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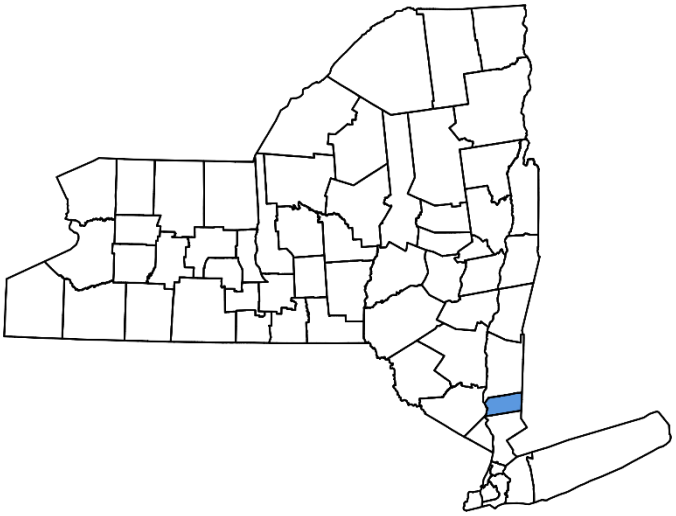

Community Health Experience Survey, Putnam County

PUTNAM COUNTY DEPARTMENT OF HEALTH

Data Gen
Insights for Healthcare®

Nuvance Health

PUTNAM COUNTY NEW YORK

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INTRODUCTION AND METHODS

During the summer and fall of 2024 Nuvance Health and Local Health Departments (LHDs) within the Nuvance service area worked collaboratively with the healthcare data analytics and consulting company, DataGen®, Inc. to promote and administer two broad-based health surveys designed to identify health needs and inform health improvement efforts in the community. The *Community Health Experience Survey* was administered to the public, and the *Community-based Organization* (CBO) Survey was administered to employees of partner organizations located in the Nuvance service area. The following report details the findings of the subset of *Community Health Experience Survey* respondents residing in Putnam County, and will contribute to Putnam County's 2025 comprehensive Community Health Assessment (CHA).

The survey instrument was based on a standardized template provided by DataGen and modified by Nuvance and the Putnam County Department of Health (PCDOH) to meet local needs. The instrument was designed to collect information to assess resident perception of health and well-being, health behaviors, health concerns, and needs in the community. Data was collected using voluntary response sampling via an online, self-administered survey. The survey was hosted by SurveyMonkey (Momentive Inc. San Mateo, California, www.momentive.ai) and was open for data collection from August 1st, 2024, to October 12th, 2024. The survey could be taken in English, Spanish, Portuguese or Haitian Creole. Paper copies of the survey were available upon request. All survey responses completed on paper were mailed to DataGen for entry into SurveyMonkey. Resident participation was promoted by news release, social media messaging, posted flyers, and in person at community events. Promotional materials were also shared with community partners for dissemination in their networks.

The following report is based on survey data and analysis, including calculation of average margin of error (MOE) at 95% confidence for each question and demographic strata, provided to PCDOH by ©2024 DataGen®, Inc. Summary charts and statistics were created in Excel by PCDOH. Data is presented in aggregate and stratified by respondent characteristics where differences were noted outside the margin of error.

SURVEY ELIGIBILITY, RESPONSE, & DISTRIBUTION

The data in this report is limited to respondents 18 years of age or older residing in Putnam County. There were 267 total respondents, though response totals for individual questions may vary. To evaluate representativeness of the sample, Table 1 displays the survey respondent demographic distribution compared to Putnam County demographic estimates. All response options offered in the survey are not represented in the table; therefore, percentages may not add up to 100%. Respondents leaving demographic questions blank or selecting "prefer not respond" were excluded from the denominator, thus determination of representativeness assumes the distribution of those providing responses is similar to those who did not.

Table 1: Respondent Demographic Distribution Compared to Putnam County Demographic Distribution

Demographic Category	Respondent %	Putnam %*
Gender		
Woman	64.0%	49.8%
Man	32.8%	50.2%
Age in years		
18-24	2.4%	9.7%
25-34	6.3%	14.0%
35-44	9.5%	15.4%
45-54	13.9%	17.9%
55-64	17.1%	19.8%
65+	50.8%	23.2%
Race		
White	90.3%	77.2%
Black	1.7%	3.4%
American Indian/Alaska Native	0.8%	0.2%
Asian	0.8%	2.4%
Native Hawaiian or Other Pacific Islander	0.0%	2.0%
Two or more races	3.8%	7.7%
other	2.5%	9.3%
Ethnicity		
Not Hispanic or Latino	89.5%	80.9%
Hispanic or Latino	10.5%	19.1%
Annual Household Income		
>= $150,000	21.8%	40.1%
$100,000-$149,999	28.2%	20.9%
$50,000-$99,999	20.1%	20.9%
$25,000-$49,999	16.7%	9.8%
<$25,000	13.2%	8.3%

*Source: US Census Bureau; 2023 American Community Survey 5-year estimates

By Gender

Due to differences in methodology, census and survey respondent gender proportions are not entirely comparable. Response options in the survey but not in the census include non-binary/non-conforming (0.4%), transgender (0.4%) and other (2.4%). Nonetheless, the survey sample is skewed toward women.

By Age, Health Insurance, and Retirement Status

The survey sample is skewed toward those age 65 years or older. All age brackets below age 65 years are under-represented. While the sample is generally representative of the population in terms of health insurance status (91.4% of the sample have health insurance as compared to 96.4% of the Putnam population), the age distribution skews the sample toward Medicare recipients, who make up 41.2% of the survey sample but only 24.6% of Putnam population. Similarly, the age distribution also skews the sample toward retirees who make up 46.1% of sample, but only 17.5% of Putnam population.

By Race

Due to differences in methodology, census and survey respondent race proportions are not entirely comparable. Census proportions include the entire Putnam population, while the survey sample excludes those less than 18 years of age. Nonetheless, White residents are over-represented in the survey, and other races are generally under-represented.

By Ethnicity

Due to differences in methodology, census and survey respondent ethnicity proportions are not entirely comparable. Census proportions include the entire Putnam Population, while the survey sample excludes those less than 18 years of age. Nonetheless, Hispanic people are under-represented in the survey.

By Household Income

The survey sample is more evenly distributed across household income brackets than the Putnam Population. Households with annual incomes less than $50,000 and those with incomes of $100,000-$149,999 are over-represented, while households with incomes greater than $150,000 are under-represented.

By Zip Code

The survey sample distribution by zip code is relatively representative of the Putnam population, however residents of 10512 and 10516 are over-represented while residents of 10541 and 12563 are under-represented.

Table 2: Distribution of Respondents and Putnam Population by Zip Code

Zip Code	10512	10509	10541	10516	10579	12563	10524	10537	12531	10542	10588	12533	12582
Respondent %	30.3%	18.1%	18.1%	10.2%	10.2%	5.1%	3.5%	3.1%	1.2%	0.0%	0.0%	0.0%	0.0%
Putnam %	25.2%	19.9%	24.9%	5.6%	8.8%	7.8%	4.6%	2.3%	0.6%	0.1%	0.1%	0.1%	0.3%

Source: 2020 Decennial Census shape files

Representativeness of Survey

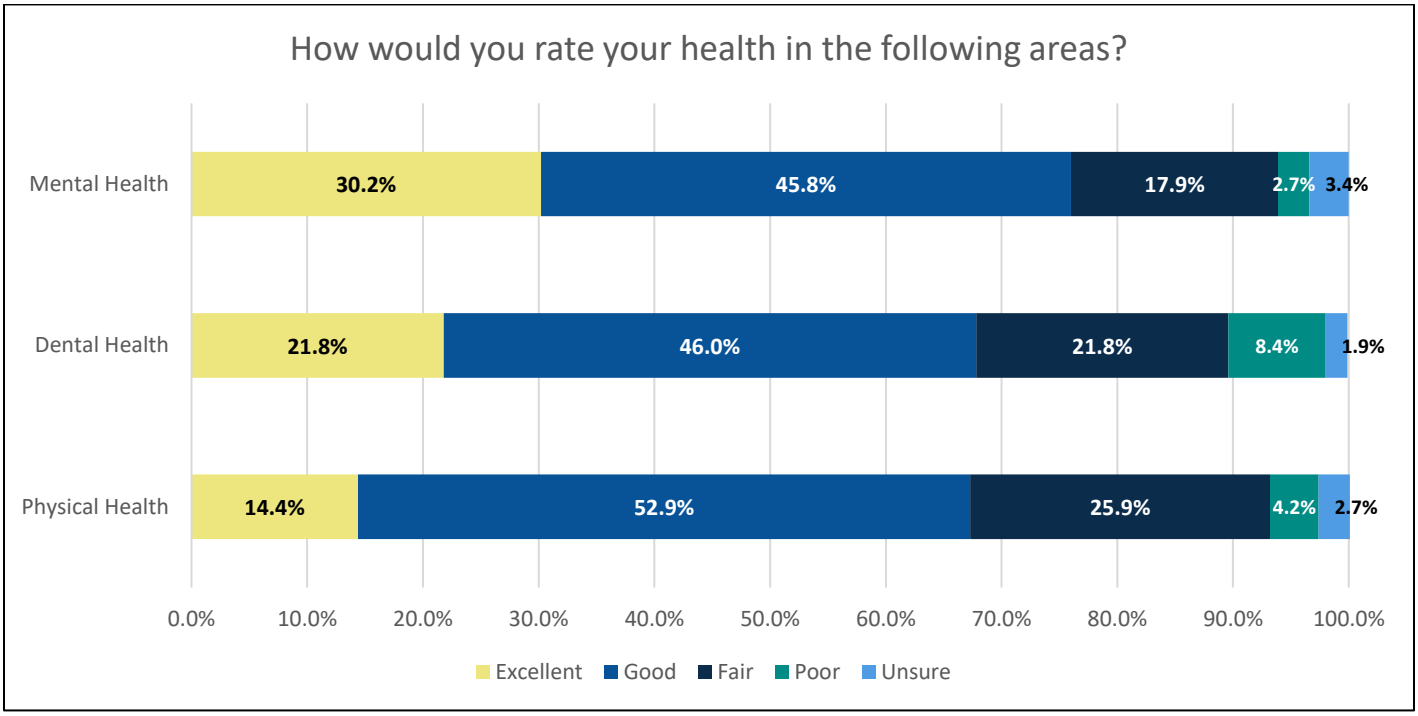
The survey has a small sample size and was conducted using voluntary response sampling. As such, results should be considered representative of the sample population rather than the Putnam County population.

