school staff and volunteers. There was no request for training of volunteers in 2015.

Linda McCarty, RN, supervised the vision program for grades K, 1, 3, 5, 7, and 9. In early 2015 (for school year 2014-15) volunteers had screened a total of 344 students in those grades at L-P and Dale Roy. 163 of those did not pass and were re-screened by McCarty, with 65 requiring referral for further evaluation. For the 2015-16 school year, Dale Roy did not contact ACCHD for vision screening. Volunteers at L-P screened a total of 340 students, McCarty re-screened 144, and 55 of those required referral for further evaluation. By Dec 31, 2015, follow-up info had been received on 19 of those referred.

Laurie McFarlin, RN, supervised the hearing program for grades K,1, 3, 5, and 9 for L-P Schools only. In early 2015 (for school year 2014-15) L-P School volunteers had screened a total of 158 students. McFarlin re-screened 22 who had not passed, with 13 requiring referral for further evaluation.

For the school year 2015-16, volunteers at L-P Schools screened 161 students and McFarlin re-screened 30 and referred 7 of those for further evaluation. By Dec 31, 2015, follow-up info had been received on 5 students.

Scoliosis Screening was performed in February and March of 2015 for the *2014-15 school year*. Linda McCarty, RN, and Laurie McFarlin, RN, examined 233 sixth, seventh and eighth graders for scoliosis in the Loudonville-Perrysville Schools. Of those, 20 with abnormal findings were referred for further evaluation. As of 12/31/15, 3 referrals had been returned with physician notes.

Ashland County Car Seat Coalition

The Nursing Division is the Ohio Buckles Buckeyes (OBB) site for Ashland County. The Car Seat Coalition has distributed 65 seats to low income families in 2015. The types of seats distributed are the convertible, big-kid booster, and backless booster. Shirley Bixby RN, BSN is a certified car seat technician. The Coalition consists of The Ashland County-City Health Department, Ashland City Fire Department and Help Me Grow. Four times a year, seats are handed out to the OBB sites for distribution. This program is funded by traffic violation ticket money.

This convertible seat is just one type of seat the Coalition is able to distribute to needy families.

One of the babies that came for a seat check at the Family Fun Day

The Car Seat Coalition was able to perform a car seat fitting station at Family Fun Day. Ashland Fire Department and the Nursing Division were able distribute seats during this event.

Family Fun Day

A **Family Fun Day** event was held at the Ashland County Service Center 2015. The event was held in conjunction with the Family and Children First Council and the Early Childhood Coordinating Committee. The event was attended by approximately 400 people. Social agencies, health services and the car seat coalition worked together to make this event enjoyable and educational for families and children.

Hena Samdani- Medical Reserve Corp Volunteer

Child attending Family Fun Day.

Cribs for Kids Program

A new program administered by the Ohio Department of Health for prevention of SIDS was started December 2014. Nine families received new pack and plays this year. Criteria for the program are lower income and a stated need for a safe place for their newborn to sleep.

Ashland City Bicentennial Celebration

Employees of the Ashland County-City Health Department were able to attend the opening ceremonies to the Bicentennial by sponsoring a booth. Free t-shirts, bibs and other giveaways were given to those attending.

2015 Report of the ACCHD Division of Public Health Emergency Preparedness, Health Education, Health Promotion, Epidemiology, Indoor Air Quality, Public Information, and the Ashland County-City Medical Reserve Corps Unit #1181 (MRC Unit #1181)

"Being trained as a U.S. Navy Hospital Corpsman, I felt I could help by becoming a member of the local Medical Reserve Corps. I have enjoyed the refresher courses and especially taking part in learning new techniques, like the training for the *Ebolavirus* crisis."

Charles Cianciola
Medical Reserve Corps Unit #1181 Member since 2012.

The objectives of the division are as follows:

A) Assist in meeting Public Health Accreditation Board (PHAB) Standards 1.2 -1.4; 2.1 - 2.4; 4.1- 4.2; 6.2 - 6.3; 7.1; 8.1- 8.2; 10.1- 10.2; and 11.1.
B) Directly meet PHAB Standards 3.1-3.2.
C) Meet the following 15 National Preparedness Capabilities in a systematic approach:

Ray Herbst, RS, REHS
Division Director

Community Preparedness
Community Recovery
Emergency Operations Coordination
Emergency Public Information and Warning
Fatality Management
Information Sharing
Mass Care
Medical Countermeasure Dispensing
Medical Materiel Management and Distribution
Medical Surge
Non-Pharmaceutical Interventions
Public Health Laboratory Testing
Public Health Surveillance and Epidemiological Investigation
Responder Safety and Health
Volunteer Management

D) Inform residents about the numerous health prevention and protection programs the community provides as well as the ACCHD nursing and environmental health divisions provide through the preparation and delivery of various presentations to community stakeholders.

E) Improve health literacy through health education events at Public Health Day, Family Fun Day, the National Demonstration Project, "Tele-Psychiatry in Mass Emergency Shelters," Ladies Day "You Can Do It," Program (ACF), the Loudonville Fair, and the Ashland County Fair.

F) Provide mechanisms for health education, health promotion, and disaster preparedness information sharing with Ashland County residents through the ACCHD website at www.ashlandhealth.com; the ACCHD Operations Center, *Ashland Reserve* on Facebook, *AshlandOhioMRC* on Youtube, *@MRC_1181* on Twitter, as well as Loudonville-Perrysville cable TV and multiple print and radio outlets.

G) Bolster public health and local emergency response by recruiting, screening, training, engaging and retaining volunteer personnel for MRC Unit #1181 to enable the ACCHD and partner agencies to respond to different hazards, such as flooding, fire, lack of heat or air conditioning, compromised air quality, power outage, wind/rain/snow storms, low or no water pressure, nuclear, chemical and biological hazards.

H) Provide community education on prevention, protection and recovery from different types of public health hazards and threats.

I) Participate in the Ashland County Emergency Planning Committee (LEPC), Ashland County Healthcare Coalition, and Ashland County Office of Homeland Security and Emergency Management Agency (EMA) efforts to reduce health risks prior to large public events in Ashland County, and

J) Conduct consultations and inspections in response to mold, lead, mercury, radon asbestos, houses formerly used as methamphetamine labs, the Ohio SmokeFree Workplace Law and Rules, and other indoor air quality complaints.

The objectives of the division were met this past year in keeping with the Preparedness Capabilities of the Assistant Secretary for Preparedness & Response at the U.S. Department of Health & Human Services, the goals of the Surgeon General of the U.S. Public Health Service, the National Association of County & City Health Officials, the Ohio Department of Health (ODH) Director's Public Health Quality Indicators, the ODH Office of Health Preparedness, the ODH Office of Communications, ODH Bureau of Health Promotion, the ODH Bureau of Environmental Health & Radiation Protection, & the national Public Health Accreditation Board standards. Specifically, the objectives of the division were met this year by:

1) Helping to:

a. Provide the means for data collection, data analysis, and two-way dialogue mechanisms and manage different public health hazards (PHAB 1.2, 1.3, 2.1)

b. Conduct timely investigations of health problems and environmental public health hazards (PHAB 2.1.)

c. Implement Emergency Response Plan components. Conduct after-action reporting and improvement planning (PHAB 2.2)

d. Provide the means for emergency access to Epidemiological and Environmental Health resources to address public health hazards. (PHAB 2.3)

e. Provide the means for 24/7/365 emergency response. (PHAB 2.3)

f. Provide access to other support personnel, equipment and training (MRC Unit #1181) as well as a regional MOU capable of providing surge capacity. (PHAB 2.4)

g. Maintain policy and procedure for urgent and non-urgent communications. (PHAB 2.4)

h. Address the needs of specific public health populations by participating on the Ashland County Healthcare Coalition, the Continuum of Care, the Alcohol and Other Drug Committee of the Ashland County Mental Health and Recovery Board (MHRB), the Rape-Crisis Domestic Violence Task Force, the LEPC, and through special agreements with the Ohio Special Response Team, Inc., MHRB, and others. (PHAB 4.1)

i. Promote community understanding and support critical to the implementation of public health policies. (PHAB 4.2)

j. Monitor and track public health issues being discussed by the entities in item (h.) above that set policies that impact on public health. Monitor and track public health issues being discussed by those on Facebook (through *Ashland Reserve*), Twitter (through *@MRC_1181*) and Youtube (through *AshlandOhioMRC*) in Ashland County. (PHAB 5.1)

k. Educate individuals and organizations on the meaning, purpose and benefit of public health laws and how to comply through one-on-one consultations and inspections; the Loudonville Fair, and the Ashland County Fair. (PHAB 6.2)

l. Follow procedure and protocols for routine situations requiring enforcement and complaint follow-up (PHAB 6.3)

m. Collaborate with various committees and groups listed in item (h.) above to assess the availability of healthcare services to the Ashland County population as a whole. (PHAB 7.1)

n. Provide pertinent educational resources to ACCHD staff and MRC Unit #1181 members in the PHEP annual planning, training and education plan from OhioTRAIN, MRC-TRAIN, and NECO R5 for on-going development of qualified public health professionals. (PHAB 8.1 and 8.2)

o. Utilize evidence-based and/or promising practices when introducing and implementing

new or revised public health emergency preparedness and response policies, procedures and plans (PHAB 10.1)

p. Promote understanding and use of the current body of research results, evaluations, and evidence-based practices in the sharing of these practices with the Boards of Health, the MHRB, the Ashland Red Cross Unit, University Hospitals-Samaritan Medical Center (UH-SMC), and Ashland EMA. (PHAB 10.2)

q. Support maintenance of information management which supports the health department's mission and workforce by providing the infrastructure for data storage, protection, and management; and data analysis and reporting (PHAB 11.1)

2) Directly:

a. Provide information to the public on protecting their health through the support of the ACCHD website, and regular release of information through various seminars, fairs, email, Loudonville-Perrysville cable TV, local terrestrial radio and TV, *Ashland Reserve* on Facebook, *@MRC_1181* on Twitter, and *AshlandOhioMRC* on Youtube. (PHAB 3.1)

b. Provide information on public health issues and public health functions through multiple methods to a variety of audiences, documenting the distribution of information to the public about the role and value of the health department and the health department's role, mission, and programs; and using the brand strategy and communication procedures to provide information outside the health dept. as Public Information Officer; Risk Communications planning through message maps and pre-designed incident-specific communication messages, and website maintenance with ODH, CDC, National Institute of Allergies and Infectious Diseases, and FDA syndications. (PHAB 3.2)

c. Improve and revise the various components of the emergency response plan such as Continuity of Operations, Strategic National Stockpile (SNS) Response Plan, Crisis Communication, MOUs, and other sections. (PHAB 5.4)

d. Conducting consultations & inspections in response to many different mold, lead, radon, asbestos, mercury, Ohio SmokeFree Workplace Law & Rules & other indoor air quality complaints. Of greatest significance were the distribution of 200 coupons to Ashland County residents for passive indoor radon test kits, investigating the use or lack thereof of those coupons, and assisting 18 residents in resolution of their residential mold concerns.

e. Actively participating in LEPC & Ashland EMA efforts to quickly & effectively communicate with residents when an incident occurs anywhere in Ashland County through the Reverse 911 program, social media, and improvement of Multi-Agency Radio Communications System (MARCS) 800 MHz structures.

f. Providing community education to administrators and key employees of multiple primary, secondary and tertiary response and care facilities in Ashland County through the expansion of the Ashland County Healthcare Coalition in addressing medical surge

and emergency public information and warning. The Healthcare Coalition's Alternate Care Facility (ACF) Standard Operating Procedure was revised. The Division Director tailored an ACF Activation and Operating Procedure and submitted this to the Coalition for review. The Division Director serves primarily in grant-writing; process analysis; and improvement roles with the coalition.

g. Bolstering public health & local emergency response by the enlistment of volunteers into MRC Unit #1181 from a wide spectrum of education and experience to enable both the ACCHD and Ashland County to adequately respond to different types of hazards. MRC Unit #1181 is registered by the U.S. Public Health Service (USPHS) & the Ohio Medical Reserve Corps of the Ohio Department of Health (ODH) & is sponsored by the ACCHD. The Unit continually looks to recruit medical & non-medical volunteers for its separate and distinct missions of health education & effective public health disaster response. In order to operate effectively, we continue to search for volunteer physicians and pharmacists as well as 4 adult coordinators to fill the following significant volunteer leadership roles: Registration, Training, Events, & Communications. Hena Samdani, MBBS, MPH, of MRC Unit #1181, has both an extensive medical and epidemiological educational background, and worked on multiple MRC and ACCHD projects this past year, including National Radon Action Month, Public Health Day, Family Fun Day, Norovirus G2 investigation, and, "The National Demonstration Project: The Use of Tele-psychiatry in Mass Emergency Shelters."

h. Providing mechanisms for health education & disaster preparedness information sharing with Ashland County residents through the ACCHD website; ACCHD Operations Center; ACCHD Health Hotline, print, terrestrial radio, terrestrial TV and cable TV outlets as well as *AshlandOhioMRC* Youtube Channel, *@MRC_1181* on Twitter, and *Ashland Reserve* on Facebook.

i. Improving health literacy through educational events such as the Ashland Resource Fair at the Ashland Salvation Army, the annual County Fair & the Loudonville Street Fair.

j. Informing residents about numerous different wellness, environmental health education, mental health treatment alternatives, general disease prevention, emergency preparedness, health information protection, and crisis communication subjects through use of the division health education audio-visual hardware and software and the *AshlandOhioMRC* Youtube Channel. The Division Director utilized the division equipment in transfer, modification and/or development of different videos throughout the year, among those being:

Community Health Assessment Report - Ashland County, Ohio*	https://www.youtube.com/watch?v=cZ_v0wyAEUI
NACCHO Challenge Grant MRC Unit 1181 Use of Tele-psychiatry to Meet Functional Needs*	https://www.youtube.com/watch?v=NEXnQ2Uky2I
Acute stress disorder*	https://www.youtube.com/watch?v=bMS5xkcysXA
Schizoaffective disorder*	https://www.youtube.com/watch?v=cZk_a7sv9aY

Post-traumatic stress disorder evaluation b*	https://www.youtube.com/watch?v=VD8AQJQyV0Q
The National Demo Project: The Use of Telepsychiatry in Mass Emergency Shelters-I*	https://www.youtube.com/watch?v=CocCAGlpPM8
Alcohol withdrawal syndrome*	https://www.youtube.com/watch?v=Qm51lEIfjGM
Catatonic schizophrenia*	https://www.youtube.com/watch?v=tBax6JCctAw
Bipolar II*	https://www.youtube.com/watch?v=XKaL-ZjrEXU
Panic attacks*	https://www.youtube.com/watch?v=y5ER2loqzog
Post-traumatic stress disorder*	https://www.youtube.com/watch?v=94QrUryG1fc
Agorophobia-panic*	https://www.youtube.com/watch?v=pk41WTr4L0U
The National Demo Project: The Use of Telepsychiatry in Mass Emergency Shelters-G*	https://www.youtube.com/watch?v=AvHRboYmDeU
The National Demo Project: The Use of Telepsychiatry In Mass Emergency Shelters-F*	https://www.youtube.com/watch?v=qBgFvBSpYCg
#Chasing the Scream... Thumbs Up or Thumbs Down?	https://www.youtube.com/watch?v=OkUY0-TPYNk
Dr Blaise Congeni Public Health Day 2015*	https://www.youtube.com/watch?v=N_qDpLNw07A
Retrospective on the 20th Anniversary of Public Health Week*	https://www.youtube.com/watch?v=6yIJS9ywPsY
No One Is Telling Us Anything-this is an exercise	https://www.youtube.com/watch?v=LuzFitMPg-k
Hospitals Not Yet in Contact With Public Health-this is an exercise	https://www.youtube.com/watch?v=F1zmtDnwqxM
Pneumonic Plague-13 counties-this is an exercise	https://www.youtube.com/watch?v=0VoZQklkmdY
Richard Hodges visits the Ashland County-City Health Department*	https://www.youtube.com/watch?v=2kYcf7HhGJc

*In-house videography in whole or in part followed by editing performed by the Division Director.

In keeping with objective 1.c. above, an after-action report and improvement plan was prepared by the Division Director after the North East Central Ohio Regional Functional Exercise (NECO 2015 Regional FE) was completed on April 9, 2015. The NECO Region covers a 13-county area. Five members of the MRC Unit #1181 served as controllers, evaluators, and observer. The exercise was designed to establish a positive learning environment for the ACCHD, Samaritan Regional Health System (SRHS), MRC Unit #1181, and the Ashland County Emergency Management Agency (ACEMA), to exercise capabilities and preparedness plans, policies, and procedures. A total of 61 injects (items requiring a specific response) were delivered over the 3-hour period.

The scenario involved agents from the Cleveland office of the (FBI) indicating a terrorist attack

at a convention hall in Akron, Ohio, using *Yersinia pestis*. In the course of the exercise, hospitals reported a surge in actual H3N2 patients and the worried well; a 12-hour push package from the Strategic National Stockpile (SNS) was deployed; about 25% of the ACCHD staff were unavailable; Ashland County residents blogged that the plague could not be treated; pressure was placed on the ACCHD to restrict movement in public places; Ashland County pharmacies indicated that there were no more antibiotics available; over-the-counter medications sold out quickly; the ACCHD/MRC Mass Call Center was overwhelmed with calls; the press interviewed residents gathered outside the service center, a superintendent closed schools, families wanted personal protective equipment and antibiotics, a person on Twitter and Facebook stated that he/she had homeopathic cures for the plague; both the primary Point-of-Dispensing (POD) in Ashland, and the secondary POD in Loudonville were opened, MRC Unit #1181 volunteers reported to the staging area at the Ashland County Service Center, voluntary quarantine measures went into effect throughout the county; a person who was exposed to the plague refused to comply with voluntary quarantine measures; internet connectivity and cell phone coverage was lost at a dispensing site, and various businesses refused to serve persons that were coughing.

As part of the Improvement Plan, the Division Director pursued a security agreement for use at the ACCHD PODs. At least one seminar for the ACCHD and MRC Unit 1181 pertaining to Incident Command System forms will be conducted. Public health videos will continue to be produced so that emergency public information and warning proficiency is maintained.

MRC Unit #1181 is a volunteer force that assists the ACCHD, UH-SMC, ACMHRB, EMA, and Red Cross in meeting parts of the 15 ASPR/CDC Capabilities as well as the health education goals of the U.S. Surgeon General. Thirty-six of 56 MRC Unit #1181 members were involved in 89 separate activities during the year, contributing a total of $29,520.63 in donated services.

MRC Unit 1181 directly contributed to national preparedness on July 13 and 14 by organizing and presenting, "The National Demonstration Project: The Use of Tele-Psychiatry in Mass Emergency Shelters." This event was a vision come true to enable those in every community across the country, like ours, to help meet the needs of those with access and functional needs in times of disaster.

It is the obligation of local public health not only have plans to help those persons with access and functional needs in times of disaster, but also maintain working relationships with agencies and organizations that help to meet these needs on a daily basis, and then exercise these plans.

The vision for the project began in September 2012 when MRC Unit #1181 and the Red Cross participated in a seminar with Cuyahoga, Ashtabula and Medina counties. At that time, it was realized that those with psychiatric needs in a mass emergency shelter in a county our size may have to be transported to a hospital and wait up to 48 hours to get the help they need.

Near that same time, the U.S. Census Bureau released a report that nearly 1 in 5 people have a disability, approximately 56.7 million people, about 19 percent of the population, with more than

half reporting the disability was severe.

Late in 2012, Hurricane Sandy affected 24 states, and this served as an additional motivation to MRC Unit #1181 to apply for a small nationally competitive grant that would demonstrate improvement in the delivery of medical services to those persons unable to be reached in ways we have become accustomed.

It was not until December 2013, that MRC Unit #1181 was awarded a Challenge Grant from the National Association of County and City Health Officials to specifically demonstrate how public health could help those with access and functional needs in a disaster in a county our size. Part of that small grant was assigned to The National Demonstration Project.

The objectives of July 2015 project were to:

•Present the latest tele-medicine technology,
•Provide each vendor an opportunity to explain how their technology works,
•Enable public health, hospitals, mental health, and emergency management representatives to inquire as to the:

a) portability of the technology,
b) bandwidth needed for it to work successfully,
c) difficulty for a layperson to set it up and use it,
d) method(s) of transferring patient data during an exam
e) cost of annual maintenance,
f) overall cost.

•Present the tele-medicine technology in action at a medical station within a mass shelter following a significant disaster that places limits on a traditional local hospital response,

•See psychiatrists at work successfully examining patients tele-medically, communicating to nurses and counselors and authorizing the issuance of medication as eight psychiatric challenges were presented by actors portraying patients.

•Enable public health, hospitals, mental health, and emergency management representatives to talk to the psychiatrists who use this technology to explain:

a) when they started working with it,
b) how long did it take them to come up to speed to use it confidently,
c) how many persons are involved in its set-up and maintenance,
d) how it met medical needs in the communities they serve,
e) what they believe are its beneficial aspects following a significant disaster,
f) what they believe its limitations are.

Many agencies and organizations graciously offered to help bring the demonstration project to fruition, among those being, MRC Unit #1181, MHRB, the Ashland County EMA, CIT International, the Division of the Civilian Volunteer Medical Reserve Corps, Office of

Emergency Management, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services, InTouch Technologies, Inc., iQ Solutions Group, LLC, My Psychiatric Partner, LLC, the National Association of County and City Health Officials, and the Psychiatric Team of The Ohio State University Wexner Medical Center.

To reach Divisional objectives throughout 2015, resources were carefully spent maintaining the communication components of the ACCHD. The components include many laptops; software programs; the 432-channel MARCS radio system; FRS-GMRS radios; cell phones; digital photography, analog video; blast faxing; & digital & analog audio equipment. Also, numerous & extensive plans are prepared; & meetings, drills & exercises conducted both in-county & with other health depts. in the region regularly to maintain a good level of readiness to assist Ashland County residents in response to various natural or man-made adverse events.

Among the plans that the division prepared or updated in 2015 were the ACCHD:

Comprehensive Local Epidemiological Response
Emergency Response
Strategic-National-Stockpile Countermeasure Preparedness and Action
Continuity of Operations
Hazard Vulnerability Analysis
Multi-Year Training and Exercise
Isolation and Quarantine
The Volunteer Policy and Procedure
Emergency Support Function #8 of the Ashland County Emergency Operations
Ashland County, Ohio Medical Surge Alternate Care Site Standard Operating Procedure
Department Operations Center
Processing The FEMA Incident Action Forms For A Specific Incident
Alternate Care Facility (ACF) Standard Operating Procedure
Responder Health and Safety Guide
Demobilization
Fatality Management Tabs to ESF-8
Public Health Emergency Preparedness & Response Training Standards
Primary and Secondary POD Site Security

The ACCHD Ebolavirus Response Plan and the Ashland County Ebolavirus Response Plan continued to undergo modifications under a special Ebolavirus Supplemental Grant.

In 2015, the Division Director completed Department of Homeland Security/FEMA IS-130 Exercise Evaluation and Improvement Planning; IS-522 Exercising Continuity Plans for Pandemics; and IS-524 Continuity of Operations Planner's Workshop courses in addition to keeping current in national youth protection training programs. Mr. Herbst also received training on the revised U.S. Centers for Disease Control Inventory Management and Tracking System (IMATS) and the revised Ohio Public Health Communications System (OPHCS).

Mr. Herbst also contributes to the preparedness and response efforts of local health departments in the region. In addition to serving on the NECO R5 Medical Reserve Corps and Public

Information Officers Committees in 2015, Mr. Herbst participated on the NECO R5 Healthcare Coalition.

Funding for the work of this division in 2015 came from the ODH Public Health Emergency Preparedness Grant (through U.S. Public Law 108-111, 42 U.S. Code 247d-3, Public Law 109-111, Public Health Service Act Sections 301, 307, 311, 317, & 319); the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (Public Law 113–5, House Resolution 307, authorized by PHS Act, Section 319C-1); the Environmental Protection Agency Office of Air and Radiation Program Grants (SIRG 25 and 26) (through the Indoor Radon Abatement Act, Section 306, 15 U.S. Code 2661); and the National Special Security Event Grant – Ebolavirus.

The funding for the work of this division in 2015 also came from the National Association of County and City Health Officials (NACCHO) Capacity Building Award contract, a special NACCHO Challenge Award contract, the ODH Smoke-Free Workplace Program contracts & the general revenue fund of the Ashland County Board of Health. Ray Herbst, RS, REHS, LRT, C-EMPDS, Division Director, was assisted by Jennifer Helbert.

Mr. Herbst serves as the administrator of the ACCHD Ohio Public Health Communications System (OPHCS), Ohio Public Health Analysis Network (OPHAN), MARCS, OhioTRAIN, MRC-Train, and OhioResponds. Jennifer Helbert serves as the ACCHD webmaster. Contract epidemiological work is performed by the Mansfield-Ontario-Richland County Health Department. Shirley Bixby, RN, BSN, DON, and Pat Donaldson, BS, RS, Director of Environmental Health, served as MARCS and OPHCS backup administrators.

