Cleveland Clinic
Akron General

Community Health Needs Assessment

2022

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Executive Summary

This Community Health Needs Assessment (CHNA) was conducted by Cleveland Clinic Akron General (Akron General or "the hospital") to identify significant community health needs and to inform development of an Implementation Strategy to address current needs in accordance with the Affordable Care Act[1].

Founded in 1914 as Peoples Hospital, Cleveland Clinic Akron General is a not-for-profit healthcare organization that serves as the hub for Cleveland Clinic's Southern Region. In addition to a 485 staffed bed[2] teaching and research medical center in downtown Akron, the Cleveland Clinic Akron General system includes a critical access hospital and health and wellness centers. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/akron-general.

The hospital is part of the Cleveland Clinic health system, which includes an academic medical center near downtown Cleveland, fourteen regional hospitals in northeast Ohio, a children's hospital, a children's rehabilitation hospital, five southeast Florida hospitals, and several other facilities and services across Ohio, Florida, and Nevada.

Cleveland Clinic is a global leader and model of healthcare for the future. We work as a team with the patient at the center of care. As a truly integrated healthcare delivery system, we take on the most complex cases and provide collaborative, multidisciplinary care supported with cutting-edge research and technology. We treat patients and fellow caregivers as family and Cleveland Clinic as our home. Our vision is to become the best place to receive healthcare anywhere, and the best place to work in healthcare. Our goals for achieving that are bold, but reachable: To serve more patients, create more value and improve the well-being of all caregivers. As we grow and double the number of patients served by 2024, everything we do and every place we are located will bear the unmistakable stamp of One Cleveland Clinic –with the same quality, experience and Care Priorities at every location.

Cleveland Clinic's ability to provide world-class patient care and best-in-class clinicians are the product of our commitment to research and education, which has also contributed to significant advancements toward the diagnosis and treatment of complex medical challenges. Figure 1 shows Our Care Priorities, which are to:[3]

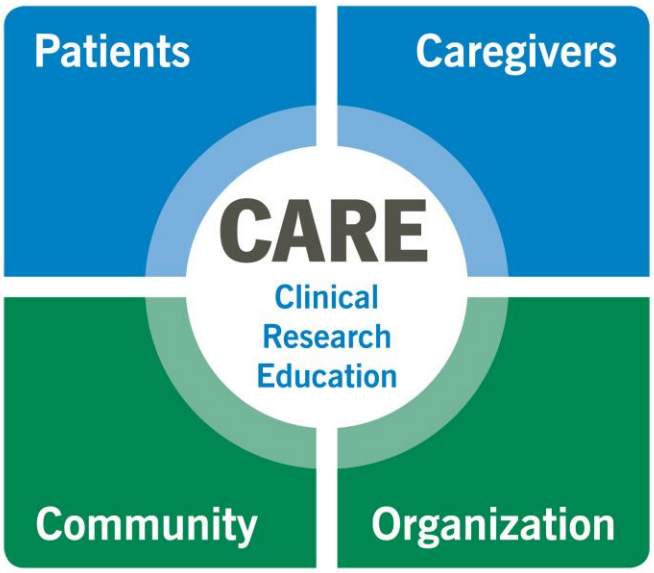
- Care for Patients as if they are our own family
- Treat fellow caregivers as if they are our own family
- Be committed to the communities we serve
- Treat the organization as our home

[1] Internal Revenue Service, Community Health Needs Assessment for Charitable Hospital Organizations – Section 501 (c) (3), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[2] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) interim financial statement is referenced for official bed count. We acknowledge that staffed bed count may fluctuate and may differ from registered or licensed bed counts reflected in other descriptions.

[3] The Cleveland Clinic Mission, Vision and Values https://my.clevelandclinic.org/about/overview/who-we-are/mission-vision-values

Figure 1: The Cleveland Clinic Care Priorities



Caring for the Community

Caring for the community is a long-standing priority at Cleveland Clinic. As an anchor institution –a major employer and provider of services in the community –our goal is to create the healthiest community for everyone. We do this through actions and programs to heal, hire and invest for the future.

Cleveland Clinic is much more than a healthcare organization. We are listening to our neighbors to understand their needs, now and in the future. The health of every individual affects the broader community.

According to the National Academy of Medicine, only 20% of a person's health is related to the medical care they receive. There are other factors that have a lifelong impact, accounting for 80% of a person's overall health.[4] These social determinants of health are conditions in which people grow, work and live –including employment, education, food security, housing and several others.[5]

In order to address health disparities, we lead efforts in clinical and non-clinical programming, advocacy, partnerships, sponsorship and community investment. We are actively partnering with leaders to help strengthen community resources and mitigate the impact of disparities in social determinants of health. By engaging with partners who

[4] Magnan, S. Social Determinants of Health 101 for Healthcare: Five Plus Five, National Academy of Medicine. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
[5] Social Determinants of Health, World Health Organization. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

share our commitment, we can make a difference in creating a better, healthier community for everyone.[6]

Each Cleveland Clinic hospital is dedicated to the communities it serves. Each Cleveland Clinic hospital conducts a CHNA to understand and plan for the current and future health needs of residents and patients in the communities it serves. The CHNAs inform the development of strategies designed to improve community health, including initiatives designed to address social determinants of health.

These assessments are conducted using widely accepted methodologies to identify the significant health needs of a specific community. The assessments also are conducted to comply with federal and state laws and regulations including IRS requirements for 501(c)(3) Hospitals under the Affordable Care Act[7].

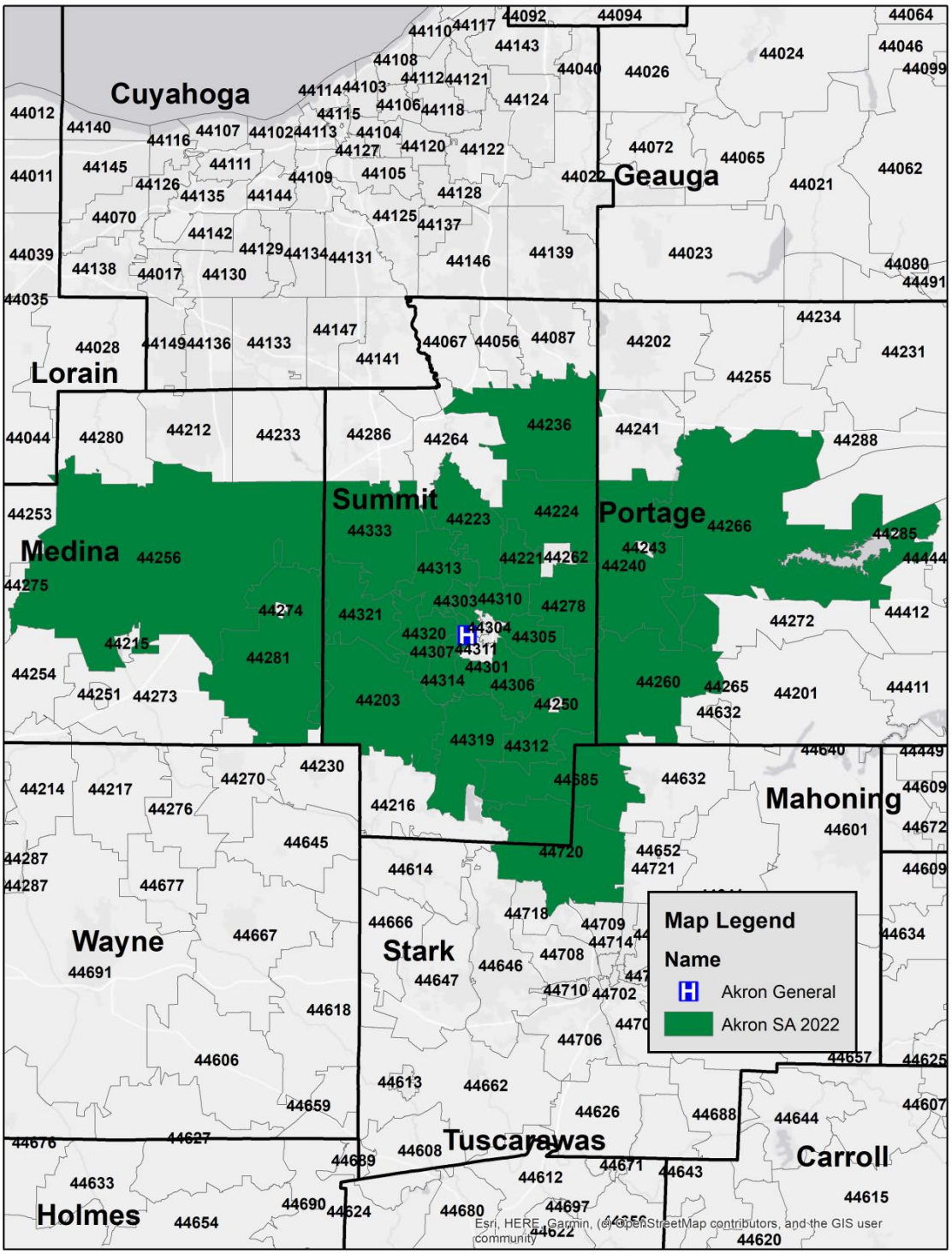
Community Definition

The community definition describes the zip codes where approximately 75% of Akron General patients reside. Figure 2 shows the service area for the Akron General Community. A table with zip codes and the associated postal names that comprise the community definition is located in Appendix C.