RESULTS

HEALTH RATINGS

Respondents evaluated their physical, dental, and mental health on a scale ranging from poor to excellent. Mental health received the highest combined "excellent" or "good" ratings (76%), exceeding those for dental health (68%) and physical health (67%). The margin of error for these estimates is approximately ±3.5%. [see Figure 1]

Figure 1



Results were stratified by respondent characteristics and the following differences outside the MOE were noted:

Physical Health:

- Respondents living with a disabled household member reported lower rates of excellent/good physical health (54%, MOE ±5.9%) than those without a disabled member (74%, MOE ±4.1%).
- A lower proportion of respondents with household income less than $25,000 per year rated their physical health as “excellent” or “good” (33.3%, MOE ±14.2%) as compared to the whole sample (67.3%, MOE ±3.4%).
- A higher proportion of respondents residing in 10516 (84.6%, MOE ±8.1%) and 10524 (88.9%, MOE ±13.1%) rated their physical health as “excellent” or “good” as compared to the whole sample (67.3%, MOE ±3.4%).

Dental Health:

- A lower proportion of Hispanic respondents rated their dental health as “excellent” or “good” (47.8%, MOE ±13.3%) as compared to non-Hispanics (68.8%, MOE ±3.7%).
- A lower proportion of veteran/active military respondents rated their dental health as “excellent” or “good” (47.3%, MOE ±10.8%) as compared to non-veteran/active military (70.0%, MOE ±3.6%).

- A lower proportion of respondents with household income of less than $25,000 per year (51.8%, MOE ±10.4%) and those with household income of $25,000-$49,999 per year (51.8%, MOE ±10.4%) rated their dental health as "excellent" or "good" as compared to those with income of $100,000-$149,999 per year (77.5%, MOE ±6.8%) or income of greater than $150,000 per year (86.8%, MOE ±7.9%).

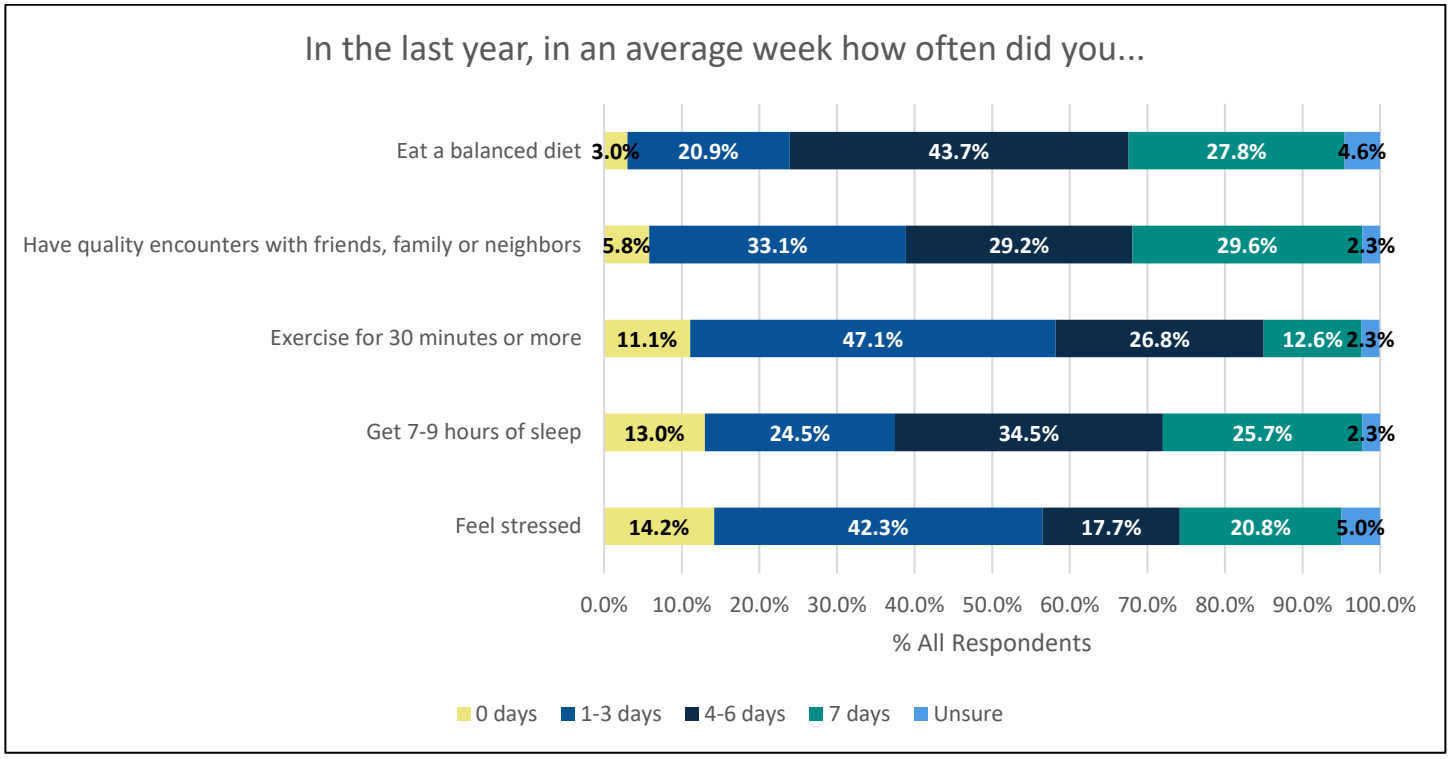
Mental Health:

- A lower proportion of respondents between the age of 18-64 years rated their mental health as "excellent" or "good" (67.7%, MOE ±5.2%) as compared to those age 65+ (83.9%, MOE ±4.7%).
- A lower proportion of respondents with a disabled household member rated their mental health as "excellent" or "good" (65.4%, MOE ±6.1%) as compared to those without a disabled household member (82.7%, MOE ±4.1%).
- A lower proportion of respondents with household income of less than $25,000 per year (52.3%, MOE ±14.2%) rated their mental health as "excellent" or "good" as compared to the whole sample (76.0%, MOE ±3.5%).

HEALTH BEHAVIORS

Respondents were asked to provide the frequency they performed several recommended health behaviors in an average week. The health behavior most commonly performed at least four days a week was eating a balanced diet (71.5%) followed by getting 7 to 9 hours of sleep (60.2 %). The health behavior least commonly performed at least 4 days per week was exercising for 30 minutes or more (39.4%). Additionally, 38.5% of respondents cited feeling stressed four or more days per week, while 14.2% responded that they were stressed zero days per week. [see Figure 2]

Figure 2



Results were stratified by respondent characteristics and the following differences outside the MOE were noted:

Balanced diet:

- A higher proportion of respondents aged 65 years or older (34.7%, MOE ±5.6%) eat a balanced diet 7 days per week as compared to younger respondents (18.5%, MOE ±6.3%).

Exercise:

- A higher proportion of White respondents exercise 4-7 days per week (41.9%, MOE ±4.6%) as compared to respondents who are not White (17.3%, MOE ±12.2%).

Sleep:

- A higher proportion of veteran/active military respondents get 7-9 hours of sleep 7 days per week (47.6%, MOE ±13.3%) as compared to non-veteran/active military respondents (24.6%, MOE ±4.7%).