Vital Statistics

The Ashland County-City Health Department maintains birth and death records occurring in Ashland County from 1908 to present. We are also able to issue certified **Birth** Certificates for anyone born in any county in the state of Ohio. **Death** Certificates must be obtained at the health department of the county where the death occurred.

Ashland County-City Health Department
1763 State Route 60
Ashland, Ohio 44805
Office Hours: Monday-Friday
8am-4pm (closed Noon-1pm)

Gayle Lantz
Registrar
glantz@ashlandhealth.com

Jennifer Helbert
Deputy Registrar
Jhelbert@ashlandhealth.com

The births and causes of death identified in this report occurred within the City and County of Ashland during 2015. The law requires the Health Department to record births and deaths in the health jurisdiction where the event took place. Some birth and deaths recorded are individuals who were not residents of Ashland City or County. Likewise, the births and deaths of some residents took place in other localities and are recorded elsewhere.

ASHLAND COUNTY BIRTHS

	MALE	FEMALE	TOTAL
CITY	176	197	374
COUNTY	26	29	55
TOTAL	202	226	428

BIRTH STATS

Out of County Residents	118
Home Births	52 County/3 City
Twins - 4 Sets	1 Male/ 7 Female
Teen Moms- 19 Years and Under	25
Unwed Moms- 19 Years and Under	25
No Father Listed- 19 Years and Under	9
Unwed Mothers-20 Years and Older	146
No Father Listed-20 Years and Older	37
Mothers 40 Years and Older	10

Total Death 2015

	MALE	FEMALE	TOTAL
CITY	264	264	528
COUNTY	52	53	105
TOTAL	316	317	633

OUT OF COUNTY RESIDENCE DEATHS 2015

COUNTY OF RESIDENCY	TOTALS
RICHLAND	31
CRAWFORD	9
KNOX	8
MORROW	4
HOLMES	4
WAYNE	9
HURON	8
OTHER	15
OUT OF STATE	2
TOTALS	90

CAUSES OF DEATH 2015

	MALE	FEMALE
ACCIDENT	9	4
ALS	0	2
ALZHEIMER/DEMENTIA	21	29
BOWEL OBSTRUCTION	3	2
CANCER (ALL)	100	86
DRUG RELATED	4	2
FAILURE TO THRIVE	8	17
FETAL	3	2
HEART RELATED	75	79
HOMICIDE	0	0
INFLUENZA	0	1
LIVER	7	3
MALNUTRITION	5	5
MULTI ORGAN FAILURE	0	1
OTHER	2	3
PARKINSON'S	2	4
PNEUMONIA	12	8
RENAL FAILURE	8	12
RESPIRATORY FAILURE	32	33
SEPSIS	7	9
STROKE	17	14
SUICIDE	1	1
TOTALS	316	317

DEATH BY AGE

	MALE	FEMALE	TOTAL
FETAL	3	2	5
1-10	1	0	1
11-20	2	1	3
21-30	11	0	11
31-40	3	6	9
41-50	9	5	14
51-60	26	23	49
61-70	62	48	110
71-80	83	52	135
91-90	85	105	190
91-99	30	65	95
100 and Over	1	10	11
TOTAL	316	317	633

CORONER CASES

MANNER OF DEATH	MALE	FEMALE	TOTAL
SUICIDE	1	1	2
REPIRATORY FAILURE	0	1	1
HEART	17	11	28
NATURAL	0	1	1
ACCIDENT	9	3	12
DRUG RELATED	3	2	5
STROKE	1	1	2
PENDING	1	1	2
TOTALS	32	21	53

ASHLAND COUNTY COMMUNITY

HEALTH ASSESSMENT REPORT

SPRING, 2015

Sponsors:

Ashland County/City Health Department

Ashland County Family & Children First Council

Family and Children First Council Planning Committee

Karen Potter, Grant Project Director

Jelayne Dray, Ash. County/City Health Department
Steve Stone, Ash. Co. Mental Health & Recovery Bd
David Ross, Ash. Co. Mental Health & Recovery Bd.
Cassandra Holtzmann, Ash. Co. Jobs & Family Services
Fredy Robles, Catholic Charities Corporation
Jim Huntington, Ash. Co. Board of Developmental Disabilities

Dr. Michael Vimont, Ashland University, Project Researcher

Diane Karther, Ash. Co. Family & Children First Council
Jill Hartson, Samaritan Hospital
Ev DeVaul, United Way of Ashland County
Catherine Swope, Ashland Parenting Plus
Cathy Thiemens, ACCESS
Darlene Woodward, Tri County ESC Help Me Grow
Deb Williams, Tri-County Educational Services Center

Funding provided through a grant from the Ohio Dept. of Health Child and Family Health Services in partnership with Wayne Co. Mental Health and Recovery Board.

Ashland County Community Health Assessment

2015

Capturing the needs and strengths of a community is a challenging undertaking. There is a variety of ways of gathering and interpreting information, and a multitude of methods of constructing data. Each method has its strengths as well as weaknesses. It was this understanding of data collection that Ashland County's Family Children and First Council made a decision to use three parallel yet divergent strategies in gathering data.

The first strategy was a community survey that provided community members an opportunity to respond to a series of largely closed-ended questions regarding various aspects of community life. Questions were also presented to members for discussion of their own personal situation and challenges in accessing health care. Using electronic as well as written surveys, this strategy allowed for the collection of information from nearly 400 community members. It also allowed for the examination of many research questions using statistical controls on variables. Despite its robust nature, conclusions can only be drawn from the sample and cannot be generalized due to the inability to conduct a true random selection strategy.

A second strategy was the use of focus groups that allowed community members to respond to open-ended questions. This allowed for richer dialogue than what is possible with surveys but is limited in the number of participants. As was the limitation of the first strategy, generalization is not possible; however, the dialogue of this type can spur inquiries for future research.

The third strategy used was the assembly of secondary data from outside sources such as the American Community Survey (ACS) and Kids Count. This method is used when generalization is desired since many of these sources adhere to random selection for its data (i.e. ACS). It also can capture a wide range of information in a variety of areas. The short-coming, however, is that the data was not gathered specifically for the purpose of this assessment, so allowances have to be made in that the specifically targeted interest might not be wholly captured by a specific data set.

It is difficult to hone down all of the findings of these assessments; however, some general findings were forthcoming. First, the Ashland community is a good place for families to raise their children. Levels of safety, quality of education, and access to services are seen as positive attributes. Second, the community struggles with income levels that have not seen an

increase in nearly ten years resulting in many families struggling to make ends meet. Jobs appear to be making a comeback; however, wages remain stagnant. Also, child poverty rates remain high despite a rebounding economy. Third, more Ashland County families now appear to have access and/or availing themselves to health care insurance; however, finding a medical provider seems to be a challenge, especially in the area of dentistry. Finally, there is a general impression that the Ashland community is on a rebound, with many other indicators such as teenage pregnancy, children in the custody of the county, and criminally involved adolescents all showing a continual decline.

The data gathered and presented here will be used by local officials to assist in the planning and prioritization of programs and initiatives. It is hoped that to this end, the results from these three assessments can provide a focus for a more deliberative effort in addressing the needs of families and their children living in Ashland County!

Community Health Needs Survey

Ashland County – 2015

Survey Description

Between April 1, 2015 and May 22, 2015 residents of Ashland County had an opportunity to respond to survey items related to their perceptions of the community's health as well as items concerning their own health condition. Surveys were administered in one of two ways; an electronic survey constructed through SurveyMonkey.com and a paper version. All surveys completed by the use of a paper copy were subsequently entered into the SurveyMonkey.com for the purpose of data collection. All data from SurveyMonkey.com were then exported to SPSS Version 17 for analysis.

The survey was organized using three broad categories of health-related subject matter. The first section dealt with perspectives respondents had concerning macro community health conditions. Examples included items related to the affordability, quality and availability of health care in the county; economic opportunity for citizens; and the level of safety. Views regarding problems faced by the community concerning pollution, discrimination, poverty, drug abuse, elder/child abuse and violent crime were also asked in this portion of the survey. Finishing up this section were items related to services offered in the county, and the view of whether these services needed to be increased.

The second section concerned itself with respondents' behaviors and health status. Although the survey was completed in an anonymous and voluntary manner, respondents were specifically asked if they wished to respond to questions concerning their personal health. Those indicating "yes" responded to items concerning their physical health as well as mental health status. Those indicating "no" to this item, were directed to the next series of questions unrelated to this topic area. Items were asked about sources respondents used to obtain health-related information, and information they feel they need to know more about concerning health related topics. Items related to physical activity and smoking habits were inquired within this section. Wrapping this section up were items related to their personal access to health care and their current health insurance coverage.

The last section covered demographic variables of respondents. These variables included age, gender, race, marital status, educational level, household income, size of household and employment status. Also to discern the area that respondents lived in within the county, an item requesting zip code was also asked.

Respondents

There was a total of 382 respondents to the survey. Twenty-five respondents indicated they were not current residents of Ashland County and therefore not eligible to take the survey. From the 357 eligible respondents, 23 did not respond to a sufficient

number of items and were therefore excluded from further data analysis. This left 334 response sets that were analyzed for this summary.

Of those respondents who indicated their gender, 75% (n = 225) were female. The variable of age was collapsed from eleven categories presented in the survey, to four categories for data analysis. Of the 304 respondents who specified their age, 17.4% (n = 53) were between 18 and 34 years old; 41.4% (n = 126) were between 35 and 54 years old; 26.3% (n = 80) were between 55 and 64 years old; and 14.8% were 65 years old or older (n = 45).

Nearly all of the respondents reported their race as *Caucasian* (98%; n = 298), and over three-quarters indicated that their marital status was *Married* (n = 228). The highest level of education received among the 304 responders included 111 reporting having a graduate or professional degree (36.5%) and 61 having a bachelor's degree (20.1%). Over half of the 299 respondents who disclosed their employment status reported being employed full-time or self-employed (54.5%; n = 173), and 18.4% reported being employed part-time (n = 55). Only ten respondents stated that they were unemployed and actively looking for work. Thirteen indicated that they were homemakers. (See Table 6 for a complete description of demographic variables.)

Summation of Responses

Macro Community Health Status

Responders were asked to provide their level of agreement with eight statements related to health care in the county; the county being a good place to raise children or to grow old; and the county being able to provide economic opportunity, safety, and help during time of need. Possible responses ranged from Strongly Agree (4) to Strongly Disagree (1).

Responders tended to agree with the statement that Ashland was a good place to raise children (M = 3.25; SD = 0.65). There was a significant difference, however, between responders who reported having at least one child in their household and responders who reported not having children. Responders without children had a greater degree of agreement (M = 3.33; SD = 0.53) than those with children (M = 3.16; SD = 0.76), $t(293) = 2.18$, $p = .03$. Survey responders tended to agree that the community was a good place to grow old (M = 3.14; SD = 0.72). There was no significant difference in the level of agreement between older and younger respondents.

The item, "There is plenty of economic opportunity in Ashland County," had the least amount of agreement (M = 2.18; SD = 0.83). Responders who reported a household income of less than $50,000 were significantly less in agreement with this item (M = 2.01; SD = 0.82) than those reporting an income of $50,000 or more (M = 2.30; SD = 0.74), $t(237) = 2.91$, $p < .01$.

While there was agreement with the item concerning the availability of healthcare (M = 3.02; SD = 0.64); less agreement was seen regarding items of affordability (M =

2.70; SD = 0.78) and quality (M = 2.70; SD = .80). Overall, respondents perceived Ashland to be a safe place to live (M = 3.12; SD = 0.51) and a place where when help is needed, help is available (M = 2.81; SD = 0.80). Table 1 (a) and Table 1 (b) display the results of these series of items, while controlling for Gender, Age, and Income.

Tabel 1(a): Level of agreement regarding Ashland County from Strongly Agree (4) to Strongly Disagree (1)

	Overall *			Gender						Age (Years Old)											
Item#				Male			Female			18 - 34			35 - 54			55 - 64			65+		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	2.70	0.78	300	2.79	0.75	67	2.69	0.77	201	2.74	0.75	50	2.70	0.78	111	2.65	0.74	72	2.90	0.79	39
2	2.70	0.80	305	2.77	0.77	65	2.69	0.80	211	2.52	0.85	48	2.68	0.75	118	2.69	0.86	71	3.12	0.50	42
3	3.02	0.64	325	3.11	0.60	71	3.00	0.66	221	2.94	0.70	52	3.06	0.65	124	2.95	0.64	78	3.21	0.57	42
4	3.25	0.65	320	3.38	0.64	71	3.21	0.63	216	3.18	0.68	51	3.20	0.67	123	3.32	0.60	75	3.45	0.50	42
5	3.14	0.72	309	3.22	0.66	69	3.13	0.71	208	3.20	0.72	51	3.10	0.70	116	3.10	0.74	72	3.38	0.54	42
6	2.18	0.83	313	2.24	0.90	72	2.18	0.78	211	2.44	0.73	50	2.16	0.84	120	2.11	0.78	75	2.22	0.82	41
7	3.12	0.51	331	3.21	0.58	73	3.11	0.48	224	2.98	0.67	52	3.17	0.45	125	3.11	0.42	80	3.25	0.49	44
8	2.81	0.80	308	2.90	0.72	68	2.76	0.80	210	2.73	0.82	48	2.82	0.82	120	2.77	0.74	73	2.95	0.71	41

1 There is affordable healthcare in Ashland County.
2 There is high quality healthcare in Ashland County.
3 There is available healthcare in Ashland County.
4 Ashland County is a good place to raise children.
5 Ashland County is a good place to grow old.
6 There is plenty of economic opportunity in Ashland County.
7 Ashland County is a safe place to live.
8 There is plenty of help for people during times of need in Ashland County.

* Includes respondents not providing demographic characteristic(s)

Tabel 1(b): Level of agreement regarding Ashland County from Strongly Agree (4) to Strongly Disagree (1)

	Overall *			Household Income (in thousands)																	
Item#				<$25			$25 and < $35			$35 and < $50			$50 and < $75			$75 and < $100			$100 +		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	2.70	0.78	300	2.46	0.96	28	2.68	0.91	28	2.38	0.83	32	2.76	0.69	49	2.83	0.59	41	3.02	0.40	44
2	2.70	0.80	305	2.46	0.88	28	2.84	0.86	31	2.66	0.83	32	2.50	0.87	52	2.83	0.62	42	2.96	0.60	46
3	3.02	0.64	325	2.93	0.53	29	3.18	0.63	34	3.03	0.73	37	2.88	0.76	52	3.11	0.53	45	3.24	0.48	46
4	3.25	0.65	320	3.04	0.85	27	3.34	0.60	32	3.08	0.54	38	3.25	0.66	51	3.46	0.50	46	3.43	0.50	46
5	3.14	0.72	309	3.00	0.94	28	3.30	0.64	33	2.97	0.61	36	3.20	0.64	50	3.40	0.54	43	3.19	0.76	43
6	2.18	0.83	313	2.07	1.00	29	2.06	0.73	31	1.92	0.75	38	2.35	0.82	51	2.26	0.62	43	2.30	0.75	47
7	3.12	0.51	331	2.97	0.73	29	3.18	0.46	34	3.00	0.46	39	3.15	0.41	53	3.28	0.46	46	3.19	0.40	47
8	2.81	0.80	308	2.77	0.73	30	2.79	0.89	33	2.71	0.84	34	2.67	0.85	49	2.93	0.87	44	3.02	0.41	42

1 There is affordable healthcare in Ashland County.
2 There is high quality healthcare in Ashland County.
3 There is available healthcare in Ashland County.
4 Ashland County is a good place to raise children.
5 Ashland County is a good place to grow old.
6 There is plenty of economic opportunity in Ashland County.
7 Ashland County is a safe place to live.
8 There is plenty of help for people during times of need in Ashland County.

* Includes respondents not providing demographic characteristic(s)

Perceived Problem Levels Regarding Community Issues

The second set of items in the survey asked responders what their perceptions were regarding fourteen conditions. These conditions were presented as possible problem areas for the county, and survey takers were asked whether they perceived a condition as being a severe problem (4); moderate problem (3); slight problem (2); or not a problem (1). Responders were also provided an option of "not sure/no opinion". If the last option was selected, it was considered to be missing data and therefore not aggregated in the final results. Items listed included pollution; elder and child abuse; domestic violence; drug abuse; discrimination/racism; lack of community support, transportation, and health insurance; poverty; homelessness; violent crime; theft; and lack of health care providers.

Conditions identified as being the severest problem areas were *Drug abuse* (M = 3.32; SD = 0.75) and *Low income/Poverty* (M = 3.07; SD = 0.82). *Domestic violence* (M = 2.89; SE = 0.79) and *Child abuse* (M = 2.73; SD = 0.84) received moderate scores; however, *Elder abuse* (M = 2.03; SD = 0.75) was seen as only a slight problem. Conditions not perceived as being a problem in Ashland County were *Pollution* (M = 1.74; SD = 0.72) and *Lack of community support* (M = 1.92; SD = 0.94). *Discrimination/Racism* was perceived as being only a slight problem (M = 2.05; SD = 0.94).

Female respondents perceived all fourteen items as being a greater problem compared to male respondents. Items with the greatest difference between mean scores were *Domestic violence* $t(268) = 3.56$, $p < .01$; *Child abuse* $t(269) = 3.16$, $p < .01$; *Violent crime* $t(273) = 3.16$, $p < .01$; and *Poverty/Low income* $t(283) = 2.88$, $p < .01$.

Similar differences were displayed between older respondents (age 55 or over) and younger respondents (under the age of 55). However, the item *A lack of or inadequate health insurance*, displayed the greatest difference between the two groups with older respondents (M = 2.63; SD = 0.91) perceiving this area to be of much greater concern than younger respondents (M = 2.32; SD = 0.91), $t(262) = 2.73$, $p < .01$.

Respondents coming from households with reported incomes of less than $25,000 perceived conditions related to access to community services, poverty/income, and discrimination/racism at a higher problem level compared to households with more income. Minimal differences were observed when comparing households with less than $50,000 and households with more than that amount of income.

Table 2 (a) and Table 2 (b) display the results of these items while controlling for gender, age, and household income.

Tabel 2(a): Perceived problem level from Significant (4) to Not A Problem (1)

	Overall *			Gender						Age (Years Old)											
Item#				Male			Female			18 - 34			35 - 54			55 - 64			65+		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	1.74	0.72	296	1.60	0.62	72	1.79	0.75	203	1.69	0.68	49	1.71	0.68	118	1.78	0.80	73	1.74	0.72	39
2	2.05	0.95	296	1.96	0.85	68	2.10	0.99	208	2.12	0.99	51	2.01	0.89	117	2.13	1.01	72	2.05	1.04	40
3	1.92	0.94	302	1.82	0.82	66	1.94	0.96	214	1.88	0.99	49	1.91	0.90	119	2.04	0.93	76	1.66	0.86	41
4	2.32	1.06	299	2.10	1.02	73	2.42	1.06	206	2.20	1.14	45	2.29	0.99	119	2.48	1.08	77	2.21	1.09	42
5	3.07	0.82	309	2.83	0.82	72	3.15	0.79	213	2.78	0.92	49	3.09	0.78	120	3.27	0.70	78	2.91	0.84	43
6	2.39	0.78	289	2.26	0.80	69	2.44	0.77	203	2.24	1.02	46	2.37	0.75	113	2.49	0.64	76	2.45	0.78	40
7	2.45	0.93	277	2.36	0.85	66	2.50	0.94	193	2.18	0.96	45	2.38	0.88	108	2.73	0.88	75	2.42	0.97	36
8	2.17	0.99	303	2.04	0.99	69	2.21	0.98	212	2.14	1.00	49	2.19	1.02	117	2.24	0.91	78	1.95	0.97	41
9	2.64	0.83	308	2.48	0.88	71	2.71	0.81	214	2.58	0.87	48	2.57	0.82	122	2.83	0.76	76	2.67	0.89	43
10	3.32	0.75	316	3.24	0.80	72	3.37	0.72	219	3.27	0.84	49	3.26	0.74	125	3.45	0.73	78	3.42	0.66	43
11	2.03	0.84	223	1.89	0.76	55	2.13	0.85	154	1.95	0.87	38	1.95	0.81	87	2.20	0.76	59	2.23	0.97	30
12	2.73	0.85	289	2.48	0.86	66	2.86	0.83	205	2.57	0.99	47	2.69	0.80	115	2.96	0.79	76	2.82	0.83	38
13	2.89	0.79	286	2.62	0.84	69	3.01	0.76	201	2.81	0.92	48	2.80	0.75	111	3.18	0.61	72	2.81	0.93	43
14	2.07	0.73	294	1.85	0.71	72	2.16	0.72	203	1.98	0.91	46	1.99	0.66	113	2.23	0.70	79	2.14	0.72	42

1 Pollution (air, water, land)
2 Discrimination/racisim
3 Lack of community support
4 Lack of transportation
5 Low income/poverty
6 Homelessness
7 Lack of or inadequate health insurance
8 Lack of health care providers
9 Theft
10 Drug abuse
11 Elder abuse
12 Child abuse
13 Domestic violence
14 Violent crime (murder, assault, rape)

* Includes respondents not providing demographic characteristic(s)

Tabel 2(b): Perceived problem level from Significant (4) to Not A Problem (1)

	Overall *			Household Income (in thousands)																	
Item#				<$25			$25 and < $35			$35 and < $50			$50 and < $75			$75 and < $100			$100 +		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	1.74	0.72	296	1.90	0.76	30	1.67	0.71	30	1.59	0.80	32	1.67	0.63	49	1.68	0.64	44	1.74	0.68	47
2	2.05	0.95	296	2.54	1.11	28	2.03	0.94	29	2.11	1.01	36	1.88	0.78	49	2.13	0.89	45	2.17	0.95	46
3	1.92	0.94	302	2.24	0.95	29	1.80	0.89	30	1.71	0.77	38	1.98	0.98	52	1.77	0.81	43	1.87	0.84	45
4	2.32	1.06	299	2.43	1.10	30	2.39	1.12	31	2.14	0.93	36	2.57	1.01	51	2.31	1.12	42	2.24	1.07	45
5	3.07	0.82	309	3.17	0.99	30	3.03	0.82	32	3.14	0.83	36	2.88	0.79	51	3.09	0.66	46	3.02	0.77	46
6	2.39	0.78	289	2.58	0.96	31	2.48	0.85	27	2.26	0.67	34	2.37	0.83	49	2.40	0.58	43	2.39	0.72	44
7	2.45	0.93	277	2.59	1.02	29	2.50	1.17	28	2.38	0.92	34	2.40	0.88	50	2.47	0.75	40	2.38	0.82	39
8	2.17	0.99	303	2.38	0.98	29	1.88	0.93	33	2.12	0.91	34	2.35	1.04	51	2.16	0.99	44	1.96	0.90	45
9	2.64	0.83	308	2.80	0.85	30	2.79	0.86	33	2.78	0.98	37	2.65	0.81	49	2.49	0.70	45	2.50	0.81	46
10	3.32	0.75	316	3.57	0.77	30	3.48	0.67	33	3.33	0.70	39	3.47	0.61	51	3.20	0.76	45	3.23	0.73	47
11	2.03	0.84	223	2.04	0.91	24	2.19	0.81	21	2.29	0.85	21	2.17	0.86	41	2.10	0.79	31	1.86	0.75	37
12	2.73	0.85	289	2.71	1.05	28	2.87	0.86	30	2.94	0.84	32	2.69	0.81	51	2.82	0.72	45	2.80	0.80	44
13	2.89	0.79	286	2.97	1.00	30	2.90	0.86	29	3.06	0.78	34	2.83	0.74	46	2.82	0.65	45	2.95	0.73	42
14	2.07	0.73	294	2.07	0.86	28	2.24	0.66	33	2.00	0.66	33	1.98	0.76	48	2.07	0.63	44	2.02	0.69	45

1 Pollution (air, water, land)
2 Discrimination/racisim
3 Lack of community support
4 Lack of transportation
5 Low income/poverty
6 Homelessness
7 Lack of or inadequate health insurance
8 Lack of health care providers
9 Theft
10 Drug abuse
11 Elder abuse
12 Child abuse
13 Domestic violence
14 Violent crime (murder, assault, rape)

* Includes respondents not providing demographic characteristic(s)

Perceptions of Risky Behaviors Impacting the Community

Respondents were asked to rate the degree of impact on the community due to each of 14 risky behaviors listed. Table 3(a) and 3(b) lists these risky behaviors as well as the mean score (4 = significant impact; 3 = moderate impact; 2 = a little impact; 1 = no impact). Respondents indicating that they did not know or had no opinion were excluded from the calculations.

Drug abuse (M = 3.46; SD = 0.74) and alcohol abuse (M = 3.37; SD = 0.74) were the two risky behaviors perceived as having the most impact on the community. This was followed by poor eating habits (M = 3.13; SD = 0.80); lack of exercise (M = 3.10; SD = 0.81) and being overweight (M = 3.10; SD = 0.82). Tobacco use (M = 3.06; SD = 0.81) and prescription drug use (M = 3.01; SD = 0.87) were two other risky behaviors assess has having at least a moderate impact. Behaviors receiving the least level of perceived impact were racism (M = 2.49; SD = 0.91); not using seat belts/child safety seats (M = 2.60; SD = 0.89); and not getting "shots"/vaccinations to prevent disease (M = 2.73; SD = 0.95).