[6] Cleveland Clinic, Community Commitment, https://my.clevelandclinic.org/about/community#:~:text=Caring%20for%20the%20community%20is,and%20invest%20for%20the%20future.

[7] Internal Revenue Service, Requirements for 501 (c) (3) Hospitals Under the Affordable Care Act – Section 501 (r), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

Figure 2: Akron General Community Definition



Secondary Data Summary

Secondary data used for this assessment were collected and analyzed from Conduent Healthy Communities Institute's (HCI) community indicator database. The database, maintained by researchers and analysts at HCI, includes 300 community indicators

covering at least 28 topics in the areas of health, social determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, nationally set targets and to previous time periods.

Due to variability in which public health data sets are available, data within this report may be presented at various geographic levels:

- The Akron General Community Definition—an aggregate of 34 zip codes.
- Medina, Summit, Portage and Stark Counties—the counties comprising the Akron General Community Definition

Primary Data Summary

Qualitative data collected from community members through key stakeholder interviews and a community engagement session comprised the primary data component of the CHNA and helped to inform selection of the significant health needs.

Conduent Healthy Communities Institute interviewed 20 key stakeholders from a diverse spectrum of community-based organizations and public health departments. To provide additional support and corroboration of vital community input, the Cleveland Clinic Foundation and Conduent Healthy Communities Institute facilitated a community engagement session featuring the Akron General Community Advisory Council (CAC) members. During the session, CAC members offered perspectives on the most important health problems in the community, barriers and challenges to improving health, identified the most underserved populations, discussed potential solutions to health challenges faced and offered success stories from existing program implementation.

Prioritized Health Needs

Following a comprehensive review of the significant community health needs throughout the Cleveland Clinic Health System, analysis of local county and state needs assessments and emerging trends, the following priority health needs for Akron General were identified:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health
- Socioeconomic Issues

Access to Healthcare

Access to Healthcare secondary data analysis results describe community needs related to consumer expenditures for insurance, medical expenses, medicines and other supplies. With more expansive parameters, primary data describes limitations to accessing

healthcare described in terms of transportation challenges, resource limitations and availability of primary care and other prevention services in local neighborhoods.

Behavioral Health

Behavioral Health encompasses two subtopics—Mental Health and Substance Use Disorder—into a single health need. Mental health secondary data indicators define suicide, Alzheimer's disease, depression and self-reported poor mental health rates. Similarly, Substance Use Disorder data outline rates related to alcohol and drug use including mortality rates due to drug overdoses. Primary data links the two together as community members and key stakeholders describe mental health challenges in the community, exacerbated by COVID-19 related stressors, resulting in increased alcohol and drug use starting in adolescence as a means of coping.

Chronic Disease Prevention and Management

This health topic encompasses several subtopics where information is available including Older Adult Health; Nutrition and Healthy Eating; Cancer; Chronic Diseases; Diabetes; Heart Disease and Stroke; and COVID-19. By addressing these issues in concert, the Cleveland Clinic Foundation hopes to impact chronic disease rates including those described in the Synthesis and Prioritization section of this report (page 35).

Maternal and Child Health

Maternal and Child Health has been a continuing health need in the community with a focus on Children's Health, Women's Health and Maternal, Fetal and Infant health. Secondary data indicators include a range of children's health needs from babies with low birth weight to consumer expenditures on childcare. Primary data describes disparities among low-income and ethnic minority and refugee populations and link access to healthcare with pre-natal care.

Socioeconomic Issues

Socioeconomic Issues for this report are defined as a subset of social determinants of health (SDOH). Prevention & Safety, Affordable Housing, Violence, Falls and Environmental Issues were the prioritized health needs described by primary and secondary data.

Additional Community Health Themes

In addition to the Prioritized Health Needs, other themes were prevalent in considering community health. These themes are intertwined in all community health components and impact multiple areas of community health strategies and delivery.

Health Equity

Health Equity issues in our communities were illuminated by COVID-19. They focus on the fair distribution of health determinants, outcomes and resources across communities.[8] Health Equity and reduction of health disparities are indicated as overarching themes in all our prioritized needs. It is described in detail and specifically as it relates to the Akron General Community in both the Disparities and Health Equity section (page 26) of the report as well as in the Synthesis and Prioritization section (page 35). Special consideration will be given to addressing prioritized health needs through a health equity lens in the Akron General implementation strategy report.

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. Social determinants of health (SDOH) are major drivers of behaviors that impact individual and community health outcomes. For a full description of social determinants of health (SDOH) see the highlighted demographic section entitled Social & Economic Determinants of Health.

Medical Research and Health Professions Education

Cleveland Clinic has a tripartite mission to care for the sick and to improve patient care through research and education. Through research we discover cures and treatment of diseases affecting our communities. This cross-cutting issue was evident in addressing the emergent pandemic of COVID 19. Our education programs train qualified healthcare providers to support the needs of our patients and communities, reducing healthcare access issues. This has been of historical importance to the work, care and mission of The Cleveland Clinic and will continue to be incorporated as Akron General moves toward development of their implementation strategy report.

[8] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

COMMUNITY HEALTH NEEDS ASSESSMENT
Akron General Hospital

Prioritized Health Needs

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention & Management
- Maternal and Child Health
- Socioeconomic Issues

Process

Additional Community Health Themes

Health Equity

Health Equity focuses on the fair and just distribution of health determinants, outcomes, and resources across communities.

Systemic racism
Poverty
Gender discrimination

Poorer health outcomes for groups such as Black persons, Hispanic or Latino persons, Indigenous communities, people experiencing poverty and LGBTQ+ communities.

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion

Medical Research and Health Professions Education

Cleveland Clinic has a tripartite mission to care for the sick and to improve patient care through research and education.

Through research we discover cures and treatment of diseases affecting our communities.

Our education programs train qualified healthcare providers to support the needs of our patients and communities, reducing healthcare access issues.

Demographics of the Akron General Community

The demographics of a community significantly impact its health profile.[9] Different racial, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community residing in the Akron General Community Definition.

Geography and Data Sources

Data are presented in this section at the geographic level. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey[10] one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