Social Encounters:

- A higher proportion of respondents aged 65 years or older (36.9%, MOE ±5.5%) have quality encounters with friends, family or neighbors 7 days per week as compared to younger respondents (22.6%, MOE ±6.3%).
- A higher proportion of White respondents have quality encounters with friends, family or neighbors 7 days per week (32.7%, MOE ±4.4%) as compared to respondents who are not White (13.0%, MOE ±12.7%).

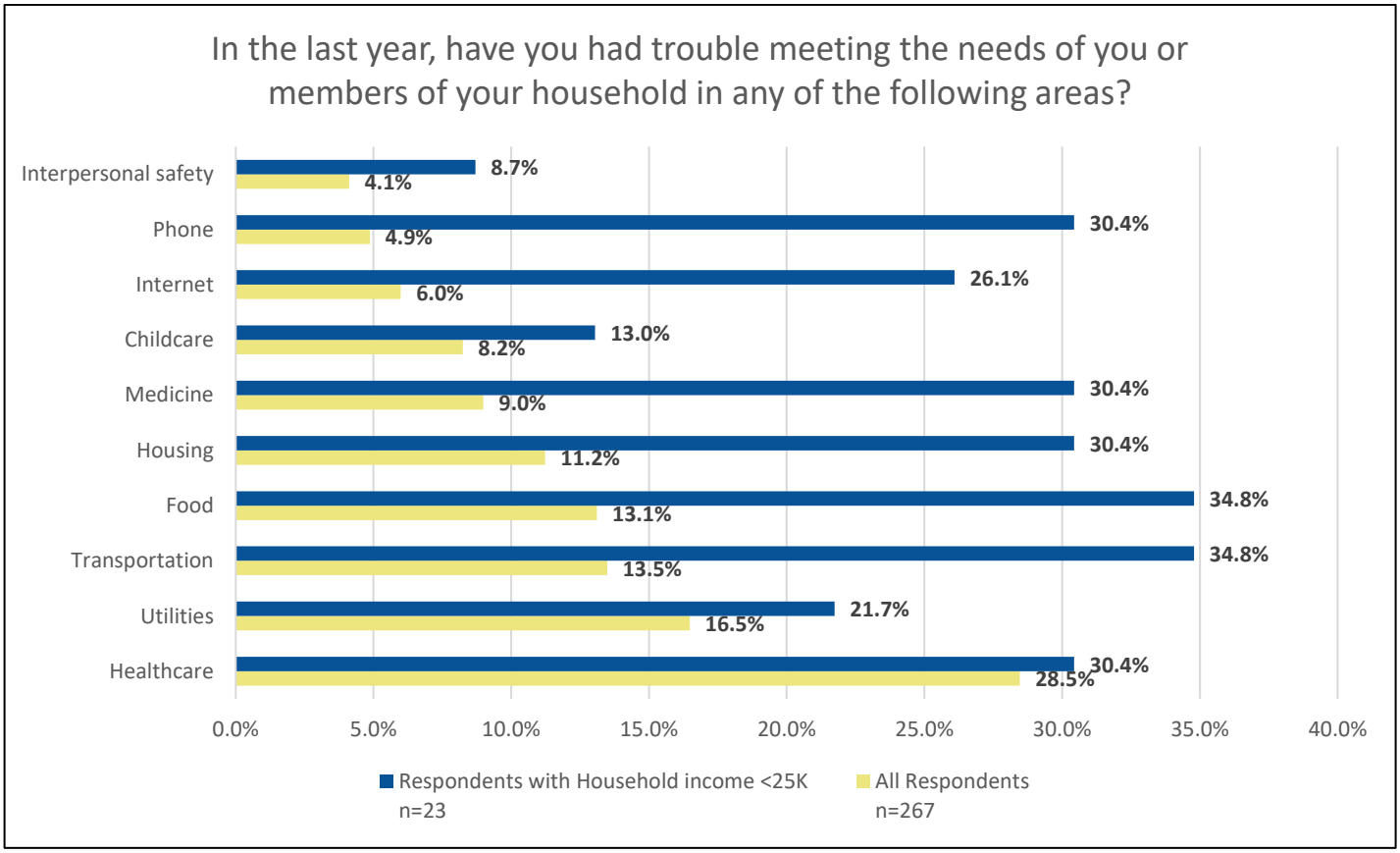
Stress:

- A higher proportion of respondents aged 65 years or older (22.3%, MOE ±6.2%) feel stressed 0 days per week as compared to younger respondents (4.8%, MOE ±6.3%).
- A higher proportion of respondents residing in 10537 (50.0%, MOE ±18.9%) and 10541 (42.2%, MOE ±9.7%) feel stressed 7 days per week as compared to the whole sample.

MEETING BASIC NEEDS

Respondents were asked if, in the last year, they had trouble meeting the needs of themselves or members of their household in any of several areas. The highest proportion of respondents had trouble meeting healthcare needs (28.5%, MOE ±3.6%). As compared to the whole sample (MOE ±3.6%), a higher proportion of respondents with household income less than $25,000 per year (MOE ±17.4%) had trouble meeting needs for transportation, food, housing, medicine, and phone. [see Figure 3]

Figure 3



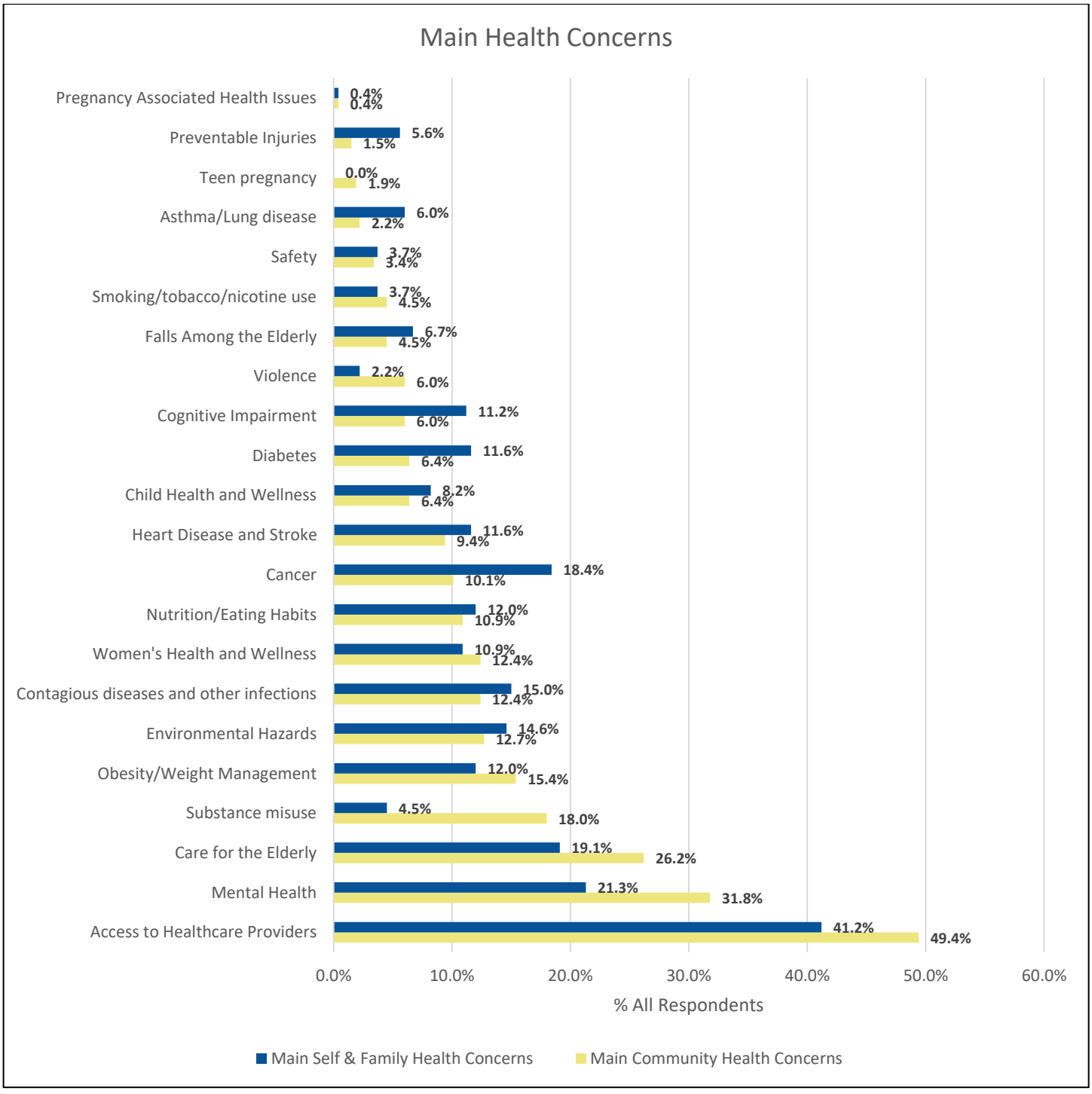
When results were stratified by respondent characteristics, other differences outside the MOE include:

- A lower proportion of respondents aged 65 or older (21.1%, MOE ±5.0%) had trouble meeting healthcare needs as compared to younger respondents (37.9%, MOE ±5.6%).
- A higher proportion of Hispanic respondents (20.8%, MOE ±14.2%) had trouble meeting needs for a phone as compared to non-Hispanic respondents (2.4%, MOE ±4.0%).
- A higher proportion of respondents with a disabled person in the household (27%, MOE ±7.5%) had trouble meeting transportation needs as compared to those without a disabled person in the household (8.8%, MOE ±4.0%).
- A higher proportion of respondents without health insurance (55.6%, MOE ±22%) had trouble meeting healthcare needs as compared to respondents with health insurance (27%, MOE ±3.6%).
- A higher proportion of respondents residing in 12563 (61.5%, MOE ±17.2%) had trouble meeting healthcare needs as compared to the whole sample.