As was observed in the prior two areas of analysis, females rated the impact on all of the risky behaviors as significantly higher than male respondents. Differences observed when controlling for gender were observed regarding at-risk behaviors of drug abuse $t(281) = 4.10$, $p < .01$; alcohol abuse $t(279) = 3.68$, $p < .01$; and not using seat belts/child safety seats $t(243) = 3.83$, $p < .01$.

Younger respondents (under the age of 35 years old) perceived bullying as having more of an impact on the community than older respondents. They also perceived racism and not using seat belts/child safety seats as more impactful than respondents 35 years old or older. Older respondents (age 55 or older) perceived behaviors associated with a lack of exercise and poor eating habits as being more of an impact.

There was little difference in perceptions of impact when controlling for income levels of the household. The three exceptions concerned behaviors associated with racism, bullying, and unsafe sex; with households with less than $25,000 in annual income perceiving them as greater than households with more income.

Tabel 3(a): Perceived impact of risky behaviors on the community

	Overall *			Gender						Age (Years Old)											
Item#				Male			Female			18 - 34			35 - 54			55 - 64			65+		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	2.94	0.87	288	2.62	0.84	65	3.04	0.86	270	3.10	0.96	51	2.88	0.84	122	3.04	0.88	67	2.69	0.76	35
2	3.10	0.82	302	3.07	0.78	72	3.13	0.83	285	3.04	0.93	50	2.94	0.83	121	3.35	0.69	74	3.25	0.75	44
3	2.89	0.88	284	2.69	0.87	65	3.00	0.85	267	2.94	0.90	47	2.84	0.87	114	3.08	0.87	72	2.85	0.81	39
4	3.01	0.87	270	2.79	0.94	62	3.10	0.83	254	3.17	0.92	47	2.96	0.93	105	3.06	0.75	69	2.89	0.80	38
5	3.46	0.74	299	3.19	0.80	70	3.58	0.67	283	3.51	0.82	49	3.46	0.76	118	3.56	0.62	79	3.36	0.73	42
6	3.37	0.74	298	3.11	0.74	72	3.47	0.71	281	3.40	0.87	48	3.30	0.74	118	3.55	0.60	77	3.30	0.77	43
7	3.06	0.81	303	2.87	0.82	70	3.14	0.78	285	3.06	0.83	49	2.94	0.86	121	3.29	0.67	77	3.05	0.79	43
8	3.10	0.81	306	3.00	0.87	73	3.15	0.79	287	2.88	0.85	50	3.03	0.84	120	3.35	0.72	78	3.16	0.78	44
9	3.13	0.80	302	3.04	0.83	72	3.17	0.78	282	2.88	0.84	51	3.10	0.82	115	3.35	0.71	79	3.14	0.72	42
10	2.73	0.95	269	2.53	0.87	60	2.82	0.97	191	2.85	1.14	47	2.66	0.92	107	2.81	0.91	69	2.76	0.83	33
11	2.49	0.91	288	2.25	0.89	67	2.60	0.91	204	2.80	0.97	50	2.35	0.80	113	2.59	0.94	73	2.45	1.01	40
12	2.88	0.89	255	2.69	0.90	59	2.93	0.88	181	2.91	0.96	46	2.80	0.93	103	3.02	0.77	66	2.76	0.83	29
13	2.98	0.85	259	2.80	0.91	59	3.03	0.83	185	3.00	0.89	47	2.92	0.87	106	3.14	0.78	66	2.83	0.85	29
14	2.60	0.89	260	2.25	0.77	60	2.74	0.89	185	3.00	0.97	46	2.55	0.81	101	2.64	0.81	67	2.28	0.94	36

1 Bullying
2 Being overweight
3 Dropping out of high school
4 Prescription drug use
5 Drug abuse
6 Alcohol abuse
7 Tobacco use
8 Lack of exercise
9 Poor eating habits
10 Not getting "shots"/vaccinations to prevent disease
11 Racism
12 Not using birth control
13 Unsafe sex
14 Not using seat belts/child safety seats

* Includes respondents not providing demographic characteristic(s)

Tabel 3(b): Perceived impact of risky behaviors on the community

	Overall *			Household Income (in thousands)																	
Item#				<$25			$25 and < $35			$35 and < $50			$50 and < $75			$75 and < $100			$100 +		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	2.94	0.87	288	3.29	0.85	28	3.00	0.88	27	3.09	0.89	32	2.92	0.85	50	2.89	0.78	44	2.86	0.77	43
2	3.10	0.82	302	3.29	0.78	31	3.16	0.77	32	2.81	0.82	36	3.26	0.72	50	3.07	0.81	45	3.24	0.87	46
3	2.89	0.88	284	3.21	0.90	29	2.69	0.93	29	2.59	0.88	32	2.91	0.94	46	3.00	0.80	45	3.02	0.75	45
4	3.01	0.87	270	3.04	1.06	27	3.21	0.90	29	2.80	1.00	30	3.23	0.70	47	3.00	0.90	38	2.91	0.77	44
5	3.46	0.74	299	3.52	0.69	29	3.55	0.83	33	3.51	0.70	35	3.48	0.67	52	3.44	0.67	43	3.53	0.65	47
6	3.37	0.74	298	3.43	0.86	30	3.58	0.56	31	3.46	0.74	35	3.33	0.82	51	3.35	0.69	43	3.39	0.58	46
7	3.06	0.81	303	3.17	0.87	30	3.21	0.74	33	3.03	0.81	36	3.08	0.76	52	3.00	0.72	43	3.00	0.89	46
8	3.10	0.81	306	3.03	1.02	31	3.21	0.74	33	2.92	0.86	37	3.10	0.71	50	3.16	0.71	45	3.23	0.87	47
9	3.13	0.80	302	3.00	0.93	31	3.25	0.76	32	2.86	0.85	35	3.20	0.63	51	3.22	0.70	45	3.24	0.85	46
10	2.73	0.95	269	2.85	1.12	26	2.50	0.92	28	2.63	1.03	30	2.71	0.97	48	2.83	0.88	36	2.85	0.81	39
11	2.49	0.91	288	3.11	1.03	28	2.24	0.95	89	2.61	1.06	33	2.45	0.84	49	2.63	0.79	43	2.51	0.80	47
12	2.88	0.89	255	2.92	1.04	25	3.12	1.05	25	2.86	0.80	28	2.82	0.82	44	2.97	0.82	38	2.81	0.83	42
13	2.98	0.85	259	3.28	0.89	25	3.00	1.02	26	2.92	0.80	26	2.96	0.82	46	3.00	0.81	41	2.95	0.83	42
14	2.60	0.89	260	2.86	1.04	28	2.36	0.99	28	2.43	1.00	28	2.58	0.85	43	2.79	0.81	38	2.62	0.71	39

1 Bullying
2 Being overweight
3 Dropping out of high school
4 Prescription drug use
5 Drug abuse
6 Alcohol abuse
7 Tobacco use
8 Lack of exercise
9 Poor eating habits
10 Not getting "shots"/vaccinations to prevent disease
11 Racism
12 Not using birth control
13 Unsafe sex
14 Not using seat belts/child safety seats

* Includes respondents not providing demographic characteristic(s)

Perceptions of Services Needed in the Community

Respondents were asked their opinion on the need to increase sixteen resources/services listed in Tables 4(a) and 4 (b). Options ranged from greatly increased

(4) to no increase needed (1). Respondents indicating that they did not know or had no opinion were excluded from the calculations.

Service or resources that obtained a mean score of 3 (needing to be increased) or higher were *Higher paying employment* (M = 3.38; SD = 0.80); *Road maintenance* (M = 3.22; SD = 0.83); *Availability of employment* (M = 3.21; SD = 0.91); and *Positive teen activities* (M = 3.15; SD = 0.86). Female respondents perceived a greater need for more services or resources than male respondents. The two items reflecting the greatest difference when controlling for gender were *Child care options* $t(257) = 2.37$, $p < .05$ and *Positive teen activities* $t(284) = 2.62$, $p < .01$.

There was no discernable difference in perceived needs for services or resources based on the age of the respondent. However, household income did display differences between those having less than $25,000 and those with greater amounts of income. Some of the services and resources displaying significant differences were *Affordable/Better housing* $t(228) = 3.85$, $p < .01$; *Services for people with disabilities* $t(225) = 3.24$, $p < .01$; *Healthy family activities* $t(262) = 4.10$, $p < .01$; and *Higher paying employment* $t(243) = 2.21$, $p < .05$.

Tabel 4(a): Opinion on need to increase services/resources to improve quality of life

	Overall *			Gender						Age (Years Old)											
Item#				Male			Female			18 - 34			35 - 54			55 - 64			65+		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	2.82	0.91	271	2.57	0.94	61	2.89	0.90	198	2.84	0.93	50	2.72	0.97	110	2.99	0.81	69	2.74	0.86	34
2	2.56	1.02	270	2.44	0.99	64	2.61	1.03	194	2.52	1.00	44	2.41	1.05	106	2.77	0.98	73	2.65	1.00	40
3	2.61	0.99	276	2.44	0.91	63	2.68	1.01	202	2.76	0.93	49	2.61	1.06	109	2.62	1.00	74	2.45	0.83	38
4	2.74	0.98	283	2.63	0.92	67	2.79	0.98	203	2.70	0.91	47	2.68	1.03	117	2.93	0.86	72	2.59	1.04	39
5	2.67	0.97	288	2.51	0.87	69	2.75	0.98	208	2.74	1.01	50	2.52	0.97	117	2.76	0.93	72	2.81	0.93	43
6	2.65	0.98	281	2.49	0.96	67	2.72	0.98	204	2.70	0.92	46	2.65	1.03	119	2.71	0.96	73	2.46	0.93	37
7	2.55	0.98	269	2.38	0.92	63	2.61	0.99	195	2.81	0.85	47	2.54	1.01	109	2.46	1.01	68	2.33	0.96	39
8	2.90	0.93	269	2.83	0.90	64	2.94	0.94	193	3.00	0.88	44	2.86	0.93	112	2.84	0.99	70	2.89	0.95	36
9	2.39	1.10	303	2.33	1.15	72	2.39	1.08	219	2.80	1.05	50	2.48	1.13	124	2.09	1.02	78	2.09	1.03	44
10	2.78	0.96	297	2.74	0.97	70	2.78	0.95	214	3.04	0.85	51	2.81	1.00	122	2.68	0.95	75	2.41	0.95	41
11	3.15	0.86	298	2.92	0.89	71	3.22	0.83	215	3.23	0.81	52	3.14	0.90	123	3.19	0.83	75	2.90	0.86	41
12	2.68	1.00	290	2.50	0.93	72	2.77	1.01	207	2.75	1.04	48	2.58	1.00	118	2.92	0.92	73	2.55	1.04	44
13	3.21	0.91	303	3.00	0.97	73	3.27	0.88	217	3.08	0.83	50	3.17	0.95	123	3.27	0.98	78	3.30	0.80	44
14	3.38	0.80	302	3.33	0.78	73	3.40	0.80	216	3.34	0.80	50	3.30	0.87	123	3.53	0.72	77	3.34	0.78	44
15	3.22	0.83	304	3.05	0.76	73	3.27	0.85	219	3.22	0.89	50	3.12	0.83	125	3.23	0.87	78	3.45	0.66	44
16	2.74	0.95	292	2.66	0.93	70	2.78	0.95	210	2.98	0.94	47	2.62	0.97	120	2.72	0.94	75	2.79	0.89	43

1 child care options
2 elder care options
3 services for people with disabilities
4 affordable health services
5 affordable/better housing
6 counseling/mental health services
7 support groups
8 drug counseling
9 better/more recreational facilities
10 health family activities
11 positive teen activities
12 transportation options
13 availability of employment
14 higher paying employment
15 road maintenance
16 road safety

* Includes respondents not providing demographic characteristic(s)

Tabel 4(b): Opinion on need to increase services/resources to improve quality of life

Item#	Overall *			Household Income (in thousands)																
				<$25			$25 and < $35			$35 and < $50			$50 and < $75			$75 and < $100			$100 +		
	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n	M	SD	n
1	2.82	0.91	271	2.96	0.98	27	2.92	0.98	26	2.84	0.90	31	2.86	0.88	50	2.64	0.82	42	2.78	0.91	41
2	2.56	1.02	270	2.93	0.98	28	2.52	1.19	25	2.50	0.99	34	2.55	0.94	49	2.59	0.95	41	2.40	1.06	42
3	2.61	0.99	276	3.17	0.81	29	2.62	1.15	29	2.79	0.99	33	2.54	0.97	50	2.57	0.91	42	2.32	0.93	44
4	2.74	0.98	283	3.07	0.88	29	2.82	1.06	28	2.71	1.12	34	2.77	0.91	48	2.55	0.94	42	2.38	0.89	45
5	2.67	0.97	288	3.31	1.00	29	2.91	0.84	33	2.82	0.92	33	2.75	1.00	48	2.49	0.87	41	2.15	0.79	46
6	2.65	0.98	281	2.73	1.00	26	2.72	1.13	29	2.59	1.01	32	2.73	0.99	52	2.62	1.04	42	2.74	0.95	46
7	2.55	0.98	269	3.07	0.98	28	2.37	1.12	27	2.42	1.05	36	2.80	1.01	47	2.54	0.98	41	2.58	0.81	40
8	2.90	0.93	269	3.14	0.89	28	2.97	0.94	29	2.90	0.98	31	2.89	0.98	47	2.76	0.99	41	2.83	0.90	40
9	2.39	1.10	303	2.61	1.12	31	2.15	1.12	33	2.44	1.08	36	2.36	1.16	53	2.43	1.13	46	2.45	1.10	47
10	2.78	0.96	297	3.20	0.89	30	2.61	1.09	31	2.67	0.93	36	2.66	0.94	53	2.76	1.04	46	2.80	0.93	46
11	3.15	0.86	298	3.37	0.77	30	3.26	0.86	31	3.14	0.83	36	3.00	0.86	53	3.13	0.92	45	3.21	0.78	47
12	2.68	1.00	290	2.94	1.03	31	2.84	1.08	32	2.56	1.03	36	2.83	0.94	52	2.74	0.97	39	2.57	1.02	44
13	3.21	0.91	303	3.52	0.85	31	3.36	0.76	33	3.22	0.89	37	3.10	0.96	52	3.17	0.83	46	3.15	0.93	47
14	3.38	0.80	302	3.68	0.60	31	3.59	0.71	32	3.30	0.81	37	3.15	0.89	53	3.40	0.69	45	3.38	0.85	47
15	3.22	0.83	304	3.58	0.77	31	3.47	0.76	32	3.24	0.85	38	3.08	0.76	52	3.04	0.87	46	3.15	0.81	47
16	2.74	0.95	292	3.10	1.01	31	2.83	0.89	29	2.76	0.98	37	2.77	0.97	48	2.38	0.86	45	2.61	1.00	46

1 child care options
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* Includes respondents not providing demographic characteristic(s)

Health Information

Individuals taking the survey were asked about the source they primarily used to obtain their health information. Respondents were asked to select one source from a list of eleven possible sources. Of the 299 respondents, over half (51%) stated that they primarily received their health information from doctors/physician assistants, and 25% received this information primarily from the internet.

Respondents who had children between the ages of birth to five, and/or were pregnant were asked to select from a list of sixteen topics, all of the topics they believed they needed more information about to assist them in their role as a primary caregiver. The five topic areas receiving the most affirmative responses were *Recreational activities* (n = 20*)*; *Social and emotional support* (n = 14); *Dealing with difficult child behaviors* (n = 13); *Finding adequate child care* (n = 12); and *Accessing programs and services* (n = 12). (See Figure 1 for a graphic representation of results.)

Respondents who had children between the ages of six and nineteen were asked about topics they felt their child(ren) needed more information about. Of the sixteen topics presented the top five were *Dealing with peer pressure* (n = 63); *Bullying* (n = 51); *Nutrition* (n = 46); *Drug abuse* (n = 42); and *Reckless driving/speeding* (n = 41). (See Figure 2 for a graphic presentation of results.)

Figure 1

Which topic(s) listed below do you need more information about to assist you in your role primary care giver?

For parents with children between birth and five years, and/or is pregnant

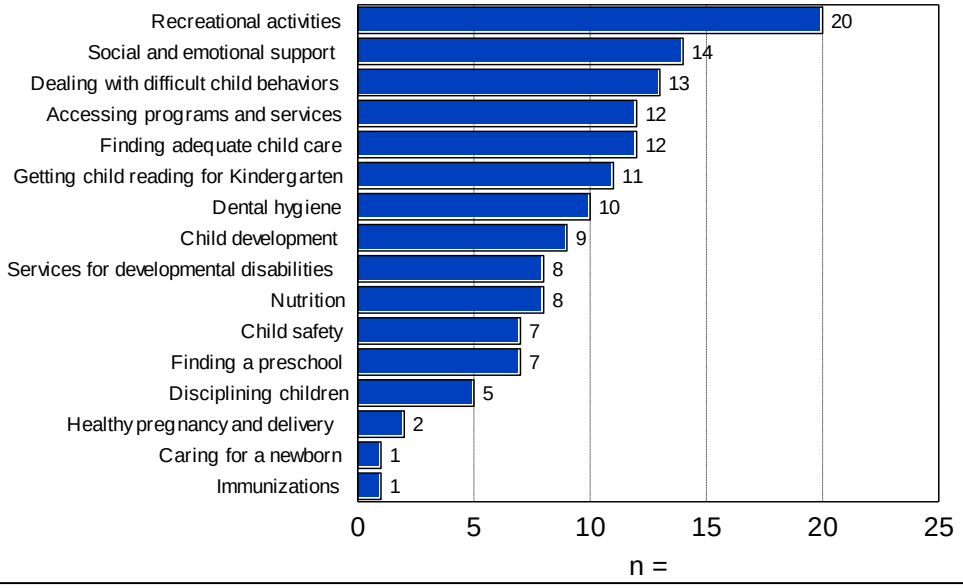
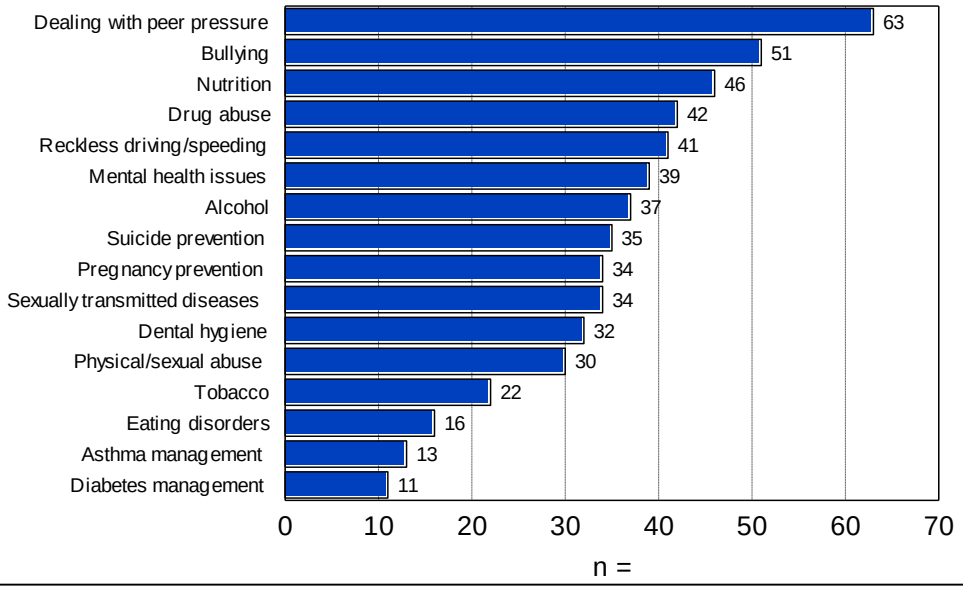


Figure 2

Which of the following health topics do you think your child(ren) need(s) more informati about?

For parents with children between the ages of 6 and 19



Personal Health Information

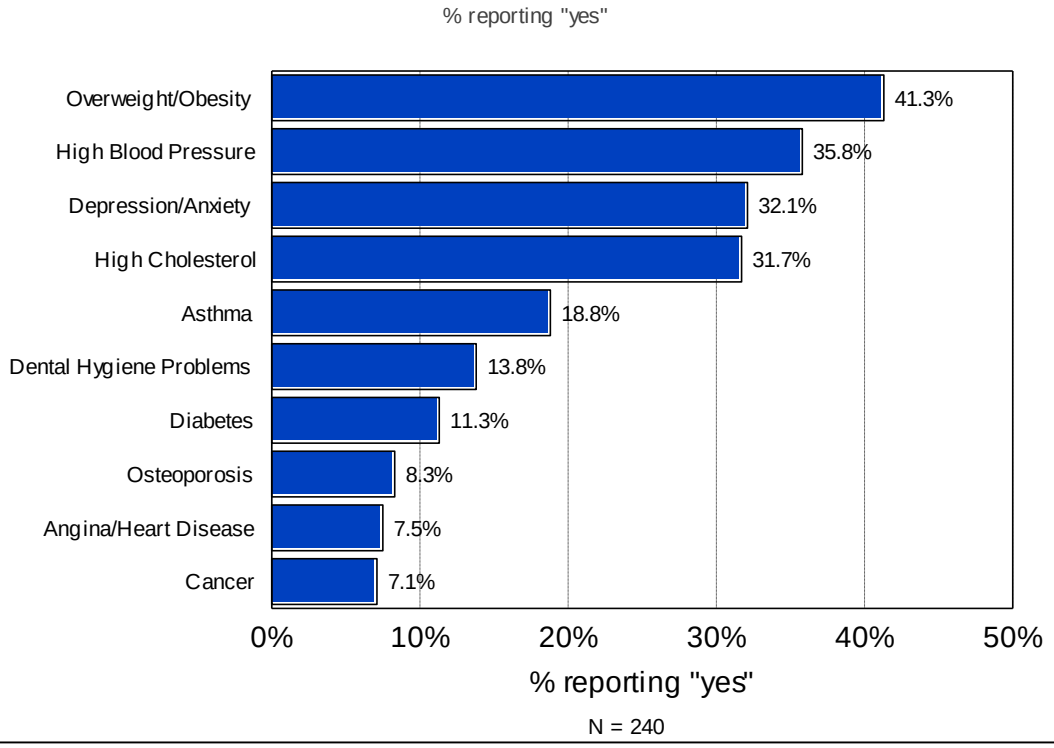
Individuals taking the survey were given an option of whether they wished to reveal personal health conditions about themselves. Of the 334 respondents, 70 stated "no" and 24 skipped the question. This left 240 individuals responding to a series of items related to personal health status. Respondents with annual incomes of less than $50,000 were significantly less likely to reveal their personal health conditions. No other demographic variable displayed a significant difference.

A list of ten health conditions were presented to respondents asking them if they "have ever been told by a doctor, nurse, or other health professional that" they have any of the health conditions listed. Figure 3 displays the list of health conditions with the proportion of respondents reporting "yes" to the item.

As Figure 3 displays, being overweight and having high blood pressure were the two most frequently reported conditions followed by depression/anxiety and high cholesterol. Nearly one out of five also reported having been diagnosed with asthma.

Figure 3

Have you ever been told by a health professional that you have any of the following conditions?



Gender

When controlling for the effects of gender, Depression/Anxiety was the singular variable displaying a significant difference between males and females. A 2 x 2 chi-square test indicated that females were significantly more likely to report having been told by a health professional that they were either depressed and/or experiencing anxiety, χ^2 (1, N = 231) = 8.19, p < .01.

Income

The demographic variable of income was recoded as a dichotomous variable with households of less than $50,000 annual income being compared to households with an income of $50,000 or more as it related to health conditions. Respondents residing in household making less than $50,000 per year were significantly more likely to report conditions of Overweight/Obesity (χ^2 (1, N = 197) = 12.54, p < .01); Angina/Heart Disease (χ^2 (1, N = 197) = 6.10, p < .05); and Dental Hygiene Problems (χ^2 (1, N = 197) = 13.28, p < .01).

Age

The demographic variable of age was recoded as a dichotomous variable with individuals between the ages of 18 and 54 years old being compared to individuals who were 55 years old or older. Those individuals who were 55 years old or older were significantly more likely to report having been told by a health professional that they had high blood pressure (χ^2 (1, N = 234) = 17.66, p < .01); high cholesterol (χ^2 (1, N = 234) = 12.76) and osteoporosis (χ^2 (1, N = 234) = 10.79, p < .01). Individuals younger than 55 years old were significantly more likely to be told that they were experiencing depression or anxiety (χ^2 (1, N = 234) = 5.08, p < .05).

Gender x Age and Depression/Anxiety

A 4 x 2 chi-square test was conducted that combined the effects of both gender and age on whether respondents had been told by a health professional of being depressed or experiencing anxiety. Results showed that females under the age of 55 years old were significantly more likely to have been told this by a health care professional compare to females 55 years old or older, or males regardless of age (χ^2 (3, N = 230) = 11.84, p < .01). Table 5 shows the cross-tab results of this analysis. Over two out of five females younger than 55 years old reported having been told by a health care professional of being depressed or experiencing anxiety.