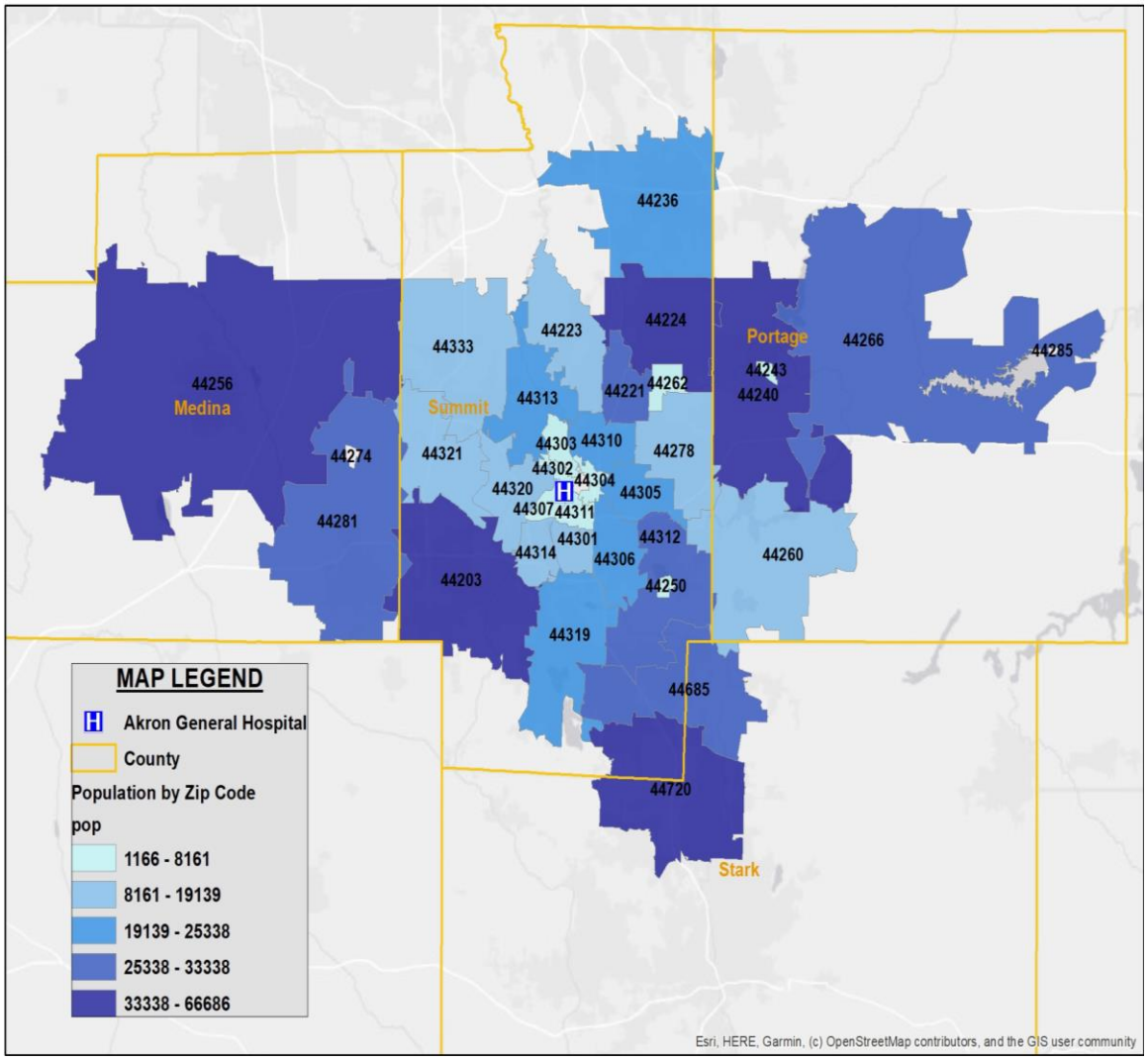
Population

According to the 2022 Claritas Pop-Facts® population estimates, the Akron General community has an estimated population of 703,575 persons. Figure 3 shows the population size by each zip code, with the darkest blue representing the zip codes with the largest population. Appendix C provides the actual population estimates for each zip code. The most populated zip code area within the Akron General Community is zip code 44256 (Medina) with a population of 66,686.

[9] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/

[10] American Community Survey. https://www.census.gov/programs-surveys/acs

Figure 3: Population by Zip Code

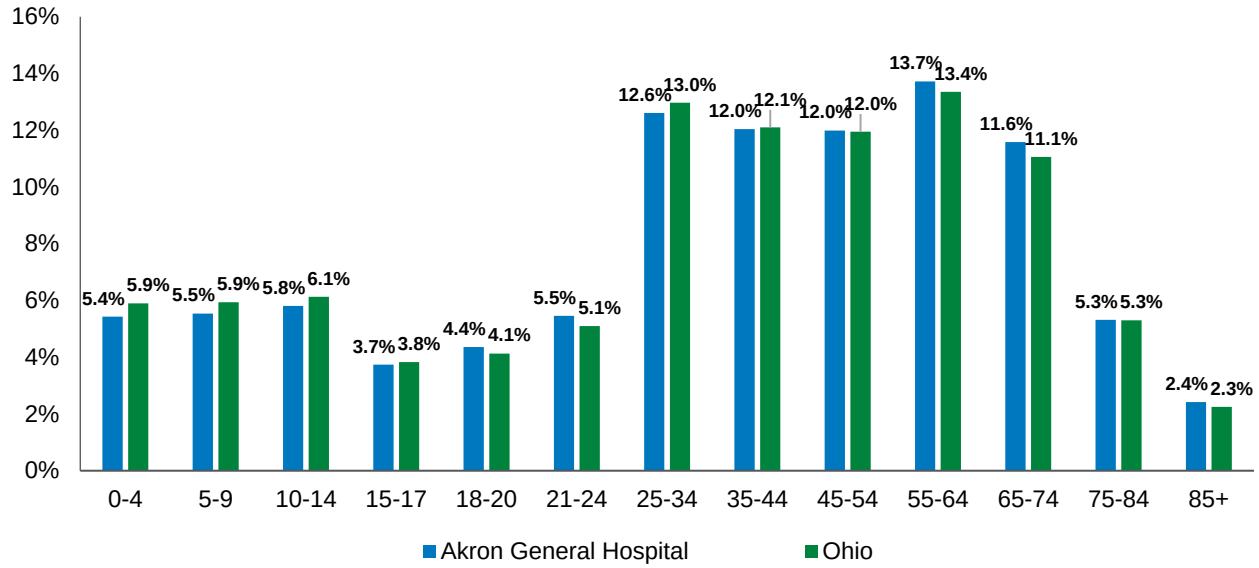


County values- Claritas Pop-Facts® (2022 population estimates)

Age

Children (0-17) comprised 20.5% of the population in the Akron General Community which is lesser when compared to the state of Ohio (21.8%). The Akron General Community has a higher proportion of residents aged 65+ (19.3%) when compared with the state of Ohio at 18.6%. Figure 4 shows further breakdown of age categories.

Figure 4: Population by Age: Hospital and State Comparisons

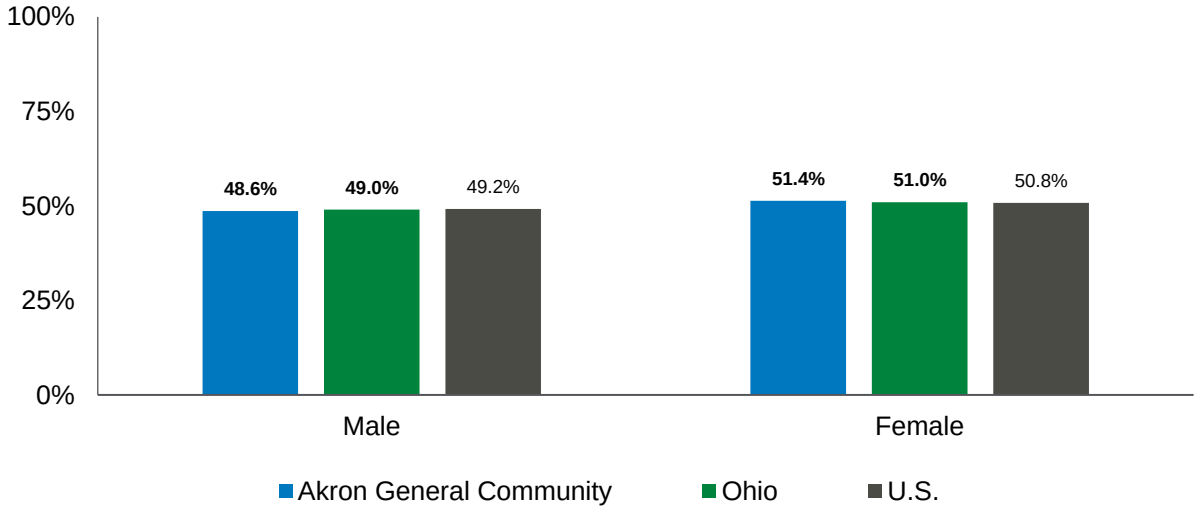


County and state values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 5 shows the population of the Akron General Community by sex. Males comprise 48.6% of the population in the Akron General Community, which is less than both the Ohio (49.0%) and U.S. (49.2%) values. Whereas females comprise 51.4% of the population in the Akron General Community which is slightly greater than Ohio (51.0%) and the U.S. (50.8%) values.

Figure 5: Population by Sex: Hospital, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2015-2019) estimates

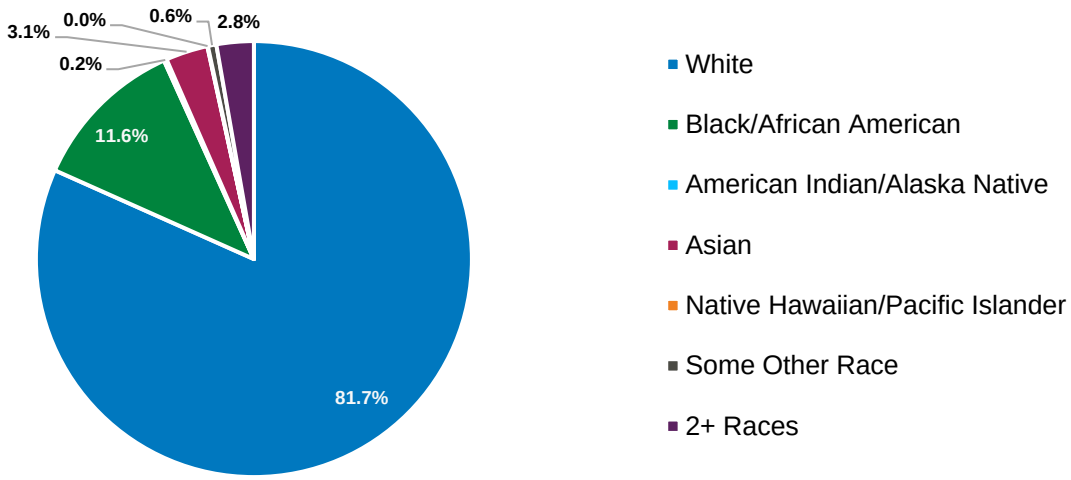
Race and Ethnicity

Race and ethnicity contribute to the opportunities individuals and communities have to be healthy. The racial and ethnic composition of a population is also important in planning

for future community needs, particularly for schools, businesses, community centers, healthcare, and childcare.