MAIN HEALTH CONCERNS

Respondents were presented with a list of health concerns and asked to select the three main concerns in the community where they live (MOE ±5.2%), and the three main concerns for themselves and their families (MOE ±3.6%). The top three health concerns, for both the community and self and family, were access to healthcare providers, mental health, and care for the elderly. [see Figure 4]

Figure 4



Differences outside the MOE in perception of main concerns for the **community** as compared to main concerns for **self and family** included:

- A higher proportion of respondents citing mental health as a main concern in the community (31.8%) as compared to for self and family (21.3%).
- A higher proportion of respondents citing substance misuse as a main concern in the community (18%) as compared to for self and family (4.5%).

It should be noted that perception of main concerns in the community may be biased by the degree of public attention given to issues, while main concerns for self and family are likely to reflect the concerns of the sample population, which is not representative of the county population.

When stratified by respondent characteristics, differences outside the MOE in perception of main concerns for the **community** include:

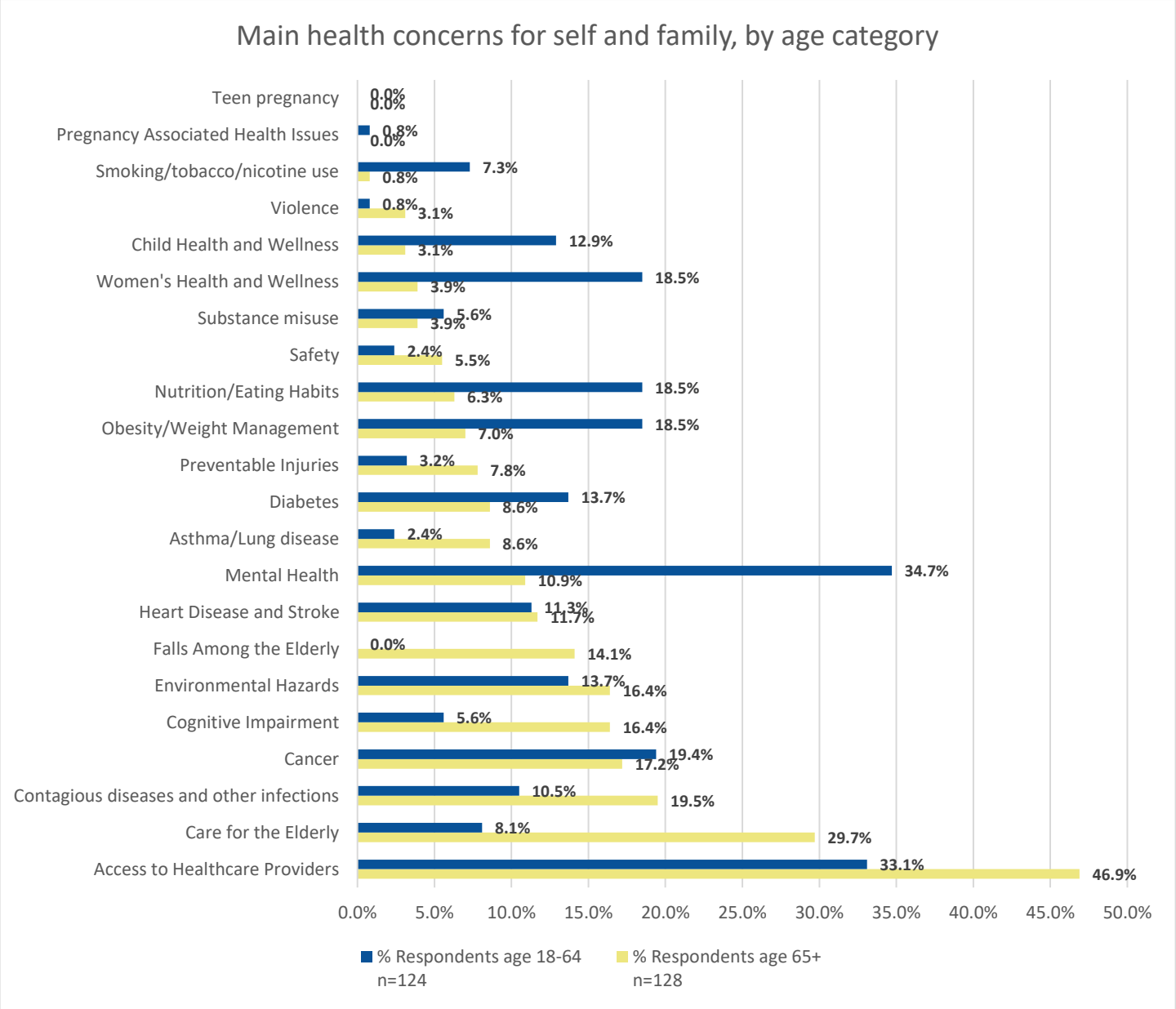
- A higher proportion of respondents aged 65 and over cited care for the elderly (39.8%, MOE ±6.5%) as compared to younger respondents (12.9%, MOE ±6.6%), while a higher proportion of younger respondents cited mental health (46%) as compared to respondents aged 65 years or over (20.3%).
- A higher proportion of women respondents cited women's health and wellness (17.9%, MOE ±5.4%) as compared to men (3.6%, MOE ±8.4%).
- A higher proportion of Hispanic respondents cited mental health (50%, MOE ±12%) as compared to non-Hispanics (32.7%, MOE ±5.4%).
- A higher proportion of veteran/active military respondents cited care for the elderly (42.9%, MOE ±11.3%) as compared to non-veteran/active military (24.4%, MOE ±5.5%), while a higher proportion of non-veteran/active military respondents cited mental health (35%) as compared to veteran/active military (9.5%).
- A higher proportion of respondents with household income less than $25,000 per year (MOE ±10.6%) cited violence (26.1%) as compared to the whole sample, while a lower proportion cited mental health (13%) and obesity (0%) as compared to the whole sample.
- A higher proportion of respondents with household income of $100,000-$149,999 (46.9%, MOE ±8.3%) and those with household income greater than $150,000 per year (52.6%, MOE ±9.0%) cited mental health as compared to the whole sample. A lower proportion of respondents with income greater than $150,000 per year (15.8%) cited care for the elderly as compared to the whole sample.
- By zip code, as compared to the whole sample, a higher proportion of respondents from 10524 (MOE ±17.3%) cited care for the elderly (55.6%), a higher proportion from 10537 (MOE ±15.4%) cited safety (37.5%), and a higher proportion from 12563 (MOE ±12.3%) cited access to healthcare providers (30.8%) and nutrition/eating habits (38.5%).

When comparing main health concerns for **self and family** by respondent characteristics**,** significant variation is seen based on age category. Mental health was the most frequently cited concern for respondents aged 18 to 64 (34.7%), while access to healthcare providers was the most frequently cited concern for respondents age 65 and older (46.9%).

Differences outside the MOE for main health concerns for self and family by age include:

- As compared to younger respondents (MOE ±4.8%), a higher proportion of respondents aged 65 years or older (MOE ±4.2%) cited access to healthcare providers, care for the elderly, contagious diseases, cognitive impairment, and falls among the elderly as main health concerns for themselves or their family.
- As compared to respondents aged 65 years or older, a higher proportion of younger respondents cited mental health, obesity/weight loss, nutrition/eating habits, women's health and wellness, and child health and wellness as main health concerns for themselves or their family. [see Figure 5]