Table 5

Gender x Age on being told by a health care professional of experiencing depresssion/anxiety

	Age			
	< 55 years		55 + years	
Gender	n =	%	n=	%
Female	43	41.7	21	30.4
Male	7	25.0	3	10.0

Personal Health Observations and Daily Functioning

Respondents indicating that they were willing to respond to items related to their health condition were asked three questions related to their psycho-social health. The three items were whether or not there had been any days during the past 30 days of being sad or worried that impacted their abilities to carry out normal business; of feeling anxious, confused, or overwhelmed; or experiencing physical pain or having health problems that deterred them from their usual activities.

Figures 4, 5, and 6 display the results of each of the three items. In each graph, the overall results of those indicating "yes" to these items are shown. Also, results while controlling for the demographic variables of gender, age, and income are displayed.

<u>In the past 30 days, have there been any days when feeling sad or worried kept you from going about your normal business?</u>

Of the 237 respondents to this item, 46 (19.2%) indicated this to be true for them. Significant differences were seen when controlling for age, with younger respondents being more likely to experience this; and when controlling for income, with lower income respondents more likely to experience this. Although females were more likely than males to say "yes" to this item, the difference was not statistically significant.

<u>In the past 30 days, have there been any days where feeling anxious, confused, or overwhelmed kept you from going about your normal business?</u>

A similar proportion of respondents (17.5%) indicated that they had experienced being anxious, confused, or overwhelmed during the prior 30 days (n = 42). However, unlike the previous item, there were significant differences when controlling for each of the three demographic variables. Females, younger respondents, and those making less income were all more likely to have experienced this when compared to their respective counterpart.

<u>In the past 30 days, have you had any physical pain or health problems that made it hard for you to do your usual activities such as driving, working around the house, or going to work?</u>

Over one-quarter of respondents (27.1%) reported having had experienced physical pain or had health problems that impeded their ability to engage in usual activities. Neither age nor gender displayed a difference between their two respective attributes; however, when controlling for income respondents with less income were significantly more likely to indicate "yes" to this item. Respondents in households with less than $55,000 annual income were nearly twice as likely to have experienced this compared with respondents coming from households with $55,000 or more in annual income.

Figure 4

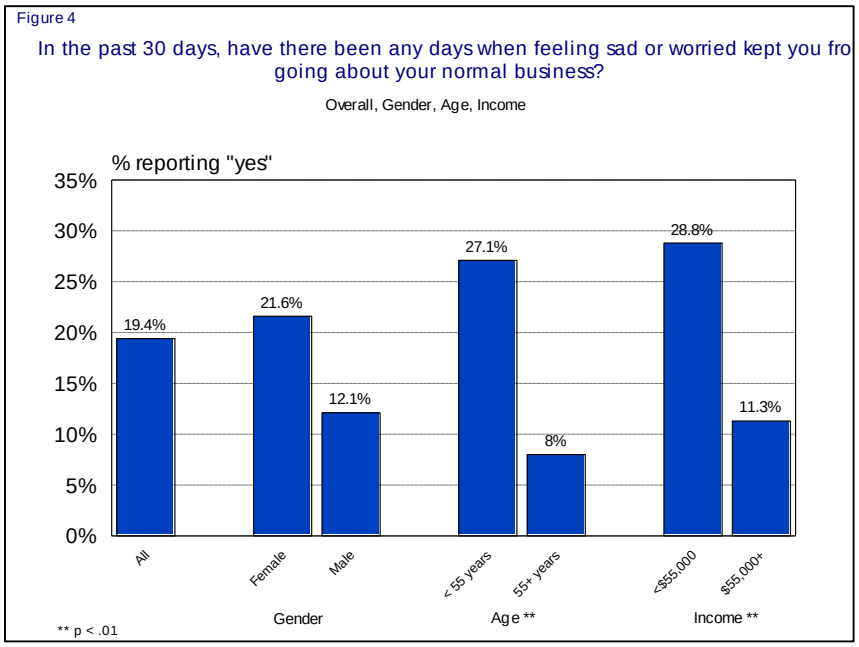
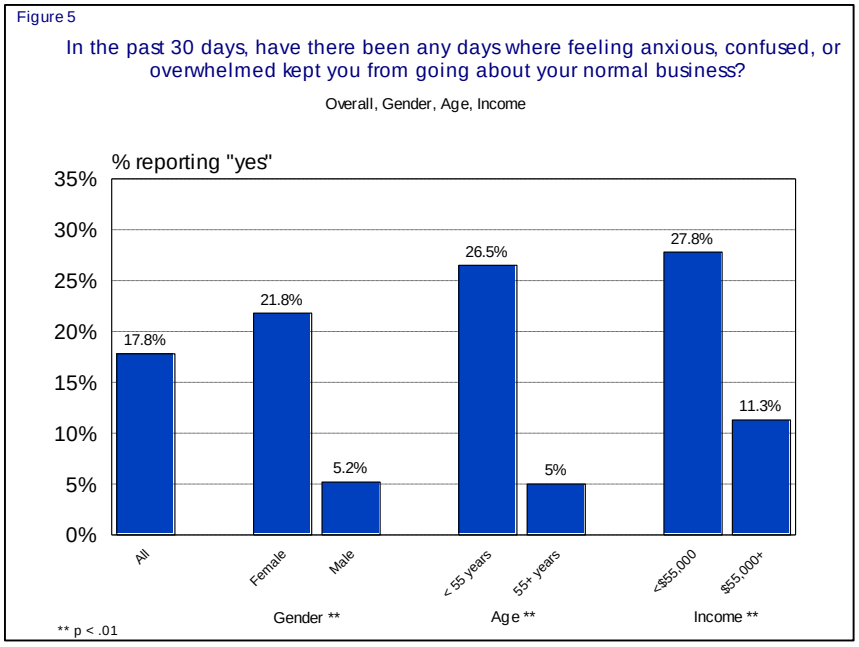
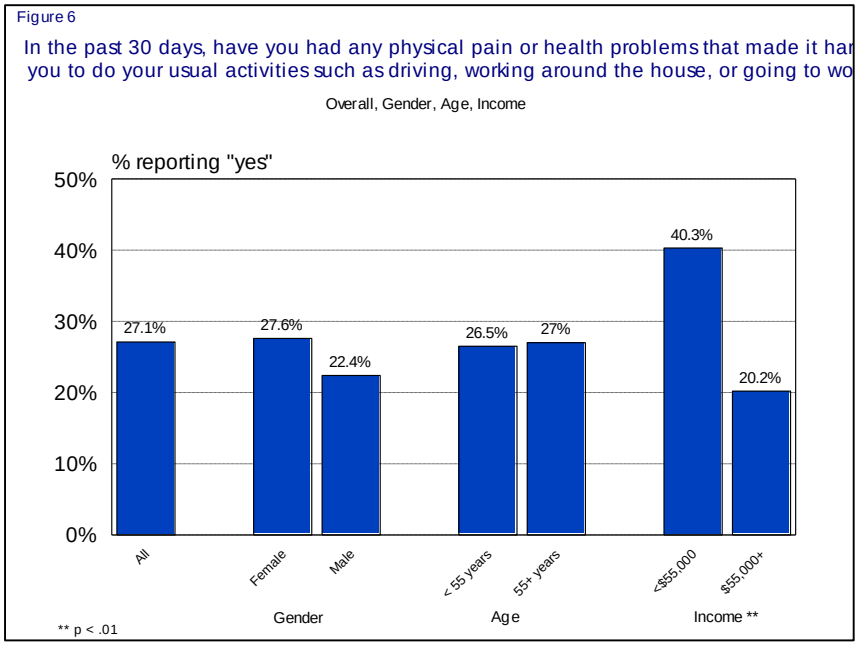


Figure 5





Physical Activity/Exercise

Respondents were asked whether or not during a normal week they engaged in physical activity or exercise for a least a half an hour at least once (not including what is performed during their regular job). Over 70% of respondents (n = 215) indicated that they did engage in such activities or exercise.

Two follow up questions were presented for those indicating that they did engage in activities or exercise. The first dealt with frequency and the second was related to the location. The majority (n = 122; 57.5%) reported that the frequency was between 1 to 3 times per week, while another quarter (n = 54; 25.5%) reported 4 to 5 time per week. The most frequent locations of these activities were at home; and in *parks/walking trails*.

Respondents who reported not engaging in activities or exercise at least once per week were addressed the question of why not. A list of 12 items were presented, and respondents were asked to select all that applied to their situation. The most cited reason given was not having enough time (n = 37; 40.7%) followed by being too tired to exercise (n = 33; 36.3%). Not liking to exercise was the third most frequently stated reason with 28.6% (n = 26) mentioning that as a reason. The other reason given that garnered over one-quarter of frequency was not having anyone to exercise with (n = 23; 25.3%).

<u>Physical Activity/Exercise x Feeling Sad/Worry</u>

Because of past studies that have shown a relationship between depressive symptoms and exercise, an analysis was conducted to study this relationship. The

variable used in this special study was whether or not a respondent engaged in physical activities/exercise at least one time per week, and whether during the past 30 days there had been any days of feeling sad or worried that kept him/her from going about normal business. Those respondents who reported not engaging in activities/exercise were over twice as likely (30.9%) to have reported being sad or worried at a level that kept them from conducting normal business (χ^2 (1, N = 235) = 7.77, p < .01) compared to respondents who did engage in such activities/exercise (15.0%).

Smoking Behaviors

The survey asked respondents if they currently use tobacco in any form, and if they do what type of tobacco product(s) they use. Of the 303 respondents, 10.9% reported using tobacco. Of those respondents who stated that they did use tobacco, 81.8% used cigarettes (n = 27) and 21.2% use e-cigarette (n = 7). Respondents with lower incomes (<$50,000) were significantly more likely to use tobacco (22.5%) than those with higher incomes (2.7%).

Accessing Health Care

Over four out of five respondents (81.6%) reported that they primarily go to the doctor's office when sick and requiring professional help. Urgent care center was a distant second in frequency response with 12% indicating that this is where they primarily go to seek professional health care related help. Only seven of the respondents (2.3%) stated that they go to the ER of a hospital as their primary source for help.

When asked about primary health insurance plans, only eleven respondents (3.6%) indicated that they did not have health insurance. Seventy-three percent (73%) reported having private health insurance, and 20.8% had either Medicare and/or Medicaid.

Primary health care provider x Primary insurance coverage

Respondents listing Medicaid as their primary health care insurance plan were more likely to use urgent care centers (17.9%) or hospital ERs (14.3%), and less likely to go to a doctor's office (60.7%) when compared with respondents who had other forms of insurance coverage. For those respondents reporting an annual income of less than $25,000, 63.3% (n = 19) stated that the doctor's office was their primary health care help compared to 84.7% (n = 182) for respondents with $25,000 or more in income.

Respondents were asked whether they had experienced any problems getting the health care they needed either for themselves or a family member during the past twelve months. Of the 299 who responded to this question, 59 (19.7%) stated that this had been true for them. Demographic groups that displayed a significant likelihood of having had problems access health care were households with less than $25,000 annual income ($\chi^2$ (1, N = 246) = 9.65, p < .01), households with children (χ^2 (1, N = 297) = 10.73, p < .01), and respondents who were between the ages of 18 and 54 years old (χ^2 (1, N = 297) = 6.35, p < .05).

The primary barrier to accessing health care when needed was due to problems with insurance with nearly half (49.2%) reporting either not having insurance to cover the needed service, deductible/co-pay being too high, or the provider did not take the insurance that the respondent had. Thirty-nine percent (39%) of respondents who indicated having a barrier to obtaining needed health care stated that a reason was due to the provider with the wait being too long, or just not being able to get an appointment. Other barriers included lack of transportation (6.8%) and not knowing where to go (5.1%).

Demographics

Table 6

Demographic Characteristics of Respondents (N = 334)

Characteristic	n	%	Characteristic	n	%
Age at time of survey (years)			Highest Level of Education		
18-19	1	0.3	Less than 9th Grade	5	1.6
20-24	7	2.3	9 - 12th Grade, no diploma	4	1.3
25-29	15	4.9	HS Grad. (or GED)	52	17.1
30-34	30	9.9	Some College (no degree)	34	11.2
35-39	31	10.2	Assoc. Degree or Voc. Trng.	37	12.2
40-44	33	10.9	Bachelor's Degree	61	20.1
45-49	24	7.9	Graduate or professional Degree	111	36.5
50-54	38	12.5	missing	30	n/a
55-59	48	15.8	Total Household Income (Annual)		
60-64	32	10.5	less than $10,000	14	5.6
65-69	20	6.6	$10,000 - $14,999	5	2
70-74	16	5.3	$15,000 - $24,999	12	4.8
75-79	6	2.0	$25,000 - $34,999	34	13.6
80-84	2	0.7	$35,000 - $49,999	39	15.6
85 or older	1	0.3	$50,000 - $74,999	53	21.2
Missing	30	n/a	$75,000 - $99,999	46	18.4
Gender			$100,000 or more	47	18.8
Male	75	25.0	Prefer not to answer or missing	84	n/a
Female	225	75.0	No. of individuals living in household		
Missing	34		1	30	10.0
Race			2	117	38.9
White (Caucasian)	298	98.0	3	52	17.3
Black or African American	1	0.3	4	63	20.9
American Indian/Alaska Native	1	0.3	5	25	8.3
Other	4	1.3	6	8	2.8
Missing	30	n/a	7+	6	2.0
Marital Status			missing	33	n/a
Never married / Single	31	10.2	Current Employment Status		
Married	228	75.2	Employed full-time	163	54.5
Unmarried partner	5	1.7	Employed part-time	55	18.4
Divorced	26	8.6	Self-employed	10	3.3
Widowed	10	3.3	Retired	32	10.7
Separated	3	1.0	Unemployed (looking for work)	10	3.3
Missing	31	n/a	Unemployed (not looking for work)	5	1.7
			Disabled, not able to work	9	3.0
			Student	2	0.7
			Homemaker	13	4.3
			Prefer not to answer or missing	35	n/a

Discussion

Sampling

Non-probability sampling, or more specifically, convenience sampling was used to gather data for this analysis. This type of sampling technique does not allow findings to be generalized to the greater population. Generalizability requires a random sample where all adults residing in the county having an equal opportunity in being selected for participation, and further for that chance to be quantifiable. As such, all findings of this study are descriptive and relate only to those who knew about the survey and voluntarily contributed their perceptions regarding the health of the community. Margin of error cannot be calculated.

The demographic make-up of the sample as compared to the population of the county does provide some conclusions regarding the representation of certain demographic groups. Sample participants had more education when compared to the population with over one-third have a graduate or professional degree. They also had a greater likelihood of being married and earning slightly higher incomes when compared to the population. The sample included a much higher proportion of females when compared to the population; however, age seemed to have been dispersed in a manner similar to the county's population. Although Ashland County is a homogenous population regarding race, the survey participants had even a greater degree of homogeneity, with nearly all (98%) reporting being White (Caucasian).

Health Status of the Ashland Community

There is a general feeling of contentment related to broad issues concerning livability. This includes a community where informal support systems are accessible when needed, and where the issue of pollution is not perceived as a major concern. There is also a consistent message being delivered by the survey participants that living in the community is good for families with children, and for adults growing older.

The area of greatest concern is related to those issues associated with the economy. Economic opportunity is viewed as limited, with a great level of discontentment among those individuals earning less than $50,000. This translated into a concern that poverty and low income is a problem area that must be addressed to enhance the overall health status of the community.

Substance abuse is also a major concern as is child abuse and domestic violence. Violence crime, however, is only of a moderate concern relative to other potential problem areas. This is consistent with the overall view that the Ashland community is a safe place to live.

Health care is perceived as being available to community members; however, affordability and quality are issues of concern. Affordability seems to be linked to issues regarding insurance either not being available or if available, having extremely high deductibles.

There was a consensus that despite having access to public facilities to enhance personal health, community members have developed habits that run counter to producing good health. Poor eating habits, lack of exercise, being overweight, and using tobacco are seen as behaviors that negatively contribute to the community's overall health status.

As discussed in the results section, females perceived a greater level of health concerns than males. This was especially valid for areas regarding children's health, child care options, services for those with disabilities, and the quality of housing. Although this survey did not have items related to respondents' role responsibilities, females tend to have more role obligations related to the caring for others. As such, this may have contributed to the greater levels of concern regarding issues related to this.

Finally, with the racial make-up of the respondents being nearly exclusively White (Caucasian), it was not surprising to observe issues of racism and discrimination receiving feedback indicating little concern regarding their impact within the community. However, those respondents reporting the least amount of annual income reported issues of racism and discrimination as being of a much greater concern than those having more income.

Health Status of Community Members

Reflecting the ever-increasing access to medical information through means not available until just recently, one-quarter of respondents stated that their primary means of obtaining medical information is through the internet. While doctors or physician assistants are the major source of information for a majority of respondents; there is a clear indication that other sources are being sought out. Further, age does not appear to be much of a factor in access medical information primarily through the use of the internet.

Much of the informational need expressed by parents with young children are factors related to resource acquisition (i.e. child care and recreational activities) and obtaining social/emotional support. Except for issues related to dealing with difficult child behavior, respondents tended not to choose items related to knowledge of child development or childhood needs. In other words, respondents felt they had the knowledge necessary to raise their children; however, they wanted information on resources to deliver those needs to their children.

For parents with older children, issues concerning peer pressure and bullying were topics that they wanted their children to know more about. Specific items related to risky behaviors such as alcohol use, drug abuse, reckless driving, etc. did not receive as high of a response as issues related to their children succumbing to peer pressure. This might be due to a belief that their children would avoid a lot of risky behaviors if they knew how to deal effectively with peer pressure.

Reflecting the concern expressed earlier that poor eating habits, lack of exercise, and being overweight were major factors impacting on the community; over 40% of

respondents indicated conditions related to these factors. With over four out of ten respondents indicating being told by a health care professional that they were overweight, had high blood pressure and/or had high cholesterol, there was a recognition that choices being made in one's lifestyle was not only impacting themselves but also the community.

Nearly one out of every three respondents stated that they had been told by a professional that they were depressed or experiencing anxiety. Combine this with results showing nearly one out five adults being impacted on carrying out their roles in life due to sad, worried, overwhelmed, etc.; the issue of mental health issues rises to the top of conditions needing to be addressed. Although no demographic characteristic were excluded from this condition, females, those with low income, and younger individuals were more likely to have reported these mental health conditions. In fact, females who were younger than 55 years old were the most likely respondents indicating having been directly impacted by symptoms related to depression or anxiety. These respondents, however, reported a need for more support groups in the community rather than increases in professional mental health services. The view may be that their experiences are not diagnosable requiring professional help but are conditions that can be addressed by enhancing connections with others facing similar challenges.

Despite the large proportion of respondents indicating bad habits leading to poor health conditions, over seven out of ten stated that they were engaged in activities or exercise at least one a week. But out of these respondents, less than half engaged in these activities or exercise more than three times per week. Most of the reasons given for not engaging in exercise was due to personal issues such as time availability, not liking to exercise, or feeling tired; rather than issues related to structural conditions of the community. The link between the lack of activity and reported conditions of depression and anxiety symptoms are clearly linked. Although a causal connection cannot be established in this study, evidence presented in other studies clearly show that enhancing activity levels as a positive effects in the reduction of symptoms related to depression and anxiety.

Just 11% of respondents indicated that they used tobacco products which is significantly lower than what has been observed in the U.S. (CDC, 2014) with nearly 18% using tobacco. This may be due to this study having a greater proportion of college educated respondents compared to the general population in Ashland. Prior studies have shown that individuals with less education are more likely to use tobacco products.

Respondents typically went to a doctor's office to receive most of their medical treatment, with very few using the ER as their primary source of treatment. This may be due in part to the large proportion of respondents stating that they had some form of health insurance. The fact that only 3.6% stated that they did not have health insurance may have been impacted again, on the level of education and employment status. A more generalizable study would probably reflect a higher proportion of community

members without insurance, and a greater proportion struggling to access health care services.

Even among respondents with health care insurance, there were reported problems in accessing needed health care due to factors related to their specific insurance policy such as deductibles or having conditions not covered by their insurance. Individuals with Medicaid reflected a reduced likelihood of going to a doctor for medical treatment opting more for either urgent care centers or hospital ERs. The reason for this is beyond the scope of this study; however, it may be due in part to finding a physician who takes Medicaid. Other barriers to accessing health care are related to the length of time it takes to see a health care professional, or just not being able to get an appointment. Those reporting having Medicare indicated the least amount of barriers for at least accessing health care, although many had concerns with the quality level of the health care services being rendered.

Focus Group Summary

Ashland County Health Needs Assessment – 2015

Group Description and Data Collection

A series of focus groups were convened to discuss with participants their perceptions and insights regarding the general health of the community. The groups were not designed to be solution-focused discussions; however, several participants offered their ideas regarding possible resolutions to the challenges they perceived needs to be addressed by County. Three of these groups met in March of 2015, facilitated by a social work intern at the Mental Health and Recovery Board of Ashland County. The other three groups met in May of 2015, facilitated by a registered nurse who is employed by the Ashland Health Department. Although attempts were made by facilitators to obtain audio recordings of discussions; either the device used malfunction, and no recording was available, or the group declined the option of having their comments recorded except for a note taker writing down comments. As a result, summaries provided through note taking of each group is the sole source of information this report is based on. There are also no quotations that can be used to highlight elements expressed in the summary. Nonetheless, the six summations provided seems to offer a good oversight in the perspectives of the participants.

Focus groups conducted by the Ashland Health Department had participants within each group from similar experiences. One group consisted of individuals working in either the school or business community. Senior citizens attended a second group, and a third group consisted of veterans of military service. The remaining three focus groups consisted of members of the Ashland Ministerial Association, attendees of the Strength in Numbers Support Group, and members of the ACCESS board.

Results

A general theme emerged from group discussions regarding positive elements found in the Ashland community. This theme was of a sense of cohesiveness and togetherness that results in the community not being nearly as isolated as is seen or felt in other communities. This closeness is expressed by the community having a lot of caring individuals who give their time,

effort and money through volunteerism. Compared to other communities, Ashland has a low crime rate and is overall a safe place to live. As a result, participants feel that Ashland is a great place to raise children as well as a good place to retire.

Positive perceptions were rendered by contributors related to the various institutions and organizations found in the community. Specifically, the community is seen as having a solid faith-based foundation supported by a great number of good churches from diverse denominations. The presence of the KROC center was viewed as a positive addition to the community, and the presence of a private University adds in the appeal of working and living in Ashland.

Economic conditions seem to have been the area of greatest concern, and there was remarkable consistency among the groups regarding the specific nature of this concern. While recognizing the improvement in the availability of jobs in the community within the past five years, concern was expressed that jobs in Ashland County are often low paying and do not offer a livable wage. This has resulted in families making hard choices often to the detriment of its members. These "choices" include not being able to attend to the needs of a sick child due to fear that if a parent misses even one day of work it would result in being fired from his or her job, relying on undependable child care arrangements (especially if working irregular hours), or working multiple jobs resulting in children in the care for most of the day by a non-parent.

There was an agreement regarding the health care delivery system found in the community. The area receiving the most concern was related to the number of doctors retiring in the community and not being replaced. This has resulted in long wait times getting in to see a doctor, and as a result many choosing to use the most expensive option, a visit to the ER of a hospital to obtain health care services. Consternation was also expressed in the number health care specialist who leave the community to maintain their practices. Dental care was a specific type of health care pointed out as being either not available or too expensive (due typically to problems with insurance coverage). Also, parents usually have little in the way of options but to miss work to take their child to a dentist because few if any have office hours after work.

A lack of coordination among social service agencies rather than a lack of such services was expressed by several group participants. Overlapping services were seen as an inefficient use of budgeted monies already in short supply. Also, among one group, there was agreement that if

a community member was not use to having to access social services, it would take a long time and considerable effort to navigate the system. Food banks were seen as responding to the needs of more individuals and families than ever before. This has resulted in long lines, often outside, presenting a barrier to obtaining help for individuals who cannot, for physical reasons, stand in line for lengthy periods of time.

Drug abuse as a social problem compromising the well-being of the county was the most prevalent problem expressed by participants. Perhaps due to the recent workshop/forum on the heroin epidemic, most participants viewed drug abuse as a condition leading to other problems seen in the community. If drug abuse could be addressed in an effective manner, other problems like homelessness, poverty, and property crimes would also be reduced.

Housing was seen as being in short supply for people with bad credit or individuals with increased physical limitations. Long wait lists are typical of assisted living arrangements, and those without financial means often have to choose between staying at home in an unsafe environment or going to a nursing home. The presence of ACCESS was seen as a positive. However, the shelter is viewed as not being able to meet the needs many individuals who find themselves homeless.

Improving public accommodations and creating a more robust transportation system would go a long way in the view of many participants to cultivating the quality of life in the community. Public accommodations included the building of playgrounds accessible to those with disabilities, and adding benches and other sitting areas in the downtown area. Enhancing public transportation included extending hours of operation to cater to the needs of those who work evening hours. One participant noted that she had observed individuals not being able to take a job offered to them due to a lack of transportation.

Other areas brought out by some of the groups included the problem with financially stressed schools in a time when education is more important than ever before. The foster care system within children's protective services was viewed as being a budgetary problem for the county. The problem presented by one individual was the number of children in custody, and the lack of county funds to meet their needs in the foster care system.

