Introduction

This Community Health Needs Assessment was developed by Wright State University, the Darke County Health Department, Wayne HealthCare, and other agencies that formed the Steering Committee during the 2015 year. This report compiles data that addresses issues of community health and wellbeing for Darke County as well as for the Wayne HealthCare service area for the time period of 2015-2017.

This research effort has included: a demographic analysis; a survey of 418 adult residents selected at random; focus group sessions with uninsured persons, low-income persons, and minority groups convened by the Darke County Department of Job and Family Services and Grace Resurrection Community Center; a focus group with school nurses; as well as analysis of data from the Ohio Department of Health, Ohio Department of Job and Family Services, the Center for Disease Control and Prevention, the Bureau of the Census' American Community Survey, the Ohio Department of Public Safety, the Ohio Development Services Agency, the Health Resources and Services Association, the Ohio Mental Health and Addiction Services, and the Robert Wood Johnson Foundation. The study addresses secondary data for maternal and infant health data, clinical and preventive services, diseases, hospital and emergency discharge data, and leading causes of death. The steering committee has met about 7 times over the past year to study the results and identify health priorities.

In Darke County, the non-profit hospital is Wayne HealthCare. To maintain their tax-exempt status, non-profit hospitals must annually report their activities which provide community benefits to the Internal Revenue Service (IRS). Community benefit defined by the IRS is "the promotion of health for a class of persons sufficiently large so the community as a whole benefits." Wayne HealthCare has joined forces with the Darke County Health Department and the rest of the steering committee, who have invested resources and significant time in gathering information to inform this Community Health Needs Assessment.

How to Read This Report and How Data Were Obtained

Data in this report are organized into topical areas, which can be located by referring to the table of contents. The report begins with a description of the service area, followed by a basic overview of the community's geographic location and its socioeconomic status. This report compiles primary and secondary data in order to comprehensively describe Darke County. Primary data are data collected from firsthand experience. Secondary data analysis refers to reprocessing and reusing information that has already been collected, such as institutional records from sources such as hospitals and the Ohio Department of Health. The framework for the report was based on key areas of need. The report integrates primary and secondary data and also compares the area's status to state and national data where possible, drawing out

areas of concern. Narrative and graphics are used to highlight the key findings. The report culminates with the presentation of priority needs for the community.

Definition of the Community Served

Darke County borders the state of Indiana and is a 30 to 90 minute drive from several major, Midwestern metropolitan communities including: Dayton, Cincinnati, and Columbus in Ohio, and Indianapolis, Indiana. According to the Office of Rural Health Policy, Darke County is considered a rural county. Approximately 83.14% of the county's land is cropland; 4.49% of the land is pasture; 9.58% of the land is considered forest; 2.16% of land used by residential, commercial, industrial, or transportation uses; 0.08% of the land is open water; and 0.54% of the land is wetlands (woodland/herbaceous).

Darke County's total population is estimated to be about 52,196. Its largest community and city is Greenville with an estimated 13,037 residents. The Ohio Development Services Agency forecasts Darke County's overall population to decrease by approximately 12% by the year 2040. The population under the age of 65 years of age is projected to decrease by approximately 11% by the year 2040 while the population over the age of 65 is expected to increase by approximately 11% by the year 2040. According to the U.S. Census Bureau, there were 52,959 people living in Darke County in 2010, with 6.5% of the population under 5 years of age, 18.3% under 18 years of age, and 17.3% age 65 and over. Compared to the State of Ohio, Darke County has a higher proportion of children (18.3% versus 17.2%) and a larger proportion of persons 65 and over (17.3% versus 14.4%).

There are 20,776 households in Darke County and 14,158 family households. About 74.4% of housing units are owner-occupied and 25.6% are renter-occupied. In nearly one in five owner-occupied households, homeowners are spending more than 35% of their income on housing costs (the recommended percentage is 28%). Nearly one-third of renters are spending more than 35% of their income on housing costs. Of those family households, 29.0% have children under the age of 18. Of households with children, 9.0% live in a female-headed household with no male present and 4.4% live in a male-headed household with no female present.

One-third of children who live in poverty are in female-headed households (35.1%). In fact, 13.7% of Darke County's population lives in poverty; among children under the age of 18, the percentage is 19.6%. Among children under the age of 5, the percentage of those living in poverty is estimated to be 19.1%. Among those ages 65 and over, the percentage living in poverty is 6.7%.

Across the county, 7,768 people received food assistance in the year 2013, which is 14.8% of the population and is 10% less than the percentage that received food assistance in 2012. The average monthly food assistance payment is $973. The total number of households who

received cash assistance dropped by 50% from the year 2012 to 2013 (from 966 recipients to 483). Federal law requires that families receiving cash assistance participate in work activities. At least 50% of all able-bodied adults receiving benefits are required to participate in work activities at least 30 hours per week. In two-adult households, at least 90% are required to participate in work activities at least 35 hours per week. In Darke County, the percentage is 62.03% versus 55.05% for the state of Ohio overall.

Approximately 13% of Darke County's population does not have a high school diploma. This is slightly lower than the state percentage (13% versus 11.5%% respectively). The percent with a bachelor's degree or higher is 11.9% versus 25.2% for Ohio. Although Darke County residents are much less likely to have a bachelor's degree or higher when compared to the state (11.9% versus 25.2%, respectively), the County is closely comparable to the average percentage of residents who have completed some college (19% in Darke County, 20.8% in the state of Ohio). Taking into account all workers in Darke County, the median hourly earnings for individual workers is $13.50 per hour; the median hourly earnings for family households are $26.96 per hour. Nearly one-quarter of jobs (24.9%) are in manufacturing or educational services, health care, and social assistance (21.3%). A sustainable wage for a household of two adults in Darke County is $15.12 per hour, as long as the person is employed full-time. For a household with one adult and one child, a sustainable wage is $17.74.

Source: Ohio Development Services Agency, 2015, http://www.development.ohio.gov/files/research/C1020.pdf; U.S. Census Bureau, 2009-2013 American Community Survey; Darke County Job and Family Services, 2013, http://jfs.ohio.gov/County/cntypro/pdf13/Darke.stm; Massachusetts Institute of Technology (MIT) Living Wage Calculator; http://livingwage.mit.edu/; Ohio Department of Job and Family Services, Ohio Labor Market Information, Local Area Unemployment Statistics (LAUS) Program, 2015, http://ohiolmi.com/laus/ColorRateMap.pdf

Partners in the Process

Many partners from multiple agencies took part in this research effort, from hosting focus group sessions to providing access to data and populations, and more.

Rep First Name	Rep Last Name	Title, Organization	Email Address
Michele	Acker	Director Cardiopulmonary/ Wellness Coordinator, Wayne HealthCare	Michele.Acker@waynehealthcare.org
Diane	Barga	Program Coordinator Family Consumer Science, Darke County Health Department	barga.8@osu.edu
Jennifer	Barga	Director of Nursing, Darke County Health Department	Jennifer.Barga@odh.ohio.gov
Jill	Brown	Cancer Coordinator, Wayne HealthCare	Jill.brown@waynehealthcare.org
Shannon	Condon	Facility Rehab Director, Versailles Health Care Center	scondon@covenantcare.com
John	Cook	Business Administrator, Darke County	jcook@co.darke.oh.us

		Commisioner's Office	
Sharon	Deschambeau	President, Chamber of Commerce	sharond@darkecountyohio.com
Wayne	Deschambeau	President/CEO, Wayne HealthCare	wayne.d@waynehealthcare.org
Denise	Dillman	Wellness	ddillman@co.darke.oh.us
Jane	Dockery	Associate Director, CUPA	jane.dockery@wright.edu
Karen	Droesch	Diabetic Educator	Karen.Droesch@waynehealthcare.org
Kristy	Earick	Administrator, Versailles Health Care Center	KEarick@covenantcare.com
Sharon	Fellers	Executive Director, Grace Resurrection Community Center	sharonf@grccenter.org
Terri	Flood	Marketing Director, Wayne Health Care	terri.flood@waynehealthcare.org
Dr. Michael	Fourman	Director of Dental Services, Family Health	mfourman@familyhealth.cc
Jordan	Francis	Wellness Director, Wayne HealthCare	Jordan.francis@waynehealthcare.org
Mike	Gray	Superintendent, Darke County Schools	dk_supt@mdeca.org
Kelly	Harrison	Prevention Specialist	kharrison@dcrs.info
Lauren	Henry	Executive Director, Darke County United Way	Lauren@darkecountyunitedway.org
Terrence	Holman	Health Commissioner, Darke County Health Department	terrence.holman@odh.ohio.gov
Cheryl	Holmes	Coordinator for Cardiac Rehabilitation and Secondary Prevention Coordinator, Wayne HealthCare	cheryl.holmes@waynehealthcare.org
Diane	Lee	Transportation Coordinator	Diann.Lee@jfs.ohio.gov
Jodi	Long	Director, Clinical Services & Evaluation	longj@tcbmds.org
Mark	McDaniel	Executive Director, Tri-County Board of Recovery and Mental Health Services	mcdanielm@tcbmds.org
Tiffany	Thomas	Eligibility Referral Supervisor, Darke County Department of Job & Family Services	Tiffany.Thomas@jfs.ohio.gov
Jeff	Vaughn	ACES Coordinator, Council on Rural Services	jvaughn@councilonruralservices.org
John	Warner	President & CEO, Brethren Retirement Community	John.Warner@bhrc.org
Dennis	Wein	Public Health Nurse, Darke County Health Department	dennis.wein@odh.ohio.gov
Erica	Wentworth	Naturalist, Darke County Park District	EWentworth@darkecountyparks.org
Laurie	White	Director of Behavioral Health and Wellness Services, Family Health	LWhite@familyhealth.cc

Demographics of the Community

Characteristics of the Population

Socioeconomic Status

Households

There are 20,776 occupied housing units in Darke County. Of these, 68.1% are family households. About 74.4% of housing units are owner-occupied and 25.6% are renter-occupied, while 8.4% are vacant housing units. Nearly 19.2% of homeowners and 31.8% of renters are spending 35% or more of their household income on housing costs. Of those family households, 29.8% have children under the age of 18. The median gross rent in Darke County is $585; this accounts for 27.1% of renters' total household income. The median monthly owners cost is $1,057; this is 21.8% of homeowners' total household income.

Source: Ohio Development Services Agency, 2015, http://www.development.ohio.gov/files/research/C1020.pdf

Poverty

The latest census estimate shows that 13.7% or 8,111 individuals in Darke County are living in households with income below the Federal Poverty Level (FPL). In fact, while 13.7% of Darke County's population lives in poverty; among children under the age of 18, the percentage is 19.6%. One-third of children who live in poverty are in female-headed households (35.1%). Among children under the age of 5, the percentage of those living in poverty is estimated to be 19.1%. Among those ages 65 and over, the percentage living in poverty is 6.7%. Racial and ethnic differences are also evident when examining poverty statistics by race. Over half (51.8%) of Black or African American (0.6% of population) and 31.8% of American Indian or Alaska Natives (0.2%) in Darke County live in poverty. This is compared to the 13.2% among the County's White residents (97.8%).

Source: U.S. Census Bureau, 2009-2013 American Community Survey

Educational Attainment

The percentage of Darke County residents having a high school diploma or GED attainment is closely comparable to the state (87% versus 88.5%, respectively). Although Darke County residents are much less likely to have a bachelor's degree or higher when compared to the state (11.9% versus 25.2%, respectively), they are closely comparable to the average percentage of residents who have completed some college (19% in Darke County, 20.8% in the state of Ohio).

Source: U.S. Census Bureau, 2009-2013 American Community Survey

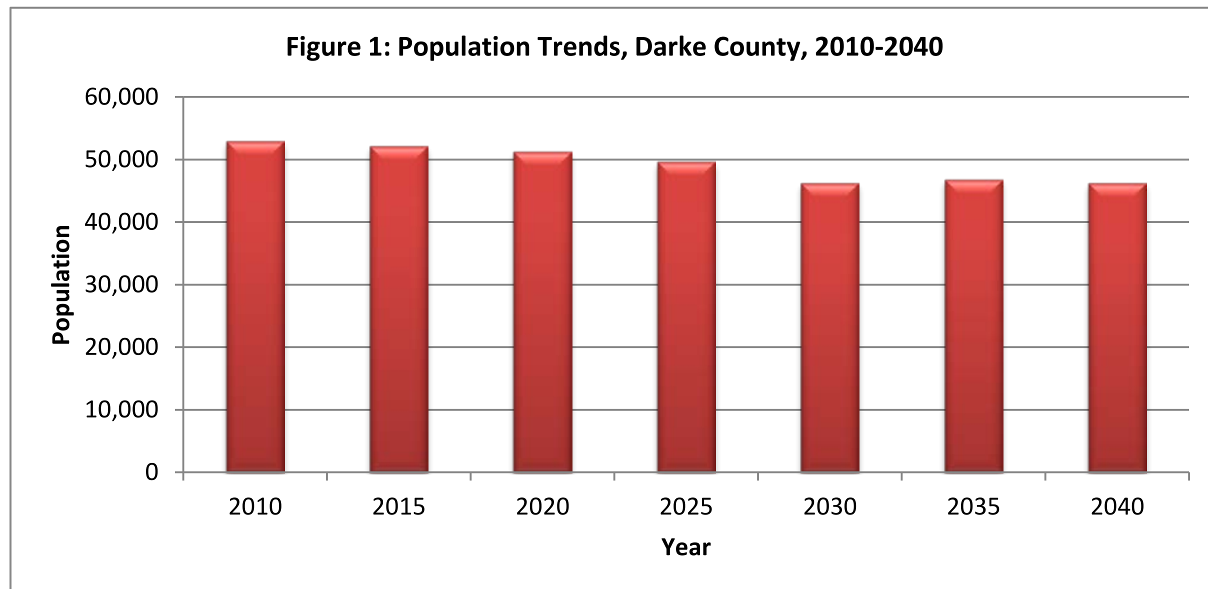
Occupations and Income

According to the Ohio Local Area Unemployment Statistics (LAUS), among the 62.9% of Darke County residents in the workforce, 4.1% are unemployed. The median earnings for individual workers in Darke County is $13.50 per hour (or $26,990 per year); the median income for family households is $26.96 per hour (or $53,929 per year) while it is $12.84 per hour (or $25,680 per year) for nonfamily households. According to the Massachusetts Institute of Technology (MIT) Living Wage Calculator, a sustainable wage for a household of two adults in Darke County is $15.12 per hour (or $30,240 a year), as long as the person is employed full-time; the poverty wage for a household of two adults is $7.00 per hour (or $14,000 a year). For a household with one adult and one child, a sustainable wage is $19.29 (or $38,580 a year); the poverty wage for a household of one adult and one child is $9.00 per hour (or $18,000 per year). The two predominant industries employing Darke County residents are manufacturing (24.9%) and educational services/healthcare/social assistance (21.3%), followed by retail trade (10.2%).

Source: U.S. Census Bureau, 2009-2013 American Community Survey; Massachusetts Institute of Technology (MIT) Living Wage Calculator; http://livingwage.mit.edu/; Ohio Department of Job and Family Services, Ohio Labor Market Information, Local Area Unemployment Statistics (LAUS) Program, 2015, http://ohiolmi.com/laus/ColorRateMap.pdf

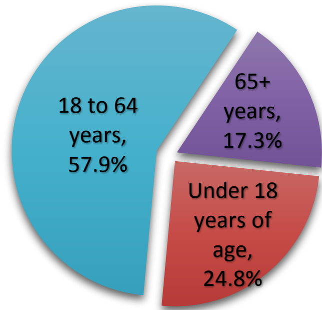
Characteristics of the Population and Socioeconomic Status

Certain characteristics of a population can be factors in determinant the health status of a community and thus the health care services required by the community. The following is a graphical analysis of the characteristics and socioeconomic status of the community being served. This analysis is provided for Darke County and provides a comparison to the State of Ohio and the United States.



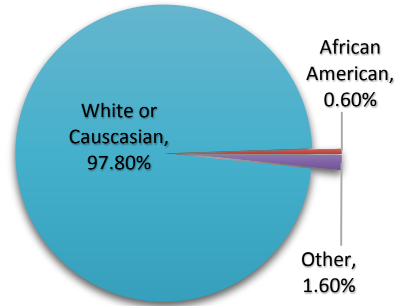
Source: Ohio Development Services Agency, 2010 to 2014 Projected Population for Ohio Counties: http://development.ohio.gov/files/research/P6090.pdf

Figure 2: Age, Darke County, 2013

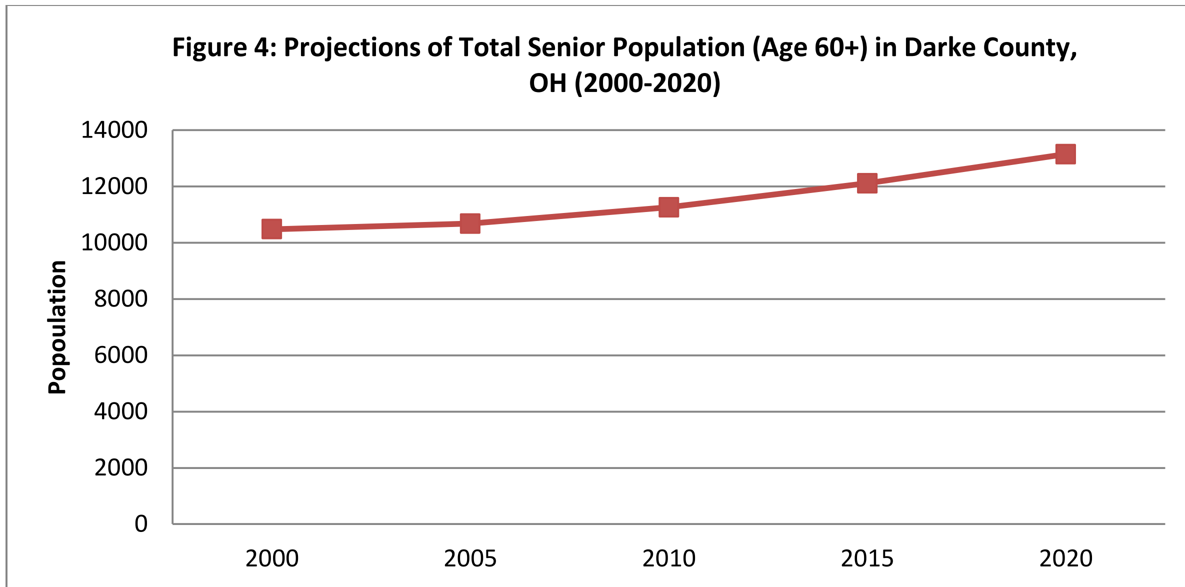


Source: US Census Bureau, American Community Survey, 2013

Figure 3: Race, Darke County, 2013



Source: US Census Bureau, American Community Survey, 2013



Source: Ohio Development Services Agency, 2010 to 2014 Projected Population for Ohio Counties – Summary 2010 to 2040 Projected, http://development.ohio.gov/files/research/P6090.pdf; and Scholarly Commons at Miami University – Profile & projections of the 60+ **population: Darke County, Ohio** http://sc.lib.muohio.edu/bitstream/handle/2374.MIA/131/fulltext.pdf?sequence=2