Figure 5

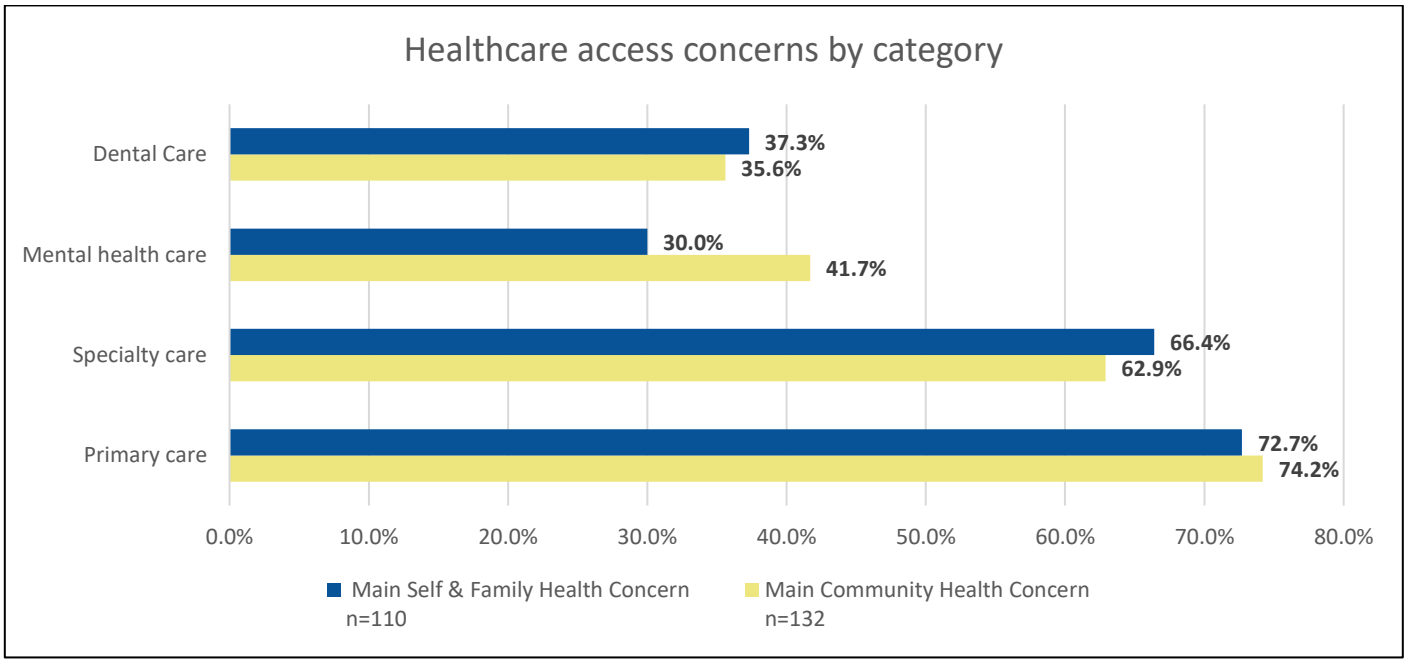


When stratified by respondent characteristics, other differences outside the MOE in main health concerns for **self and family** include:

- A higher proportion of male respondents cited diabetes (18.1%, MOE ±5.3%) as compared to female respondents (6.8%, MOE ±4.6%) while a higher proportion of female respondents cited women's health and wellness (15.4%) as compared to male respondents (3.6%).
- A higher proportion of White respondents cited mental health (23.9%, MOE ±4.1%) as compared to non-White respondents (13%, MOE ±6.7%), while a higher proportion of non-White respondents cited nutrition/eating habits (26.1%) as compared to White respondents (12.2%).
- A higher proportion of Hispanic respondents cited care for the elderly (29.2%, MOE ±4.1%), diabetes (25%), and women's health and wellness (16.7%) as compared to non-Hispanic respondents (19.5%, 10.2%, and 0% respectively, MOE ±5.4%).
- A higher proportion of veteran/active military respondents cited access to healthcare providers (52.4%, MOE ±8.2%) and contagious diseases (28.6%) as compared to non-veteran/active military respondents (39.3% and 14.5% respectively, MOE ±3.8%).
- A higher proportion of respondents with a disabled household member cited mental health (30.9%, MOE ±6.5%) as compared to those without a disabled household member (17.1%, MOE ±4.4%).
- A higher proportion of respondents with household income of $100,000-$149,999 cited mental health (36.7%, MOE ±7.5%) as compared to the whole sample (21.3%).
- Differences by zip code, as compared to the whole sample, include:
    - A higher proportion of respondents residing in 10509 (MOE ±5.6%) cited child health and wellness (17.4%).
    - A higher proportion of respondents residing in 10516 (MOE ±6.7%) cited falls among the elderly (19.2%).
    - A higher proportion of respondents residing in 10524 (MOE ±9.8%) cited cancer (33.3%), care for the elderly (33.3%), and cognitive impairment (55.6%).
    - A higher proportion of respondents residing in 10537 (MOE ±13.9%) cited diabetes (37.5%) and falls among the elderly (25%).
    - A higher proportion of respondents residing in 10579 (MOE ±7.2%) cited obesity and weight management (23.1%) and women's health and wellness (23.1%).
    - A higher proportion of respondents residing in 12563 (MOE ±6.6%) cited mental health (38.5%), nutrition and eating habits (30.8%), smoking/tobacco/nicotine use (15.4%) and women's health and wellness (30.8%).

Respondents who selected **access to healthcare providers** as a main health concern in the community or for themselves or their family were asked to further specify the categories of healthcare where access was of concern. The highest proportion of respondents cited access to primary care, followed by access to specialty care. The proportion citing concerns in the community was similar to that with citing concern for self and family across all categories except for mental health care, where a higher proportion cited community concern than concern for self and family. [see Figure 6]

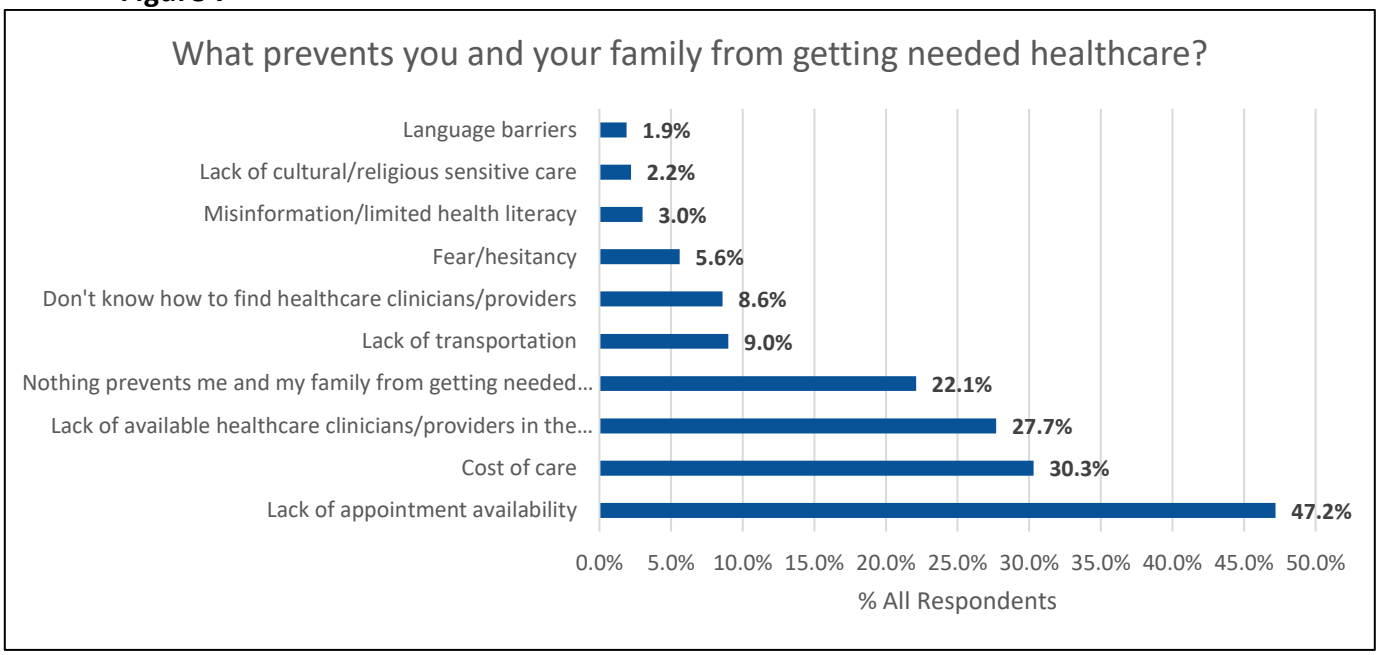
Figure 6



HEALTHCARE BARRIERS

Respondents were presented with a list of potential barriers to getting healthcare and asked to select up to three that had prevented themselves or their family from getting needed healthcare. Looking at the whole sample (MOE ±3.7%), the top three barriers selected were lack of appointment availability (47.2%), cost of care (30.3%), and lack of healthcare providers in the community (27.7%). Twenty-two percent of respondents stated that nothing prevents them or their family from getting needed healthcare. [see Figure7]