Finally, one group stressed a concern with the lack of intact families, described as a family unit with both a mother and father in it. This group agreed that many problems would go away if a dad was present in the family. This same group also expressed concern that people were getting use to not working and relying upon public assistance to meet their needs. So while it was recognized that there was an economical need for higher wages and a more robust local economy, much fault was found within the character of individuals in need of assistance.

Summation

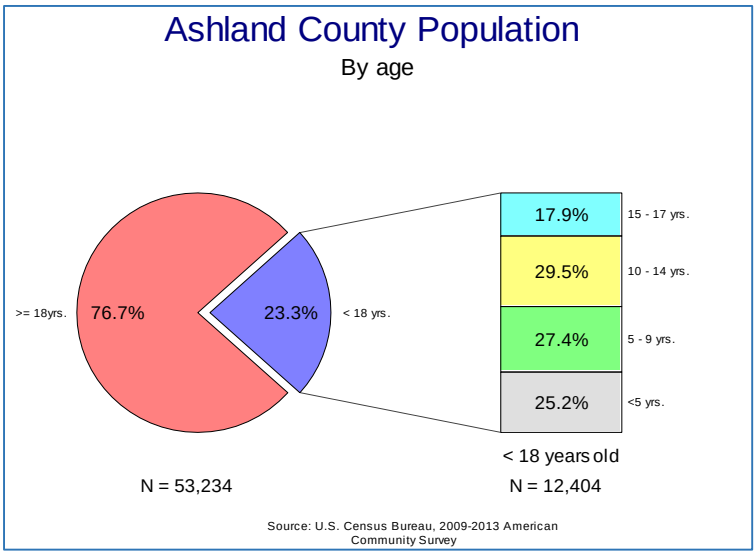
While it is not possible to render a prototypical response from these focus groups due to the diversity of observations and opinions, four themes emerged from the discussion. First, economic conditions due to low wages persist in the community and affects the well-being of all community members either directly or indirectly. Second, drug abuse is a social problem that must be addressed, however, the idea that it can be addressed through incarceration is faulty. More treatment options are needed. Third, health care needs are present due to a lack of access to local primary as well as specialized physicians. Finally, the Ashland community with all of its challenges is a great place to live for citizens regardless of age.

Ashland County, Ohio

Secondary Data Analysis on the Condition of Families and Children

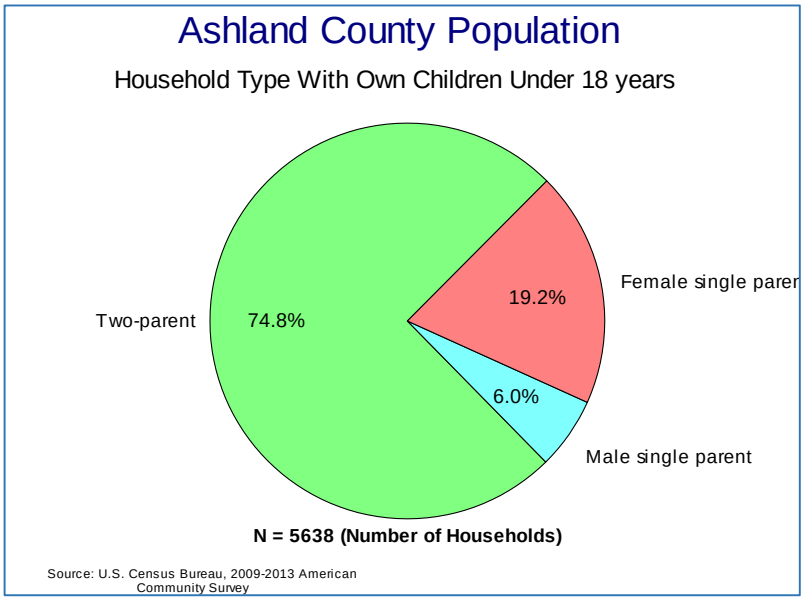
2015

Demographic Information

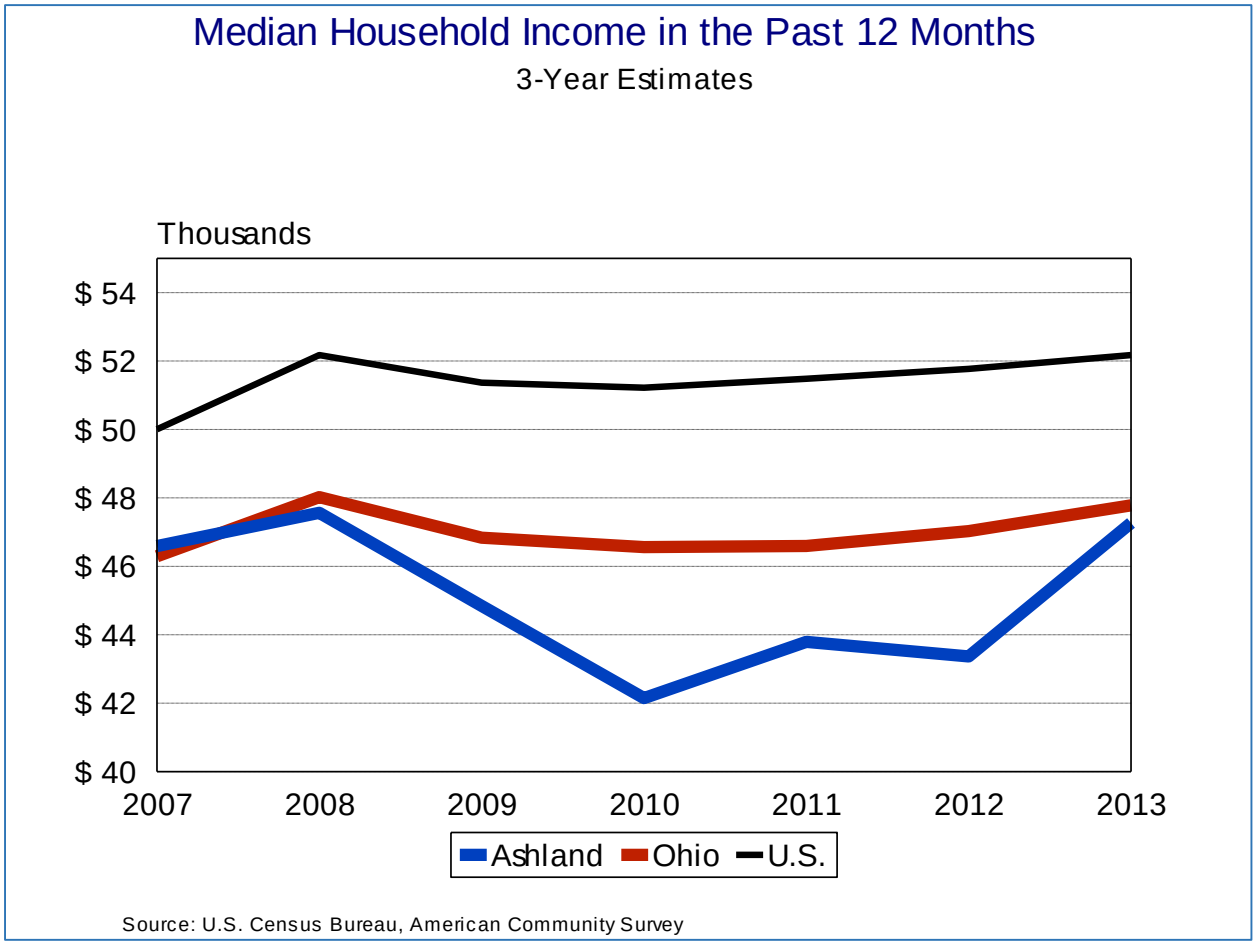


Nearly one-quarter of individuals residing in Ashland County, Ohio are children under the age of 18 years old who reside in 5,638 households. One-quarter of these children are under the age of five. One-quarter of households with at least one child are single parent families. Three-quarters of these single parent families are headed by a female.

The general trend seen over the past two decades is a reduction in the proportion of the population that are children, and an increase in the proportion of children living in single-parent households.



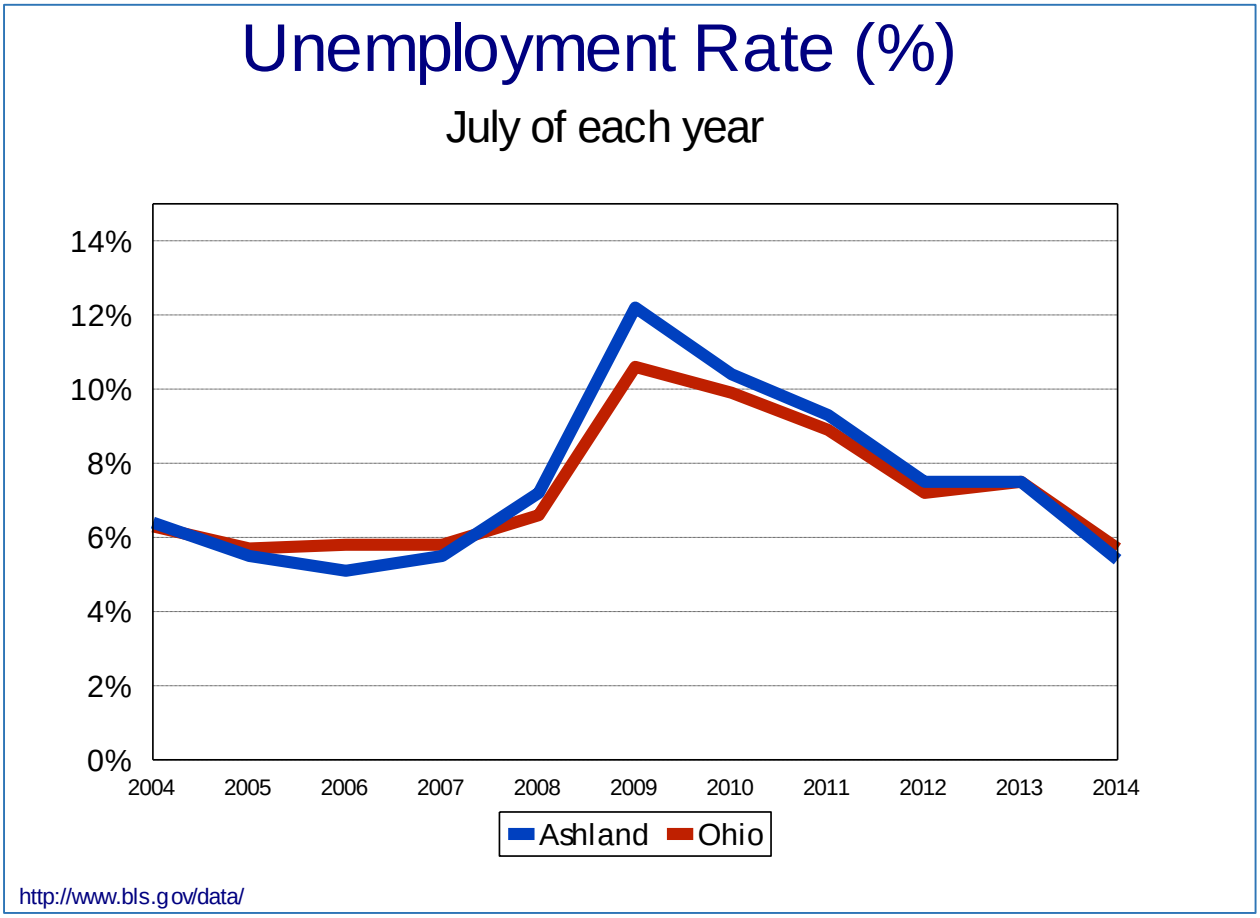
Median Household Income



The recession that began in 2008 had a severe effect on median income that resulted in a reduction of $5,000 between 2008 and 2010. It has taken three years to recover partially from this reduction in median income. Over a seven-year period beginning in 2007, the trend has been flat.

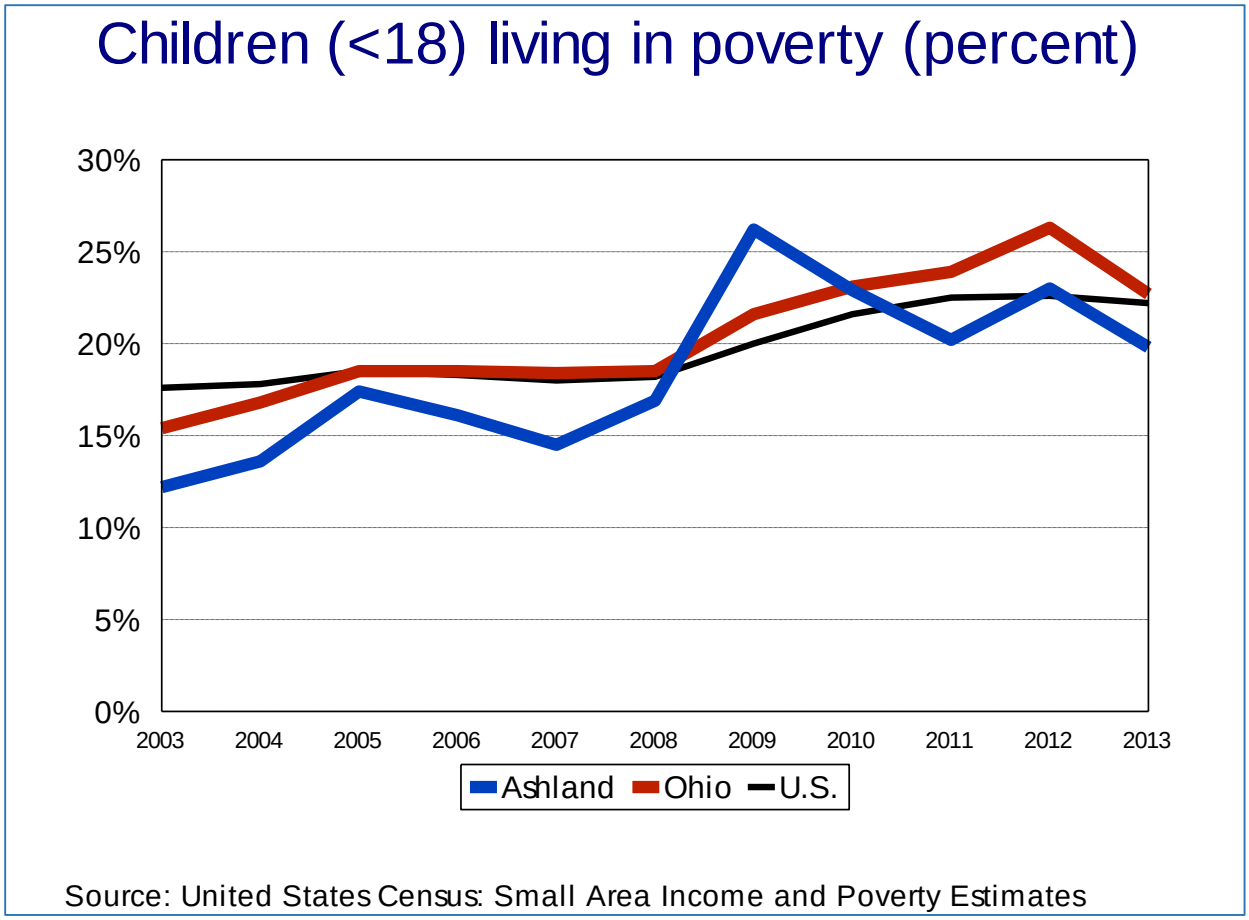
Ashland County trend is similar to that observed in Ohio and the United States. The significant increase in Ashland between 2012 and 2013 resulted in the median income being nearly the same as Ohio's median income, after having been significantly lower than the state. This has not been observed since 2008.

Unemployment Rate



Since spiking in 2009, the unemployment rate in the County has been cut in half over a six-year period. The rate in the County is currently the rate seen ten years ago when it was at 6%. The trend in Ashland has been identical to trends observed in Ohio. Measurements are taken in July of each year and controls for the effect of seasonal employment.

Children Living in Poverty

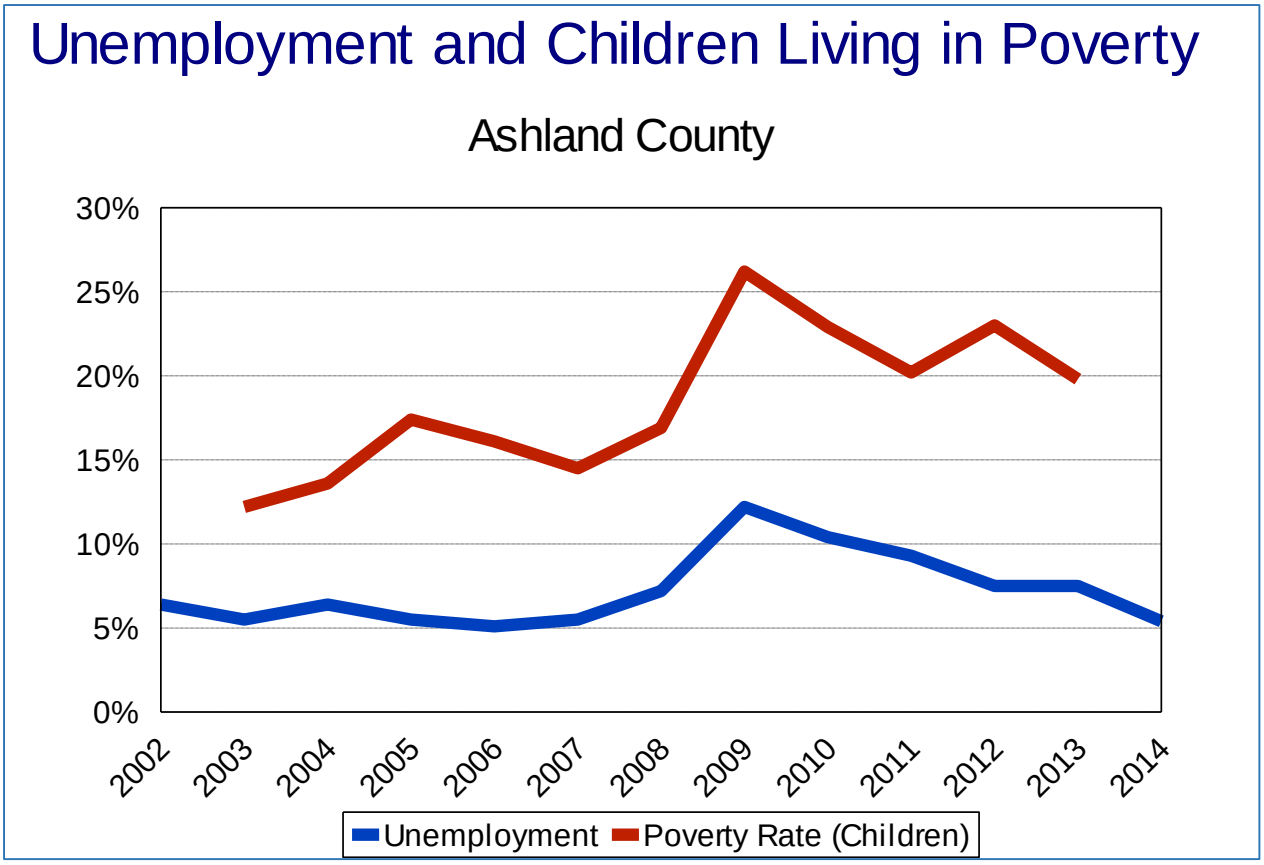


Source: United States Census: Small Area Income and Poverty Estimates

In 2009 one out of every four children living in Ashland County were living in poverty. Four years later a steady improvement has resulted in one of every five children living in poverty. Despite this reduction, the proportion of children living in poverty is still well above what the proportion was in 2003 when less than 13% were living in such conditions.

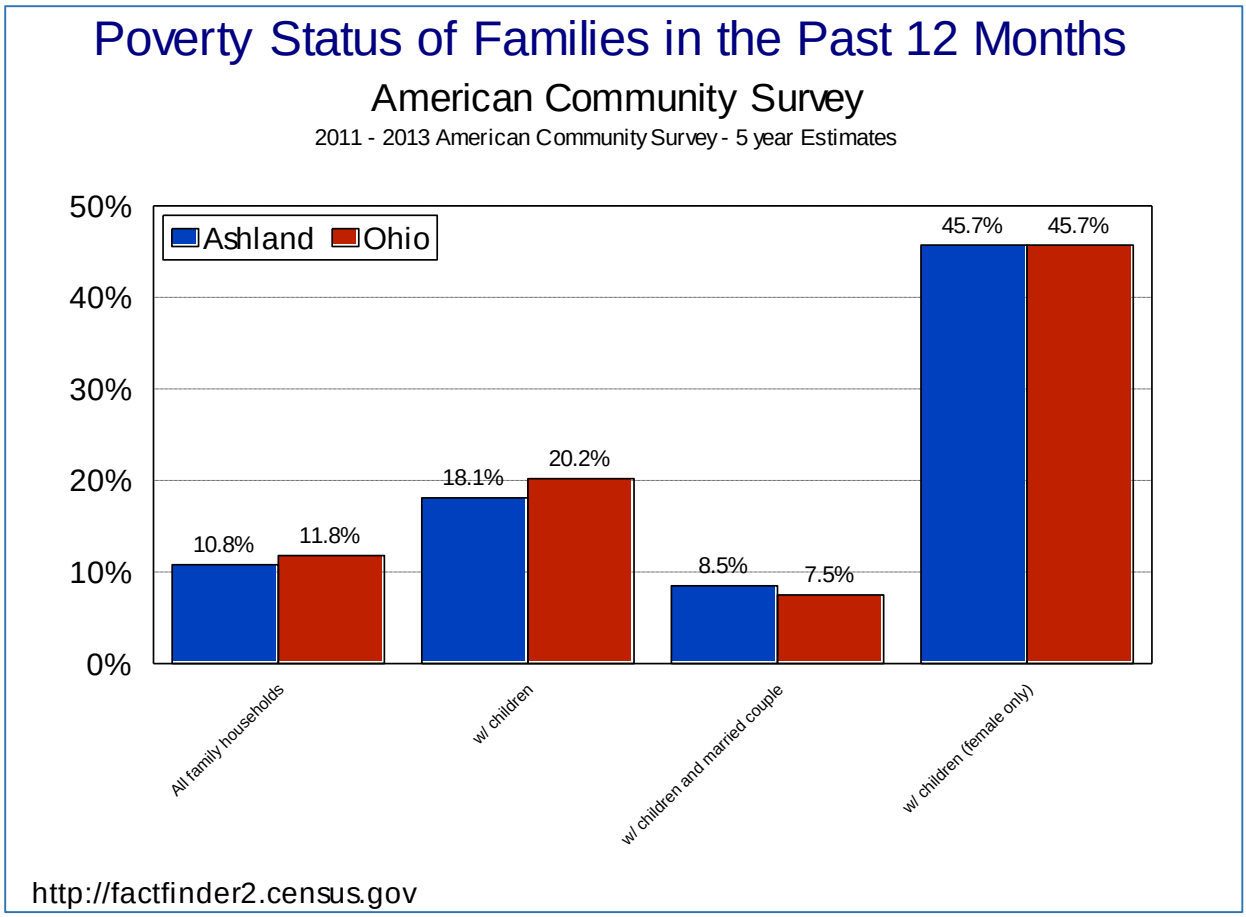
The trend observed is similar to trends observed across the country and in Ohio. The nearly 20% in Ashland County is slightly below the proportion in Ohio and the U.S. which in 2013 was approximately 23%.