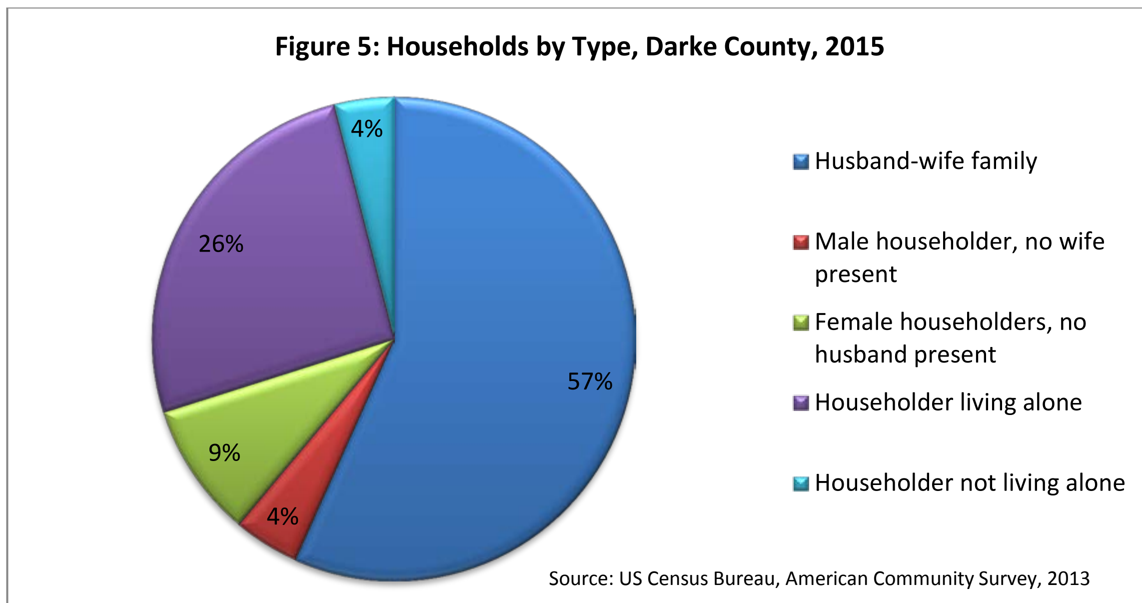


Figure 6: Occupied Housing Units, Darke County , 2009-2013

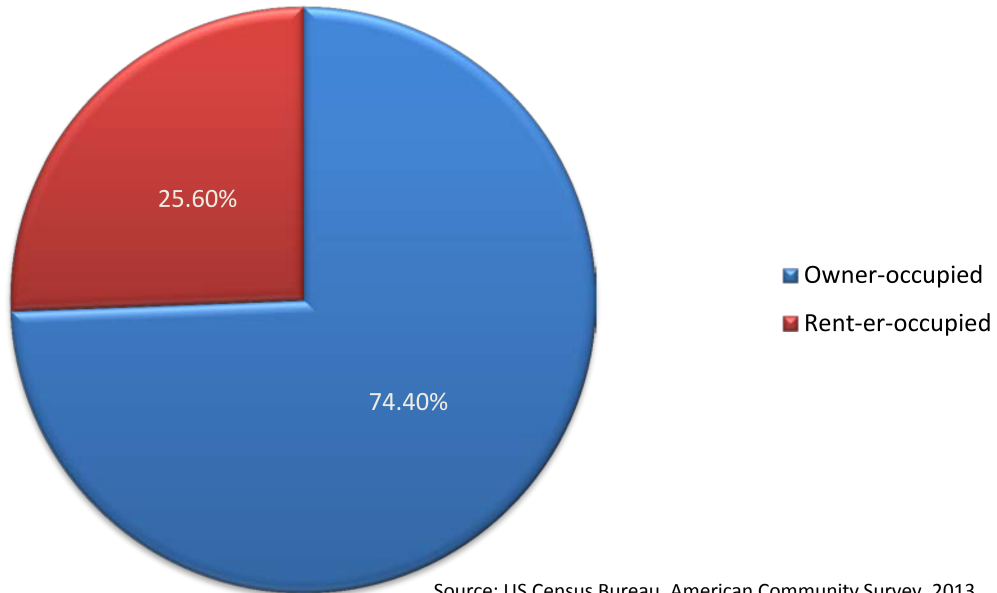
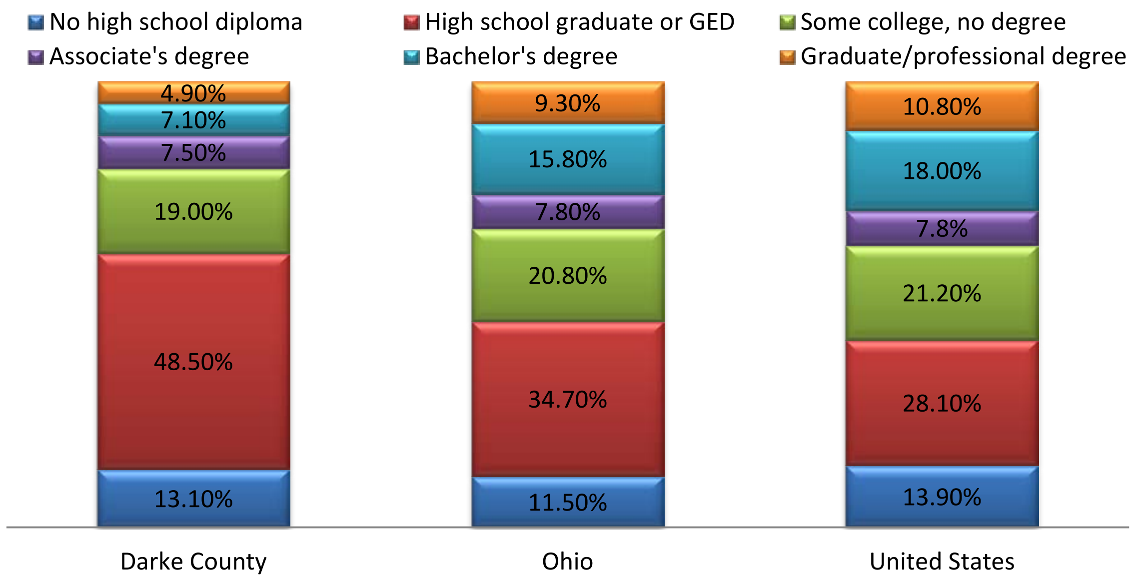
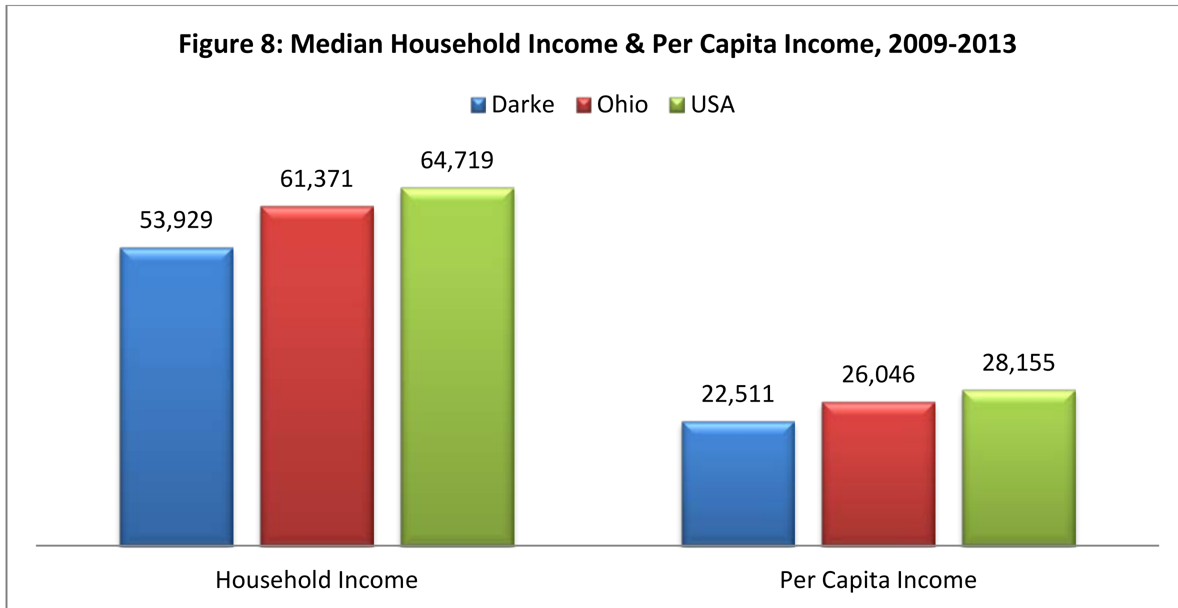


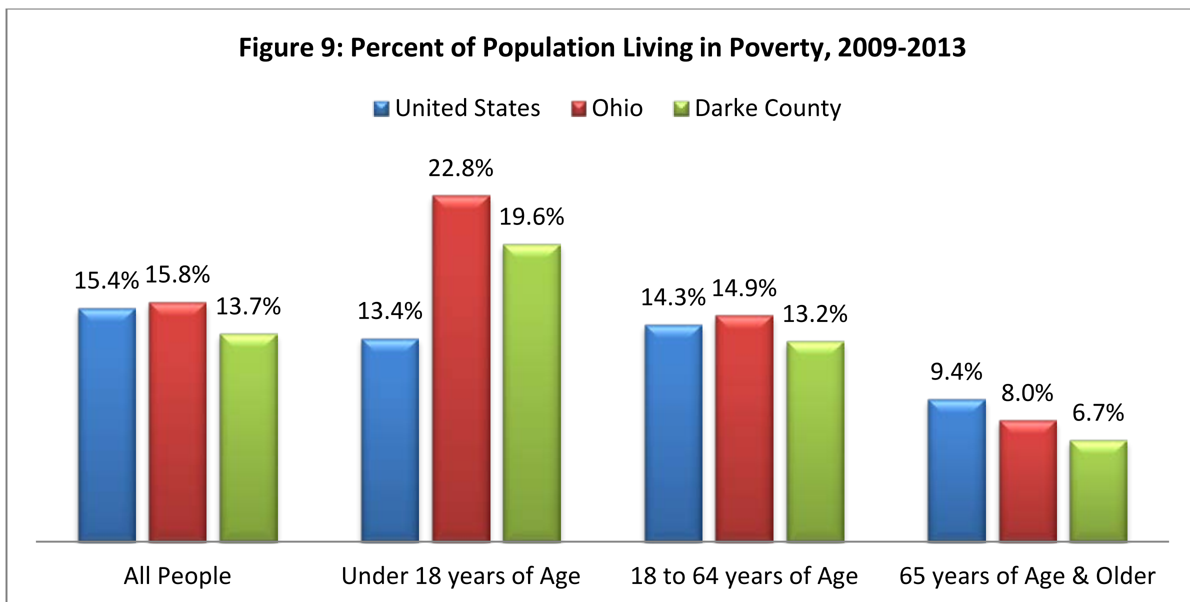
Figure 7: Educational Attainment for the Population 25 Years of Age & Older, 2009-2013



Source: US Census Bureau, American Community Survey, 2013



Source: US Census Bureau, American Community Survey, 2013



Source: US Census Bureau, American Community Survey, 2013

Health Care Facilities and Resources within the Community[1]

Wayne HealthCare

Wayne HealthCare is a rural, 104-bed licensed, nonprofit acute care hospital facility that offers inpatient and outpatient health care.

Table 1: Total Available Beds	
Short-term Care	
6	Special Care
76	Adult Medical-Surgical
10	Obstetrics Level I
92	**Total Short-term Care Beds**
Newborn Care	
12	Newborn Care – Level I
12	**Total Newborn Care Beds**
104	**Total Available Beds**
Source: Directory of Registered Hospitals, Ohio Department of Health http://publicapps.odh.ohio.gov/eid/reports/Report_Output_RS.aspx, last accessed August 2015	

Physicians and other Health Providers

According to the Health Resources and Services Association (HRSA), the following physicians and other health providers provide services in Darke County. Darke County is designated as a Health Professional Shortage Area (HPSA) in the area of mental health and primary care, especially for low income residents. A HPSA is defined as "a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals." Several different criteria are used to determine HPSA designations.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Health Workforce, Health Professional Shortage Areas (HPSAs), 2015 http://bhpr.hrsa.gov/shortage/hpsas/

Table 2: Primary Care Physicians	25.0
PCP Phys/100K Pop	47.7

Table 3: Obstetricians/Gynecologists	2.0
OB/GYN/100K Pop	7.5

[1] Darke County's health care infrastructure is comprised of one hospital, six nursing homes, one hospice, and four federally-qualified community health centers.

Gen/Fam/100K Pop	36.3
Internal Medicine	5.0
Internal Medicine/100K Pop	9.5
Pediatricians/100K Pop	7.1

Table 4: General Surgeons	0.0
General Surgeons/100K Pop	0.0

Table 5: Psychiatrists	0.0
Psychiatrists/100K Pop	0.0

Table 7: Dentists	13.0
Dentists/100K Pop	24.8

Source: Health Resources and Services Administration, Health Resources Comparison Tool,http://ahrf.hrsa.gov/arfdashboard/HRCT.aspx, last accessed August 2015

Clinics

There are four federally qualified health centers in Darke County. They are all managed by Family Health Centers, Inc. and are located in the city of Greenville, Arcanum, Versailles, and New Madison. The clinics offer services on a sliding fee basis, including: wellness exams for adults and children, provide acute care, administer vaccinations, and perform laboratory and medical procedures on site. The Family Health Services of Darke County are designated to be a Comprehensive Health Center with Health Professional Shortage Areas (HPSA) in the areas of primary care, mental health, and dental health.

Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Data Warehouse, HPSA Find, 2015: http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

Table 6: Health Centers	
Community Health Centers	4
Federally Qualified Health Centers	4
Source: Health Resources and Services Administration, Health Resources Comparison Tool, http://ahrf.hrsa.gov/arfdashboard/HRCT.aspx, last accessed August 2015	

Nursing Homes

Table 7: Nursing Homes			
OHL01687	BRETHEREN RETIREMENT COMMUNITY	**OHL01836**	UNION CITY CARE CENTER
	750 Chestnut Street		907 East Central Street

	Greenville, OH 45331		Union City, OH 45390
	Licensed Capacity: 130		Licensed Capacity: 43
OHL01690	HEARTLAND OF GREENVILLE	**OHL1797**	VERSAILLES HEALTH CARE CENTER
	243 Marion Drive		200 Marker Road
	Greenville, OH 45331		Versailles, OH 45380
	Licensed Capacity: 92		Licensed Capacity: 112
OHL01721	REST HAVEN NURSING HOME	**OHL41817**	VILLAGE GREEN HEALTH CAMPUS
	1096 North Ohio Street		1315 Kitchen Aid Way
	Greenville, OH 45331		Greenville, OH 45331
	Licensed Capacity: 100		Licensed Capacity: 51

Source: Ohio Department of Health http://publicapps.odh.ohio.gov/EID/reports/Report_Output.aspx

Mental Health Care Capacity

Darke County is designated as a Health Professional Shortage Area (HPSA) in Mental Health. According to the Health Resources & Services Administration, there is a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists, in the area. There are different designation requirements for a geographic area, population group, or health facility to be considered a HPSA in the area of mental health. In general, the regulation for a mental health HPSA designation is based on a psychiatrist to population ratio. The ratio is 1:30,000, meaning that if there are 30,000 or more people per psychiatrist, then a geographic area is designated as a mental health HPSA.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Health Workforce, Health Professional Shortage Areas (HPSAs), 2015 http://bhpr.hrsa.gov/shortage/hpsas/

With the mental health HPSA designation in mind, the Darke County Community Health Needs Assessments asked, *“If you felt depressed or suicidal, would you know where to go or who to talk to?”* Among survey respondents, 19.7% indicated they would not know where to access mental health care.

Darke County is part of a three-county board – the Tri-County Board of Recovery & Mental Health Services. This organization plans, funds, monitors, and evaluates substance abuse and mental health services for Miami, Darke, and Shelby counties.

The Tri-County Board of Recovery & Mental Health Services provides 24/7 coverage for mobile crisis assessments at three local hospitals (Wayne, Wilson, and UVMC), the Darke, Miami, and Shelby county jails, and West Central Detention Center. Mobile responders provide crisis and assessment services for people with mental health and drug and alcohol needs. Services are also provided at the local police departments as well as the David L. Brown Youth Center in Miami County. Fees for services are on a sliding scale and are based on the individual’s financial

status. For those who qualify, Medicaid funds substance abuse and mental health treatment services are available.

The board contracts with the following providers to deliver substance abuse and mental health services for any resident of Miami, Darke, or Shelby County across all age groups:

- Community Housing Inc.
- Darke County Recovery Services
- Hopeline (peer support line)
- Miami County Recovery Council
- SafeHaven Inc. (peer operated social center)
    - *Services are free of charge – made possible by federal and state tax dollars and by support from the local Mental Health and Recovery tax levy*
- Shelby County Counseling Center
- The Mental Health Clinic – serving Miami and Darke counties
    - Miami County (937) 335-7166
    - Darke County (937) 548-1635
- Tri-County Crisis Hotline & Crisis Team

Services provided include:

- Individual, couples, family, and group counseling
- Services for children, adolescents, and the elderly
- Treatment for alcoholism and other addictions
- Suicide prevention, education, and outreach
- Counseling for victims of violent crimes
- 24-hour emergency services
- Medication management
- Access to hospitalization, detoxification, and residential services when appropriate
- Pre-discharge planning and aftercare services for people who’ve been hospitalized
- Supervised living with access to other safe, affordable housing options for people with mental disabilities

WAITING FOR INFO ON FAMILY HEALTH FROM DR. LAURIE WHITE.

Health Needs of the Community

Community Input

Community input on the perceived health needs of Darke County was used to complement analysis of publicly available data. The community health assessment used an inclusive and systematic process to collect information pertaining to the community's perceptions of its health needs.

To gather community input, a steering committee was convened to provide broad-based input on the health needs present in the community. Additionally, adult and youth surveys were conducted; and focus groups and key informant interviews were convened for the purpose of discussing the health needs of Darke County and the community served. These groups were made up of:

- Persons with special knowledge or expertise in public health
- Representatives from the local health department, hospital, and other agencies and organizations serving the community
- Members of medically underserved, low income, minority populations, and populations with chronic disease
- Other stakeholders in community health (see Appendix D for a more complete list and description of community participants)

Focus Groups Interviews Summary

Background

A series of three focus groups were held throughout Darke County during August and September 2015; two groups each were held at the Darke County Department of Jobs & Family Services in Darke County and Grace Resurrection Community Center; one group was held at the Darke County Health Department. The intent was to discuss community health perceptions, barriers and disparities in coverage, and access to health services. The focus group participants included low-income or marginalized residents, school nurses, and other underserved populations. There is no identifying information connected with the comments, as participants were asked to speak candidly and assured of anonymity and confidentiality.