Figure 7

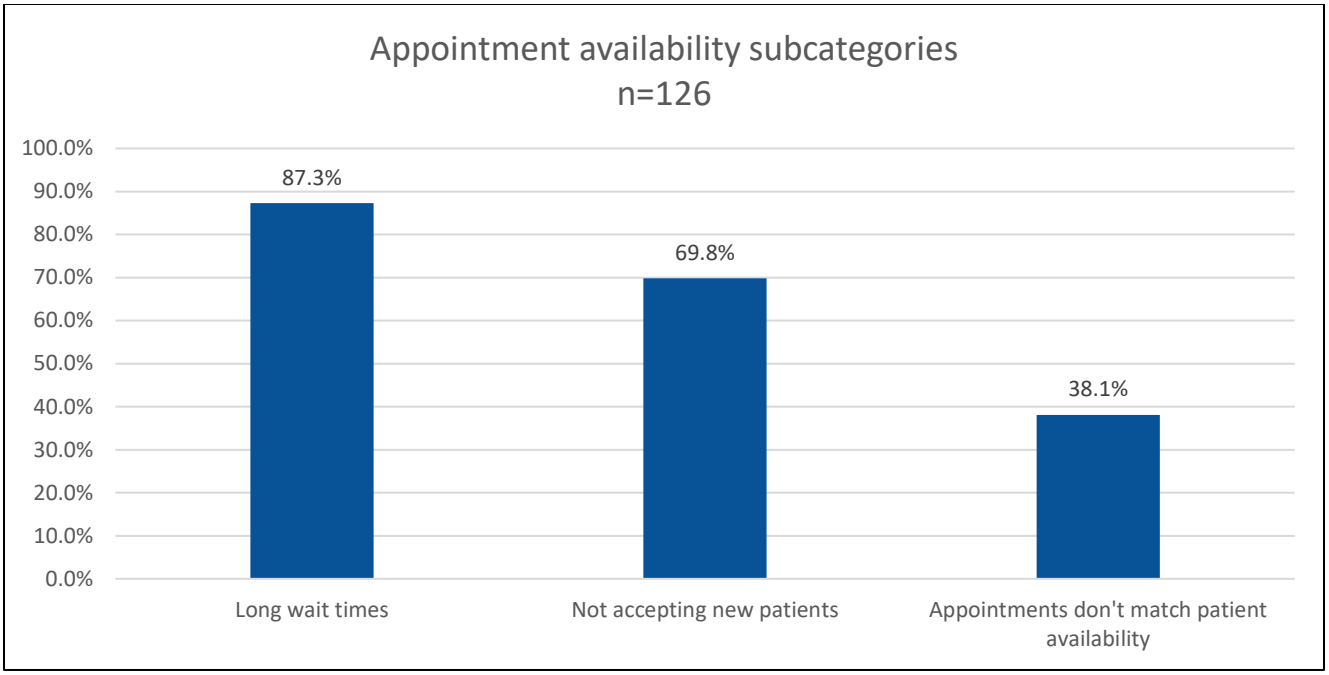


Results were stratified by respondent characteristics and the following differences outside the MOE were noted:

- A higher proportion of female respondents (MOE ±4.8%) cited lack of appointment availability (53.1%) and lack of availability of healthcare providers in the community (32.1%) as compared to men (39.8% and 18.1%, respectively, MOE ±6.2%). A higher proportion of male respondents stated nothing prevents them or their family from getting needed healthcare (32.5%) as compared to women (17.9%).
- A lower proportion of respondents with a disabled person in the household (MOE ±7%) stated nothing prevents them or their family from getting needed healthcare (13.6%) as compared to those without a disabled person in the household (27.1%, MOE ±4.3%).
- A higher proportion of respondents with annual household income between $50,000-$99,999 (MOE ±8.6%) cited cost of care (42.9%) and lack of appointment availability (60%) when compared with the whole sample (30.3% and 47.2%, respectively MOE ±3.7%). A higher proportion of respondents with annual household income of $150,000 or more (MOE ±8.1%) stated nothing prevents them from getting needed healthcare (36.8%) as compared to the whole sample (22.1%).
- A higher proportion of respondents without health insurance (MOE ±13.6%) cited cost of care (66.7%) and lack of appointment availability (66.7%) as compared to respondents with health insurance (29.1% and 46.7% respectively, MOE ±3.8%).
- A higher proportion of respondents residing in 12563 (MOE ±12.7%) cited a lack of appointment availability (84.6%) when compared with the whole sample (47.2%).

Respondents who selected lack of appointment availability as a barrier to getting needed healthcare were asked to further specify availability issues they faced. Long wait times were the most common issue cited (87.3%) followed by practices not accepting new patients (69.8%) and appointments not being available at times when respondents were available (38.1%). [see Figure 8]

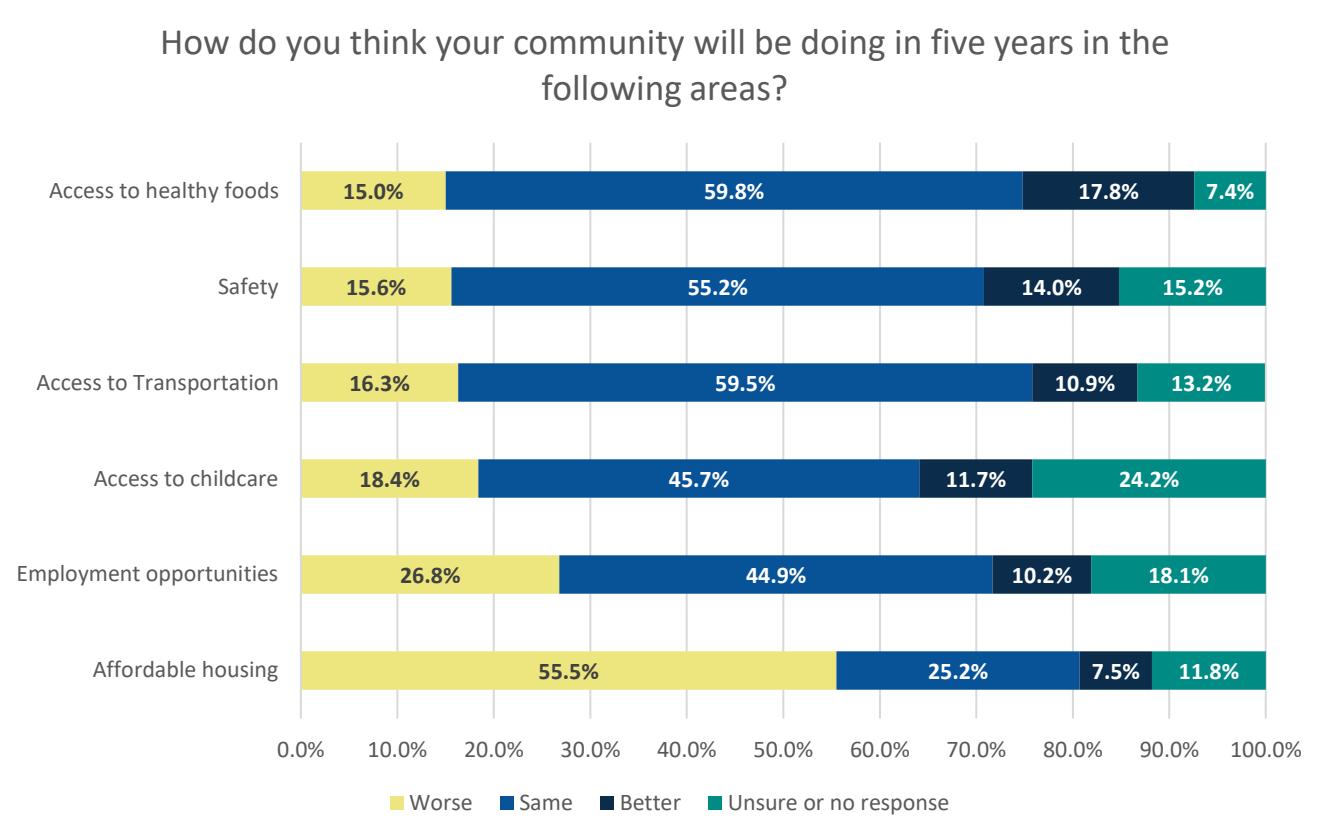
Figure 8



COMMUNITY OUTLOOK

Respondents were asked for their opinion on how their communities would be doing five years from now in several areas. Affordable housing had the highest proportion of respondents with an unfavorable outlook (55.5%, MOE ±4.0%), while access to healthy foods had the highest proportion with a favorable outlook (17.8%, MOE ±3.8%). [see Figure 9]