The racial makeup of Akron General area shows 81.7% of the population identifying as White, as indicated in Figure 6. The proportion of Black/African American community members is the second largest of all races in the Akron General Community at 11.6%.

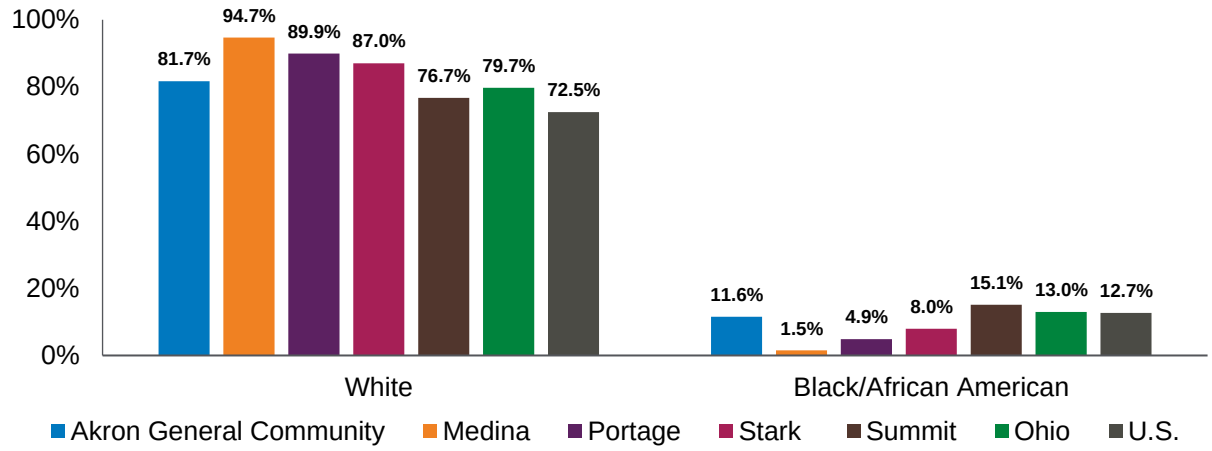
Figure 6: Population by Race: The Akron General Community



County values- Claritas Pop-Facts® (2022 population estimates)

Those community members identifying as White represent a higher proportion of the population in the Akron General Community (81.7%) when compared to Ohio (79.7%) and the U.S. (72.5%), while Black/African American community members represent a lower proportion of population in the Akron General Community (11.6%) when compared to Ohio (13.0%) and the U.S. (12.7%). Summit County has the largest percentage of community members identifying as Black/African American (15.1%) compared to the other counties included in the Akron General Community Definition. (Figure 7)

Figure 7: Population by Race: Hospital, County, State, and U.S. Comparisons

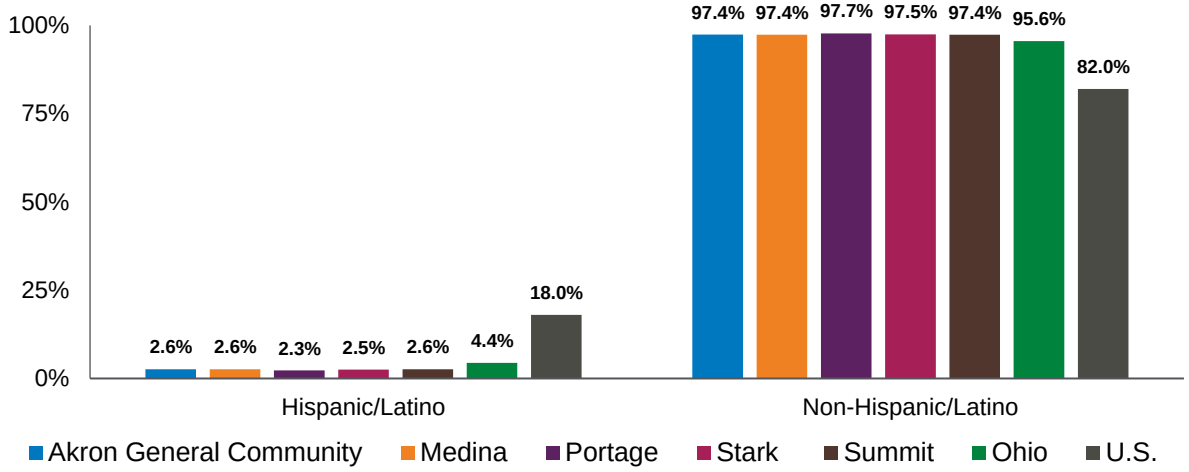


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

As shown in Figure 8, 2.6% of the population in the Akron General Community identify as Hispanic/Latino. This is a lesser proportion of the population when compared to Ohio

(4.4%) and the U.S. (18.0%). Medina (2.6%) and Summit County (2.6%) have the largest percentage of community members who identify as Hispanic/Latino.

Figure 8: Population by Ethnicity: Hospital, County, State, and U.S. Comparisons

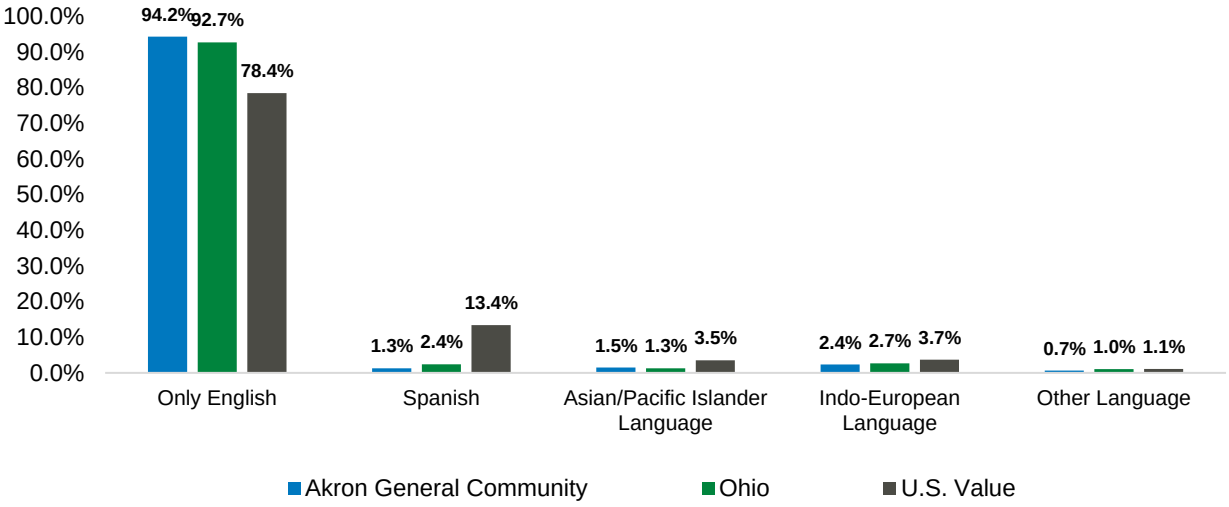


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system.
In the Akron General Community, 94.2% of the population age five and older speak only English at home, which is higher than both the state value of 92.7% and the national value of 78.4% (Figure 9). This data indicates that 1.3% of the population in the Akron General Community speak Spanish, 1.5% speak an Asian/Pacific Islander language, 2.4% speak an Indo-European Language, and 0.7% speak Other Languages at home.