Table 8: Key Informant Focus Group	Date
Darke County – Department of Jobs & Family Services	August 3rd and 27th, 2015
Grace Resurrection Community Center	August 11th and 13th, 2015
Darke County School Nurses	September 18th, 2015

Final participation included representative of the organizations outlined below:

- Darke County – Department of Job & Family Services
- Grace Resurrection Community Center
- Darke County School Nurses

The following questions were selected for use in guiding focus groups with community members:

Focus Group with Community Members

1. What is the first thing that comes to mind when you hear the phrase, "healthy lifestyle"?
2. What do you and others do to stay healthy?
3. Focusing on specific health issues, what would you say are the biggest health problems in the community?
4. Where do you usually get healthcare when you need it? Why?
5. Did you or someone you know have difficulty obtaining health care services in the past few years? If yes, what are the reasons?
6. If you had one suggestion on how to improve the health of the community, what would it be?
7. Do you feel that people in the community are fully aware of the healthcare services/options that are available to them? Why or why not?
8. Where do you currently get health information?
9. In what format would you like to receive future health information?

The following questions were selected for use in guiding a focus group with Darke County school nurses:

Focus Group with School Nurses

1. What do you see as major health problems affecting youth and students in your community?
2. Where do you feel there are gaps in health services for the youth you service?
3. What types of needs are identified by students or their parents?
4. What kinds of things do you think could be done or programs developed to improve community health in Darke County?
5. Where do you believe teens get most of their health information?
6. What are the greatest barriers in providing health education or services to the youth you serve?

Key Themes from Focus Groups with Medically Underserved, Low-Income Populations

We asked participants to tell us what they believe were the top health issues affecting their community in Darke County.

The primary concerns among the participants included:

1. Quality of Care
2. Health Communication
3. Insurance Barriers
4. Structural Barriers
5. Aging Populations
6. Mental Health & Substance Abuse

Each theme is discussed in further detail below.

Quality of Care

While the overall majority of participants had identified a source of health care (either through Wayne HealthCare or FamilyHealth), most expressed some dissatisfaction with the quality of the healthcare. A need to improve the reputation of the hospital was mentioned. Additionally, participants cited dissatisfaction with physicians' cultural competence of rural, low-income populations.

> One mother remarked, "Being poor makes it hard to focus on being healthy, buying healthy food, and getting out of bed… let alone making time to exercise."

Participants were asked, "What recommendations do you have for the healthcare providers to improve delivery of care?"

> One participant said, "Better understanding of the community and citizens within the community. Wealthy people can't understand poor people."

Several participants alluded to the stigma of being "poor" or "blue-collar." Providing culturally competent services has the potential to improve health outcomes, improve the efficiency of clinicians and result in greater patient satisfaction. Cultural competence also informs the efficacy of health communication between patients and healthcare providers.

Health Communication

A common theme from the focus groups included the improvement of patient-centered, health communication in the rural health system. This included patient-provider communication, as well as communication within the community.

When asked, "*Are you able to understand the health information the provider gives you*?" over half of the focus group participants indicated that they did not.

Participant remarks included:

- "Anything they tell us, they won't expand on it – they're really vague."
- "It's like they are speaking a different language."
- "They get so involved in their profession; they don't know how to explain it to you."
- "Jibberish."
- "They won't give you information in layman's terms."

When asked for suggestions as to how to improve health communication, one participant remarked,

> "The doctor told me I had abrasions and contusions – don't tell me that. Tell me I have cuts and bruises."

The interrelationship of culture and health literacy skills was identified as a significant consideration for developing health communication and promotion materials for rural, low-income or marginalized populations.

When asked, "*What kinds of health information would be most helpful and how would you like to receive it*?" participants gave several suggestions. The health information that was most commonly cited as being helpful included:

- What transportation is available to and from health facilities
- Where to access affordable medication

Most participants indicated that they obtained information from their healthcare provider, whether a physician or nurse. However, many went on to imply the need for further community engagement. Suggestions for health communication within the community included the use of newspapers, television, text messages, and internet. Additionally, many added comments about increasing community engagement in public spaces.

> One participant remarked, "You should go into the community and just talk and let people know what kind of services I can actually get."

Rural, low-income populations systematically suffer worse health outcomes than non-disadvantages populations. Engaging members of the rural, low-income communities in public health initiatives can positively impact health outcomes in these groups.

When asked, “*Do you feel that people in the community are fully aware of the healthcare services and options that are available to them?”* the overall consensus was poor. Participants mentioned the lack of a central location for health information.

> One participant remarked, “Help is available, but if you don’t know about it, then what’s the point?”

> Another participant commented, “I only know because of my friends.”

Insurance Barriers

Recent expansions in insurance coverage have improved access to healthcare for populations from lower socioeconomic backgrounds. The presence of family physicians in rural communities has made primary care services more easily accessible. However, despite the expansion of healthcare coverage, focus group participants indicated barriers to accessing healthcare, leaving them “underinsured.” Although all focus group members reported having insurance, finances played an important role. One participant raised concerns of a “coverage gap” in which individuals whose incomes are above Medicaid eligibility levels but below eligibility levels for tax credits will be left without an affordable insurance option.

> One participant said, “It makes it rough when you live on a fixed income and they cut your insurance because you got a raise.”

Participants further elaborated on the interrelationship between insurance, access, and cost. Many families felt “invisible” to healthcare providers. One participant remarked that he felt like a “second-class citizen” because he had insurance through Medicaid.

> One participant remarked, “Doctors are more interested in your insurance card than seeing you. They’re more interested in making money.”

Participants voiced their frustration from trying to navigate the health care system because their interactions have often resulted in denied care due to having public coverage.

> Another participant noted, “It’s frustrating trying to understand what your insurance covers and which doctor will take it.”

Several participants commented on the need to travel outside of the county to access services.

> One participant mentioned, “There’s only certain things Medicaid will cover and only certain doctors will do some procedures for Medicaid insurance patients.”

> Another participant added, “Medicare won’t cover services at Wayne; I have to go out of the county to get healthcare.”

For those individuals who had secured public health insurance, the major challenge became access.

Structural Barriers

The majority of participants cited the need to travel to outside of the county for high quality health care. The problem is compounded because many participants also cite a lack of reliable transportation. Access to health care services is contingent upon transportation being available.

When asked, “What are the top issues you see facing your community – among the people you know or in your neighborhood?” the lack of transportation was brought up during every single focus group.

> One participant remarked, “How are you supposed to get to North Dayton if you don’t have a care?”

Suggestions for the improvement of the health of the community often included suggestions for the improvement of transportation access. Participant remarks included:

- “Transportation to get to and from doctors; some transportation don’t accept Medicare.”
- “Health care, to get to the doctor or pharmacy, is not easily accessible in rural areas, especially for old people.”
- “Have more services locally, if you have to go to Dayton, that’s hard when you have a lack of transportation.”

Participants explained that structural barriers, including vehicle access and geography, impact their ability to access preventative and follow-up health care.

Aging Populations

A special emphasis was placed on the challenge of access to quality healthcare access for Darke County’s elderly population. Participants voiced the need for improved health care access for the county’s aging population.

> One participant commented, “Most people are caring for their grandparents but don’t know all the resources available.”

Physical access to healthcare was cited as the greatest challenge for elderly, rural residents. Travel cost and vehicle access is a barrier for elderly, rural patients receiving specialty services that are not available locally in Darke County.

> One participant commented that there is “not transportation available to get to the doctor on time or pharmacy, especially for old people.”

Mental Health & Substance Abuse

Mental health was described as an overlooked but central issue in the county.

> A participant commented that, "Everything is a circle; it starts with eating healthy then taking care of yourself and visiting the doctor. It's mind and body, both."

When participants were asked "*If you have one suggestion on how to improve the health of the community, what would it be*?" several participants indicated a need to improve mental health or substance abuse care.

> A participant remarked, "The County doesn't provide enough mental health services and recovery for addicts. They don't provide good services. Have you been down there? It's bad."

> Another participant mentioned that, "There's not enough mental health care and it forces some to seek treatment from far away or go without treatment."

The barriers to accessing mental health care included a lack of resources within the county and long waiting times. One participant offered his experiences with attempting to access mental health care in Darke County:

> "I went to the ER because I wanted to kill myself, but they made me wait 6 hours. So I went home and overdosed on purpose and came back so they'd take me, because I know I needed help."

The majority of focus group and telephone survey respondents expressed concern about drug sales and abuse in the county.

> One participant remarked, "There's a bad drug problem in Darke County. We just moved out of a neighborhood where you used to know everyone on your street; they were mostly elderly. Some of them passed away or went into nursing homes. Now their homes became rentals so drug deals increased in the neighborhood."

> Another participant said, "I've seen people sell drugs – heroin, marijuana, pills, all of it."

Key Themes from Focus Groups with School Nurses

We asked school nurses working in Darke County to tell us what they believe were the top health issues affecting youth in their community.

The primary concerns among the participants included:

1. Social Determinants of Health
2. Access to Healthcare: including dental care, vision care, and mental health services

3. Access to Social Services
4. Sexual Health Education

Each theme is discussed in further detail below.

Social Determinants of Health

In addition to discussing health concerns during the focus groups, participants typically discussed one or more social determinants of health that affected the health of the youth in their community. The Centers for Disease Control and Prevention (CDC) defines a social determinant as "factors that contribute to a person's current state of health." The determinants of health include: personal, social, economic, and environmental factors that influence an individual's health status.

Housing

School nurses discussed housing as a community need. One concern is the long waiting lists for subsidized housing:

> "Metropolitan housing has been using a waiting list for years – and Greenville has a lot of homeless."

Another nurse mentioned the lack of availability for homeless families:

> "In my [school] building, we have a lot of homeless situations. There are not enough homeless shelters to go around. And then the rule at the homeless shelter, from what I understand, is 8 to 4 everyday, they have to be out looking for a job."

> "And they're only allowed to stay for a certain time, like 30 days. It's not like we have 30 shelters."

Concerns about the quality and safety of available housing for homeless were mentioned:

> "They have different apartments designated for homeless people, but they don't advertise where they're at because some families might be in domestic abuse situations."

> "There was a house, too, at one time, but I also know that some people are afraid to stay there because of the other people that are there. There might be ex-convicts or whatever. There are no locks on the doors or the rooms they stay in."

Transportation

Transportation is an endemic issue in rural counties. Transportation and distance were repeatedly mentioned as a major barrier preventing low-income residents and youth from receiving adequate healthcare services. Focus group participants cited that it is difficult for many to get transportation to access healthcare services, partially due to Darke County's rural, geographic location and also a lack of reliable transportation.

When asked, “Where do you feel there are gaps in health services for the youth you service?” the lack of transportation was brought up by the majority of the focus group participants. Participants explained that physical barriers, including reliable transportation and geographic location, impact the ability of youth and their families to access preventative and/or follow-up health care:

> One nurse remarked, “I work at the opposite end of the county, so another barrier could be accessing the care, or transportation, vehicle not working, not able to get to children’s [hospital], to get a prescription, to get it filled. Even to come and pick up their child at school when they’re sick. They say, “Oh no, I can’t come pick them up.” Well, your child has a fever. Or they say, “My husband drove the car to work and we only have one care.” Or they have jobs that won’t let them leave work.”

The majority of participants cited the need to travel to outside of the county for certain health care services that are unavailable in the county, such as dental, vision, or mental health services. The problem is compounded because many participants also cite a lack of reliable transportation. Access to health care services is contingent upon transportation being available. Focus group members suggested transportation assistance and the promotion of existing transportation services to help address this barrier.

Access to Healthcare

Access to health care was a predominant theme in the discussion of addressing health in Darke County. The discussions about health care access were often related to provider shortages or long waiting lists to receive care. This is reflected in the Health Resources and Services Administration (HRSA) designation of Darke County as a Health Provider Shortage Area (HPSA) in the disciplines of primary care, dental health, and mental health.

Access to Dental Care

One concern was the lack of access to dental care:

> One nurse commented, “The mobile dental clinic is great for preventative or maintenance, however, the problem is when a student breaks a tooth and can’t get to the dentist. You can’t just call – and that’s the problem. If they’re not established with someone locally, then they can’t get in.”

The lack of dental coverage was an important topic of discussion among school nurses throughout the county. Participants related poor dental health with poor mental health and overall poor physical health. The most common concern related to dental care was a lack of access to dental care for low-income community residents.

> A nurse explained, “I think our community has gotten much better at providing services; we have many more doctors than we did, say, 20 or 30 years ago. However, our dental care at

Family Health was just a recent thing and they will take anybody. Last spring, I called – and they aren't taking new patients. So that was really a negative – lack of access to dental care for low-income. We have plenty of dental care and we have insurance, but if you don't have insurance, a lot don't have dental insurance. And then you deal with the emergency, you know? They come in with the toothache. I had a little boy this morning tell me, "My tooth hurts." Well, why does it hurt? "I have a cavity, but mom said we have to wait to go to the dentist." And, you know, he's in second grade. His mommy told him he had to wait. This poor little boy is in pain."

Access to Vision Care

Another important health care issue for youth in the community that was discussed was vision health care. The most common concern related to vision care was the lack of vision care centers accepting Medicaid or Medical Assistance. Participants commented on the need to travel outside of the county access vision services:

> "There are very few vision people who take Molina Care Source. I don't even think there are any around here who take Medicaid. I think the nearest is Piqua or Troy."

Another participant commented:

> "I think every community has a Lions Club to prevent blindness. The funding might be there, but the line of resources isn't. You have to go that route instead of having them have actual access to care – you have to go behind the scenes to get them care."

Access to Mental Health Services

Mental health issues were discussed at length and were a major concern for school nurses at every school. Focus group participants cited the limited availability of pediatric mental health services and psychological/psychiatric specialists as a major issue facing youth in the community. The school nurses brought a wealth of insight from their own firsthand experience as they worked to navigate the mental health system in Darke County.

> One nurse explained, "A problem I see when I look at my kids, especially my high school kids, is mental health - even some of my elementary. I think it's bigger than we even realize. Something as simple as - not even necessary diagnoses mental health conditions – but say there was a loss in the family, or mom and dad separated. All of these different stressors the kids are facing that we don't always know and then they're coming to school and not able to focus."

> Another nurse described a firsthand experience: "We do have some from Darke County Mental Health who come and have sessions in our schools. Say a child loses a parent, they have groups. We have two counselors who come in and do a group on a regular basis, and I think that helps with that but only if it escalates into a bigger problem. We have a student who has only been there twice since the beginning of school. She refuses to come to school, she shaved her head the other day – she's crying out for help but we've had a hard time getting help."

Several participants expressed concerns that without early care, mental health issues could escalate.

> One nurse commented, “I think sometimes these itty bitty mental health things develop into these huge mental health things because there’s no help for them.”

Participants believed that existing mental health services have a limited capacity to meet the demand for services due to poor physician retention and recruitment. As result, the focus group spoke of a fragmented system to find available services as they expressed:

> One nurse recounted a first-hand example saying, “I have a student - who the family does have health insurance, mom works at the school, is very well-involved - her son is having some really high anxiety related to stress of coming to school, and to the point they needed to actually get him some care. So they took him to the family doctor who, fortunately, prescribed him some medicine to help him with that because it was the second week of school and he was just trembling - he couldn’t come. He gave him medicine with a referral to see a psychologist – however, she cannot find one. She has called and called and no one is taking patients. I mean, she even went into Miami County. She said, “Oh we think we found one in Piqua!” and they got into that, and once he got into the scheduler, they said, “We are not taking patients.” Nobody that she could find anywhere is taking them. And she wanted to take him wherever, so it’s not like they’re being particular about where she’s going and, fortunately, the family doctor prescribed some medicine. But not all family doctors would be comfortable doing that for children – I mean, he’s only in fifth grade.”

> Another nurse explained that, “Our mental health center here in Greenville is so overworked and so stretched thin – and they’re converged with Miami and Preble. And the psychiatrist that comes to mental health is only here one day out of who knows how many. Then they end up leaving, and they have to get a new doctor. I have kids in that situation, who need medication but the family doctor won’t give it. But he quits, and now they gotta find another doctor. So they’re in limbo for months. We just don’t have mental health care like we should.”

The school nurses also referenced funding cuts contributing to mental health shortages - which are occurring on a national and regional level – that affect the limited availability of school psychologists and counselors.

> One nurse shared her frustration with limited access to the guidance counselor, stating, “Being in a K-12 building, we have one guidance counselor for the whole school. So, technically, he can’t see elementary kids because he’s trained for high school kids. So that’s a problem. There are not just enough people.”

In addition to simply not having enough providers to service all the students, focus group participants went on to explain that there are not enough providers to service each, individual school and that funding cuts have forced schools to “share” school psychologists:

> “In all honesty, there’s not enough money. Most of us share our psychologist who travels from school to school. So we share our resources… but their responsibilities are full time.”

Furthermore, the focus group participants all showed overwhelming concern that funding cuts have forced school psychologists and counselors to do focus on tasks unrelated to mental health.

> One nurse explained, “I know that – psychologists for schools, for regular people – there is a shortage across the nation. And nowadays, school psychologists don’t do school psychology. It’s all counseling. They do Evaluation Team Reports. They do the evaluations for testing. They don’t do the counseling. They can do a little bit here and there, but it’s not what they end up doing. And our guidance counselors are the same way. They are the testing and scheduling people, in addition to that job. And they hate it. At least the one that I work with hates it.”

The barriers mentioned related poor mental health and a “lack of education and knowledge” about mental health with poor performance in school, absenteeism, truancy, and other general health issues:

> One nurse stated, “I don’t think kids are aware that’s an issue that they need to talk to somebody about.”

> Another nurse explained, “They may come to school or they may refuse to come to school, then you’re dealing with absenteeism or truancy. Or their tummy hurts so badly because there are other things going on.”

Navigating Social Services and Health Care Services

Another predominant theme among school nurses was the navigation of social services and health care services by low-income or underserved families, specifically the availability and accessibility of health care facilities and resources, emergency room overuse, and cost related barriers.

Focus group participants repeatedly cited the challenges of accessing health care, including transportation, cost, and provider availability. Additionally, they cited the difficulty of navigating social services and health care services, especially among underserved, low-income families.

> One participant explained, “I don’t know if we can incorporate this somehow, but today I got a firsthand taste of how difficult it can be to get services. We have a family in my district who is new to the district who is from out of state, and it’s a mom who is guardian over 5 children. This mom doesn’t work, she has a cell phone, but that’s it and it doesn’t get good service. She has no vehicle, she walks the kids back and forth to the school, and every time you see her, she is always smiling and always friendly. I tried to get Kiwanis to cover glasses for the girls because they need them, Kiwanis said “no, because she’s eligible for Medicaid, but hasn’t applied for Medicaid yet and she has no insurance. So until she seeks insurance, we can’t allocate our resources to help them if they qualify for Medicaid because Walmart takes Medicaid.” So today, I’m thinking, “Why can’t this woman drive to Greenville and get signed up?” Like, doesn’t that seem so simple? And she obviously gets there to get groceries for the kids, but listen, she has a boyfriend who works. They have one vehicle. He is gone Monday through Friday on long hours working to help provide for them. She has five kids and no vehicle to get to Greenville. So I pick up the phone and call Darke County Job and Family Services. This is call was no user-friendly - and I understand they have to make it non-user-friendly so they don’t make it too easy for

people – I didn’t know what button to push. I mean, it was ridiculous. I mean, you could never get to a person if you wanted to. I had to leave a message, and I didn’t know if I was even leaving it at the right place. All I wanted to know was the hours they were available and the hours that they’re open, because they don’t have a website with that information on it. I want to know what hours are they open because there’s a family I’d like to help get transportation there, and if they’re not available to help get transportation there, can they send me paperwork so I can at least get started on it and fax it. This is a family with a true need and I’m having difficulty trying to help her. This is crazy, so I don’t understand how some people have such an easy way of getting things. And here’s a family whose kids do not have nice things, but they’re always clean. I mean, she walks every kid up to school and always smiles. This is crazy. So, I know who she got guardianship from but it’s a situation from out-of-state. What Kiwanis said was that it is an instant thing that you qualify for Medicaid when you move to another state, you just have to go give the paperwork. But here’s a person who can’t even get over there to get paperwork. But here’s what I don’t understand is, here I can’t even get ahold of somebody so that I can help somebody who truly has a need. That’s a real problem. So the services that we’re supposed to be using to help people aren’t even working. And I thought, “Oh, I’ll be smarter than this after the third call, I’ll just push zero.” And it told me, “Invalid entry.” Are you kidding me? So I see that as a real barrier, because it’s just frustrating.”