Figure 9



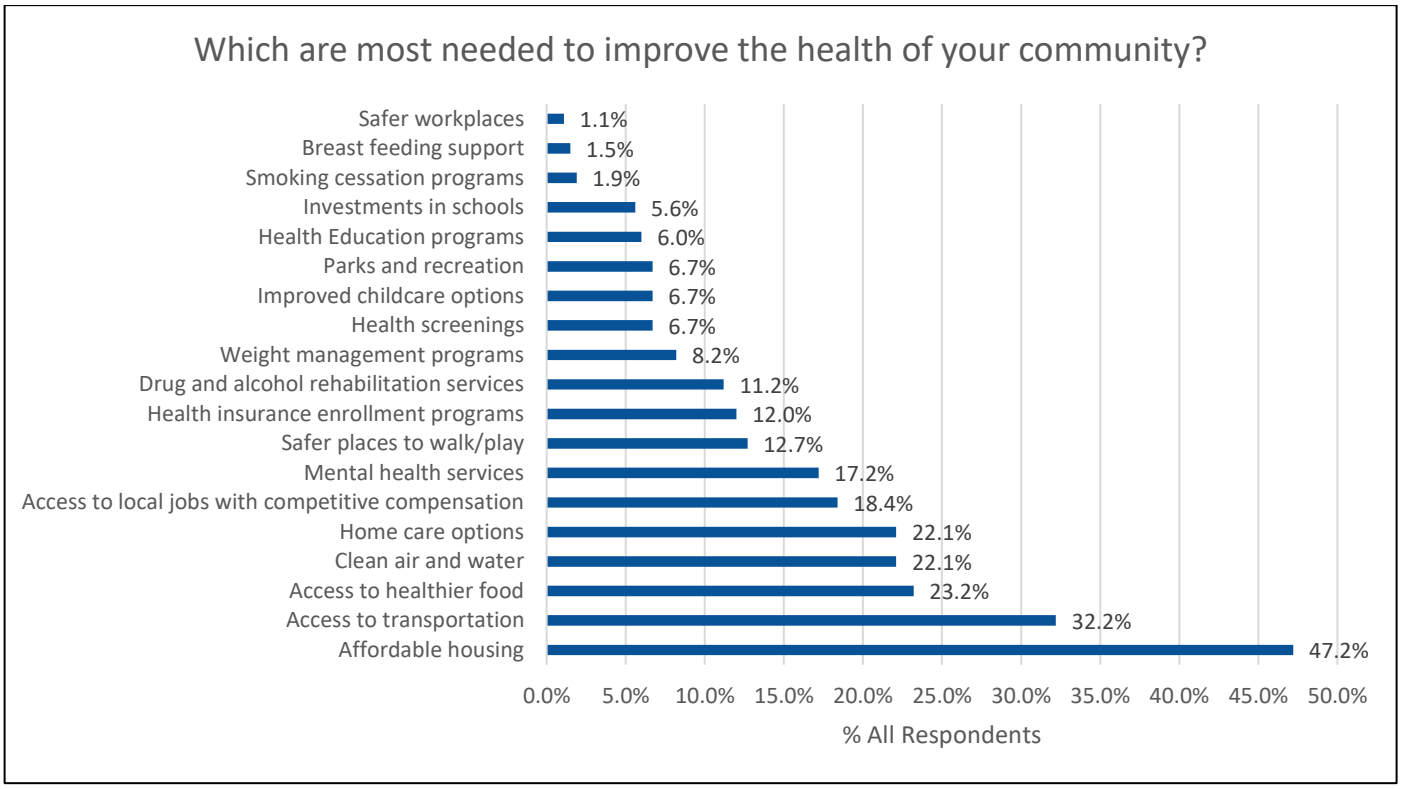
Results were stratified by respondent characteristics and differences in outlook for affordable housing outside the MOE were noted by age and gender:

- A higher proportion of respondents less than 65 years of age (MOE ±5.4%) had a poor outlook (62.9%) as compared to respondents 65 years of age or older (47.5%, MOE ±5.9%).
- A higher proportion of women (MOE ±4.8%) had a poor outlook (62.7%) as compared to men (43.8%, MOE ±6.8%).

COMMUNITY NEEDS

Respondents were provided with a list of things that can improve population health and asked to select the three that are most needed in their communities. Amongst all respondents (MOE ±3.7%), affordable housing (47.2%), access to transportation (32.2%), and access to healthier food (23.2%) were most commonly selected. [see Figure 10]

Figure 10



Results were stratified by respondent characteristics and the following differences outside the MOE were noted:

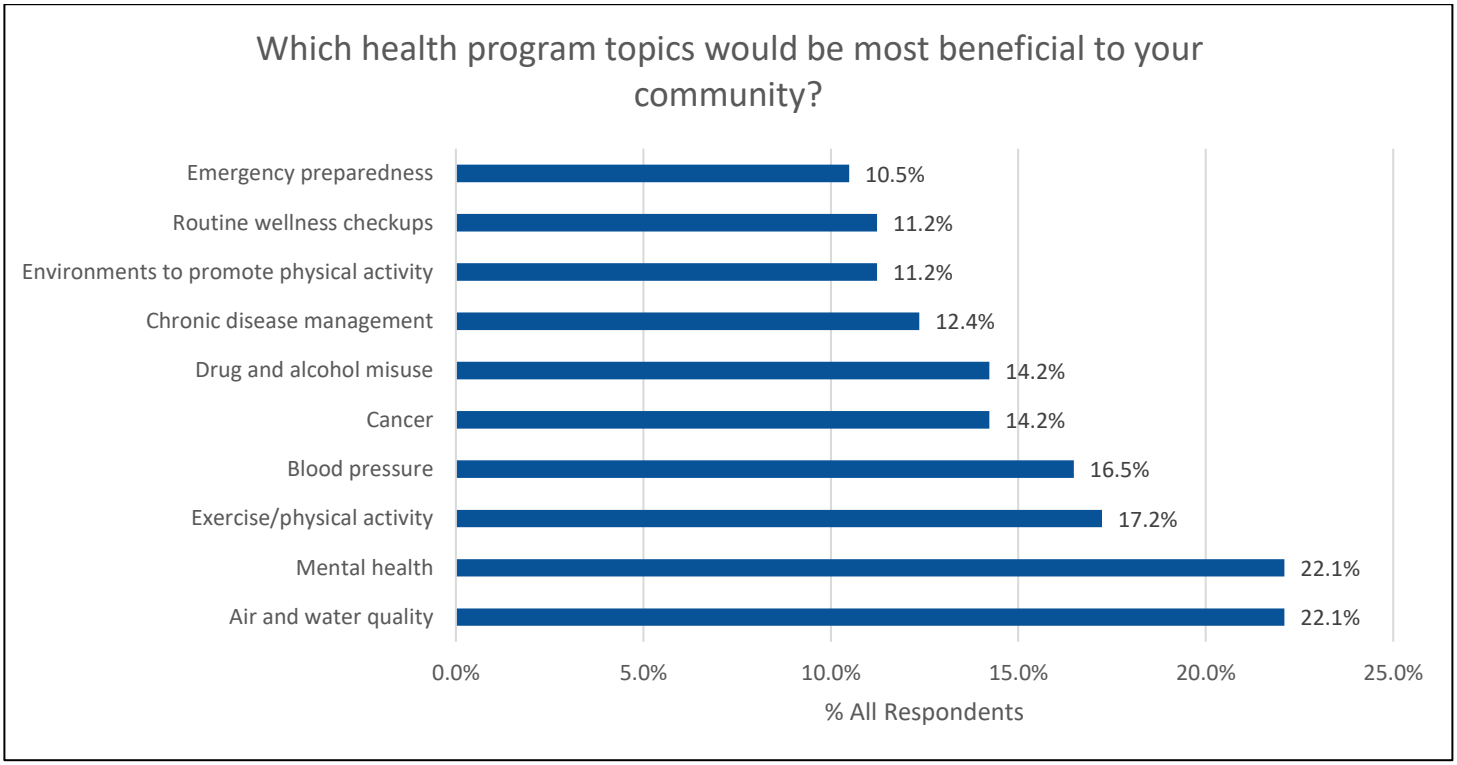
- A higher proportion of respondents aged 65 years or older (MOE ±5.0%) selected access to transportation (37.5%) and home care options (30.5%) as compared to younger respondents (26.6% and 12.1% respectively, MOE ±5.5%), while a higher proportion of younger respondents selected local jobs with competitive salaries (25%) as compared to respondents aged 65 or older (13.3%).
- A higher proportion of female respondents selected local jobs with competitive salaries (22.8%, MOE ±4.6%) as compared to male respondents (10.8%, MOE ±6.6%).
- A higher proportion of White respondents (MOE ±4.1%) selected access to transportation (34.7%) as compared to non-White respondents (13%, MOE ±12.3%).
- A higher proportion of Hispanic respondents (MOE ±10.9%) selected access to healthier food (50%) as compared to non-Hispanic respondents (18.5%, MOE ±4.2%).
- A higher proportion of respondents with a disabled person in the household (MOE ±6.4%) selected access to transportation (40.7%) as compared to respondents with no disabled person in the household (28.8%, MOE ±4.6%).
- A higher proportion of respondents residing in 10516 (MOE ±9.2%) selected access to transportation (53.8%) as compared to the whole sample (32.2%, MOE ±3.7%).

- A higher proportion of respondents with household income less than $25,000 per year (MOE ±9.9%) selected affordable housing (60.9%) and clean air and water (39.1%) as compared to the whole sample (47.2% and 22.1% respectively, MOE ±3.7%).

HEALTH SCREENING AND HEALTH EDUCATION TOPICS

Respondents were provided with a list of health screenings and health education/information topics and asked to select the three that would be most beneficial to their community. Mental health and air and water quality were most selected most frequently (22.1%). Figure 11 displays the ten most frequent selections.