Figure 9: Population 5+ by Language Spoken at Home: Hospital, State, and U.S. Comparisons

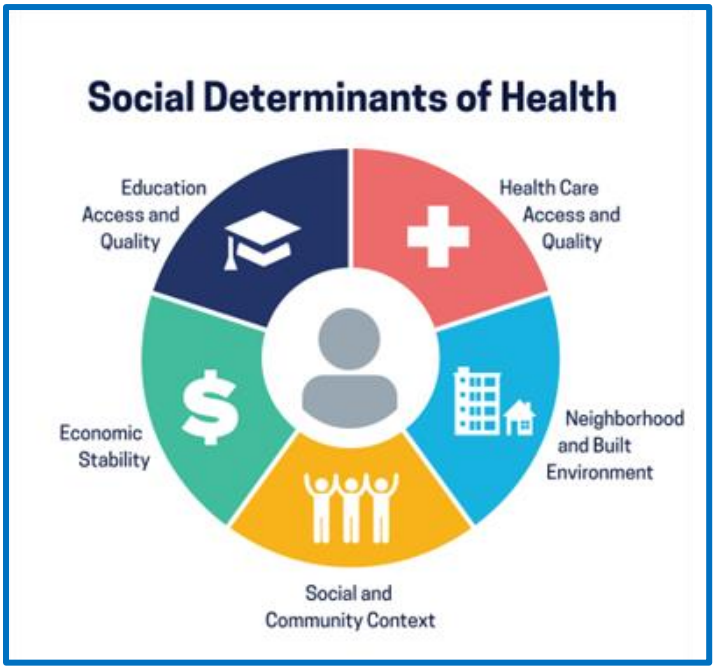


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Highlighted Demographics: Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Akron General Community. The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems[11]. The Social Determinants of Health (SDOH) can be grouped into five domains. Figure 10 shows the Healthy People 2030 Social Determinants of Health domains[12].

Figure 10: Healthy People 2030 Social Determinants of Health Domains



Geography and Data Sources

Data in this section are presented at various geographic levels (zip code and/or county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data can sometimes mask what could be going on at the zip code level in many communities. While indicators may be strong when examined at a higher level, zip code level analysis can reveal disparities.

[11] World Health Organization. Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[12] Healthy People 2030, 2022. Social Determinants of Health Domains. https://health.gov/healthypeople/priority-areas/social-determinants-health

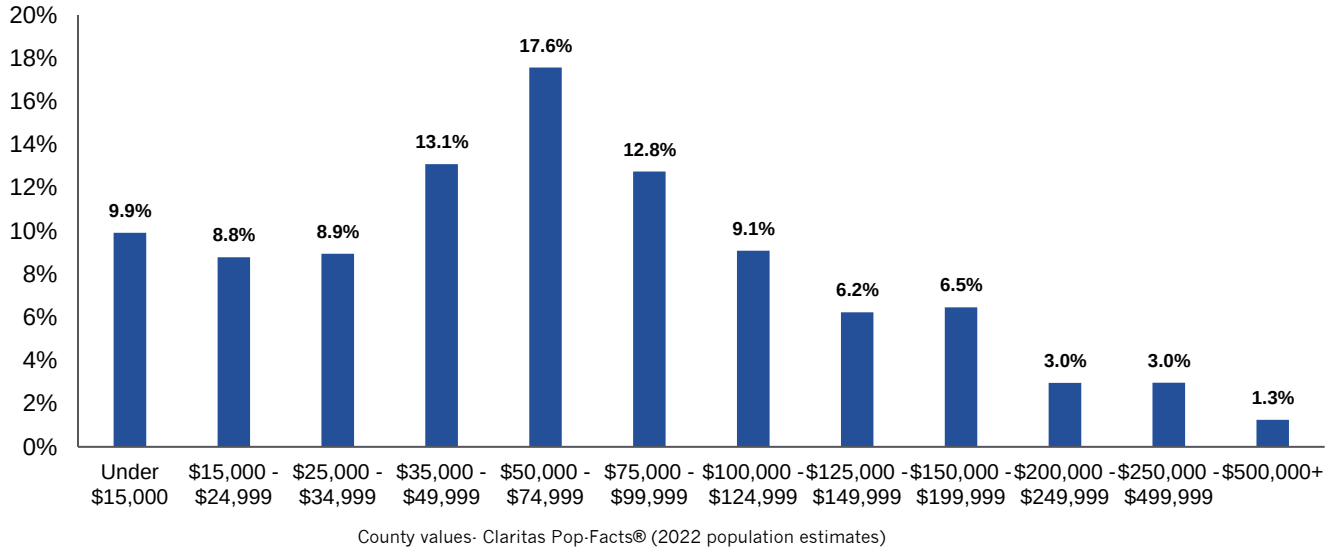
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[13]

Figure 11 provides a breakdown of households by income in the Akron General Community Definition. A household income of $50,000 - $74,999 is shared by the largest proportion of households in the Akron General Community (17.6%). Households with an income of less than $15,000 make up 9.9% of households in the Akron General Community.

Figure 11: Households by Income: The Akron General Community

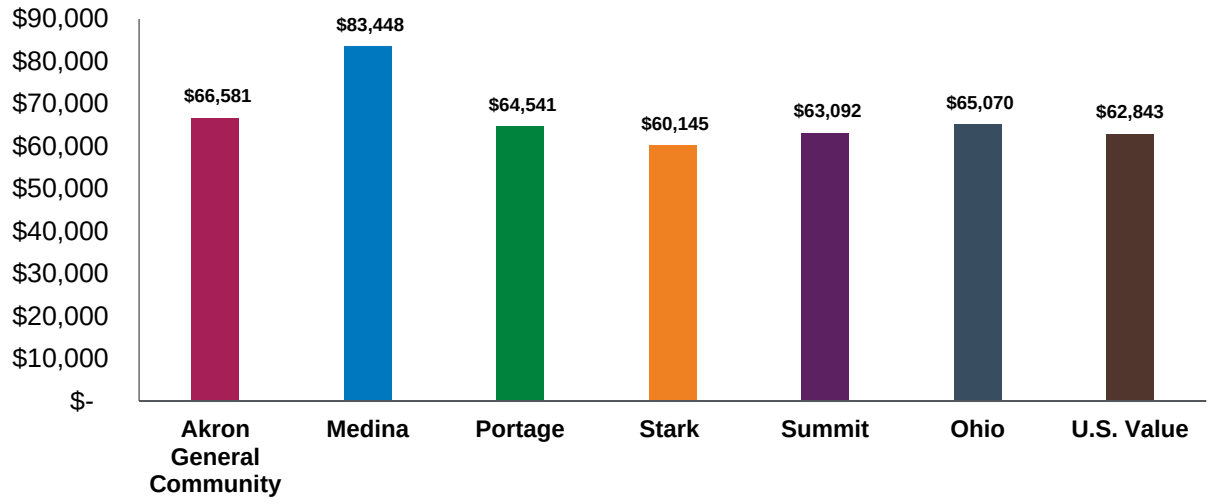


County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for the Akron General Community is $66,581, which is higher than the state value of $65,070 and national value of $62,843 (Figure 12).

[13] Robert Wood Johnson Foundation. Health, Income, and Poverty. https://www.rwjf.org/en/library/research/2018/10/health--income-and-poverty-where-we-are-and-what-could-help.html

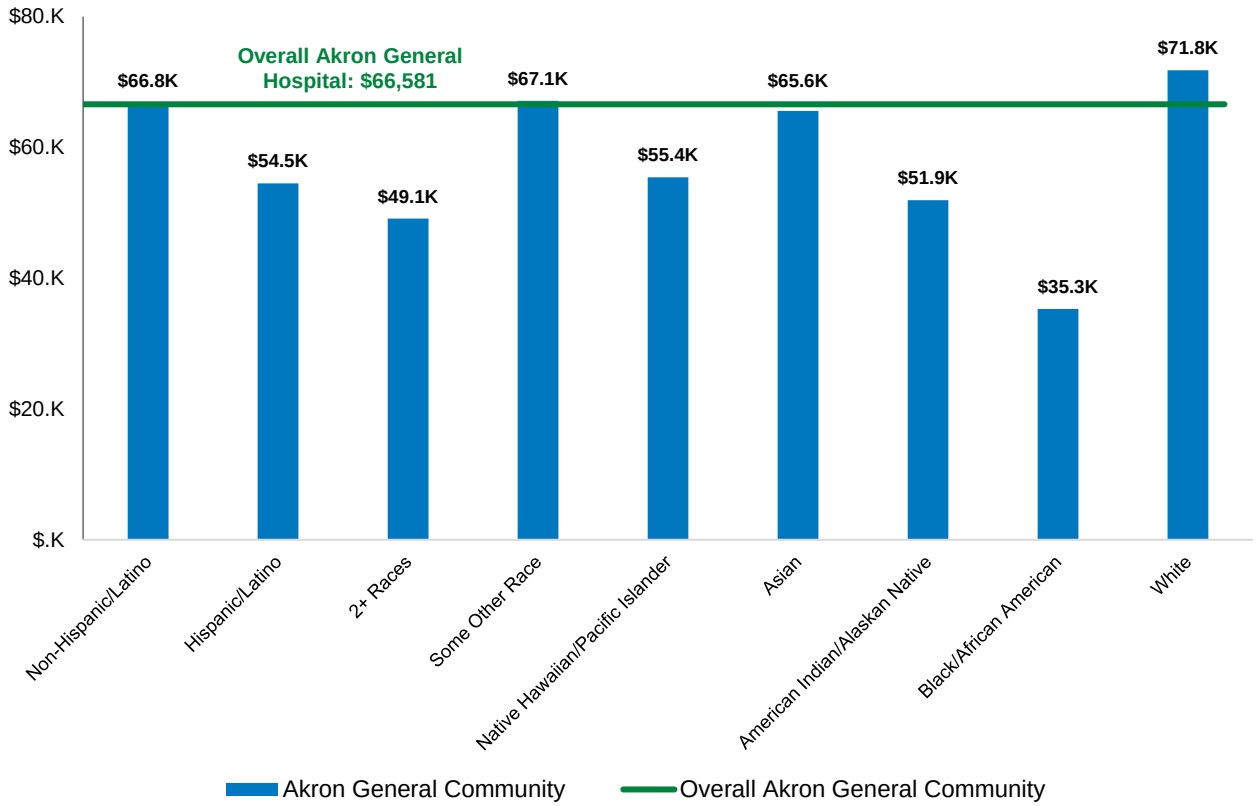
Figure 12: Household Income by: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Figure 13 shows the median household income by race and ethnicity. Three racial/ethnic groups – White, Some Other Race, and Non-Hispanic/Latino– have median household incomes above the overall median value. All other races have incomes below the overall value, with the Black/African American population having the lowest median household income at $35,273.