Unemployment Levels and Children Living in Poverty



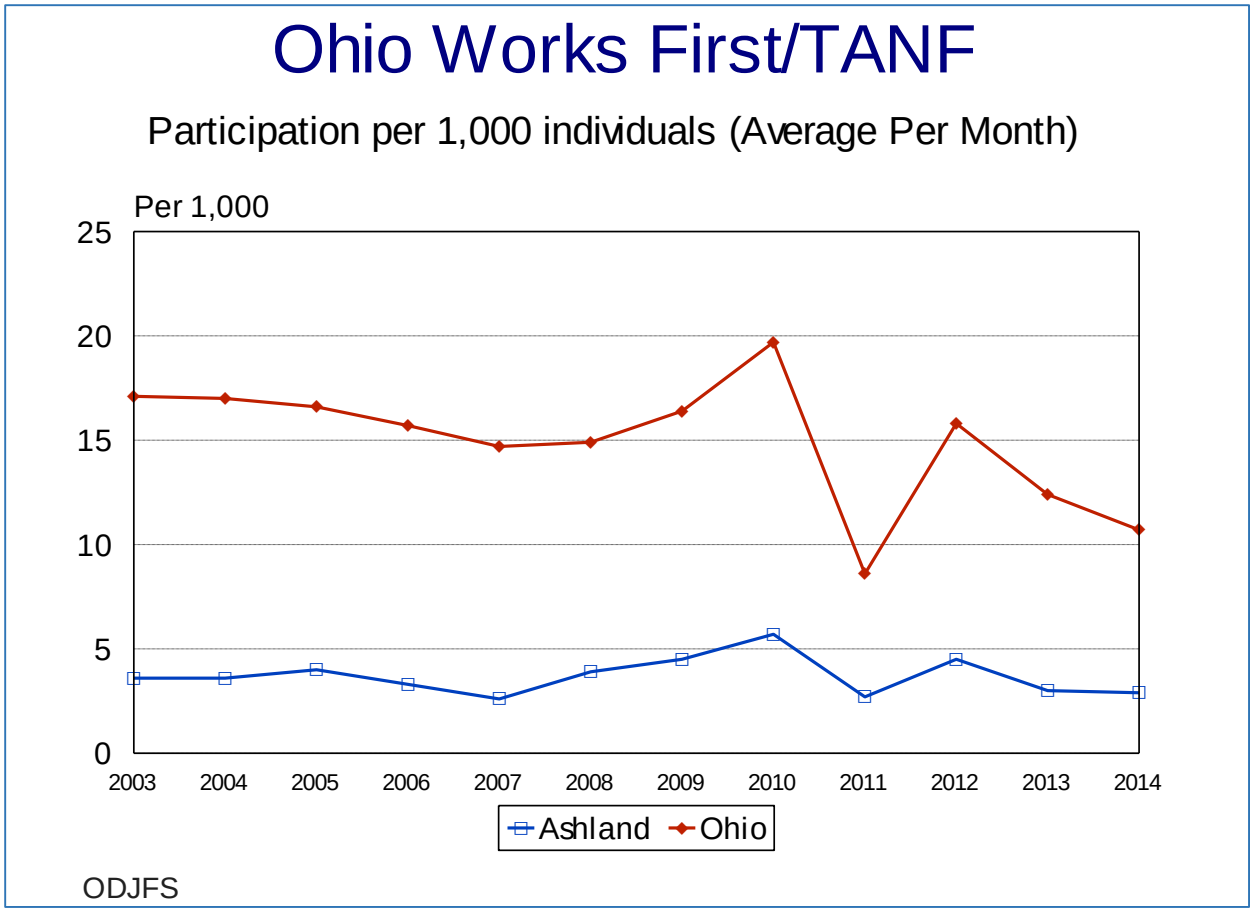
There is a strong correlation between unemployment levels in the County and the poverty rates of children residing in the County. However, based on historical data, the proportion of children living in poverty is significantly higher than what would be expected given the unemployment rate. For example in 2004 when the unemployment rate hovered around 6% the children's poverty level was 14%. In 2013 with a similar unemployment rate was nearly 20%. This suggests that although a greater proportion of people are employed, for many, the wages are not sufficient in keeping their household out of poverty.

Poverty Status of Families (By Type of Household)



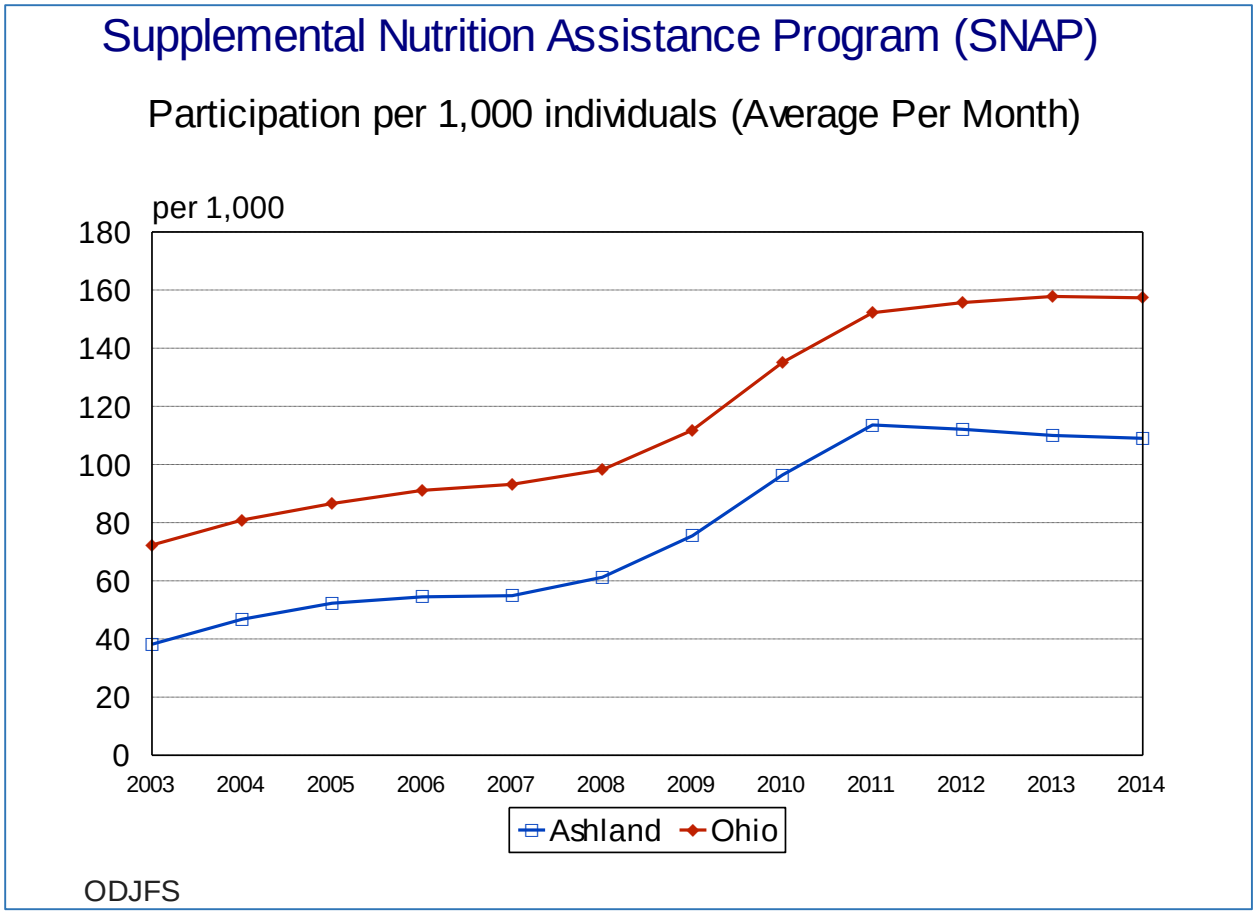
The presence of children in families with a single parent significantly increases the chances of those families being in poverty. Two parent households had a poverty rate of 8.5% whereas those headed by a single female parent had a poverty rate of 45.7%. Similar figures are presented for the State of Ohio.

Participation Rate in Ohio Work First (TANF) Program



Ohio Works First (OWF) is the financial assistance portion of the state's Temporary Assistance to Needy Families program, which provides cash benefits to needy families for up to 36 months. Despite the high poverty rate of children living in poverty, the participation rate in OWF in Ashland County is extremely low. Four out of 1,000 individuals participate in the program that is far lower than what is observed in Ohio where the figure is closer to eleven out of 1,000. The trend in Ashland is similar when compared to Ohio's trend in the participation rate.

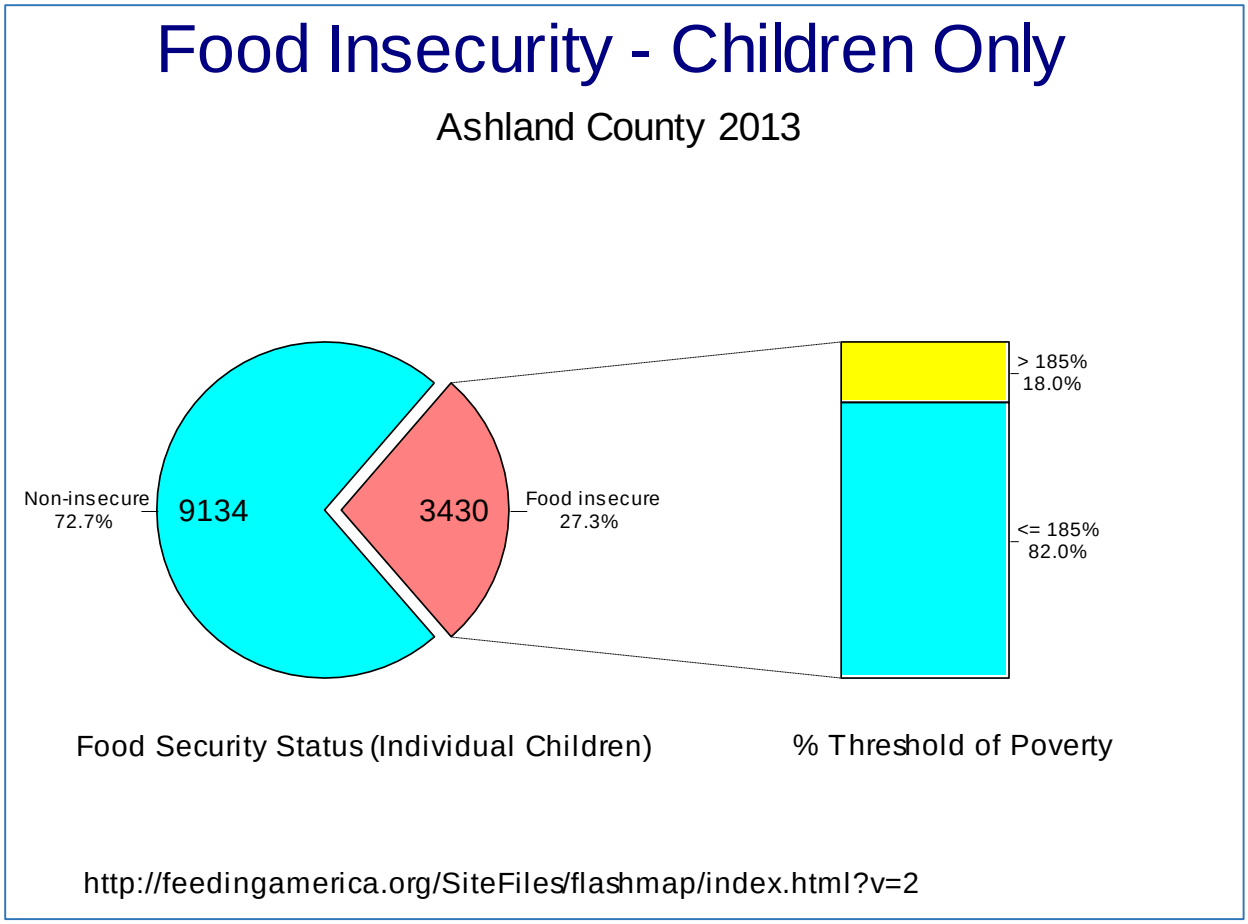
Supplemental Nutrition Assistance Program Participation Rate



The Supplemental Nutrition Assistance Program (SNAP) is designed to raise nutritional levels, to expand buying power, and to safeguard the health and well-being of individuals in low-income households in Ohio. Unlike Ohio Works First (OWF) program there is no requirement for a child to reside in the household; therefore, the figures shown include households with and without children.

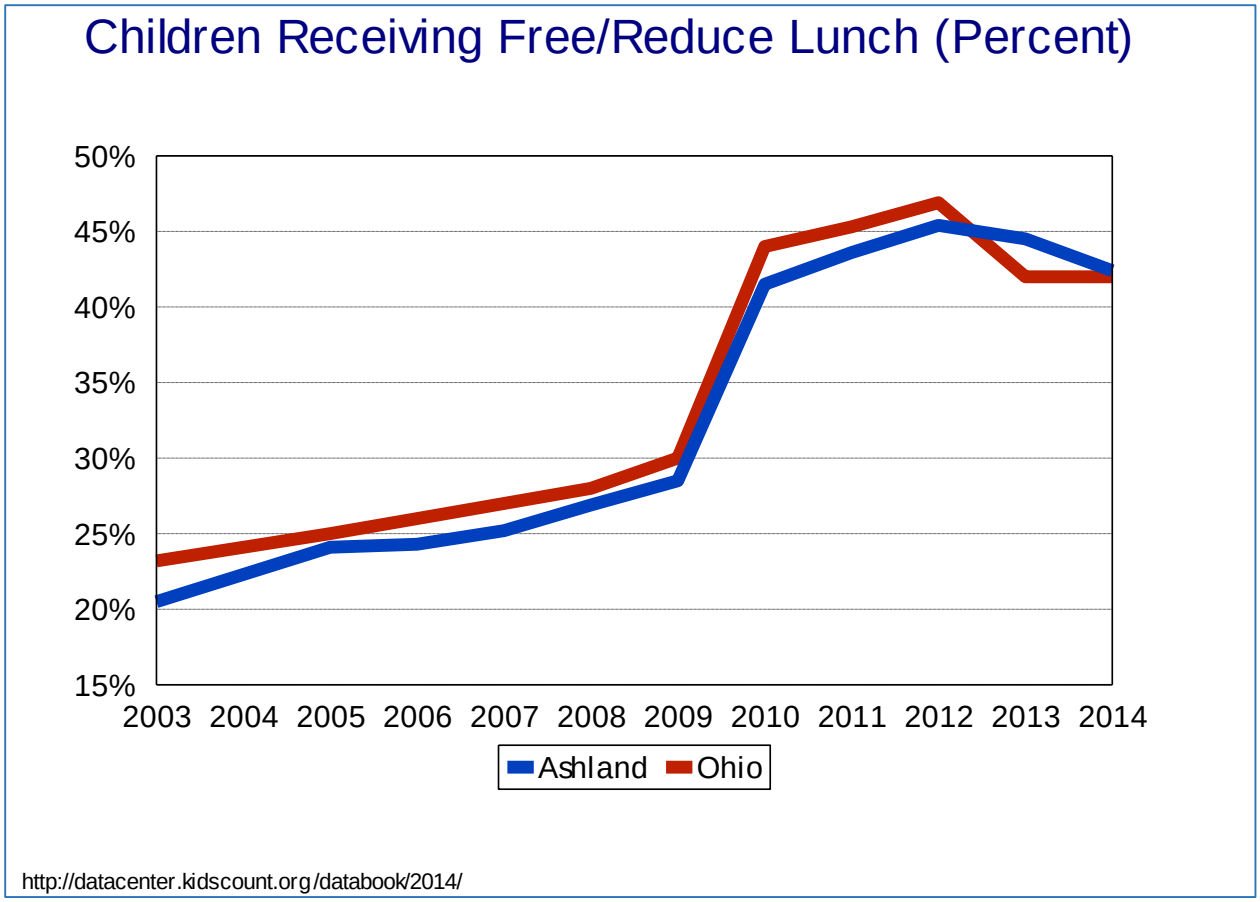
The trend in participation correlates much closer to poverty rates than OWF and also correlates closely with Ohio's trend. In Ashland in 2014, approximately 110 out of 1,000 individuals participates in this food assistance program that is lower than Ohio's participation rate of nearly 160 out of 1,000.

Food Insecurity Experienced by Children



Food insecurity is a term that means a household-level economic and social condition that results in limited or uncertain access to adequate food. The United States Department of Agriculture (USDA) measures and monitors this condition utilizing a household survey. In 2013, Ashland County's children had a one in four chance of living in a household where this condition was present. Of the 3,430 children living in these conditions, 18% live in households with nearly twice the income above the poverty line yet still cannot establish guaranteed access to adequate food for their children.

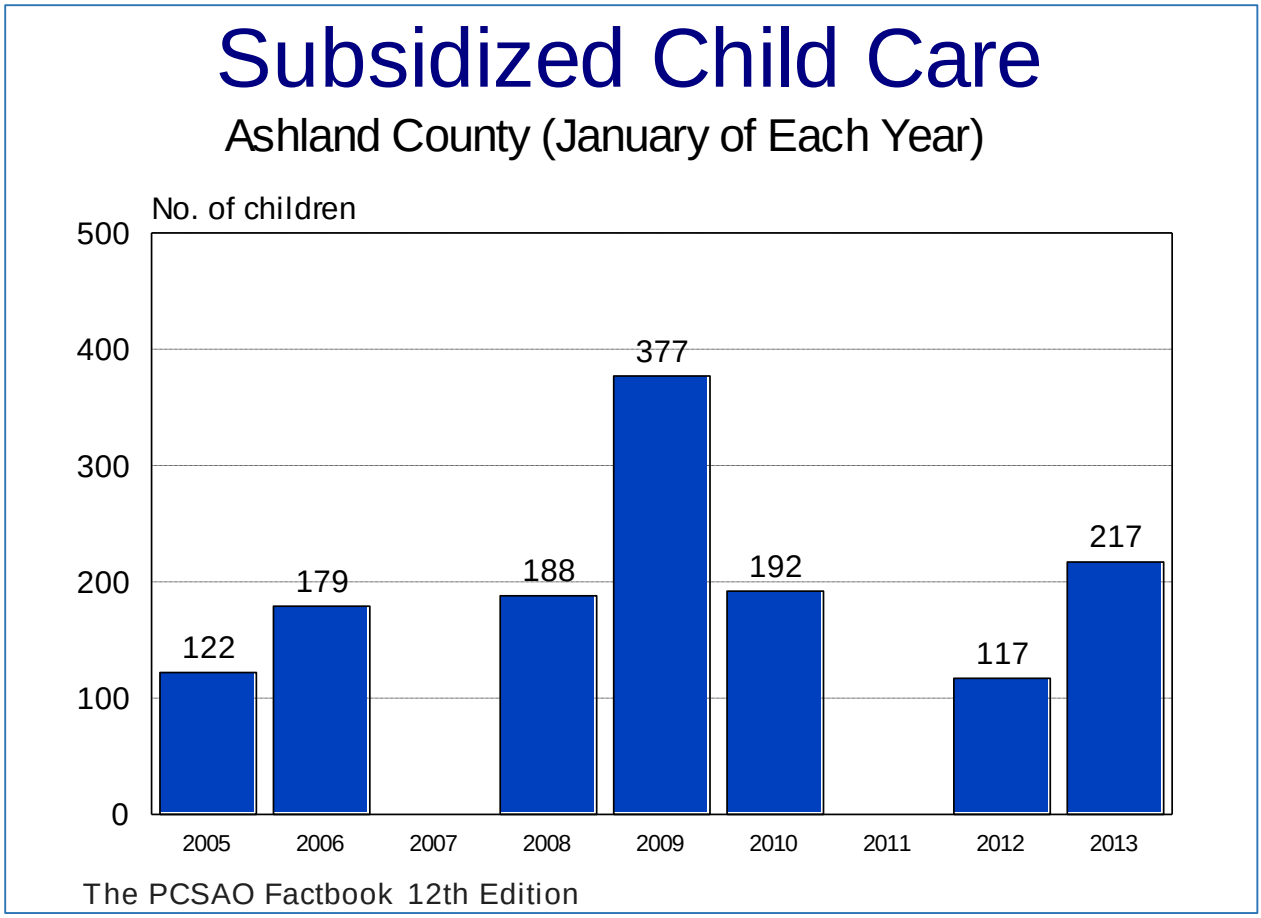
Children Receiving Free or Reduced Price Lunches



http://datacenter.kidscount.org/databook/2014/

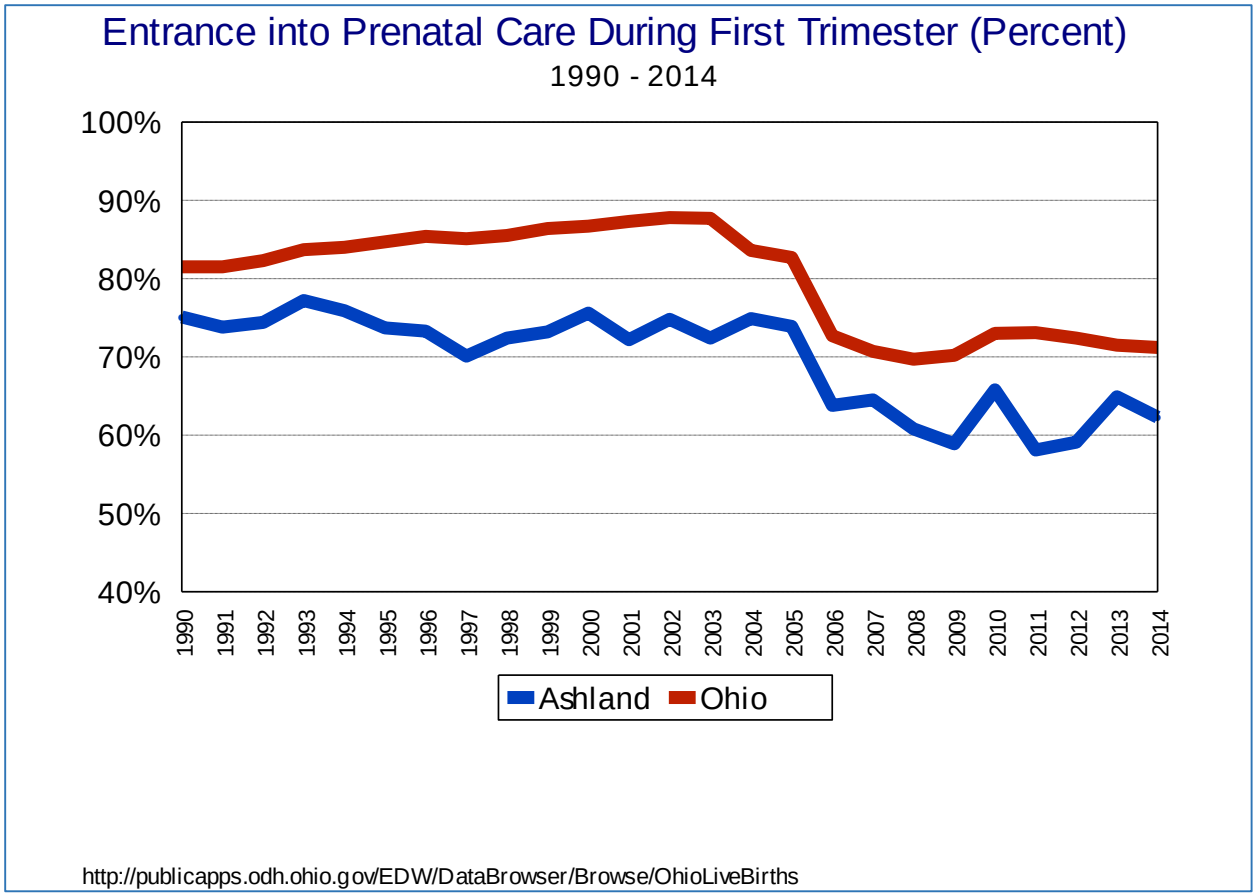
Between 2009 and 2010 there was an increase of 13% of children receiving free or reduced lunches at school. This proportion continues to increase for the next two years when in 2012 over 45% were receiving this subsidy. A slight decline has taken place since 2012, with 42% obtaining this assistance. This is nearly identical to Ohio's current rate. Trends seen in Ashland are nearly identical to Ohio trends, and levels have been very close to one another of the past 11 years.

Subsidized Child Care



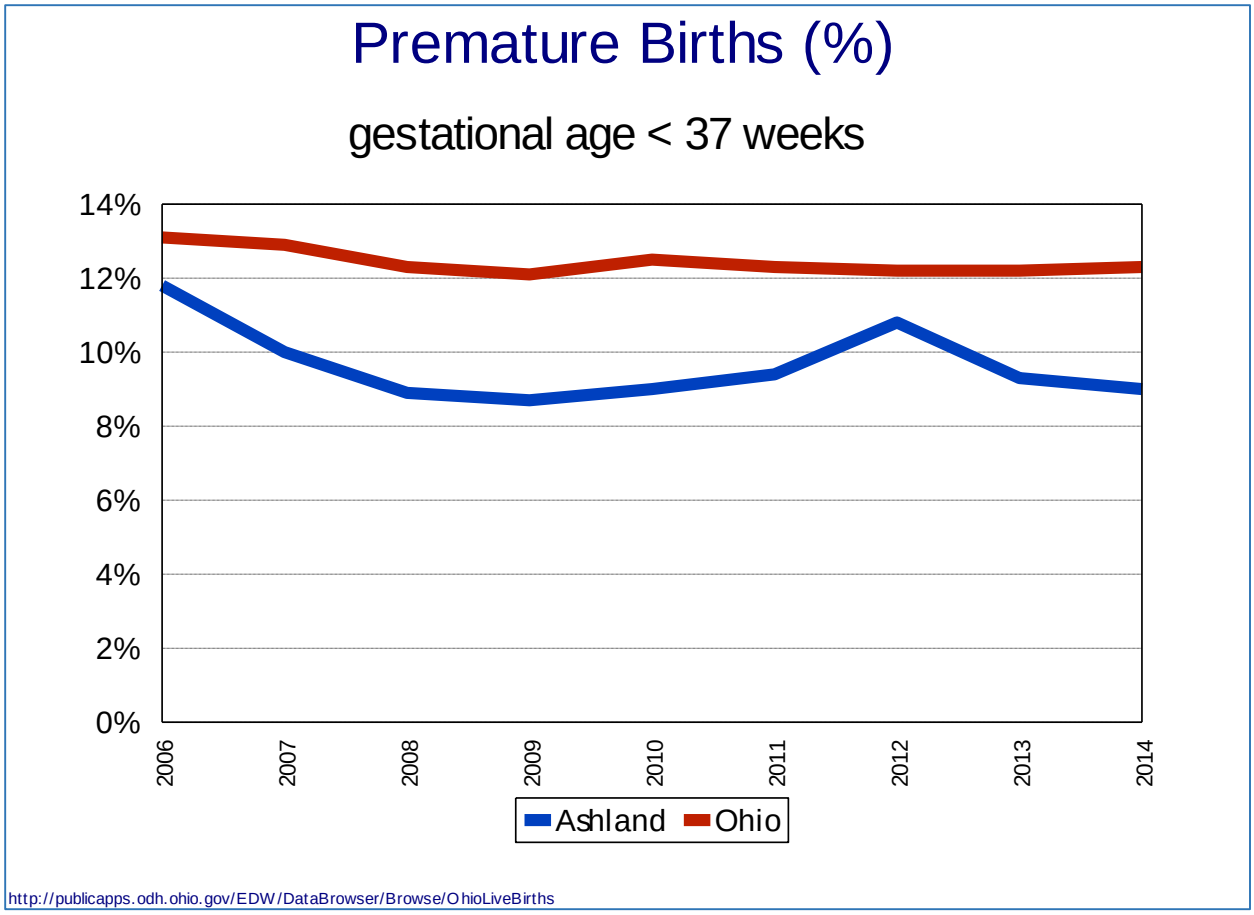
The number of children receiving subsidized child care has shown much fluctuation between the years of 2005 and 2013. Between 2012 and 2013 there was an increase of 100 children receiving this type of assistance with a total of 217 obtaining it. This was the second highest total seen since 2005. Caution, however, needs to be taken when interpreting his statistical report due to changes in eligibility standards. In other words, the fluctuation may be due, at least in part, to broader or more restrictive eligibility standards for the assistance.