Figure 11



Results were stratified by respondent characteristics and the following differences outside the MOE were noted:

- A higher proportion of respondents aged 65 years and older (MOE ±4.1%) selected blood pressure screening (22.7%) as compared to younger respondents (11.3%, MOE ±4.4%), while a higher proportion of younger respondents selected mental health (33.1%) as compared to respondents 65 years of age or older (13.3%).
- A higher proportion of male respondents (MOE ±5%) selected air and water quality (27.7%) as compared to female respondents (18.5%, MOE ±3.8%), while a higher proportion of female respondents selected chronic disease management (17.3%) and dental screenings (11.7%) as compared to males (4.8% and 1.2%, respectively).
- A higher proportion of Hispanic respondents (MOE ±8.1%) selected air and water quality (37.5%) and dental screenings (20.8%) as compared to non-Hispanic respondents (19% & 6.8% respectively, MOE ±3.4%).
- A higher proportion of veteran/active military respondents (MOE ±8.7%) selected exercise and physical activity (28.6%), emergency preparedness (23.8%) and diabetes/pre-diabetes (28.6%) as

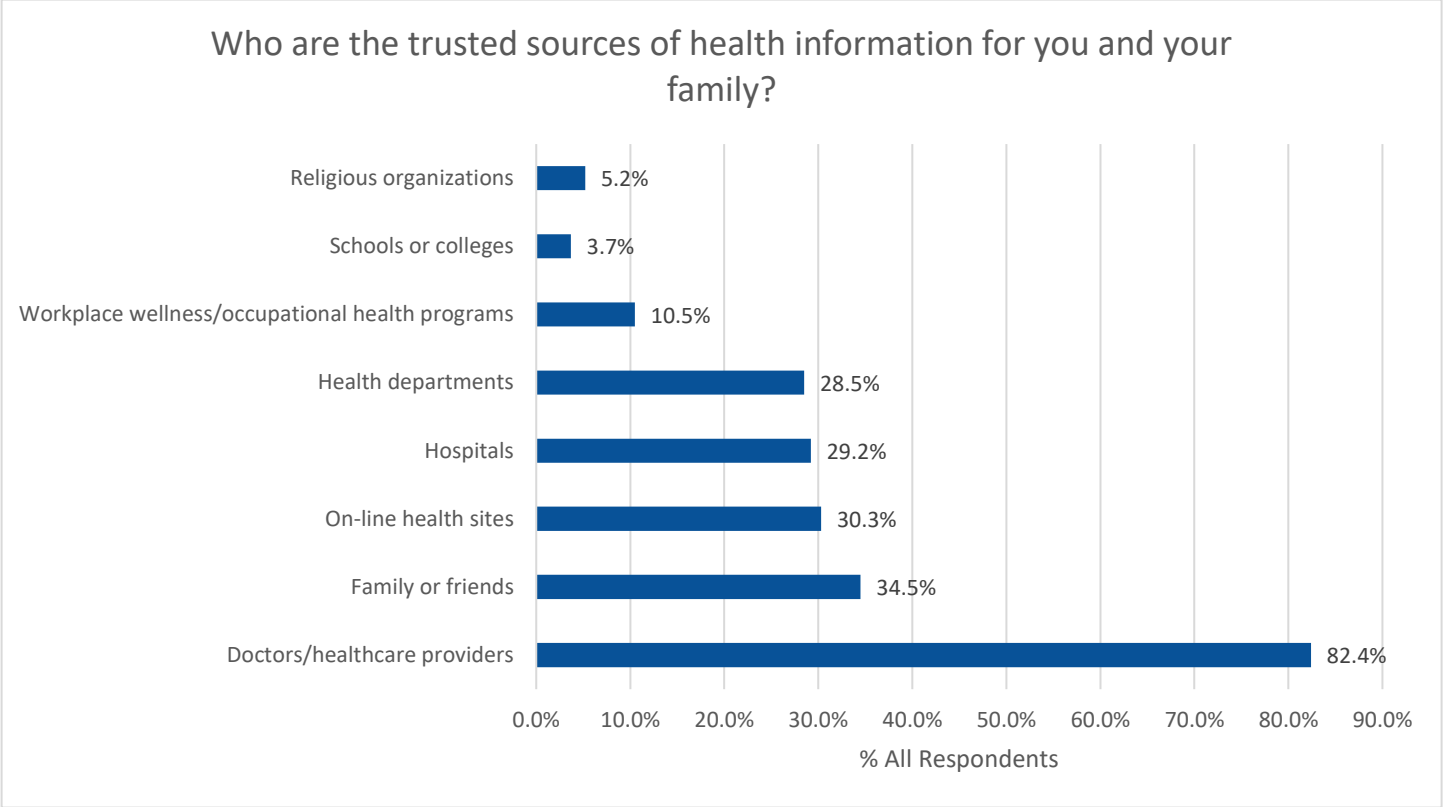
compared to non-veteran/active military respondents (16.7%, 9.4%, and 6.8% respectively, MOE ±3.2%).

- A higher proportion of respondents with household income less than $25,000 (MOE ±7.5%) selected air and water quality (39.1%) and blood pressure (39.1%) as compared to the whole sample (22.1% and 16.5% respectively, MOE ±2.9%), while a higher proportion of respondents with household income greater than $150,000 (MOE ±6.8%) per year selected mental health (36.8%) and drug and alcohol misuse (31.6%) as compared to the whole sample (22.1% and 14.2% respectively).

TRUSTED SOURCES OF HEALTH INFORMATION

Respondents were asked to select trusted sources of health information for themselves and their families. By far the most frequently selected trusted source of information was doctors/healthcare providers (82.4%). Considering the MOE of ±4.4%, there was little difference in the proportion of respondents selecting family and friends (34.5%), online health sites (30.3%), hospitals (29.2%), and health departments (28.5%). [see Figure 12]

Figure 12



Results were stratified by respondent characteristics and the following differences outside the MOE were noted:

- A higher proportion of male respondents (MOE ±7.7%) selected health departments (39.8%) as compared to female respondents (24.7%, MOE ±5.7%).
- A lower proportion of respondents residing in 10516 (MOE ±13.5%) selected online health sites (11.5%) and hospitals (11.5%) as compared to the whole sample (30.3% and 29.2% respectively), while a higher proportion of respondents residing in 12563 (MOE ±16.8%) selected family and friends (61.5%) as compared to the whole sample (34.5%).

DISCUSSION

LIMITATIONS

Several limitations should be considered in interpreting the results of the Community Health Experience Survey. First, responses were obtained through voluntary response sampling, and as such are subject to both self-selection and non-response bias, meaning individuals who choose to take a survey are likely to have stronger opinions (either positive or negative) than the rest of the population. Second, the survey population is not demographically representative of the Putnam County population. Finally, generalizability is further limited by the small sample size which increases risk for random variation in results. Survey results should be considered representative of the survey sample, and caution should be taken in generalizing to the Putnam County population.

CONSIDERATIONS AND RECOMMENDATIONS

Results of this survey are not generalizable to the Putnam population and this report should not be used as a stand-alone assessment to inform County program planning. The findings may be a useful adjunct to data found in other components of the CHA when prioritizing and designing initiatives and interventions to improve health in Putnam County. Overarching themes of the survey results include the following:

Meeting Basic Needs:
While difficulty meeting healthcare needs impacted the highest proportion (28.5%) of survey respondents, difficulty meeting needs for housing, food, transportation, and utilities in the last year were also cited by more than 10% of respondents. Respondents with household incomes of less than $25,000 per year had trouble meeting all basic needs in higher proportions than the overall sample population.

Healthcare Access:
Evidence for issues accessing healthcare appeared repeatedly in survey results. In addition to the high proportion with difficulty meeting healthcare needs in the last year, the highest proportion of respondents also selected access to healthcare providers as a main health concern for both the community and for themselves and their families. Primary care, followed by specialty care, were the most frequently specified categories of care for access issues. Lack of availability of clinicians and appointments, and cost of care, were the most frequent reasons selected for having difficulty accessing care.

Affordable Housing:
Affordable housing emerged as a chief concern for survey respondents. The highest proportion of respondents selected affordable housing as an area of need to improve health in the community and more than half of respondents anticipate that housing affordability will be worse in five years.

Mental Health:
Several differences were noted between respondent sub-populations on the topic of mental health. Higher proportions of respondents less than 65 years of age, those living with a disabled household member, and those with household income less than $25,000 per year had unfavorable self-ratings for mental health. Similarly, a higher proportion of respondents less than 65 years of age selected mental health as a top concern in the community and for self and family, and as a health program that would be most beneficial to the community. In contrast, a higher proportion of respondents in higher income brackets selected mental health as a top concern in the community and for self and family, and as a health program that would be most beneficial to the community.

Trusted Sources of Health Information:
The great majority of respondents consider healthcare providers a trusted source of health information (82.4%). Other health sectors sources such as health departments and hospitals were only selected by about a third of respondents, similar to the proportion selecting friends and family as a trusted source.

Other Differences by Respondent Characteristics:
Responses were not uniform across the sample population. Differences outside of the MOE were noted based on a wide variety of respondent characteristics. Alongside other data sources, these findings should be given consideration when trying to identify areas of need and/or concern for various sub-populations within the county.