Figure 13: Median Household Income by Race/Ethnicity: The Akron General Community



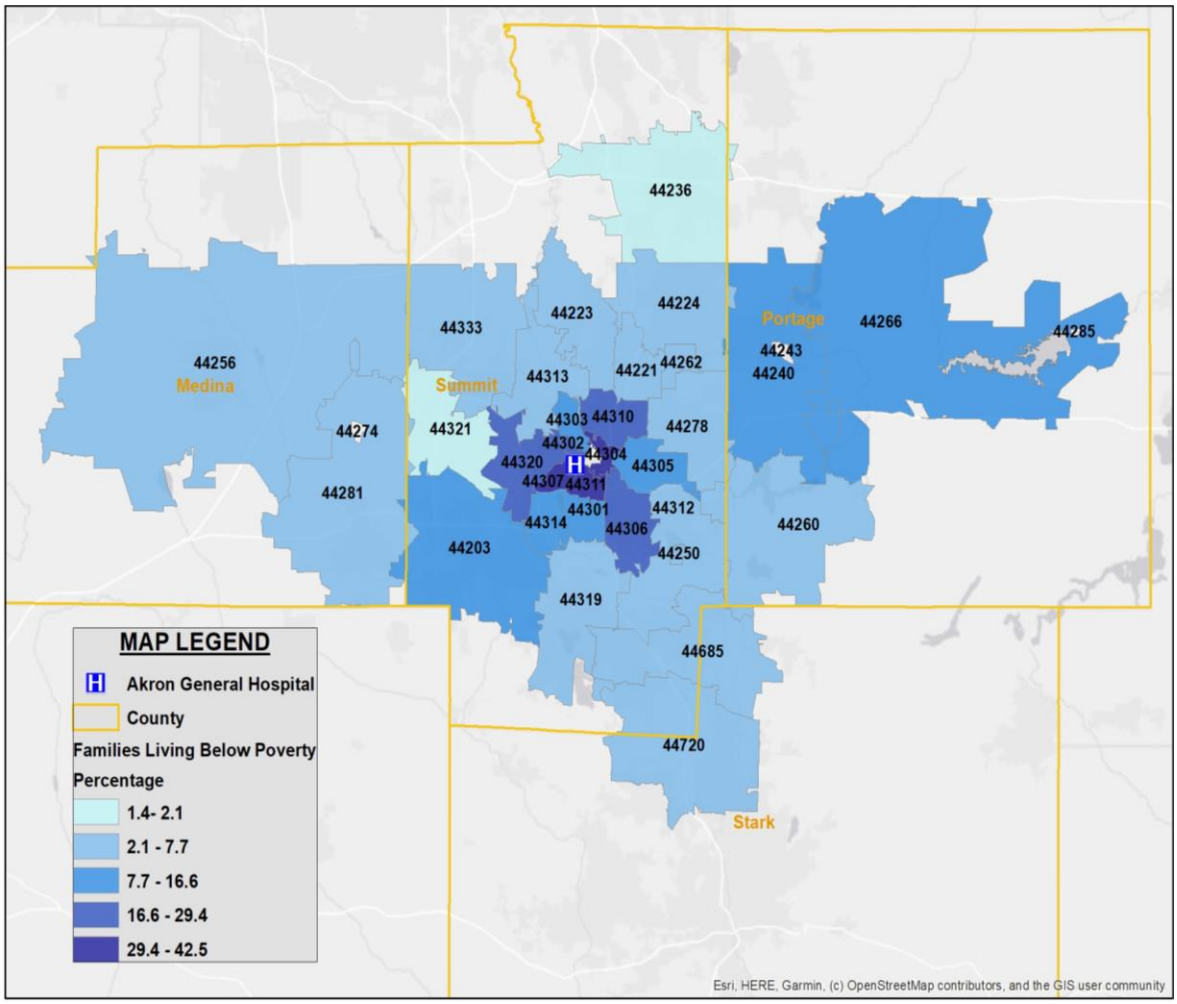
County values- Claritas Pop-Facts® (2022 population estimates)

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[14]

Figure 14 shows the percentage of families living below the poverty level by zip code. The darker blue colors represent a higher percentage of families living below the poverty level, with zip codes 44307 (Akron) and 44304 (Akron) having the highest percentages at 42.5% and 38.9%, respectively. Overall, 9.1% of families in the Akron General Community live below the poverty level, which is lower than both the state value of 9.6% and the national value of 9.5%. The percentage of families living below poverty for each zip code in the Akron General Community is provided in Appendix C

Figure 14: Families Living Below Poverty



County Values- Claritas Pop-Facts® (2022 Population Estimates)

[14] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

Employment

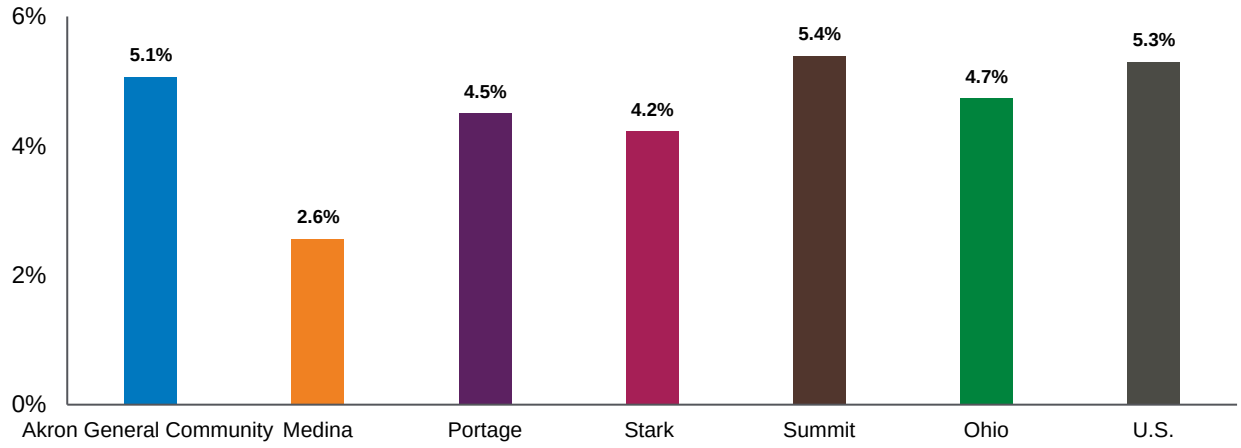
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[15]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[15]

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[15]

Figure 15 shows the population aged 16 and over who are unemployed. The unemployment rate for the Akron General Community is 5.1%, which is higher as compared to the state value of 4.7% but slightly lower than the national value of 5.3%.