Sexual Health Education

Several focus group participants cited sexual health as a concern in the community, particularly for youth. Participants discussed that limited sex education in schools and cultural stigmatization and acceptability have led to increasing teen birth rates and increasing rates of sexually transmitted infections in the county.

One participant mentioned, “The school is very hesitant to bring in sexual health information into the schools.”

Another participant commented, “The parents get mad because little Susie tells them what she learned in school and the parents are like, “Oh my God!” but they’re not teaching them either. They’re not learning the proper way. They’re learning from the TV or the internet. High school has a sophomore health class where they talk about STDs, but it’s too late. We used to have it in fifth or sixth, but then the whole education and money thing cut it. We should start in elementary.”

Several participants mentioned that rural areas often have a more conservative identity which serves as a barrier to assessing the status of sexual health needs and education in the community.

> One participant commented, "I would've been one of those parents who were asking, "What are you teaching my kids?!" I'm very conservative. But I don't know how many times I've been like, "Ok, you're sexually active; you need to make sure you're protecting yourself." And then they don't. And we can't even ask them a question about it on the youth survey and that bothers me. Are we just going to pretend we're in the dark about what's happening?"

They discussed that adolescent and teenaged girls were at highest risk for life-changing consequences, including pregnancy or sexually transmitted infections. They also mentioned that, overall, adolescents and teenagers were a hard to reach population regarding this topic.

> One participant commented, "I don't work with teenagers, although we have had a sixth grader pregnant, but that being said, we're not allowed to ask those questions on the youth survey."
>
> Another explained, "I do have a lot of girls that are on birth control and, I mean, the parents – a lot of them – know they are. If they're not on birth control, it's very rare they are not on birth control. That's easier for the parents than actually teaching them about sex. "

Sexually transmitted infections were seen as exceptionally concerning since the rates have nearly double over the past ten years, according to one participant.

> Another participant explained, "I had to start educating fifth graders about STDs in the fifth grade talk because we had a sixth grader that had an STD. Isn't that sad? They're hearing about something they don't have a clue about anyway. But we have to start educating because we are starting to see it. I hate the fact that they won't allow you to ask sexual health questions on the youth health risk survey. I know we're rural and more conservative, but it's still happening. I just don't know why we can't."

Participants were also concerned that families and organizations were inaccessible to youth for support and information about positive sexual health.

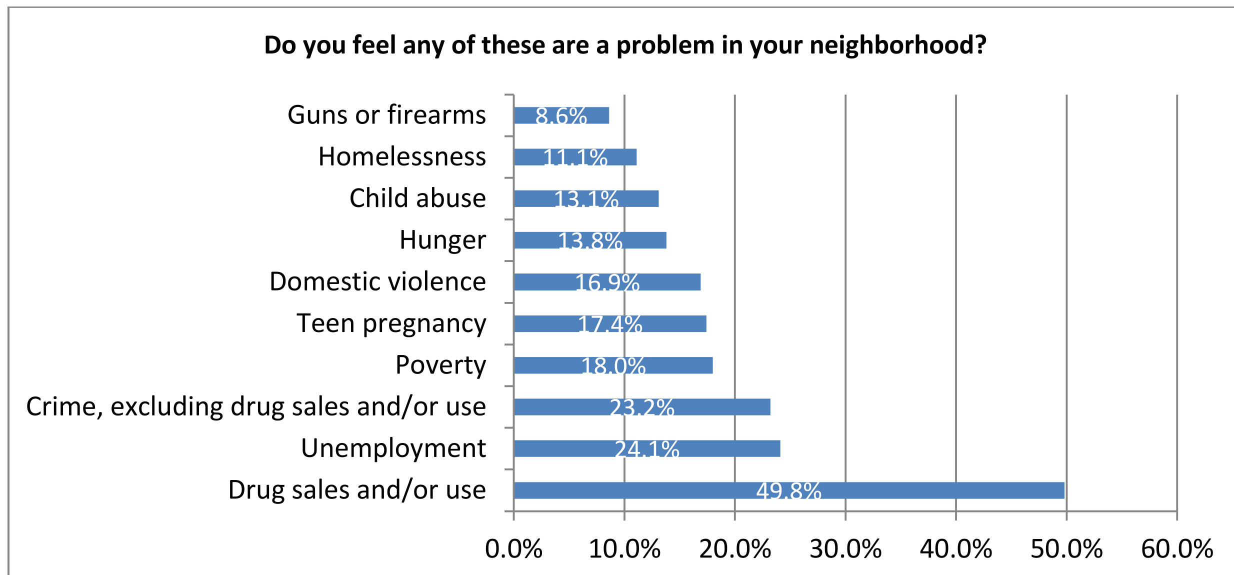
> One participant explained, "They're either not getting any [sexual health] education or they're getting it from their friends, but not correctly. "
>
> Another participant commented on existing resources and said, "The Pregnancy Crisis Center, they're a great resource, and they're only abstinence only but you still have to get permission from your superintendent or your board for them to even come in."

Community Needs Assessment Primary and Secondary Data Results

Darke County residents were asked to indicate whether they felt any of the social issues listed below were an issue in their own community. Approximately half (49.8%) of survey respondents felt that drug sales and/or drug abuse was a problem in their neighborhood.

Nearly a quarter or respondents felt that unemployment (24.1%) and crime excluding drug sale/use (23.2%) were a problem in their neighborhood.

Figure 10: Health Issues in Neighborhood



Darke County residents were asked to indicate the single most important health issue affecting their community. The three health issues that community members perceive to be the most important are: drug abuse, cancer, and obesity.

A list of health issues based on frequency is presented below:

Table 9: Respondents' Perceptions of Top Health Issues Affecting Darke County

Health Issue	Number of Respondents who indicated this was an important issue
Drug Abuse	108
Cancer	34
Obesity	17
Aging Population	9
Not Enough Rural Healthcare Providers	7
No Visible Problem in Community	7
High Cost of Healthcare Services	7
Communicable Disease (Cold and Flu)	6
Heart disease	5
Affordable Health Care/Insurance	5
Lack of Health Literacy	5
Poverty	4
Excessive Alcohol Use	3
Pediatric Care (Ear problems, Vaccinations, Lack of Dental or Vision Care)	3

Environmental (Allergies, Pollution, Pollen & Dirt)	3
Alzheimer's	3
Lack of Exercise/Physical Inactivity	3
STD's and Teen Pregnancy	2
Lack of Mental Health Services	2
Diet	2
Quality of Care	2
Hunger	1
Employment	1
Diabetes	1
Abortion Education	1
Lack of Education	1
Lack of Resources to See a Doctor	1
Homelessness	1
Unemployment	1
Lack of Specialists	1
Gun Violence	1
Lack of Urgent Care Center	1

County Health Rankings Data

Table 10: County Health Rankings Data

	Darke County	Ohio	National Benchmark	National Median	Rank (of 88)
Overall Health Outcomes					
Maternal and Infant Health					
Teen Pregnancy (15-19) in 2011	33.9%	30.5%			30th
Low Birth Weight	6.2%	8.6%	5.9%		
Pregnant mothers who smoked (ODH)	19.2%	17.8%			
Mothers without 1st trimester care (ODH)	63.7%	56.4%			
Behavioral & Other Risk Factors					
Adult smoking (% of adults that smoke ≥ 100 cigarettes)	23%	21%	14%		
Adult obesity (BMI: ≥ 30)*	32.2%	29.6%	25%		
Physical inactivity* (No leisure time physical activity)	35%	26%	20%		
Excessive drinking (Consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or drinking more than 1 (women) or 2 (men) drinks per day on average)	11%	18%	10%		
Motor vehicle crash death rate (Crude mortality	21	10			

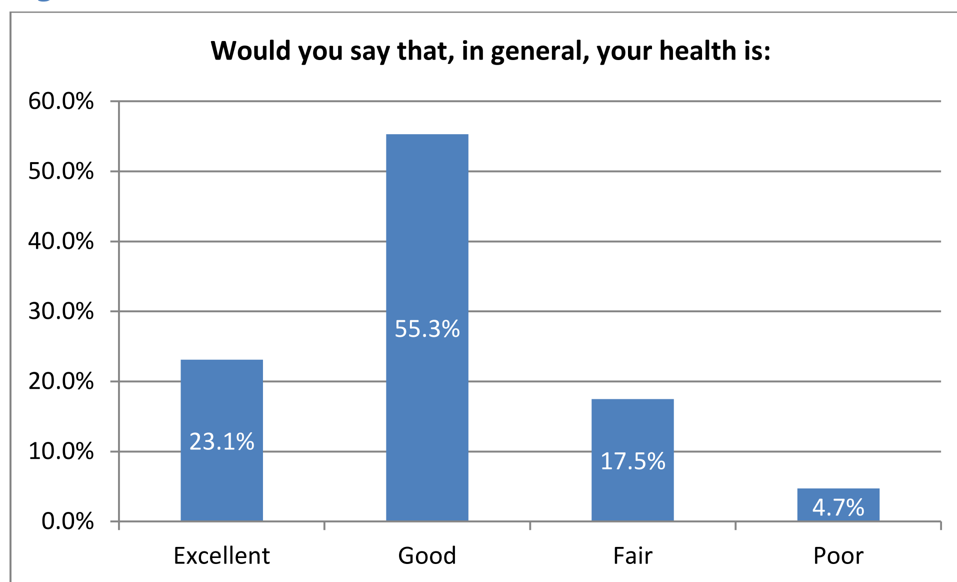
rate per 100,000 population due to traffic accidents involving a motor vehicle) (Source: County Health Rankings, 2006-2012)			
Sexually transmitted infections (Chlamydia rate per 100,000 population)	240	460	138
Limited access to healthy foods (% low-income population who are low income and do not live close to a grocery store) (Source: County Health Rankings, 2010)	2%	6%	
Clinical Care			
Uninsured (% population < age 65 without health insurance)	14%	14%	11%
Primary care physicians (Primary care physicians include practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. Population per physician)	2,100:1	1,336:1	1,045:1
Dentists (Population per dentist)	3,741:1	1,746:1	1,377:1
Mental health providers (Population to the number of mental health providers including child psychiatrists, psychiatrists, and psychologists active in patient care)	1,940:1	716:1	386:1
Preventable hospital stays (Hospital discharge rate for ambulatory care-sensitive conditions per 1,000 Medicare enrollees)	70	72	41
Diabetic monitoring (Percentage of diabetic Medicare enrollees age 65-75 that receive HbA1c monitoring.)	88%	84%	90%
Mammography screening (% of female Medicare enrollees ages 67-69 that receive mammography screening)	63.1%	60.3%	70.7%
Disease			
Poor or fair health* (Measure is based on a survey question)	21.6%	15.3%	
Poor physical health days	3.1	3.6	2.6
Poor mental health days (Measures is based on a survey question)	3.0	3.8	2.3
High blood pressure* (Measure is based on a survey question asking, "Has a doctor every told you that you have high blood pressure?)	30.2%	28.8%	
Heart attack (myocardial infarction)* (Measure is based on a survey question asking, "Has a doctor every told you…?")	4.6%		-

Coronary heart disease* (Measure is based on a survey question asking, “Has a doctor ever told you…?”)	2.6%		-	
Diabetes* (Measure is based on a survey question asking, “Has a doctor ever told you…?”)	12.6%		8.9%	
Leading Causes of Death				
Premature death (Years of potential life lost before age 75 (YPLL-75) presented as an age-adjusted rate per 100,000 population)	6,672	7,466		25th
**Note: Self-reports from the Darke County Community Needs Assessment Survey; all other Data from RWJF except where noted*				

Overall Health Status

Over three-quarters (78.4%) of Darke County survey respondents reported that their general health is “Excellent” or “Good”; this percentage is less than that of the State of Ohio (84.7%).

Figure 11: Health Status



Source: 2015, Darke County Health Behavior Risks Telephone Survey

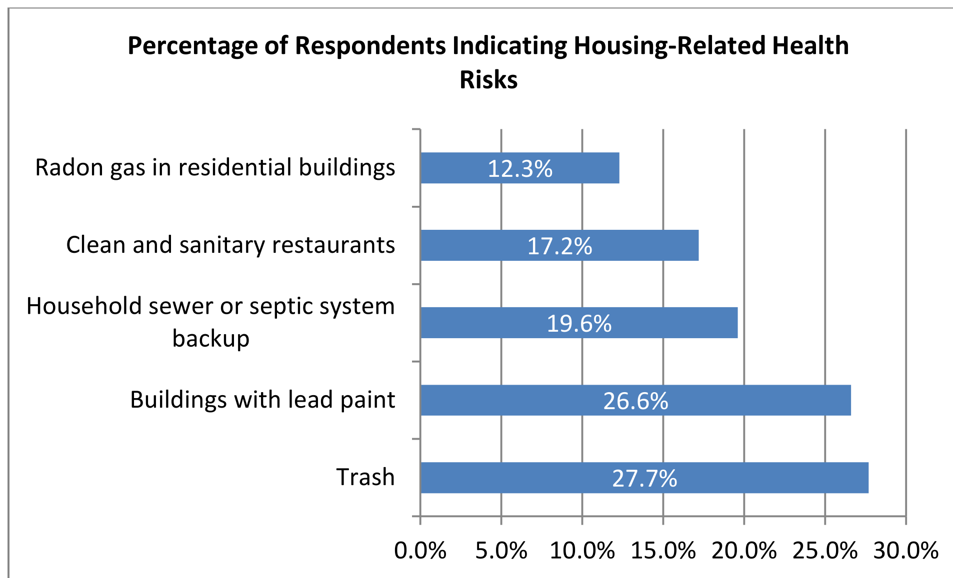
Housing-Related Health Risks

The quality of housing is a significant social determinant of health. Poor housing conditions are associated with a number of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health. The Darke County Health Department recognizes the need for information on housing quality at the community level.

Survey respondents in Darke County were asked to indicate whether several housing-related health risks were a “big problem,” “moderate problem,” or “no problem at all.” Figure 11 shows

the percentage of Darke County residents who believed each problem was either a “big problem” or “moderate problem.” Approximately a quarter of Darke County residents indicated that trash (27.7%) and buildings with lead paint (26.6%) were either a “big problem” or “moderate problem” in their communities. Household sewer or septic system backup was indicated as a “big or moderate problem” by 19.6% of survey respondents. Clean and sanitary restaurants are a concern for 17.2% of survey respondents, while radon gas in residential buildings was indicated as a “big or moderate problem” by 12.3% of survey respondents.

Figure 12: Percentage of Respondents Indicating Housing-Related Health Risk

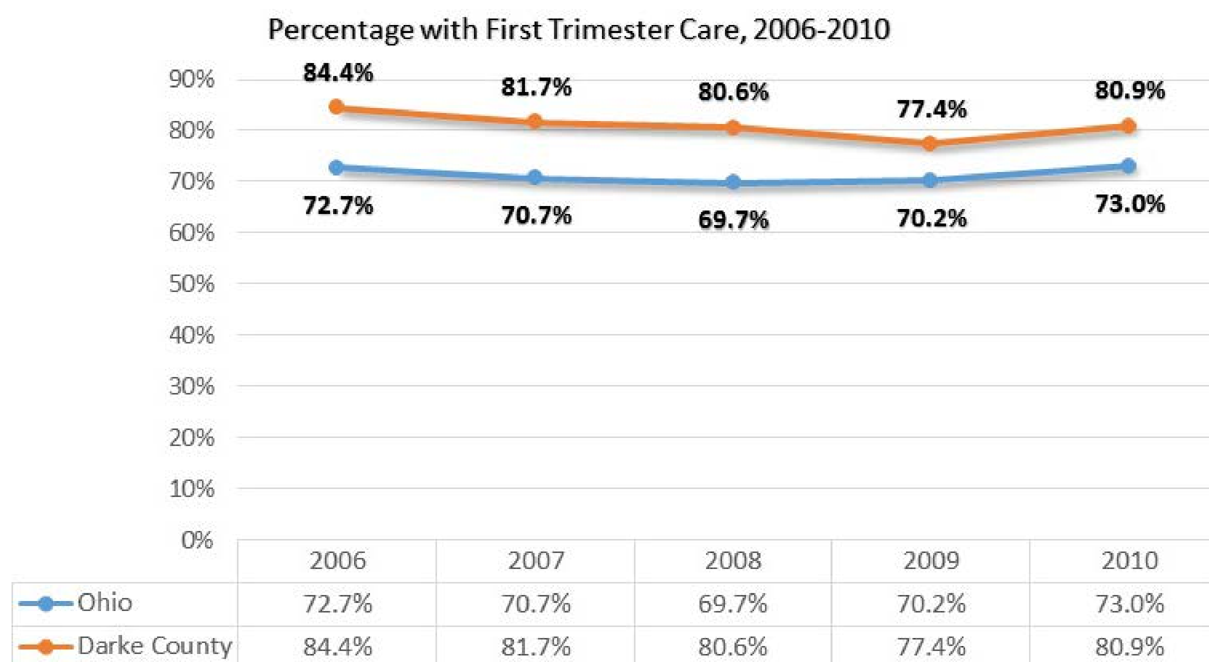


Maternal and Infant Health

First Trimester Prenatal Care

The percentage of women obtaining first trimester prenatal care decreased from 2006 to 2009, a trend that reversed in the year 2010. Over the study period, the percentage of pregnant women in Darke County receiving first trimester prenatal care is higher than for Ohio.

Figure 13: Percentage of Births with First Trimester Prenatal Care, 2006-2010



	2006	2007	2008	2009	2010
Ohio	72.7%	70.7%	69.7%	70.2%	73.0%
Darke County	84.4%	81.7%	80.6%	77.4%	80.9%

Source: 2006-2010, Ohio Department of Health, Vital statistics annual birth summaries.

Infant Mortality Rate

According to the Centers for Disease Control and Prevention (CDC), infant mortality is defined as the death of an infant before his or her first birthday; this occurrence is measured per 1,000 live births. The death of an infant before his or her first birthday is a major indicator of a community's health status.