Entrance Into Prenatal Care During First Trimester



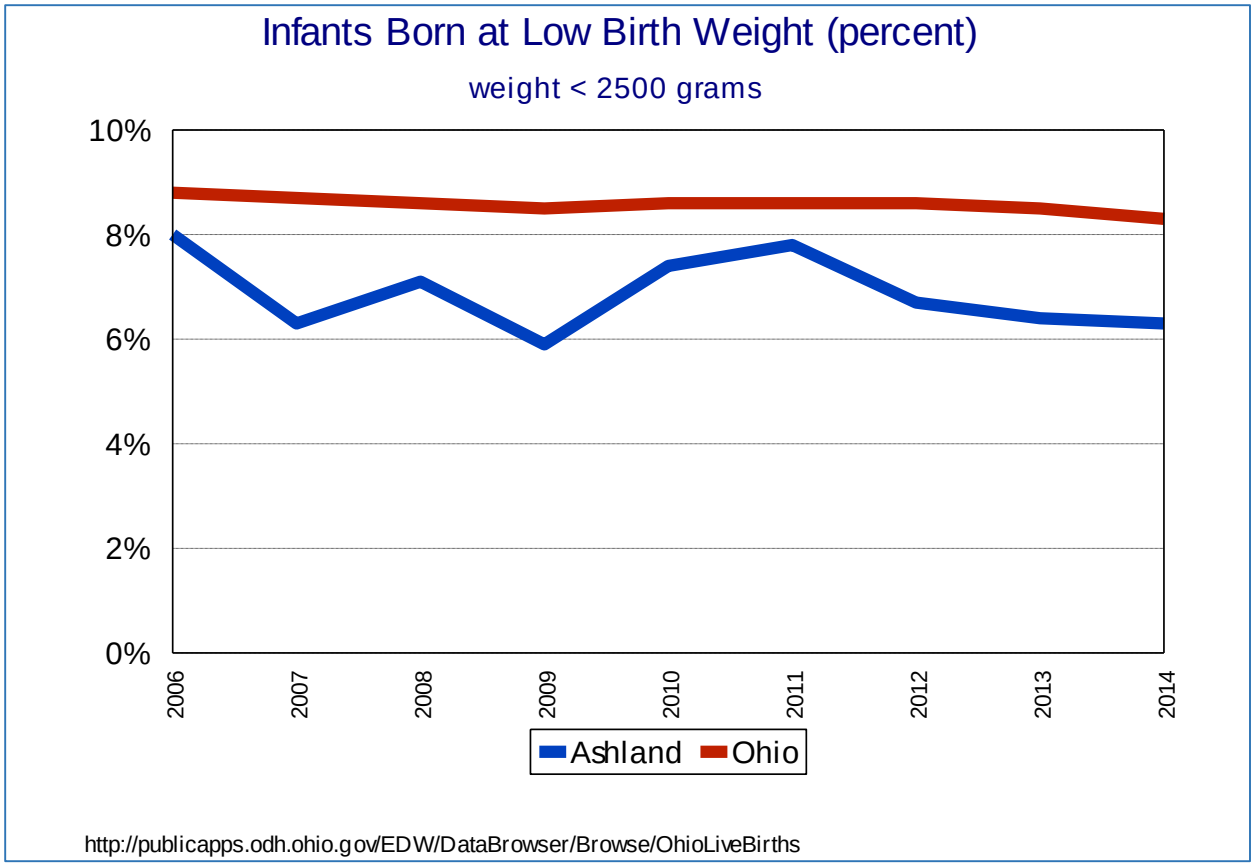
Beginning in 2006, the proportion of women obtaining prenatal care during the first trimester of pregnancy decreased well below 70% that had been the level prior to that time. In 2014, 62.3% had this type of care during their first three months of pregnancy. The level in Ashland has always been below the levels seen in the state; however, the trend over the past 25 years is similar. This decrease in early prenatal care, however, has not resulted in an increase in problems typically associated with a lack of early care (i.e. premature births, low birth rate).

Premature Births



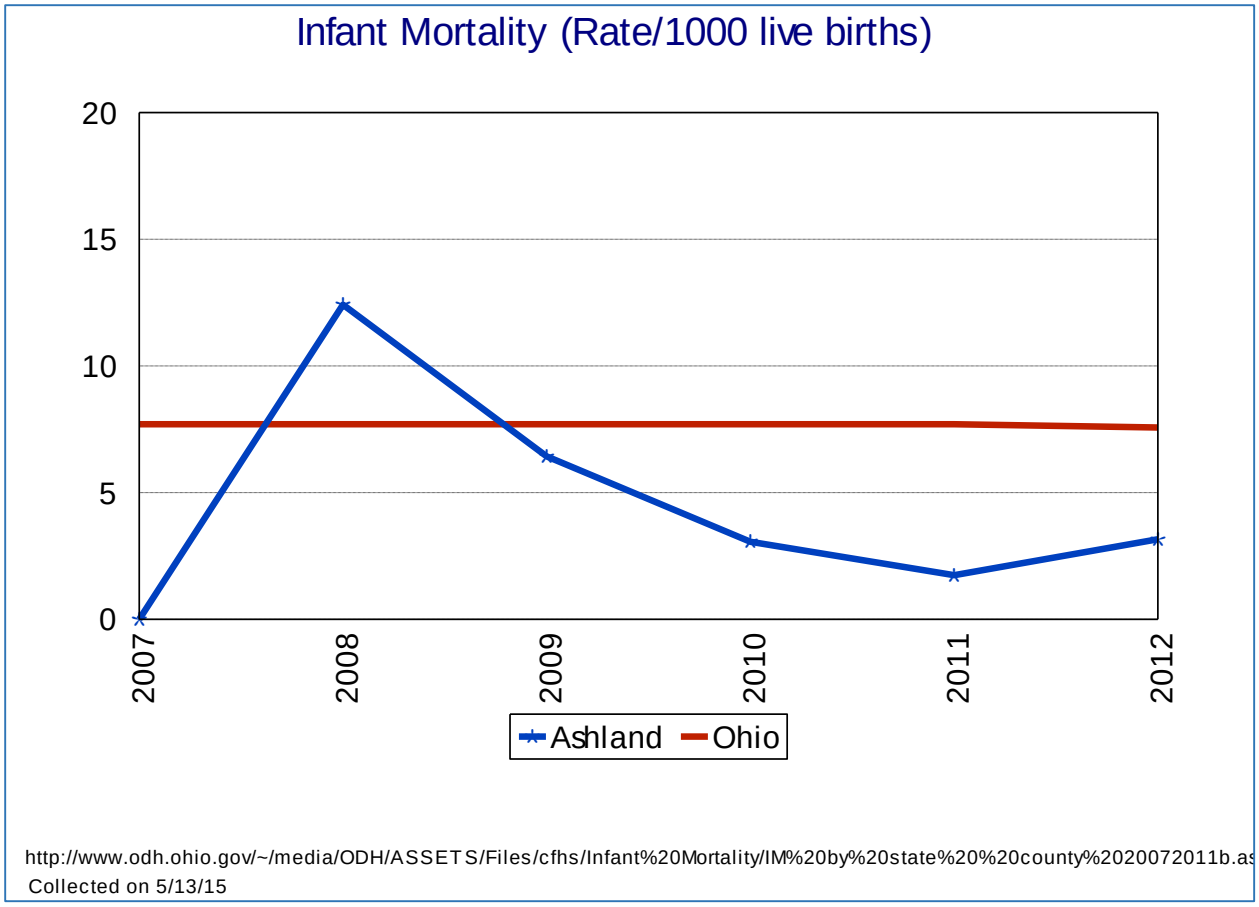
Premature births, defined as a live birth prior to 37 weeks of gestation has steadily declined during the past two years. The proportion of 9% in 2014 is the same as it was in 2010. Since that time, the rate had increased topping out at 10.8% in 2012. Ashland's proportion of premature births is consistently lower when compared to the state's proportion that has always been above 12% since 2006.

Infants Born at Low Birth Rate



The percentage of infants born with a low birth rate, defined as weighing less than 2500 grams has shown little fluctuation during the past eight years. Proportions have ranged between 6% and 8% with 2014 at 6.3%. Compare to the state, Ashland's percentage has always been lower with Ohio showing rates above 8%.

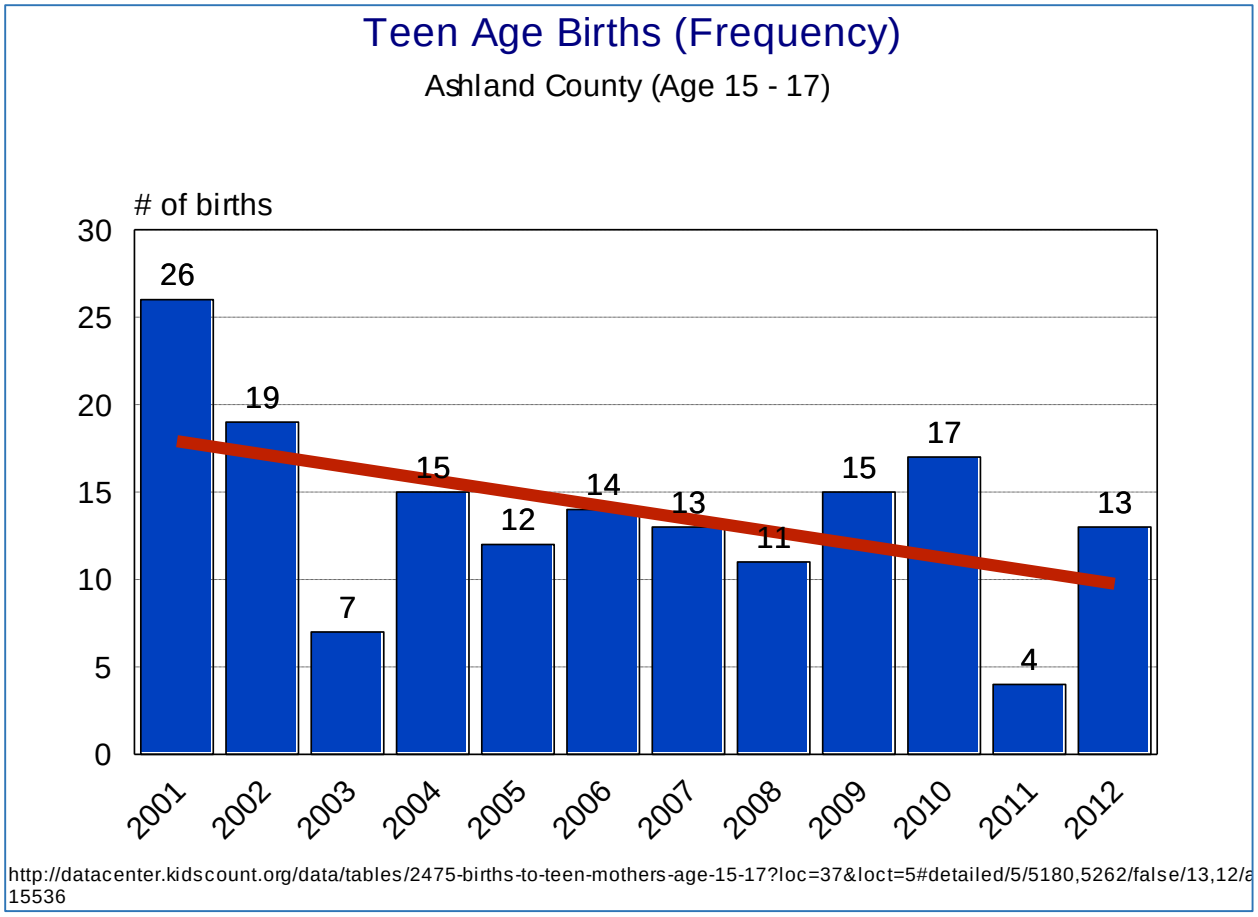
Infant Mortality Rate



http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/cfhs/Infant%20Mortality/IM%20by%20state%20%20county%2020072011b.as
Collected on 5/13/15

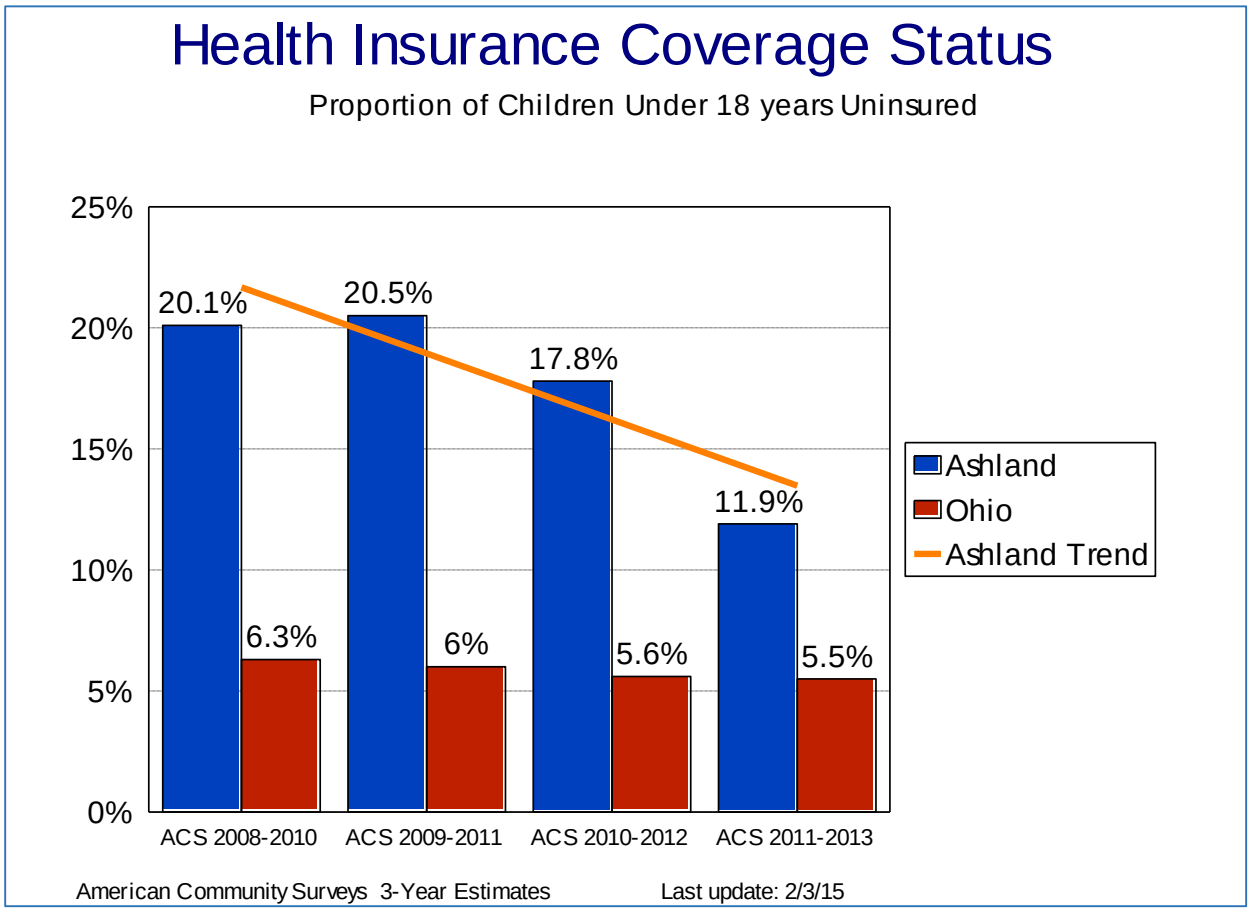
Infant mortality, death to a child prior the age of one year, has displayed little change during the years between 2010 and 2012. Presented as the rate based on 1,000 live births, Ashland County has been between 2 and 3 for every 1,000 live births since 2010. In 2008, the rate was an unusually high figure of 12.42 but has steadily declined since then. Ohio's rate has been between 7.6 and 7.7 since 2007.

Teen Age Births



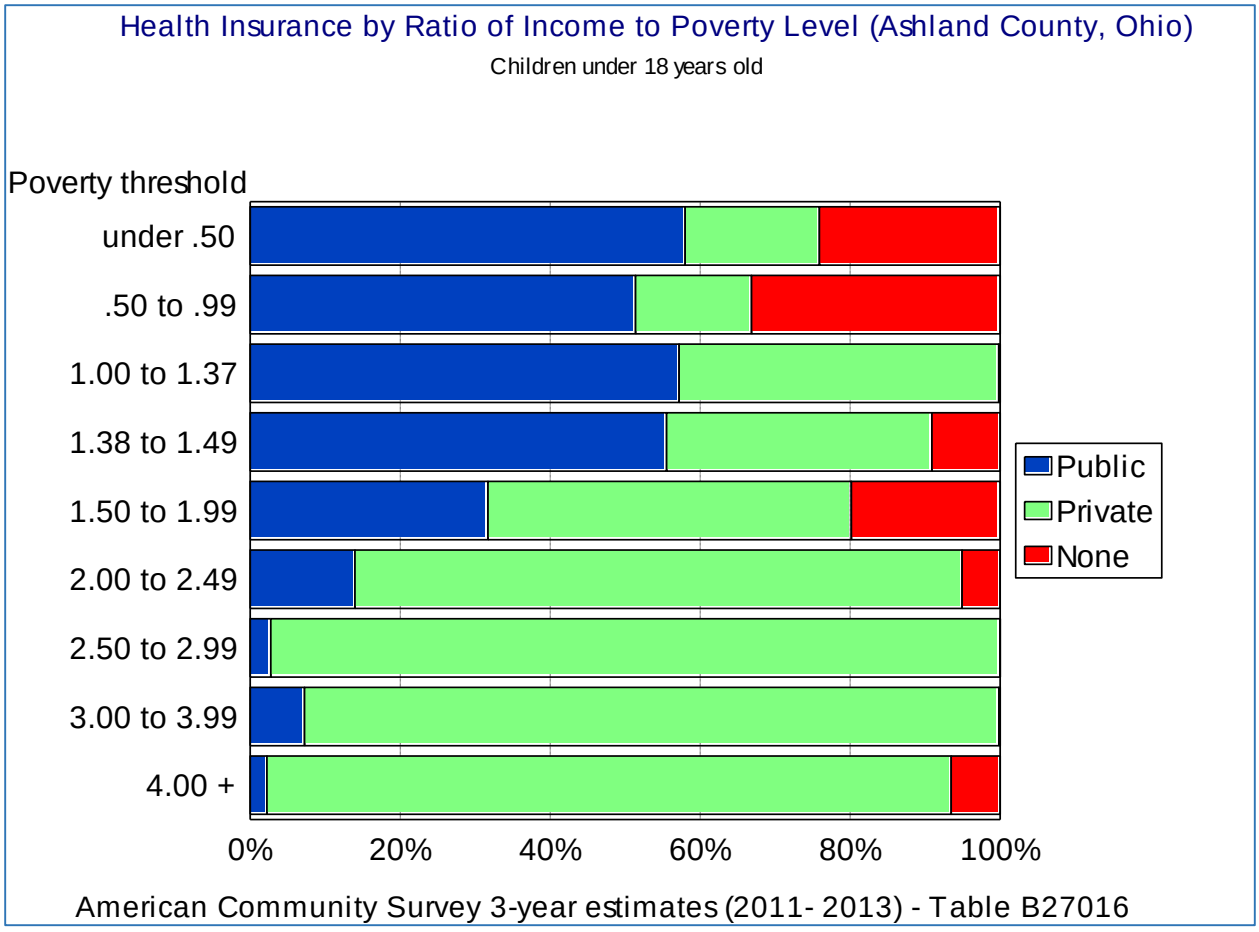
Teenage births have been on a steady decline since 2001. In 2012, there were 13 births where the mother as younger than 18 years old at the time of birth. Much of the decline occurred between 2001 and 2003. Since 2004, the rate has been fairly consistent except the year 2011 when there were only four such births.

Health Insurance Coverage



A significant decline in the proportion of children without health insurance coverage occurred between 2012 and 2013. Although the rate in Ohio remained virtually unchanged, Ashland had a decrease from 17.8% to 11.9%. This decline began in 2011 when over 20% of children were uninsured.

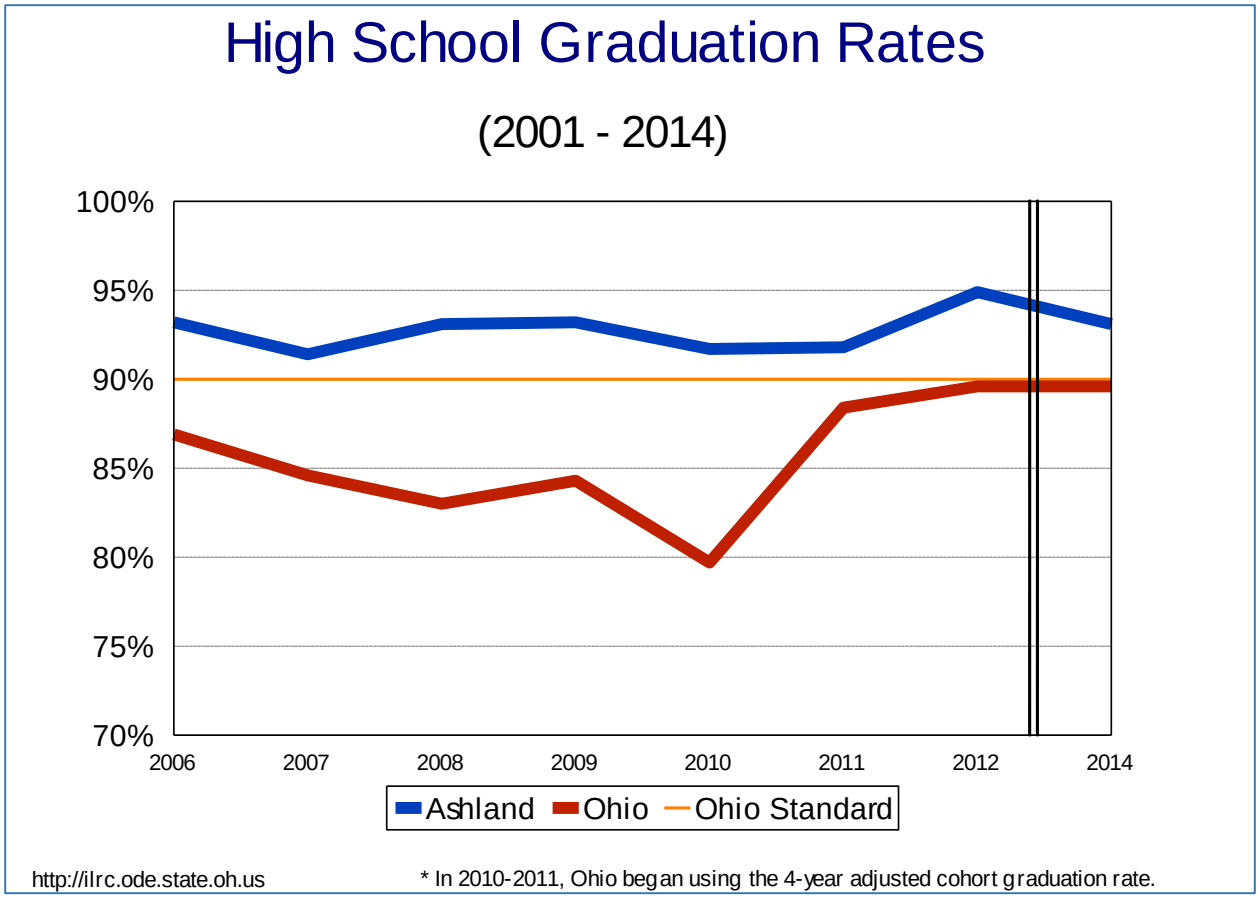
Health Insurance Coverage Based on Poverty Levels



Children who live in households below the poverty level are the most likely group of children to not have health insurance. Children living in households that have income that is more than twice the poverty level are the least likely to be without health insurance.