Figure 15: Population 16+ Unemployed: Hospital, County, State, and U.S. Comparison



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Education

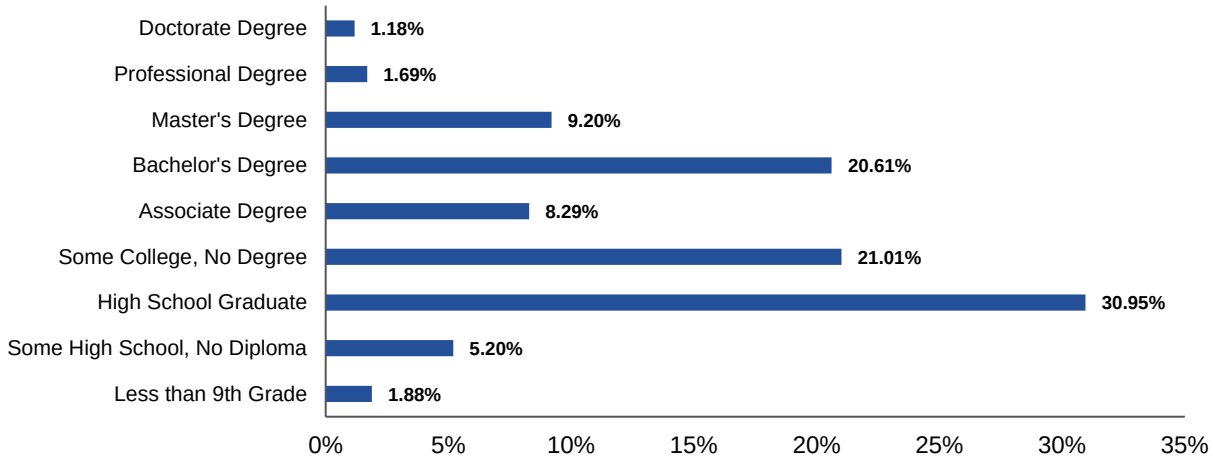
Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[16]

[15] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment

[16] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

Figure 16 shows the percentage of the population 25 years or older by educational attainment.

Figure 16: Population 25+ by Education Attainment: Akron General Community

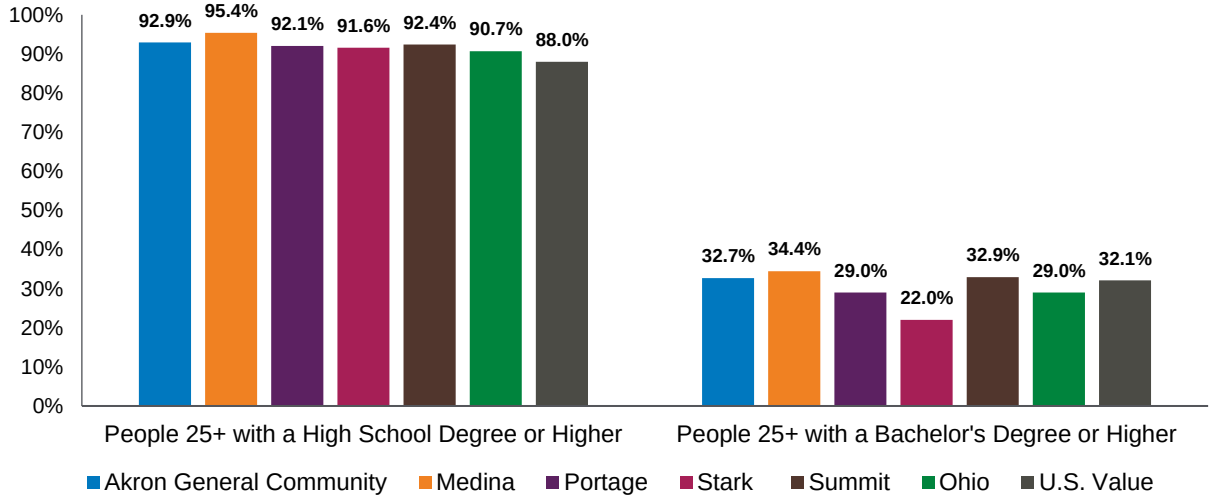


County values· Claritas Pop-Facts® (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[17]

Figure 17 shows that the Community has a higher percentage of residents with a high school degree or higher (92.9%) and bachelor's degree or higher (32.7%) when compared to the state of Ohio value (90.7% and 29.0%) and the U.S. value (88.0% and 32.1%) respectively.

Figure 17: Population 25+ by Education Attainment: Hospital, County, State, and U.S. Comparisons



County and state values· Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

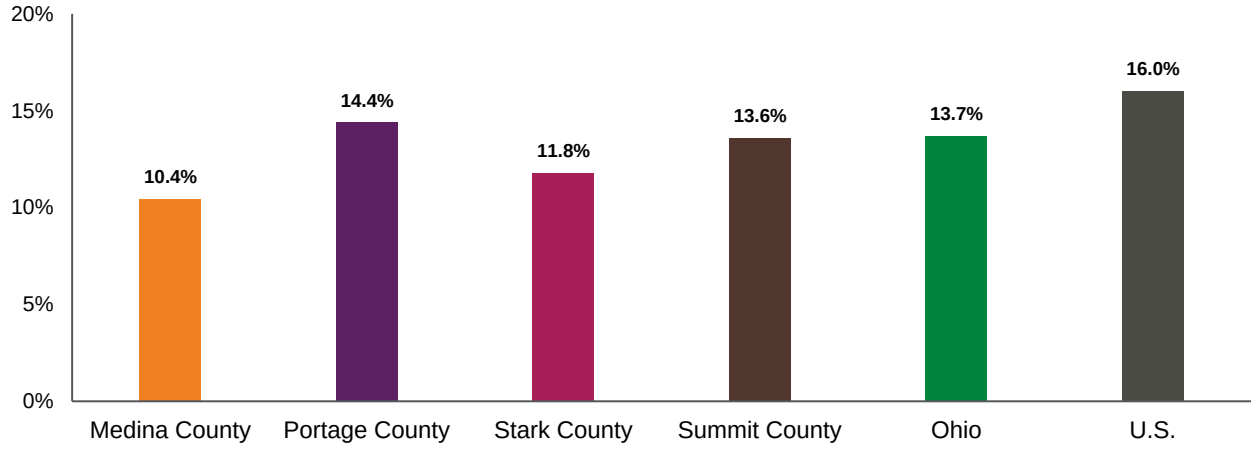
[17] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[18]

Figure 18 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities.

Figure 18: Severe Housing Problems: County, State, And U.S. Comparisons



County, state values, and U.S. values taken from County Health Rankings (2013-2017)

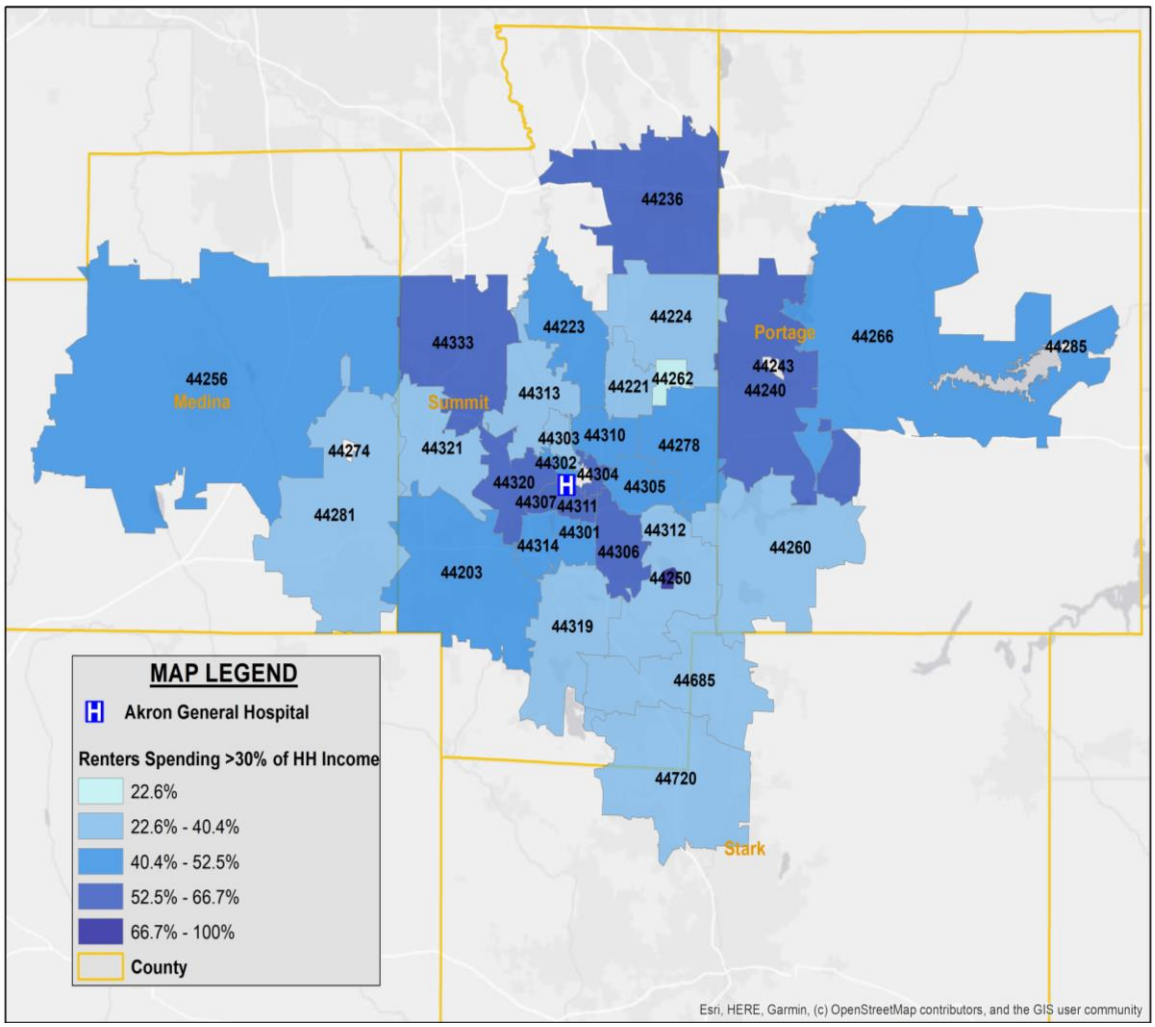
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.[19]