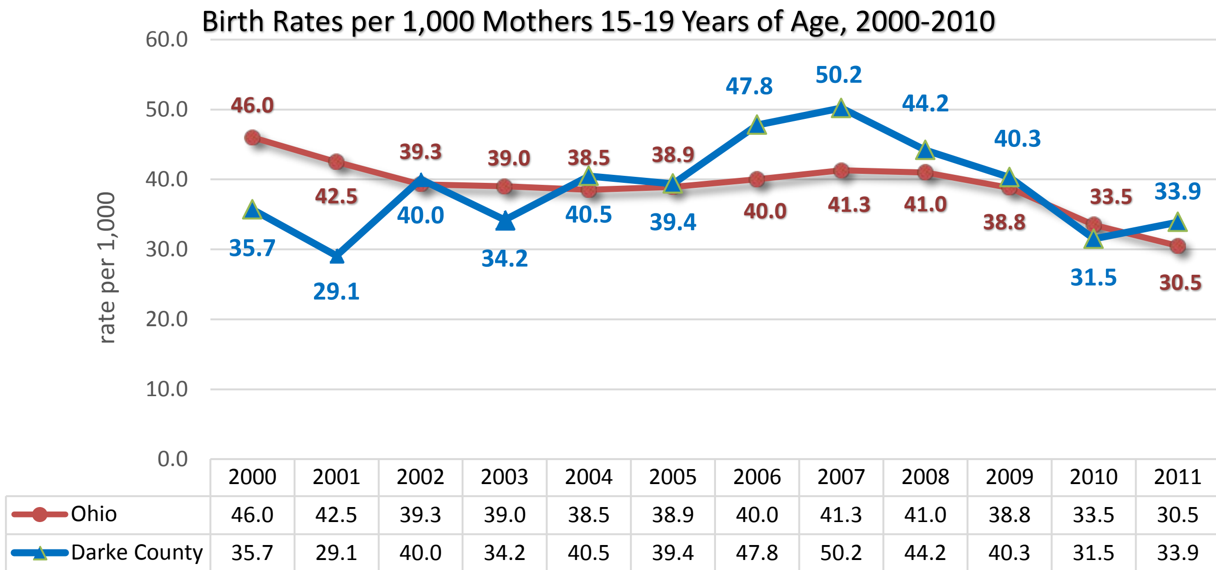
The trend in Ohio is higher than the Healthy People 2020 goal of 6.0 and was 7.4 in 2013. The infant mortality rate in Darke County is generally below the state rate, but due to a very small number of infant deaths, the rate for the County is not presented.

However, the difference in death rate between black infants and white infants is significant. In the state of Ohio, the death rate for black infants (13.1) is 2.1 times the rate for white infants (6.3). It is suspected that black infants in Darke County may be at a higher risk for death than white infants; however, the data are not reportable due to very small numbers.

Teen Birth Rates

The teen birth rate is declining in both the County and the State. While Darke County's rate was higher than the State's rate for much of this time period, it dropped below the State rate in 2010 and has been on a decline since 2007.

Figure 15: Teen Birth Rate



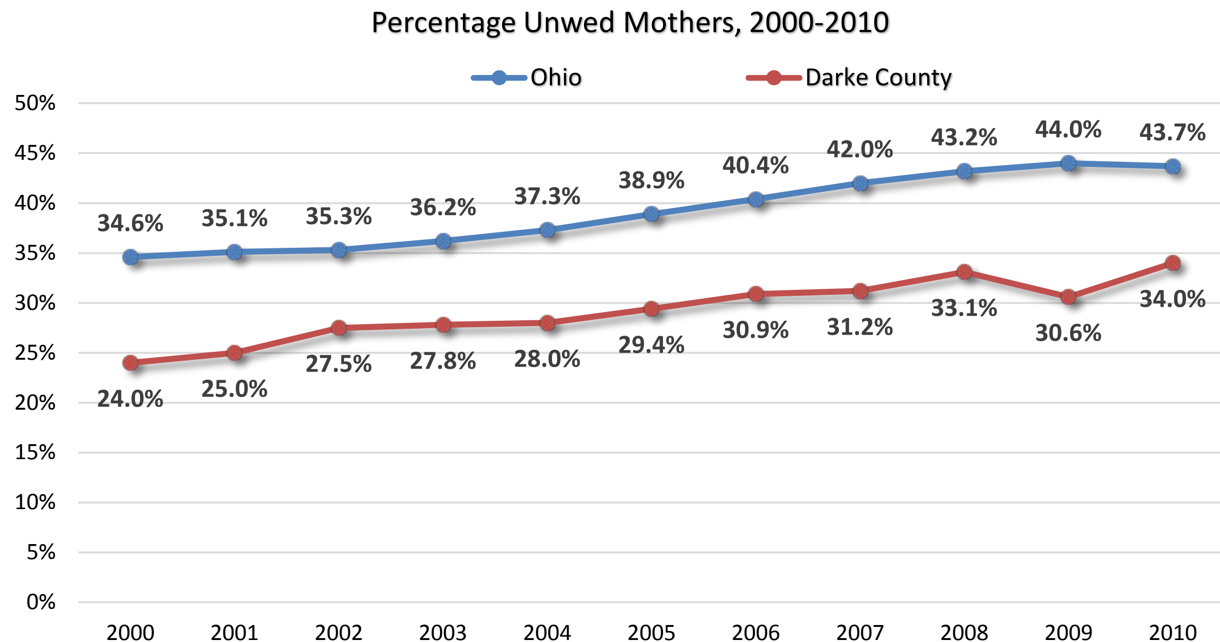
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ohio	46.0	42.5	39.3	39.0	38.5	38.9	40.0	41.3	41.0	38.8	33.5	30.5
Darke County	35.7	29.1	40.0	34.2	40.5	39.4	47.8	50.2	44.2	40.3	31.5	33.9

Source: 2000-2013, Ohio Department of Health, Vital statistics annual birth summaries.

Births to Unwed Mothers

The percentage of births to unwed mothers is steadily increasing, with the County's rate remaining below the State rate for all years studied. Nationally, non-marital birth rates fell in all age groups under age 35 since 2007; rates increased for women aged 35 and over.

Figure 16: Births to Unwed Mothers

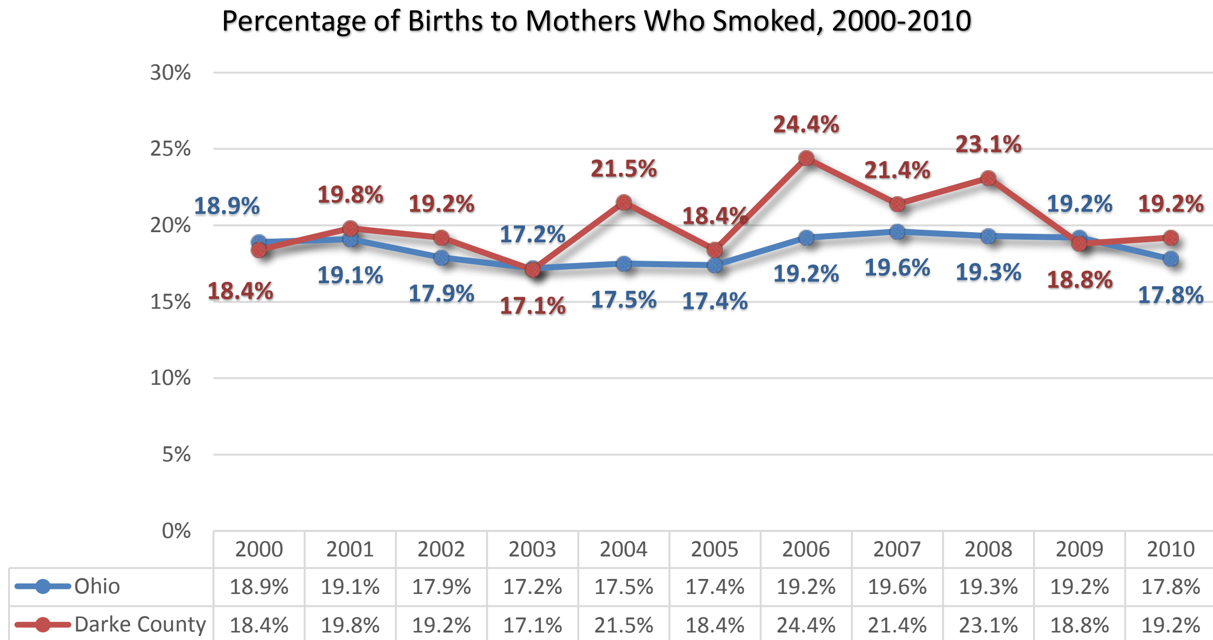


Source: 2000-2013, Ohio Department of Health, Vital statistics annual birth summaries.

Births to Mothers Who Smoked

The percentage of Darke County mothers who smoked while pregnant is higher than the State percentage for most of the years studied and is 19.2% versus 17.8% in 2010. The County percentage is 1.8 times higher than the national percentage (10.4%). The Healthy People 2020 goal is to reduce the percentage to 1.4%.

Figure 17: Births to Mothers Who Smoked



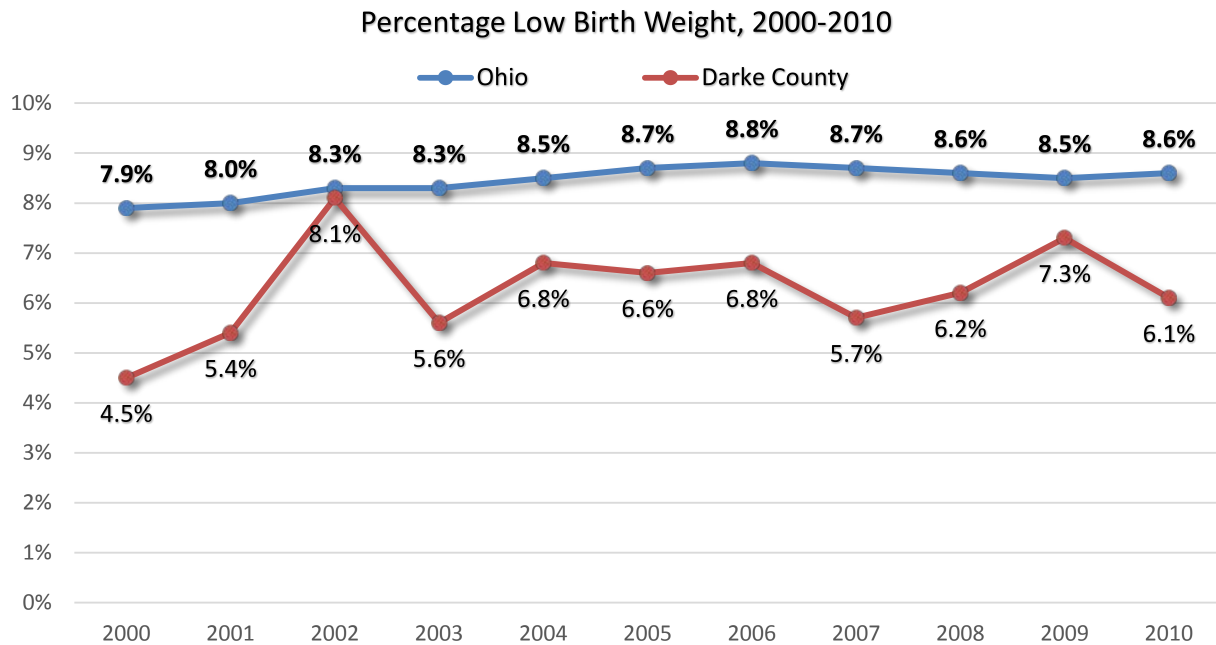
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Ohio	18.9%	19.1%	17.9%	17.2%	17.5%	17.4%	19.2%	19.6%	19.3%	19.2%	17.8%
Darke County	18.4%	19.8%	19.2%	17.1%	21.5%	18.4%	24.4%	21.4%	23.1%	18.8%	19.2%

Source: 2000-2013, Ohio Department of Health, Vital statistics annual birth summaries.

Low Birth Weight Rate

The State's low birth rate is maintained at 8.5%, while the national rate is 8.2%; the national target from Healthy People 2020 is 7.8%. Darke County's rate has been lower than the State's rate for every year in the study period and is below the national target.

Figure 18: Percentage of Low Birth Weight Babies



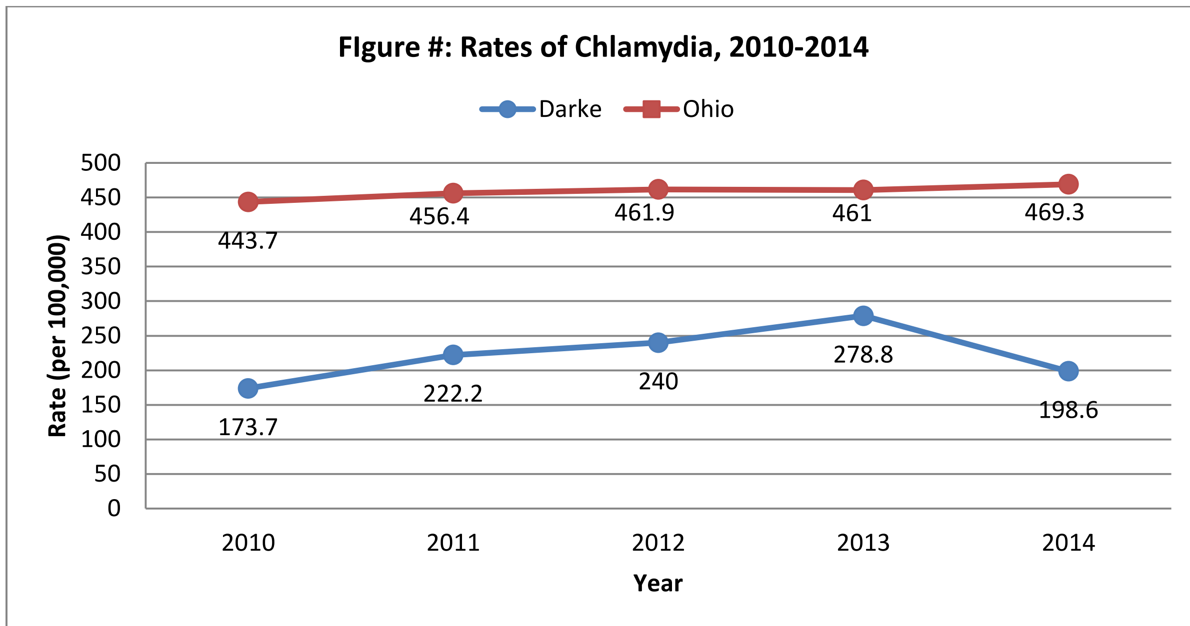
Source: 2000-2013, Ohio Department of Health, Vital statistics annual birth summaries.

Sexually Transmitted Infections

According to the Community Health Needs Assessment survey, 84.6% of Darke County residents reported that they did not use a condom last time they had sexual intercourse. Roughly 5% of respondents reported having sexual intercourse with more than 2 people in the past 12 months.

The rates per 100,000 in population of chlamydia cases in Ohio are steadily increasing, while in Darke County they increased over the study period until the year 2014. The rate for the County is substantially lower than the rate for the State.

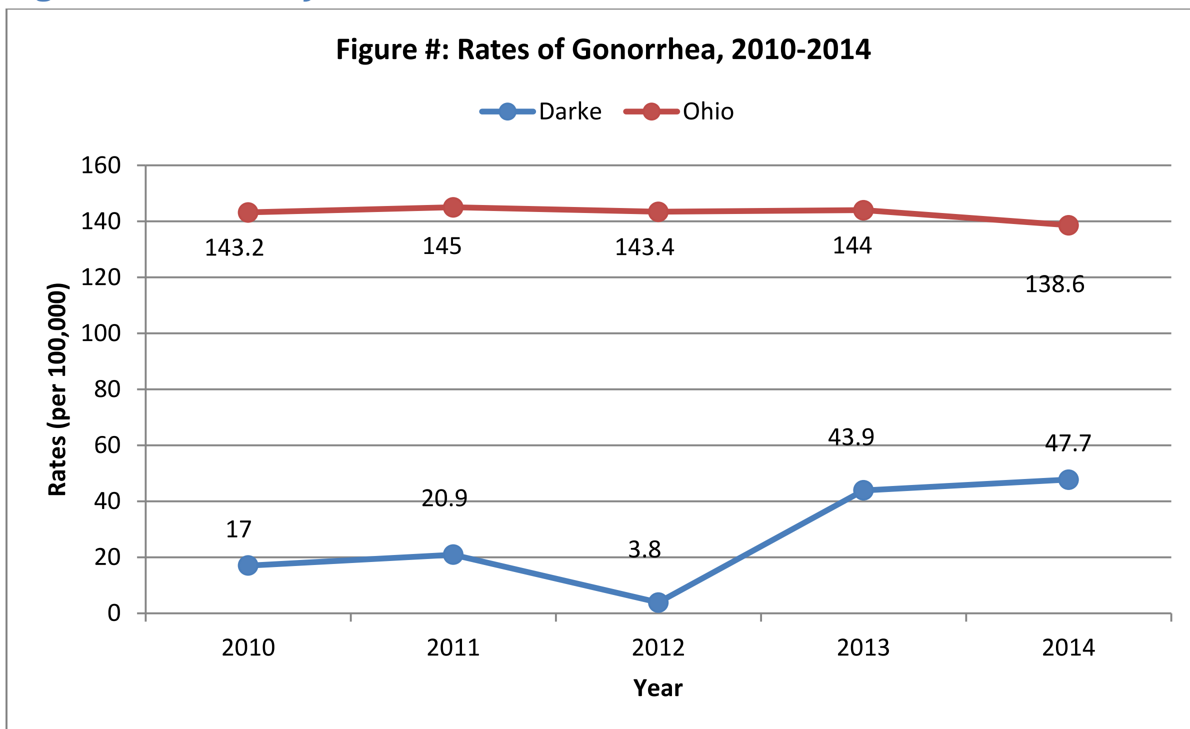
Figure 25: Rates of Chlamydia, 2010-2014



Source: 2010-2014, Ohio Department of Health, STD Surveillance Program.

The rates per 100,000 in population of gonorrhea cases in Ohio are steadily decreasing, but are increasing in Darke County.

Figure 26: Rates of Gonorrhea, 2010-2014



Source: 2010-2014, Ohio Department of Health, STD Surveillance Program.

Youth Behavioral Risk Factors

Waiting on analysis for HS/MS surveys

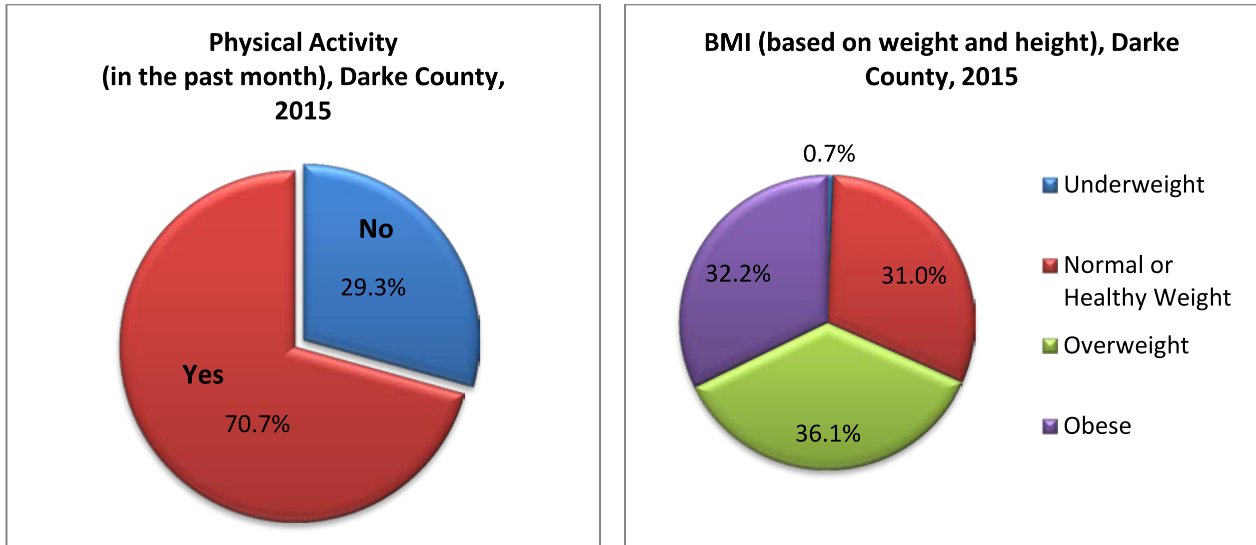
Behavioral Risk Factors

In this section of the report, data from multiple sources are used to describe the behavioral risk factors for adults in Darke County, including a household survey as well as hospital and public health data.