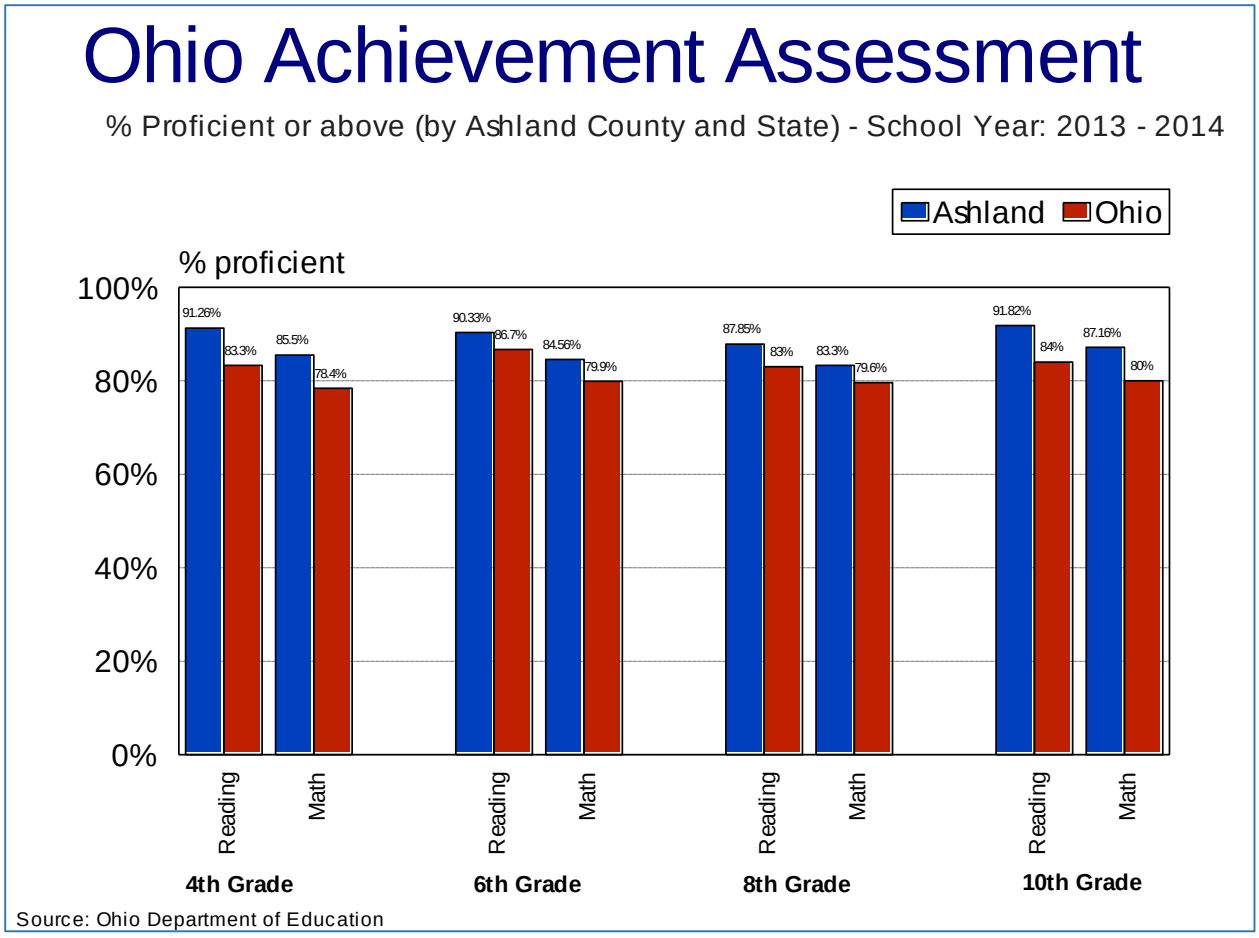
Ohio figures (not shown) displays a somewhat different trend. Across the state, children who live in households below the poverty line were slightly less likely to be without health insurance compared to children living in households with an income twice the poverty rate.

High School Graduation Rate



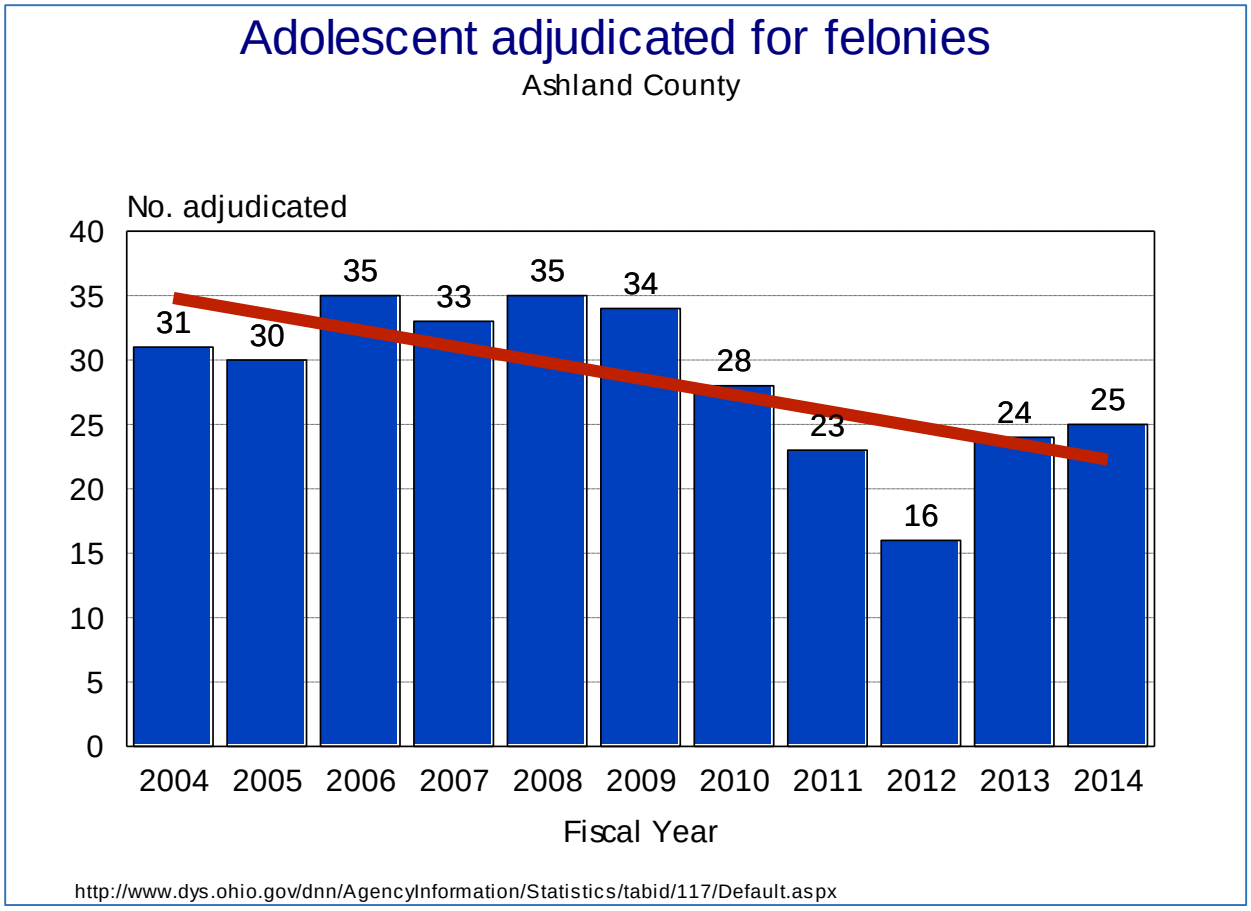
Graduation rates in Ashland County have been consistently higher when compared to the state's level and has always been above the Ohio Standard threshold of 90%. There has been little fluctuation since 2006 with rates being between 92% and 95%.

Ohio Achievement Assessment



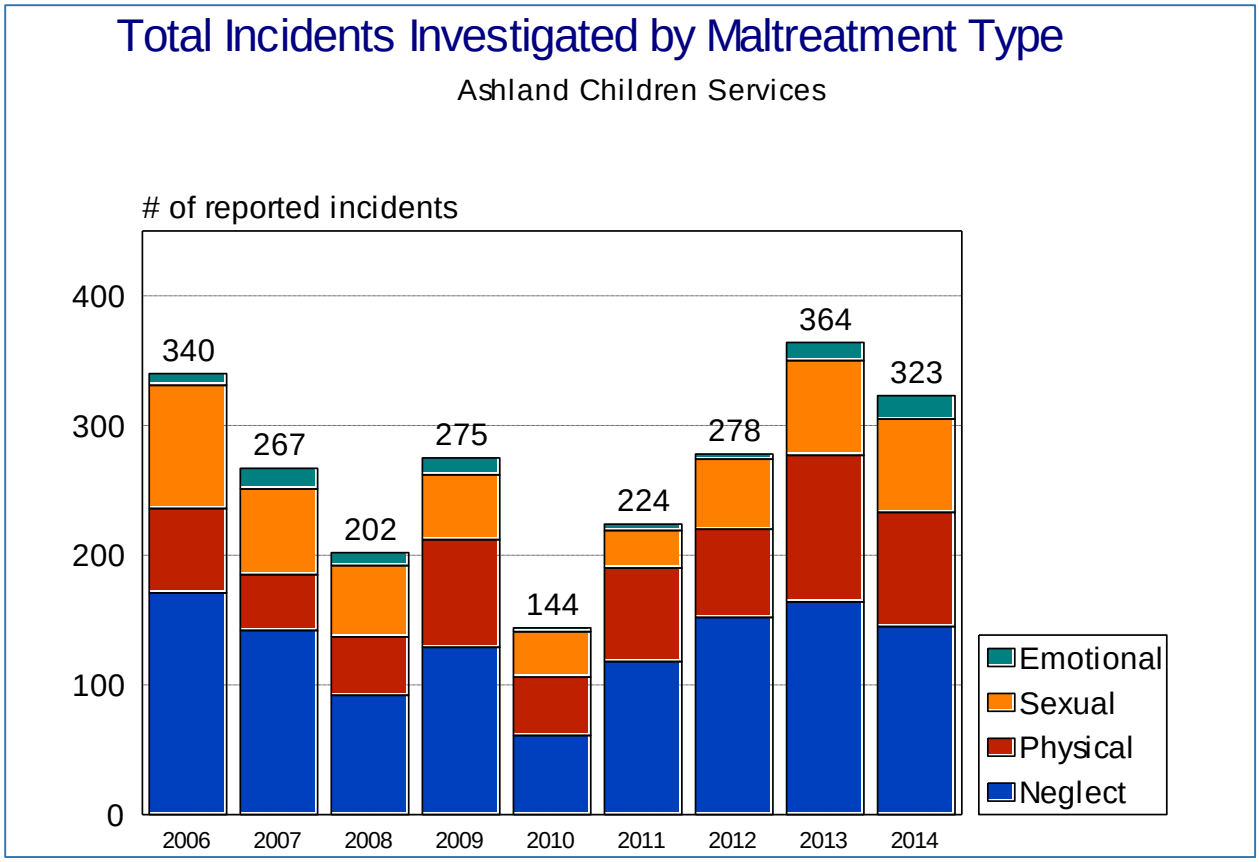
Results of the Ohio Achievement Assessment show a higher level of proficiency in the key areas of reading and math when compared to results from across the state. Proficiency levels are generally above 90% for reading and above 85% for math. The grade level with the lowest proficiency level is 8th grade; however, the level is still significantly higher when compared to Ohio overall.

Adolescents Adjudicated for Felonies



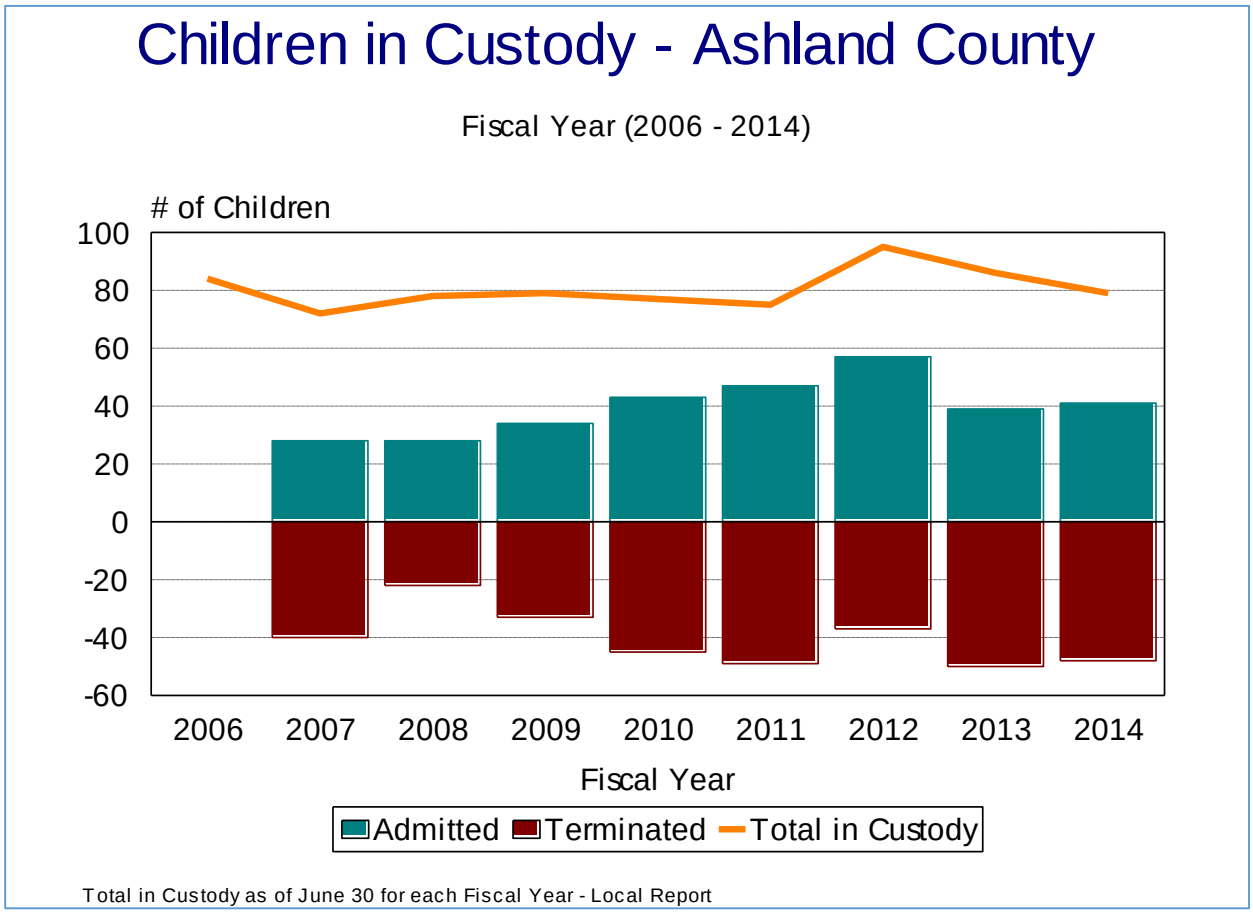
For the past decade, there has been a steady decline in the number of adolescents being adjudicated for felonies. The year 2012 displayed the lowest number during this time; however, since 2009 the number has never been greater than 28. Prior to 2008, the number adjudicated was consistently 30 above.

Child Maltreatment Allegations Investigated

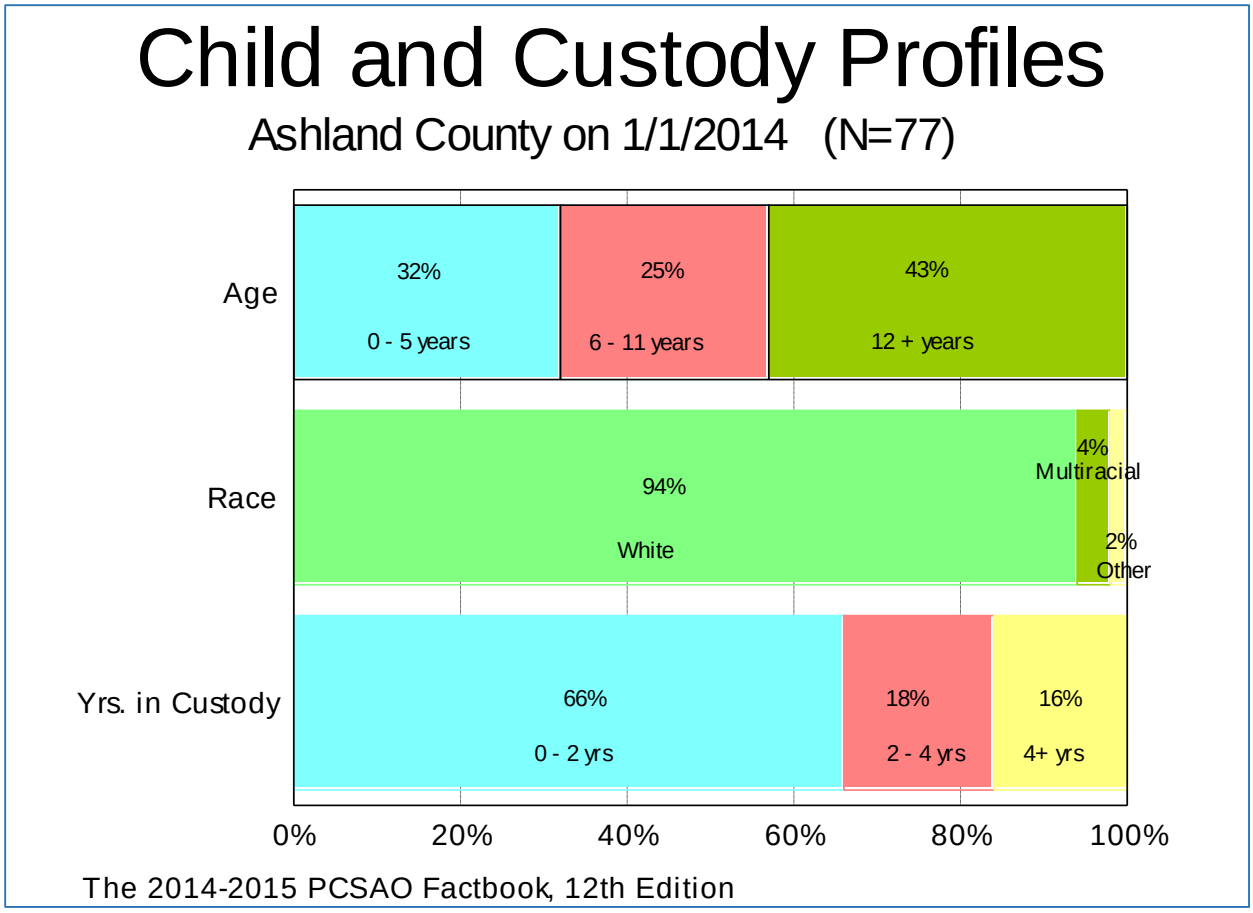


There have been many fluctuations over the past nine years on the number of child maltreatment investigations that were conducted by Ashland Children Services. The number of investigations that took place during the last two years is significantly more than at any other time since 2006. Regardless of the number of investigations, neglect was the most common type of alleged maltreatment. Of the 323 reports investigated in 2014, 145 was due to neglect, 88 for physical maltreatment, and 72 for sexual abuse.

Children in Custody



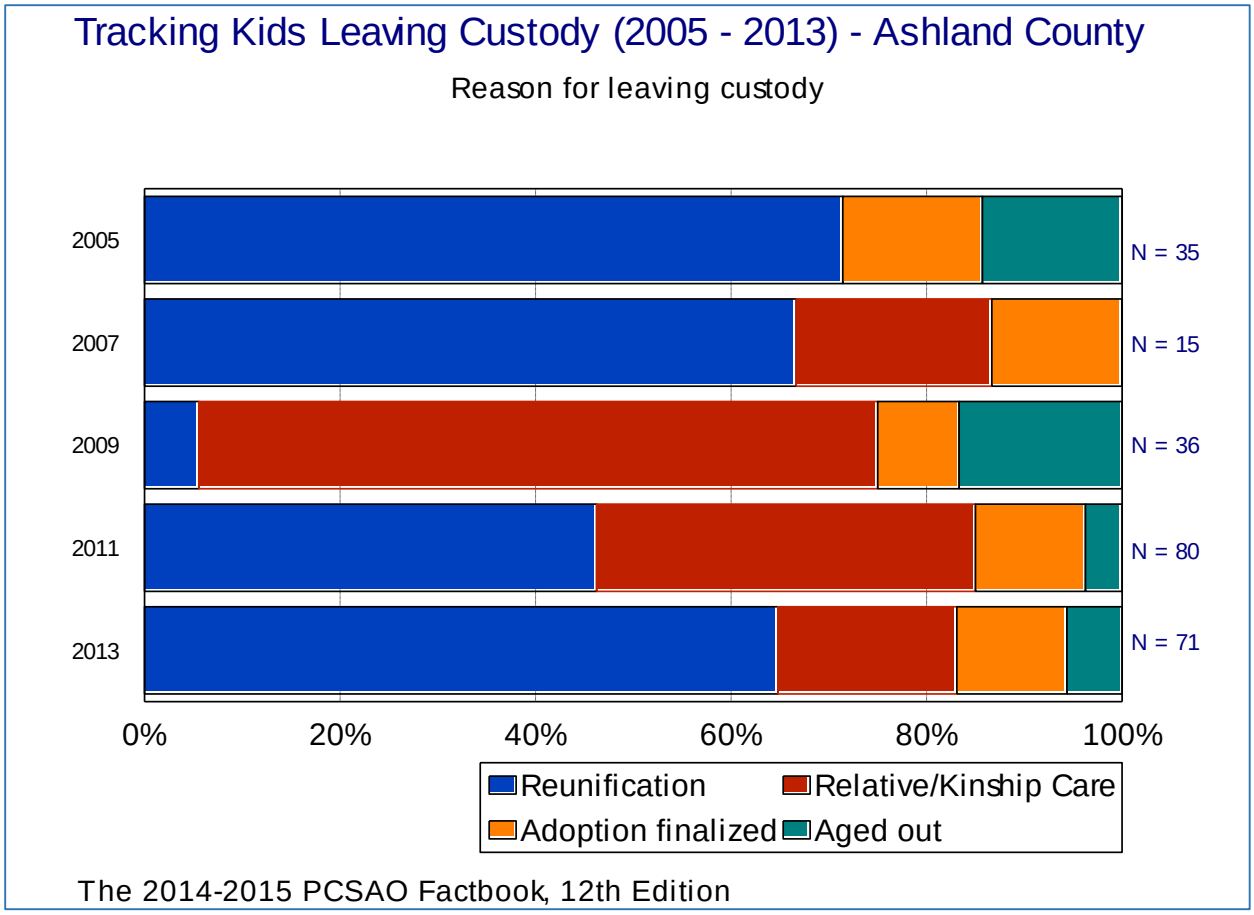
The number of Ashland County children who are in the custody of the County has fluctuated between 72 (Year 2007) and 95 (Year 2012). These numbers represent the number of children in custody on June 30th of each year. The bar graphs indicate the number of children adjudicated into custody by the juvenile court system (blue bar) during the previous year, and the number of children leaving custody (red bar) during the previous year. Since 2012, more children were leaving custody than entering into custody resulting in a decrease from 95 to 79 (Year 2014). Children enter into custody due to maltreatment or dependency.



On January 1, 2014 there were 77 children in the custody of Ashland County. Two-thirds of these children had been in the County's care for less than two years while 16% had been in custody for four or more years. Historical data indicates that when children have been out of their homes for over two years the likelihood of reunification is diminished greatly. Therefore, permanency plans are usually adoption, kinship care, or long-term foster care.

Nearly one-third of these children were five years of age or younger, and over two out of five were twelve years of age or older. The racial makeup of the children in custody resembles racial categories found in the population of Ashland, with 94% of the children reported as white, and 4% being multi-racial.

Tracking Kids Leaving Custody



There are four reasons for children to leave the custody of the County; reunification with the family of origin, care going to a relative or kin, adoption being finalized, or aging out. The data gathered every odd year, displays contrasting reasons for children leaving custody. In 2005 prior to kinship care being used as a formal method of transferring custody from the County, 25 of the 35 children leaving custody were reunited with their families. In 2007 when kinship care began, no child aged out of the system; however in 2009, six of the 36 children did age out of care. Only two children in 2009 were reunified, with a transfer to kinship care being by far the most common reason for departure from custody (n=25). In 2011, the percentage of children being reunified increased from 2009, and kinship care remaining a common reason for leaving custody. The year 2013 displayed a return to what was seen in 2007 with 65% (n=46) being reunified with their families.