Physical Activity & Obesity

Approximately 3 out of 10 Darke County adults did not participate in any physical activity in the past month. At the same time, about the same proportion are obese—32.2%. Another 36.1% of Darke County adults are overweight. For Ohio, 30.4% of adults are obese and 34.7% are overweight (2013 data from the CDC).

Figure 19: Physical Activity and Weight Status

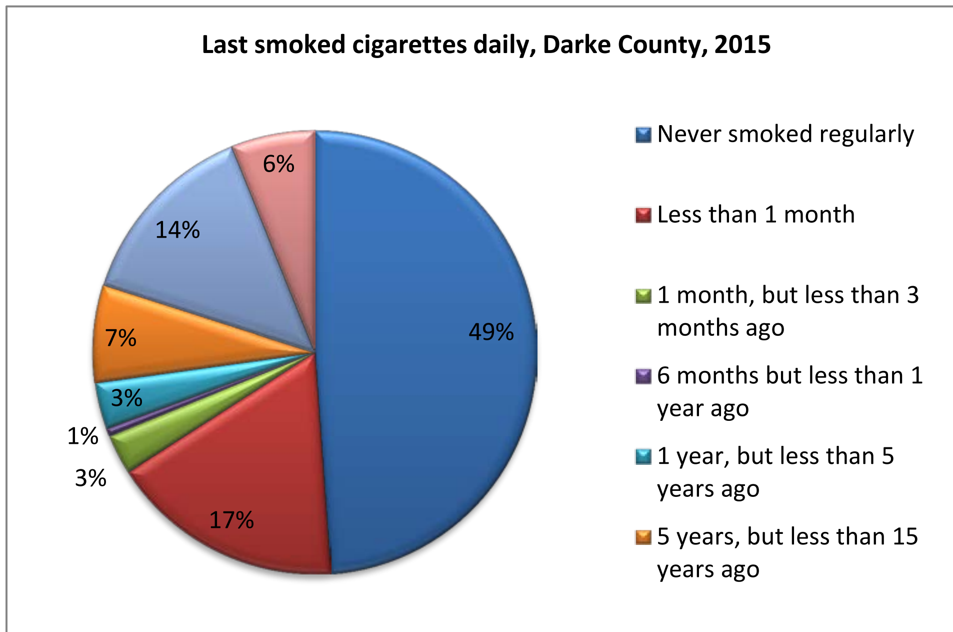


Source: Darke County BRFSS, 2015

Source: Darke County BRFSS, 2015

Adult Tobacco Use

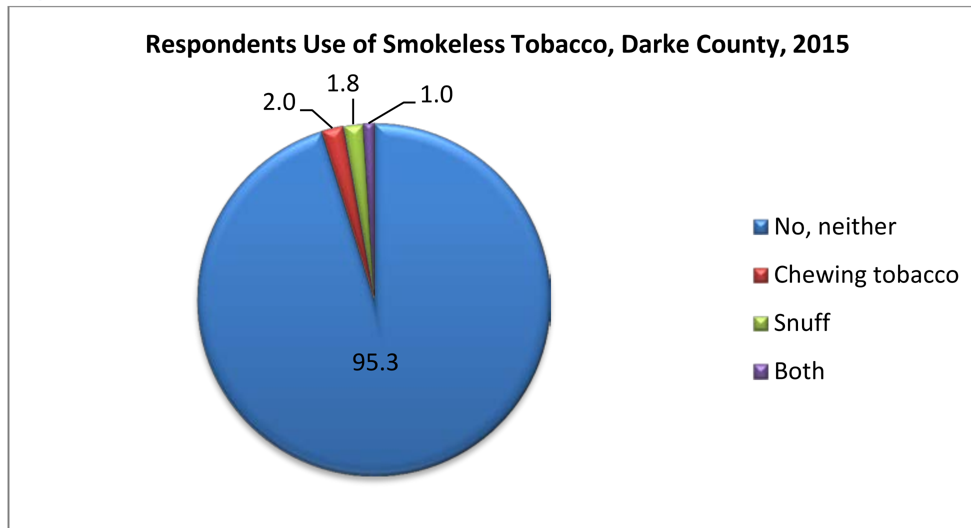
Figure 20: Smoking Cigarettes Daily, 2015



Source: Darke County BRFSS, 2015

Less than 5% of Darke County adults reported using smokeless tobacco (chewing tobacco, snuff, or both).

Figure 21: Smokeless Tobacco Use, 2015



Source: Darke County BRFSS, 2015

Substance Abuse

The Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists located in the following regions of the state: Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo, and Youngstown.

Darke County is located within the "Dayton" region. According to the 2014-2015 report, the Dayton region rates "high" in availability of crack cocaine, heroin, prescription opioids, and sedative-hypnotics; and rates "moderate" in availability of Suboxone and prescription stimulants (i.e., Adderall, Vyvanse); rates "variable" for the availability of methamphetamine; and rates "low" for availability of ecstasy. These reported ratings are comparable to the other seven regions in the state.

Table 11: Reported Change in Availability of Substances in the Past 6 Months, 2014-2015, 2010-2014

Reported Change in Availability of Substances in the past 6 months, January 2014-2015								
	Akron-Canton	Athens	Cincinnati	Cleveland	Columbus	Dayton	Toledo	Youngstown
Crack Cocaine	High	High	High	High	Moderate to High	High	High	High
Heroin	High	High	High	High	High	High	High	High
Prescription opioids	High	High	Moderate	High	High	High	High	High
Suboxone	High	High	High	High	High	Moderate	High	Moderate to High
Sedative-	High	High	High	High	High	High	High	High

Hypnotics								
Methamphetamine	High	High	Variable (high in rural, low in urban)	No consensus	High	Variable	Variable (high in rural, low in urban)	Moderate to High (higher in rural areas)
Prescription Stimulants (i.e., Adderall, Vyvanse)	High	High	No consensus	Moderate to High	Moderate to High	Moderate	Moderate	High
Ecstasy	Low	Moderate	Low	Low to Moderate	Moderate	Low	No consensus	No consensus

Source: Surveillance of Drug Abuse Trends in the State of Ohio, January 2014-2015, http://mha.ohio.gov/Portals/0/assets/Research/OSAM-TRI/January-2015-Full-Report_Surveillance-of-Drug-Abuse-in-the-State-of-Ohio.pdf

The table below summarizes the data from Ohio Department of Mental Health & Addiction Services (OMHAS) related to Ohio's opiate epidemic as of January 2015.

Table 12: Impact of Opiate Epidemic in Darke County and state of Ohio, 2015

Impact of Opiate Epidemic in Darke County and State of Ohio, 2015

	Darke	Ohio
Total Hospital Admissions (per 10,000 persons)	16.3	29.9
Hospital Emergency Room Discharges (per 10,000 persons by county patient of residence)	10.8	16.5
Discharge Rates for Neonatal Abstinence Syndrome (per 1,000 live births)	3.1	8.8
Unduplicated admissions for opiate abuse and dependence	13.0%	30.4%
Prescription opioids as primary drug choice	4.2%	12.7%
Heroin as primary drug choice	10.2%	15.2%
Prescription opioid doses (per capita)	42.9	61.2
Charges for drug possession for all drugs (per 10,000 persons)	25.4	N/A
Charges for drug possession for all opiates (per 10,000 persons)	10.3	N/A
Incarceration rates for drug offenses (per 10,000 persons)	3.1	6.4
Property crime charges (per 10,000 persons)	63.2	215.5

Source: Ohio Department of Mental Health & Addiction Services, 2015, http://mha.ohio.gov/Default.aspx?tabid=701

According to the five-year weighted average from 2009 to 2013 from the Ohio Hospital Association, Darke County saw a rate of 16.3 per 10,000 persons for hospital admission rates

for opiate abuse, dependence or poisoning among persons admitted from emergency rooms into inpatient or observation settings, as well as those persons treated and released from emergency rooms. This is lower than the average rate (29.9) for the State of Ohio.

With a rate of 10.8 per 10,000 persons, Darke County's rate is lower than the State of Ohio's rate (16.5) in emergency room discharge rates for persons diagnosed with opiate (i.e., heroin or Rx opioid) abuse, dependence, or poisoning.

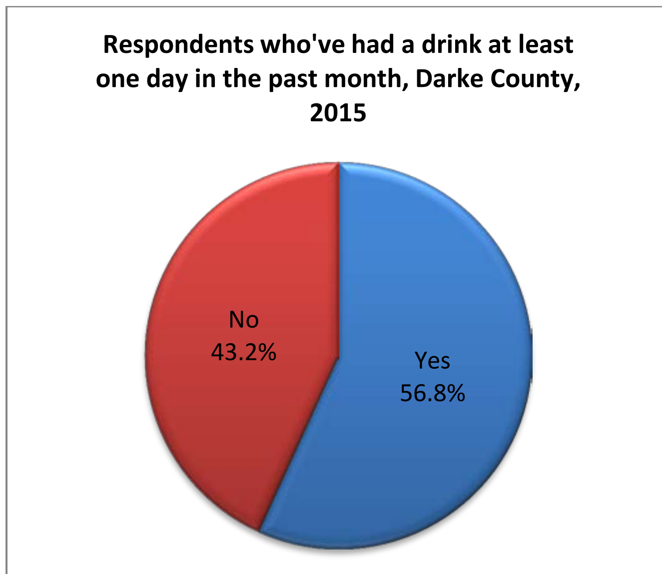
The discharge rate for neonatal abstinence syndrome (NAS) in Darke County was 3.1 per 1,000 live births; this compares favorably to the state average rate of 8.8 per 1,000 live births.
Source: Ohio Department of Mental Health & Addiction Services, 2015, http://mha.ohio.gov/Default.aspx?tabid=701

In Darke County, alcohol & drug related conditions ranked as the primary reason people were admitted to the Emergency Room and the sixth ranking reason people were admitted to the hospital. Alcohol and drug related conditions were the 11th leading cause of death in Darke County.

The community health needs assessment survey asked Darke County adults to indicate the single most important health issue affecting the community. The number one response was "drug abuse." Adults were also asked, "*Do you know anyone who uses illegal drugs or prescription drugs that are not theirs?"* Approximately 13.3% of Darke County residents indicated that they knew someone who was currently abusing or misusing illegal drugs and prescription drugs.

According to the community health needs assessment survey, over half of Darke County adults (56.8%) drank alcohol at least one day in the past 30 days. Among Darke County residents, 11% reported having binged at least once in the past 30 days; this percentage is lower than the state average percentage (18%). A binge is defined as consuming at least 5 drinks on one occasion for males or at least 4 drinks on one occasion for females.

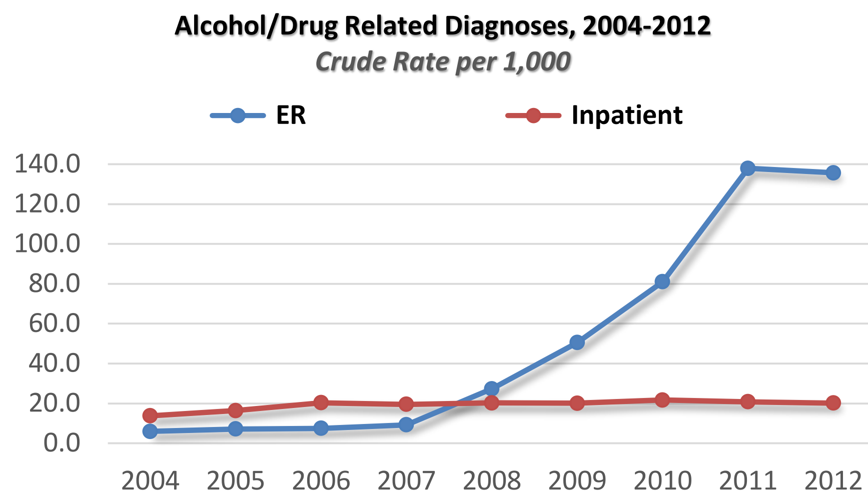
Figure 22: Alcohol Use in the Past Month, 2015



Source: Darke County BRFSS, 2015

According to Ohio Hospital Association data, the Emergency Room (ER) alcohol and drug related diagnoses since 2007 has sharply increased, with the most recent year presenting a possible leveling off of this trend.

Figure 23: Alcohol/Drug Related Diagnoses, Darke County, 2004-2012



Source: Ohio Department of Public Safety, Alcohol impaired drivers by age and type of unit, 2010-2015

Mental Health and Wellness

Access to Mental Health Care Providers

County Health Rankings reports that Darke County has a 1,940:1 population to provider ratio including child psychiatrists, psychiatrists, and psychologists active in patient care, while the

State's ratio is 716:1. This measure represents the ratio of the county population to the number of mental health providers in a given county.
Source: University of Wisconsin Population Health Institute. *County Health Rankings 2015*.

Poor Mental Health Days

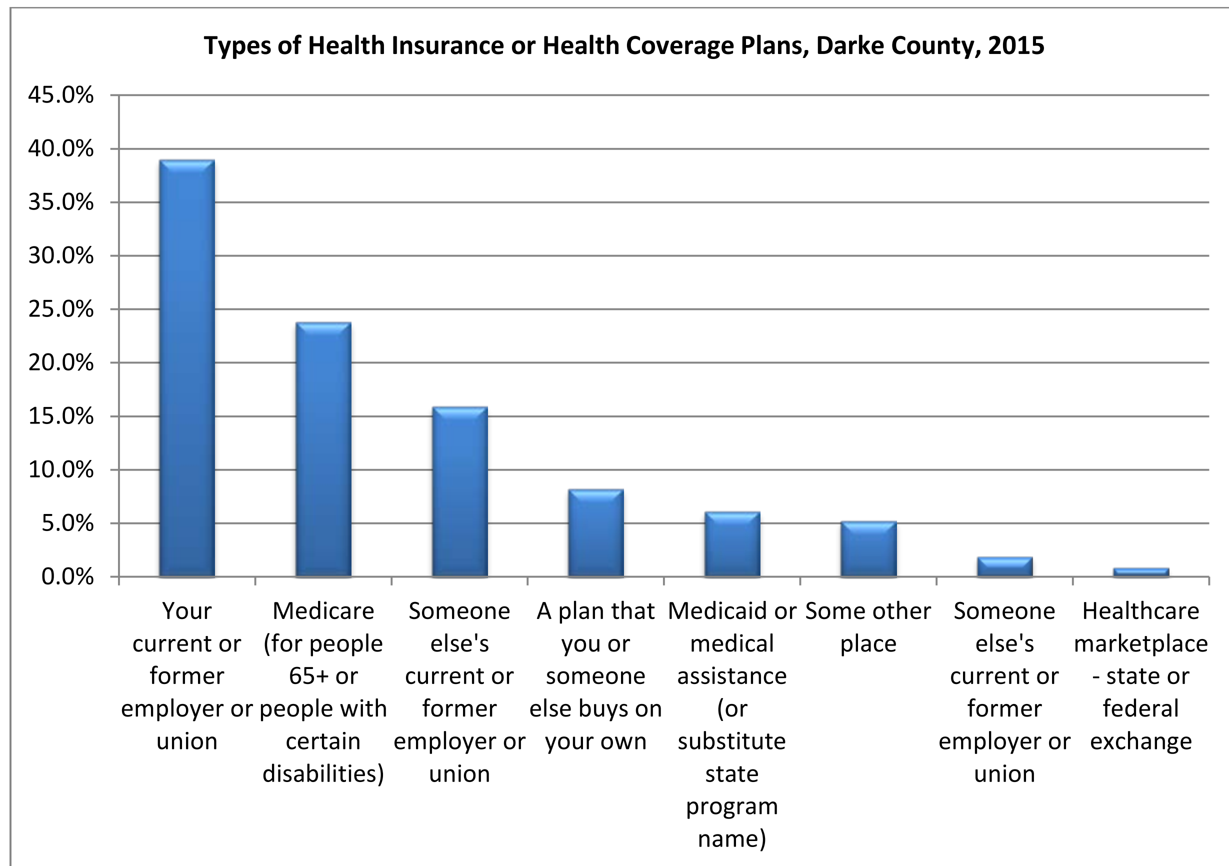
Adults in Darke County reported a slightly lower number (3.0) of poor mental health days in the past 30 days versus the number of days for Ohio (3.8) and the United States (2.3).
Source: University of Wisconsin Population Health Institute. *County Health Rankings 2015*.

Clinical & Preventive Services

Health Care Access

In Darke County, the percentage of residents covered by private insurance (69.2%) is nearly equal to that of the entire state (69.6%); the percentage of Darke County residents with public health care coverage (33.3%) is nearly equal to that for the State (31.1%). Public coverage includes: Medicare, Medicaid, Children's Health Insurance Program (CHIP), military health care (i.e. TRICARE and CHAMPVA), and Indian Health Services.
Source: U.S. Census Bureau, 2009-2013, 5-Year American Community Survey

Figure 27: Types of Health Insurance or Health Coverage Plans



Among respondents to the Darke County Community Health Needs Assessment survey, 4.9% of adults reported difficulty accessing medical care in the past 12 months due to prohibitive costs. Also, 3.3% of respondents indicated difficulty accessing medical care in the past 12 months due to lack of transportation.

Table 13: Percentage of Respondents Indicating Difficulty to Accessing Medical Care and Other Services

Percentage of respondents indicating difficulty accessing:	
Medical care due to cost	4.9%
Medical care due to lack of transportation	3.3%
Employment/services	3.4%
Safe and adequate housing	2.2%
Adequate transportation	2.9%

Clinical Care Access

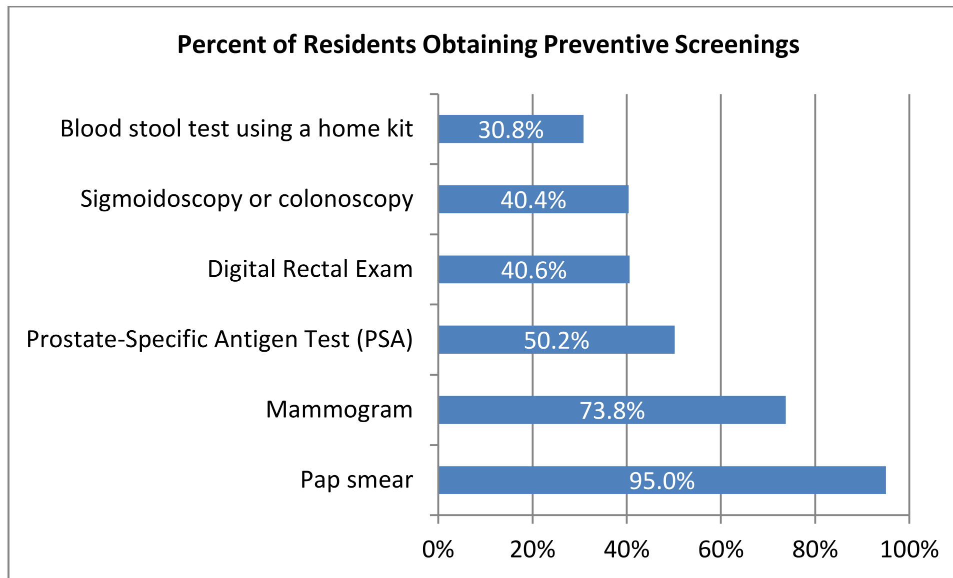
The table below lists (from greatest to least) the percentage of Darke County survey respondents who were not able to get specified types of medical care during the past 12 months.

Table 14: Lack of Access to Specific Types of Medical Care

What types of health services are you interested in but have a difficult time getting into?	Percent of Respondents
Comprehensive primary health care (adults, pediatrics, acute/chronic care)	4.8%
Preventive dental (tooth cleaning)	4.7%
Behavioral health (mental health, substance abuse counseling, therapy)	3.0%
Nutrition/dietician services	2.0%
Disease management programs (diabetes, heart failure, PT, cardio rehab)	0.8%
Pharmacy	0.7%
Voluntary family planning	0.6%
Diagnostic lab (blood tests, x-ray)	0.4%
Health screenings (cancer, cholesterol, lead poisoning, vision, hearing)	0.2%
Prenatal and perinatal (before, during, and after pregnancy)	0.0%

The chart below presents the percentage of Darke County adults obtaining preventive screenings, as self-reported in the adult BRFSS survey.

Figure 28: Percent of Residents Obtaining Preventive Screenings



Disease

Poor Health

The Darke County adult survey questions were based on the Behavioral Risk Factor Surveillance System (BRFSS) developed by the Centers for Disease Control and Prevention (CDC). The key question on the survey asked how the respondent would rate his/her health—excellent, good, fair or poor. The table below presents the percentage in the County that reports their health as fair or poor. The percentage for Darke County is higher than the percentage for the State and the nation. On the other hand, the number of days in the past 30 days that adults report their physical health was not good is 3.1 days for the County versus 3.6 days for the State.

Table 15: Poor Health Status

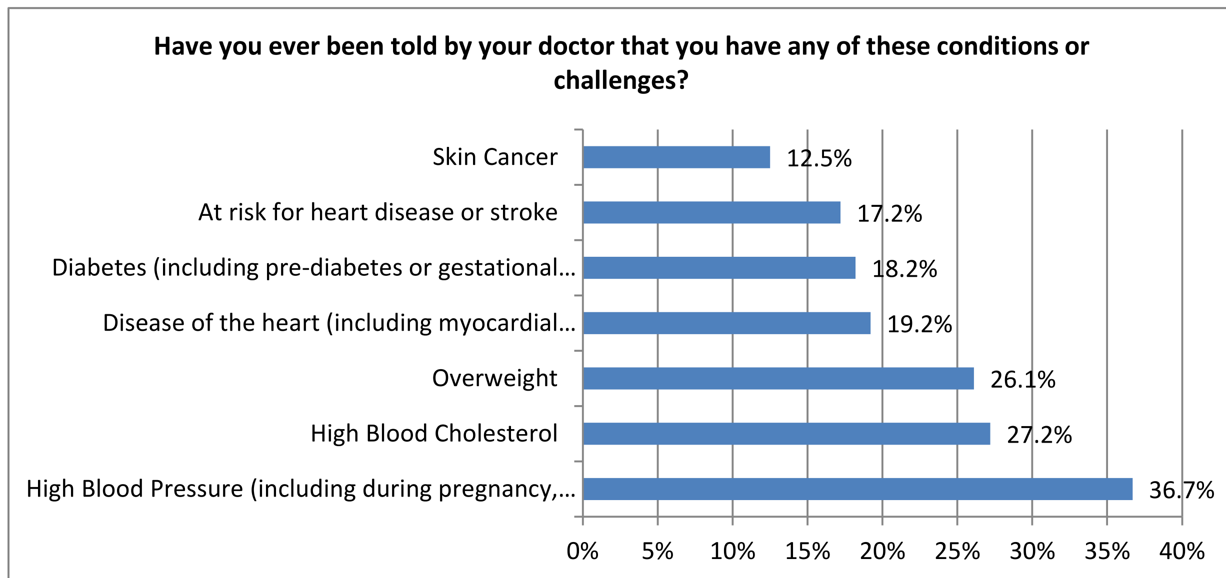
Condition	County	State	US Benchmark
Poor or fair health	19.1%	15.3%	10.0%
Poor physical health (days)	3.1	3.6	2.6

Source: BRFSS

Self-Reported Disease Status

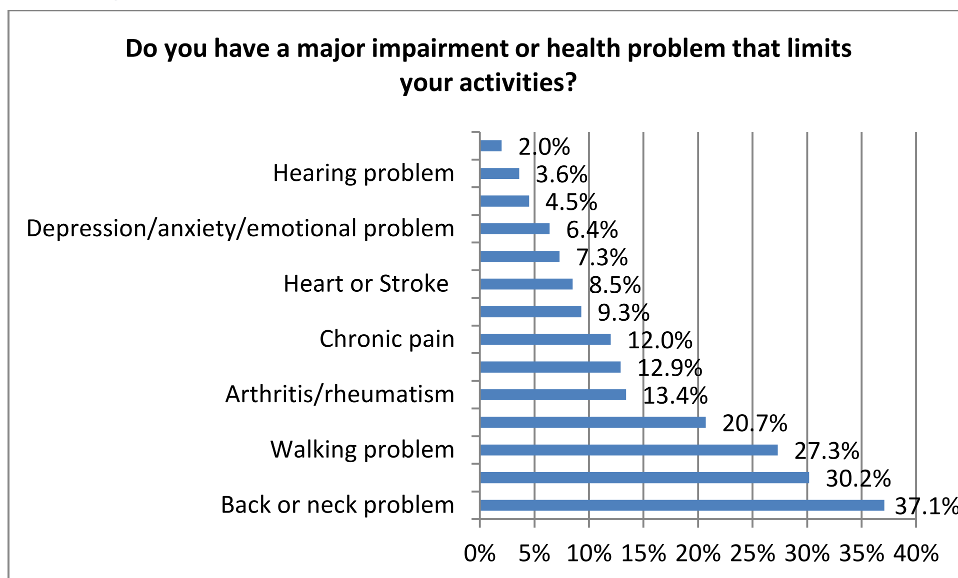
In the survey of Darke County adults, respondents were asked about their health status. The figure below presents the percentage of adults having one or more of the listed health challenges or conditions.

Figure 29: Prevalence of Health Conditions or Challenges



Among respondents, 19% indicated that they had a major impairment or health problem which limited their daily activities. The figure below presents the percentage of adults having one or more major impairments or health problem which limits their daily activities.

Figure 30: Prevalence of Major Impairments or Health Problems Limiting Activity



Oral Health

Dental care contributes to the prevention of chronic disease, including cardiovascular disease, lung disease, stroke, low-birthweight, premature births, and diabetes. The American Heart Association published a Scientific Statement in 2012 which supported a relationship between periodontal disorders, such as tooth loss and gingivitis, and cardiovascular disease. Although there is no conclusive evidence indicating whether the treatment of gum disease – periodontitis – is able to decrease the incidence, rate, or severity of artherosclerosis, a link between oral health and overall health has been established. Cardiovascular disease and periodontitis share risk factors, including smoking, diabetes, overweight or obesity, and physical inactivity.

Source: The American Heart Association. (2012). Periodontal Disease and Atherosclerotic Vascular Disease: Does The Evidence Support an Independent Association? A Scientific Statement from the American Heart Association. Circulation. 125(20, 2520-2544, doi:10.1161/cir.0b013e31825719f3

When Darke County adults were asked, "*What is the main reason you have not visited the dentist in the last year?"* nearly half (44.4%) indicated "No reason to go/no problems with teeth." Other reasons are listed in the table below:

Table 15: Main Reason Respondents Has Not Visited Dentist in the Last Year, 2015

Main Reason Respondents Has Not Visited Dentist in the Last Year, 2015	
No reason to go/no problems with teeth	44.4%
Other	12.9%
Other priorities	11.2%
No insurance	9.7%
Cost	8.1%
Fear, apprehension, nervousness, pain, dislike going	6.7%
Do not have/know a dentist	4.1%
Have not thought of it	1.5%
Dentist doesn't accept my insurance	1.2%

Less than two-thirds (61.6%) of adults in Darke County have visited the dentist in the past year. Another 9.9% of respondents have visited the dentist in the past two years. However, 14.8% of respondents last visited the dentist 2-5 years ago, while 12.7% of respondents indicated that their last dental visit was 5 or more years ago and 1.1% of respondents have never visited the dentist. The percentage of Darke County respondents (61.6%) who have visited a dentist in the past year is slightly higher than the State* (60.5%).

Table 16: Last Visit to the Dentist or Dental Clinic for Any Reason

Last Visit to the Dentist or Dental Clinic for Any Reason		
	Darke County	Ohio
Never	1.1%	
Less than 1 year ago	61.6%	60.5%*
1 year but less than 2 years ago	9.9%	
2 years but less than 5 years ago	14.8%	
5 or more years ago	12.7%	

Source: Data is from the 2015 Darke County Community Health Assessment Survey.
*Data marked with an asterisk is from the Ohio Oral Health Surveillance System, 2012.
http://publicapps.odh.ohio.gov/oralhealth/ReportsDisplay.aspx?Report=BOHSReport&Format=pdf&CountyName=Darke&ReportVersion=2012

Oral Health Care Access

In Darke County, the Family Health Services Center is designated as a Health Professional Shortage Area (HPSA) in the area of dental health. A HPSA is defined as "a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals." Several different criteria are used to determine HPSA designations.

Currently, the State of Ohio offers a program in partnership with the Ohio Dental Association called Ohio Partnership to Improve Oral health through access to Needed Services or "OPTIONS." The mission of OPTIONS is "to assist Ohioans with special health care needs and/or financial barriers to obtain dental care." This program offers services to low-income residents and elderly patients who live on a fixed income. This program is dependent on volunteer dentists who have agreed to reduce fees for dental care. As of 2012, Darke County had only one dentist working for OPTIONS, making the ratio of low-income patients per OPTIONS dentist to be 22,669:1 in the county.

According to the 2012 Ohio Oral Health Surveillance System, Darke County currently has 12 licensed dentists and nine (9) primary care dentists (general and pediatric). The ratio of population per dentist is 4,376:1. In Darke County, seven (7) dentists treated Medicaid patients during the study period, making the ratio of Medicaid population per dentist who treats Medicaid patients to be 1,398:1.

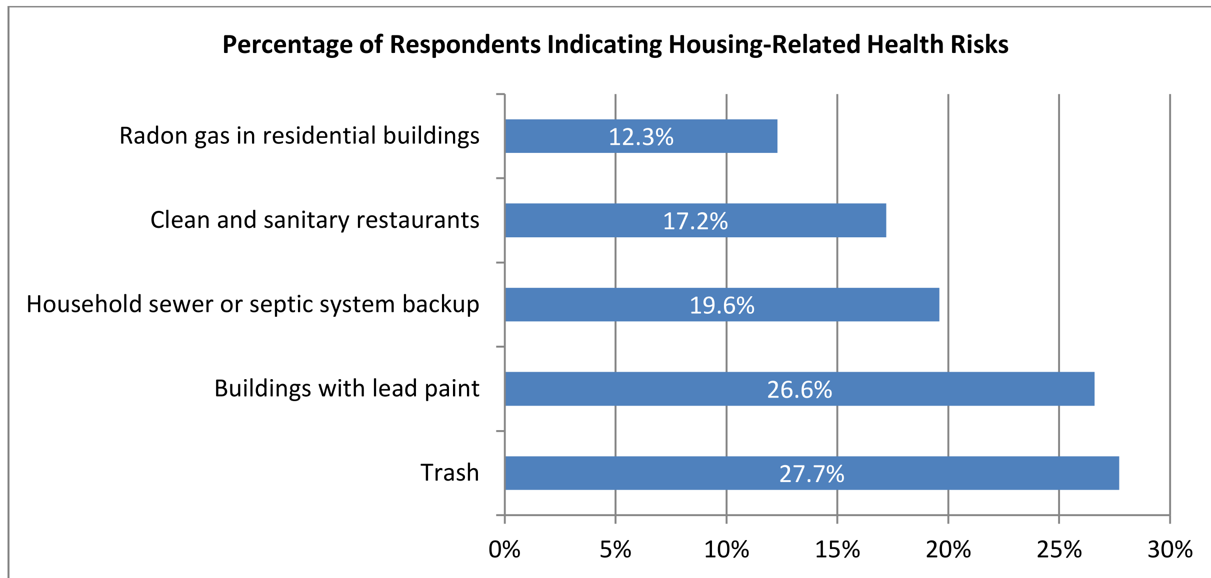
Source: Ohio Oral Health Surveillance System, Darke County, 2012
http://publicapps.odh.ohio.gov/oralhealth/ReportsDisplay.aspx?Report=BOHSReport&Format=pdf&CountyName=Darke&ReportVersion=2012

Housing-Related Health Risks

The quality of housing is a significant social determinant of health. Poor housing conditions are associated with a number of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health. The Darke County Health Department recognizes the need for information on housing quality at the community level.

Survey respondents in Darke County were asked to indicate whether several housing-related health risks were a "big problem," "moderate problem" or "no problem at all." Figure 11 shows the percentage of Darke County residents who believed each problem was either a "big problem" or "moderate problem." Approximately a quarter of Darke County residents indicated that trash (27.7%) and buildings with lead paint (26.6%) were either a "big problem" or "moderate problem" in their communities. Household sewer or septic system backup was indicated as a "big or moderate problem" by 19.6% of survey respondents. Clean and sanitary restaurants are a concern for 17.2% of survey respondents, while radon gas in residential buildings was indicated as a "big or moderate problem" by 12.3% of survey respondents.

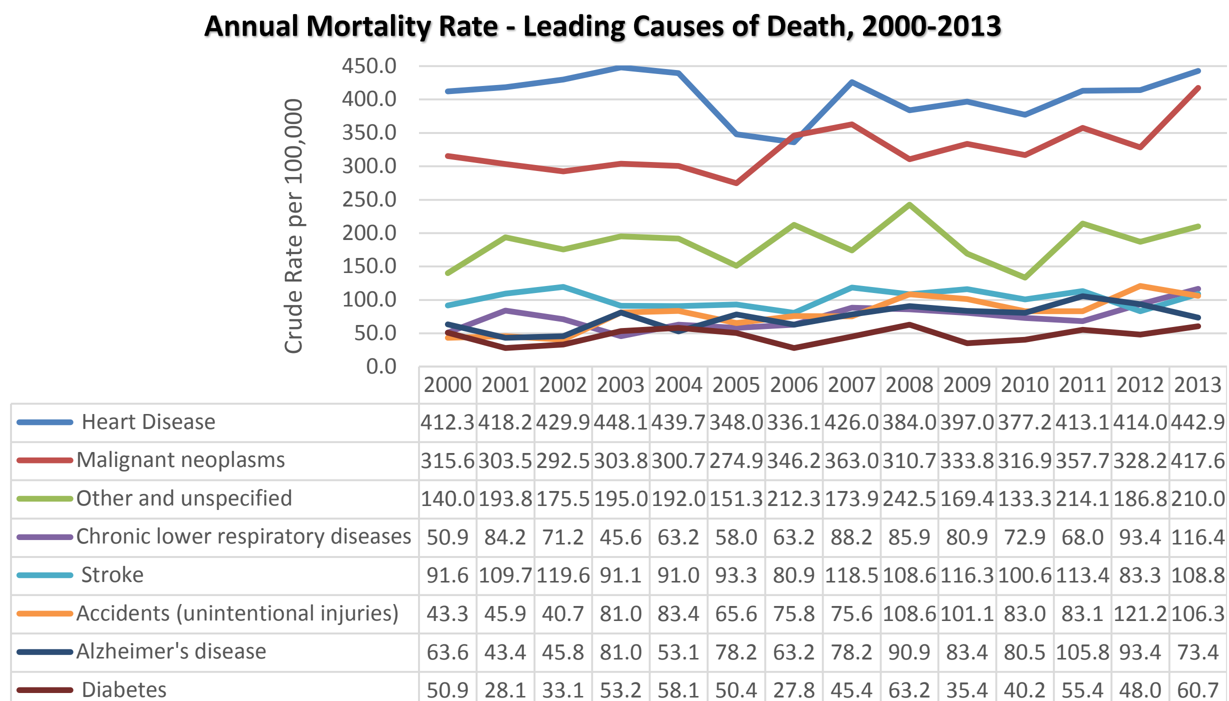
Figure 12: Percentage of Respondents Indicating Housing-Related Health Risk



Leading Causes of Death

The top two leading causes of death – heart disease and cancer (malignant neoplasms) – have rates that are 7 times greater than deaths due to diabetes, which is ranked as the 7th leading cause of death for Darke County residents (see chart below). Death due to heart disease and cancer has been steadily increasing over the study period. This may be related to the increasing older population (age 60 years or older). The rate of death due to diabetes or chronic lower respiratory disease has nearly doubled in the last five years. The rate of death due to accidents (unintentional injuries) has steadily increased over the decade. For a comparison of the top four leading causes of death in the County compared to the State, refer to Appendix A.

Figure 32: Leading Causes of Death, 2000-2013



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Heart Disease	412.3	418.2	429.9	448.1	439.7	348.0	336.1	426.0	384.0	397.0	377.2	413.1	414.0	442.9
Malignant neoplasms	315.6	303.5	292.5	303.8	300.7	274.9	346.2	363.0	310.7	333.8	316.9	357.7	328.2	417.6
Other and unspecified	140.0	193.8	175.5	195.0	192.0	151.3	212.3	173.9	242.5	169.4	133.3	214.1	186.8	210.0
Chronic lower respiratory diseases	50.9	84.2	71.2	45.6	63.2	58.0	63.2	88.2	85.9	80.9	72.9	68.0	93.4	116.4
Stroke	91.6	109.7	119.6	91.1	91.0	93.3	80.9	118.5	108.6	116.3	100.6	113.4	83.3	108.8
Accidents (unintentional injuries)	43.3	45.9	40.7	81.0	83.4	65.6	75.8	75.6	108.6	101.1	83.0	83.1	121.2	106.3
Alzheimer's disease	63.6	43.4	45.8	81.0	53.1	78.2	63.2	78.2	90.9	83.4	80.5	105.8	93.4	73.4
Diabetes	50.9	28.1	33.1	53.2	58.1	50.4	27.8	45.4	63.2	35.4	40.2	55.4	48.0	60.7

Source: 2000-2013, Ohio Department of Health Vital Statistics

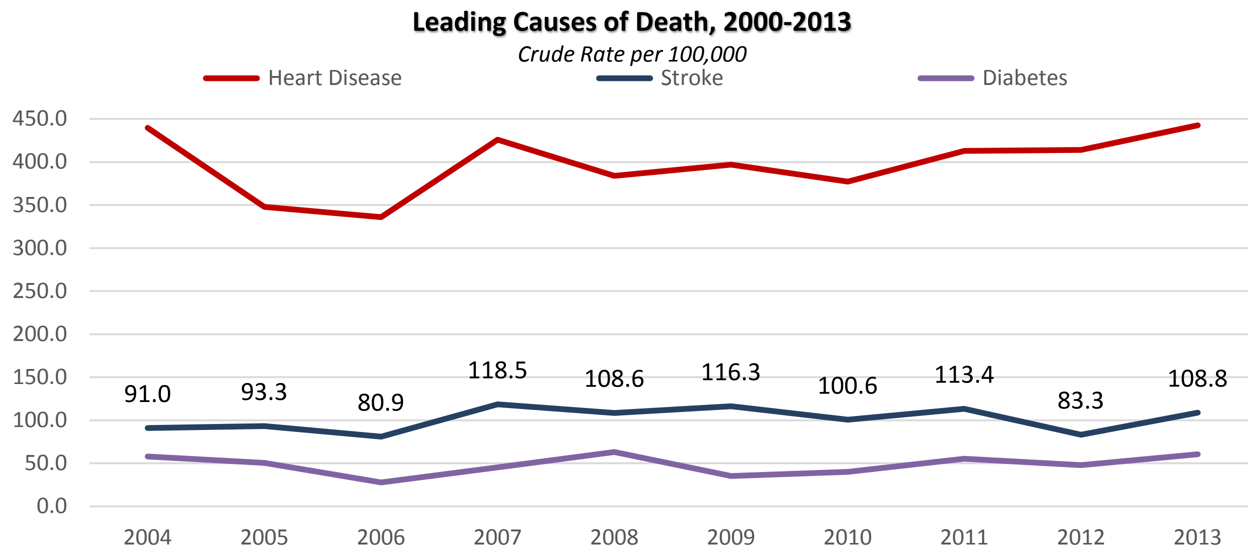
Table 17: Chronic Disease Risk Factors (Behavioral & Other)

Table 17: Chronic Disease Risk Factors (Behavioral & Other)	Darke	Ohio
Adult smoking *(% of adults that smoke ≥100 cigarettes)*	23%	22%
Adult obesity *(BMI: 25-29.9=overweight; BMI 30+=obese)*	32.2%*	29.6%
No exercise *(No leisure time physical activity)*	29.3%	24.8%
Excessive drinking *(Consuming >4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or drinking more than 1 (women) or 2 (men) drinks per day on average)*	11.4%	18.4%
Fewer than 5 servings of fruit/vegetables per day *(Adults that report fewer than 5 servings of fruit/vegetables a day)*	81.4%	78.2%
High blood pressure *(Percent of adults that report having been diagnosed with high blood pressure)*	22%	28.8%
Oral Health *(Percent of adults that report having been to the dentist or dental clinic for any reason less than 1 year ago)*	61.6%	60.5%

Source: All data from 2006-2012 BRFSS unless otherwise noted.

*Darke County BRFSS, 2015

Figure 33: Leading Causes of Death (Heart Disease, Stroke, and Diabetes), 2000-2013



Process for Identifying and Prioritizing Community Health Needs

The data collection and analysis efforts described above expose community health priority needs. The process used to select priorities from this needs assessment depends upon shared decision criteria. The first set of criteria used pertain to prevalence, seriousness (e.g., hospitalization and death), and comparison to state and/or national averages. The next step is for the subject matter experts to review the results of the Community Health Needs Assessment and apply a second set of criteria as the following:

- Urgency – what are the consequences of not addressing this issue?
- Prevention – is the strategy preventative in nature?
- Economics – is the strategy financially feasible? Does it make economic sense to apply this strategy?
- Acceptability – will the stakeholders and the community accept the strategy?
- Resources – is funding likely to be available to apply this strategy? Are organizations able to offer personnel time and expertise or space needed to implement this strategy?

Methodology

The Community Health Needs Assessment is comprised of data from both quantitative and qualitative sources. A brief summary of the components is included below:

- **<u>Quantitative Data</u>:**
    - **Secondary Data**

    - Population and household statistics
    - Education and economic measures
    - Morbidity and mortality rates
    - Incidence rates
    - Sources:
        - Centers for Disease Control and Prevention
        - US Department of Health and Human Services
        - US Census Bureau
        - Ohio Department of Health
        - Ohio Development Services Agency
        - Health Resources and Services Administration (HRSA), Health Resources Comparison Tool: to determine if the county as a "Health Professionals Shortage Area" or HPSA.
        - Wayne HealthCare
        - Robert Wood Johnson Foundation
        - Ohio Department of Public Safety
        - Ohio Network of Care

  - **Primary Data**
    - A household telephone survey was conducted with 418 randomly-selected Darke County adult residents using computer-aided telephone interviewing software. The survey was based on the Center for Disease Control & Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS). This survey assessed health status, health behavior risks, health care access, and preventive health practices related to chronic diseases.
- **Qualitative Data:**
  - Six focus groups were held with community members during the month of August and September. Two focus groups were held with low-income populations at the Darke County Department of Jobs & Family Services; two focus groups were held with low-income populations at the Grace Resurrection Community Center; and one focus group was held with school nurses working at various schools within the Darke County Board of Education.

Limitations of the Data

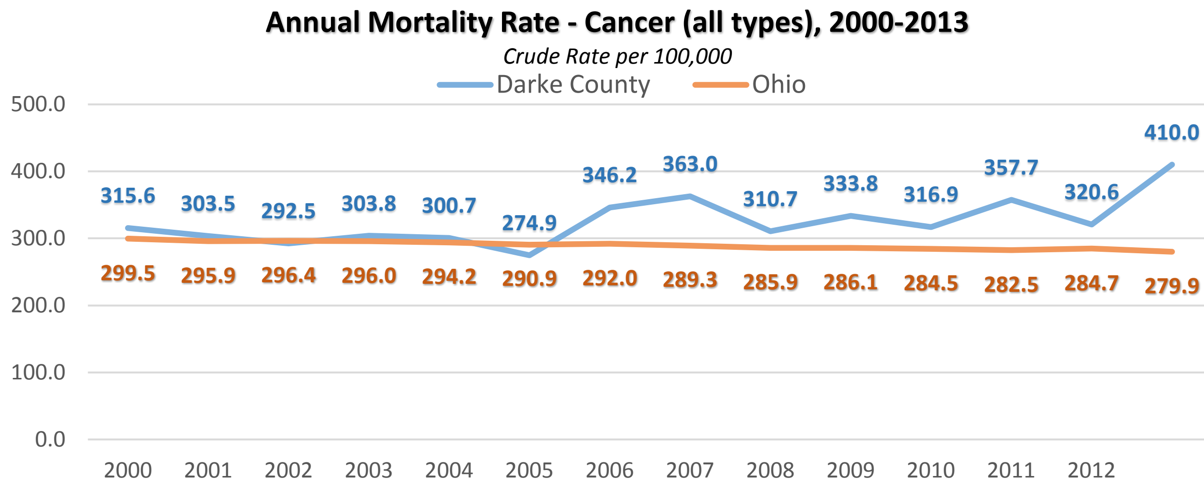
While this assessment is comprehensive, all aspects of community health cannot be measured and all possible populations of interest cannot be adequately represented.

Information gaps that limit the ability to assess the community's health needs include:

- No data are included from private clinics
- The most recent data from the Ohio Department of Health for mortality is 2013 and in some cases is 2010
- The health data presented in this report is not exhaustive

Appendix A: Cancer – State Comparison

Figure 34: Cancer (all types), 2000-2013



Appendix B: Leading Causes of Death – State Comparison

Figure 35: Diseases of the Heart, 2000-2013

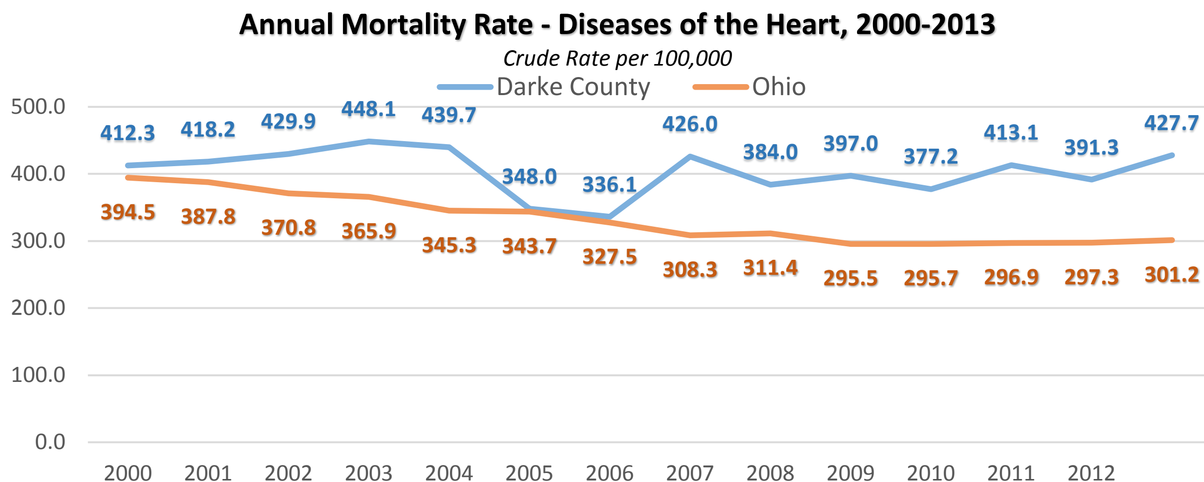


Figure 36: Diabetes Mellitus, 2000-2013

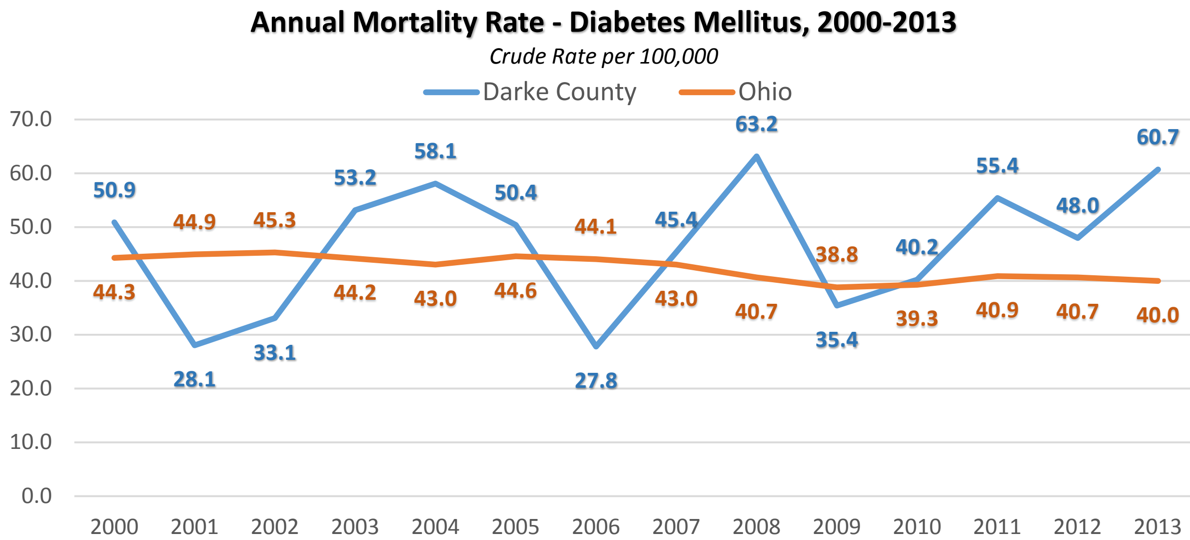


Figure 37: Accidents (unintentional injuries), 2000-2013

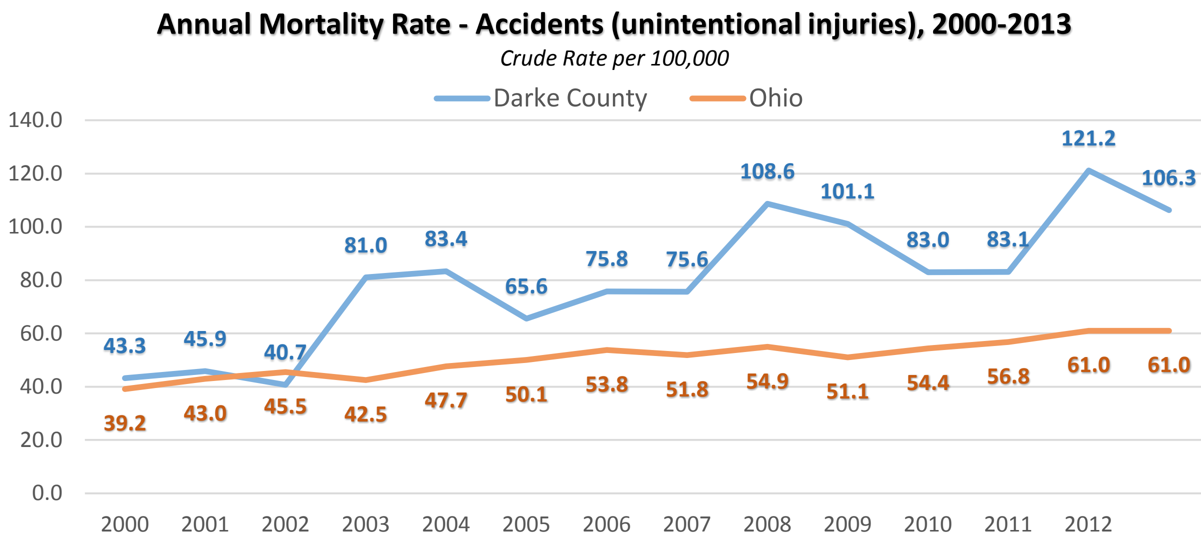
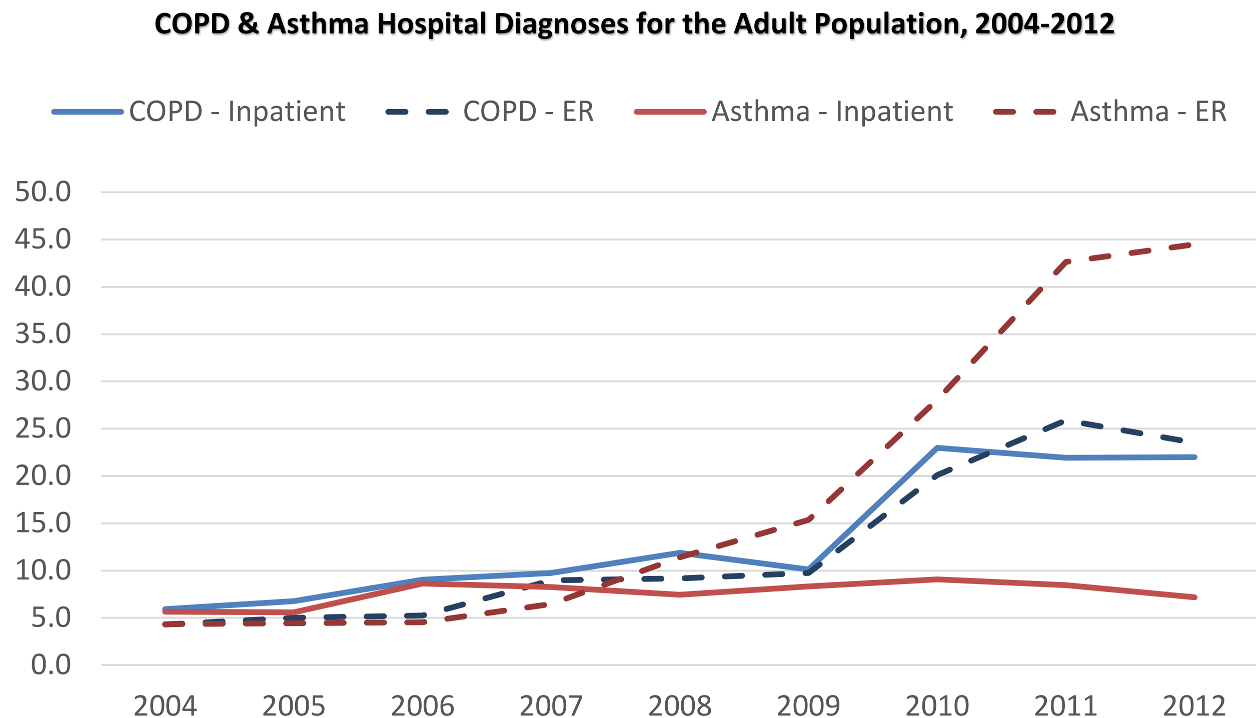


Figure 38: Chronic Obstructive Pulmonary Disorder and Asthma – Hospital Diagnoses for the Adult Population, 2004-2012



Appendix C: Community Participants

Rep First Name	Rep Last Name	Title	Email Address
Michele	Acker	Director Cardiopulmonary/ Wellness Coordinator	Michele.Acker@waynehealthcare.org
Diane	Barga	Program Coordinator Family Consumer Science	barga.8@osu.edu
Jennifer	Barga	Director of Nursing	Jennifer.Barga@odh.ohio.gov
Jill	Brown	Cancer Coordinator	Jill.brown@waynehealthcare.org
Sharon	Deschambeau	President	sharond@darkecountyohio.com
Wayne	Deschambeau	President/CEO	wayne.d@waynehealthcare.org
Denise	Dillman	Wellness	ddillman@co.darke.oh.us
Jane	Dockery	Associate Director, CUPA	jane.dockery@wright.edu
Karen	Droesch	Diabetic Educator	Karen.Droesch@waynehealthcare.org
Kristy	Earick	Executive Director	KEarick@covenantcare.com
Terri	Flood	Marketing Director	terri.flood@waynehealthcare.org

Dr. Michael	Fourman	Director of Dental Services-Family Health	mfourman@familyhealth.cc
Mike	Gray	Superintendent of Darke County Schools	dk_supt@mdeca.org
Kelly	Harrison	Prevention Specialist	kharrison@dcrs.info
Lauren	Henry	Executive Director	Lauren@darkecountyunitedway.org
Terrence	Holman	Health Commissioner	terrence.holman@odh.ohio.gov
Cheryl	Holmes	Cardiac Rehabilitation and Secondary Prevention Coordinator	cheryl.holmes@waynehealthcare.org
Diane	Lee	Transportation Coordinator	Diann.Lee@jfs.ohio.gov
Jodi	Long	Director, Clinical Services & Evaluation	longj@tcbmds.org
Mark	McDaniel	Executive Director	mcdanielm@tcbmds.org
Tiffany	Thomas	Eligibility Referral Supervisor	Tiffany.Thomas@jfs.ohio.gov
Jeff	Vaughn	ACES Coordinator	jvaughn@councilonruralservices.org
John	Warner	President & CEO	John.Warner@bhrc.org
Dennis	Wein	Public Health Nurse	dennis.wein@odh.ohio.gov
Erica	Wentworth	Naturalist	EWentworth@darkecountyparks.org
Laurie	White	Director of Behavioral Health and Wellness Services	LWhite@familyhealth.cc