Figure 19 shows the percentage of renters who are spending 30% or more of their household income on rent.

[18] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

[19] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Figure 19: Renters Spending 30% Or More Of Household Income on Rent



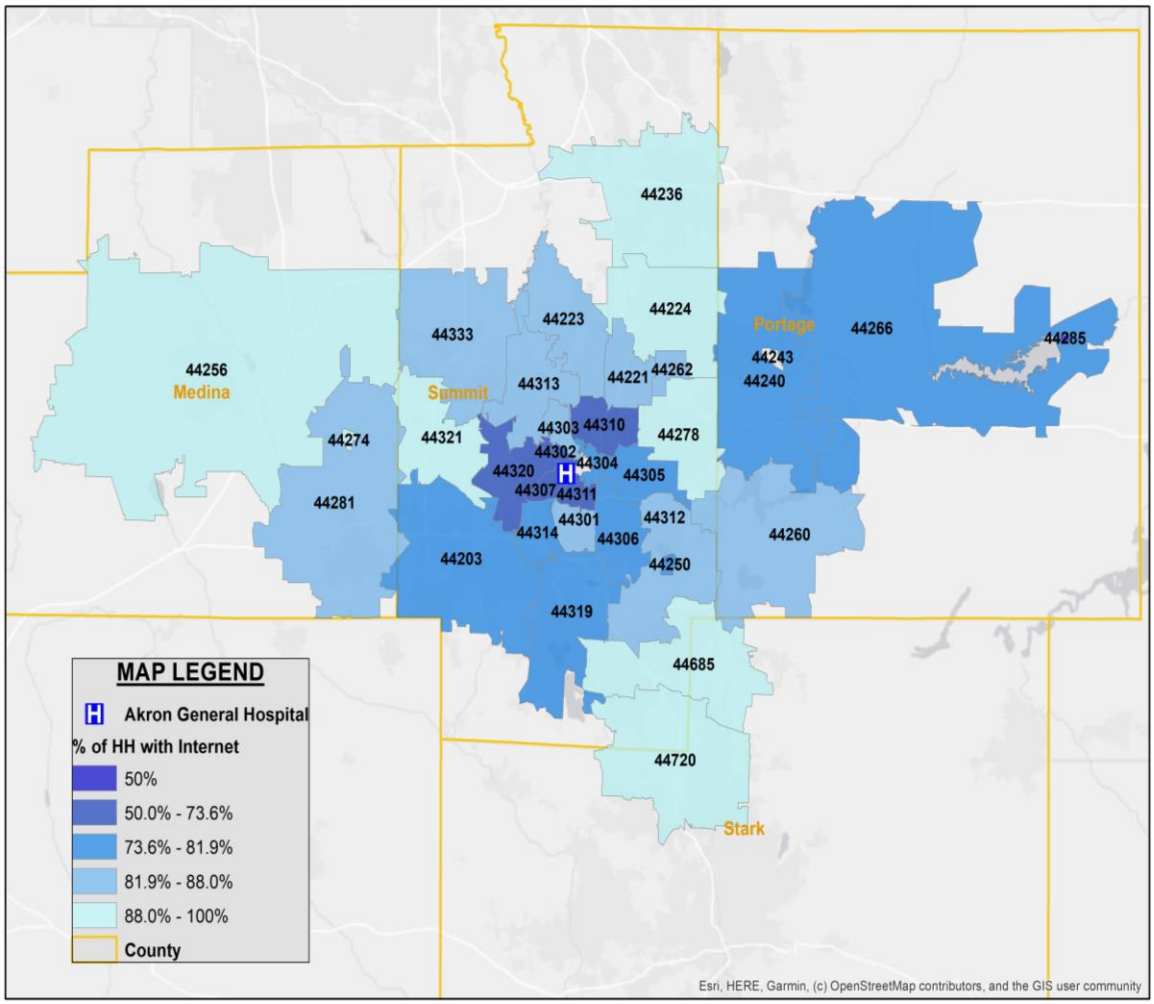
County values- American Community Survey five-year (2015-2019) estimates

Neighborhood and Built Environment

Internet access is essential for basic healthcare access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.[20]
Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[20] Figure 20 shows the percentage of households that have an internet subscription.

[20] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Figure 20: Households with an Internet Subscription



County values- American Community Survey five-year (2015-2019) estimates

Highlighted Demographics: Disparities and Health Equity

Identifying disparities by population groups and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity.

Health Equity

Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities.[21] National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American, Hispanic/Latino, Indigenous, communities with incomes below the federal poverty level, and LGBTQ+ communities.[22]

Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, gender, and age. It is important to note that the data is presented to show differences and distinctions by population groups. And a data variation within each population group may be as great as that between different groups. For instance, Asian or Asian and Pacific Islander persons encompasses individuals from over 40 different countries with very different languages, cultures, and histories in the U.S. Information and themes captured through key informant interviews and community engagement session discussions have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[23] analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or gender) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix A.

Table 1 below identifies secondary data indicators with a statistically significant race or ethnic disparity for the Akron Hospital Community, based on the Index of Disparity.

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[21] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

[22] Baciu A, Negussie Y, Geller A, et al (2017). Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/

[23] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

Table 1: Indictors with Significant Race or Ethnic Disparities

Health Indicator	Group(s) Negatively Impacted
Age-Adjusted Death Rate due to Diabetes	Black/African American
Age-Adjusted Death Rate due to Kidney Disease	Black/African American
Age-Adjusted Death Rate due to Prostate Cancer	Black/African American
Babies with Low Birth Weight	Black/African American, Hispanic/Latino
Babies with Very Low Birth Weight	Black/African American, Asian/Pacific Islander
Children Living Below Poverty Level	Hispanic/Latino, Black/African American, Two or More Races
Families Living Below Poverty Level	Hispanic/Latino, American Indian/Alaska Native, Black/African American, Other Race, Two or More Races, Asian/Pacific Islander
HIV/AIDS Prevalence Rate	Black/African American, Hispanic/Latino
People 65+ Living Below Poverty Level	Hispanic/Latino, Black/African American, Two or More Races
People Living Below Poverty Level	Black/African American, Hispanic/Latino, American Indian/Alaska Native, Asian/Pacific Islander, Two or More Races, Other Race
Persons without Health Insurance	Two or More Races, Hispanic/Latino
Workers Commuting by Public Transportation	White (Non-Hispanic)
Workers who Walk to Work	White (Non-Hispanic), Two or More Races
Young Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Two or More Races

The Index of Disparity analysis for Medina, Portage, Summit, and Stark counties reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Asian/Pacific Islander, Two or More Races, and Other Race group populations are disproportionately impacted by various measures of poverty, which is often associated with poorer health outcomes. These indicators include Families Living Below Poverty Level, Children Living Below Poverty Level, People 65+ Living Below Poverty Level, Young Children Living Below Poverty Level, and People Living Below Poverty Level. Furthermore, Black/African American and Hispanic/Latino populations are disproportionately impacted by HIV/AIDS. Babies in these populations often experience low and very low birth weight. Additionally, Black/African American populations experience a heavier burden related to chronic diseases, such as diabetes and kidney disease. Hispanic/Latino and Two or More

Race groups also have the highest rates of Persons without Health Insurance, compared to other races/ethnicities in the region.

Finally, White (Non-Hispanic) and Two or More Races populations are disproportionately impacted across measures of public transportation (Table 1).

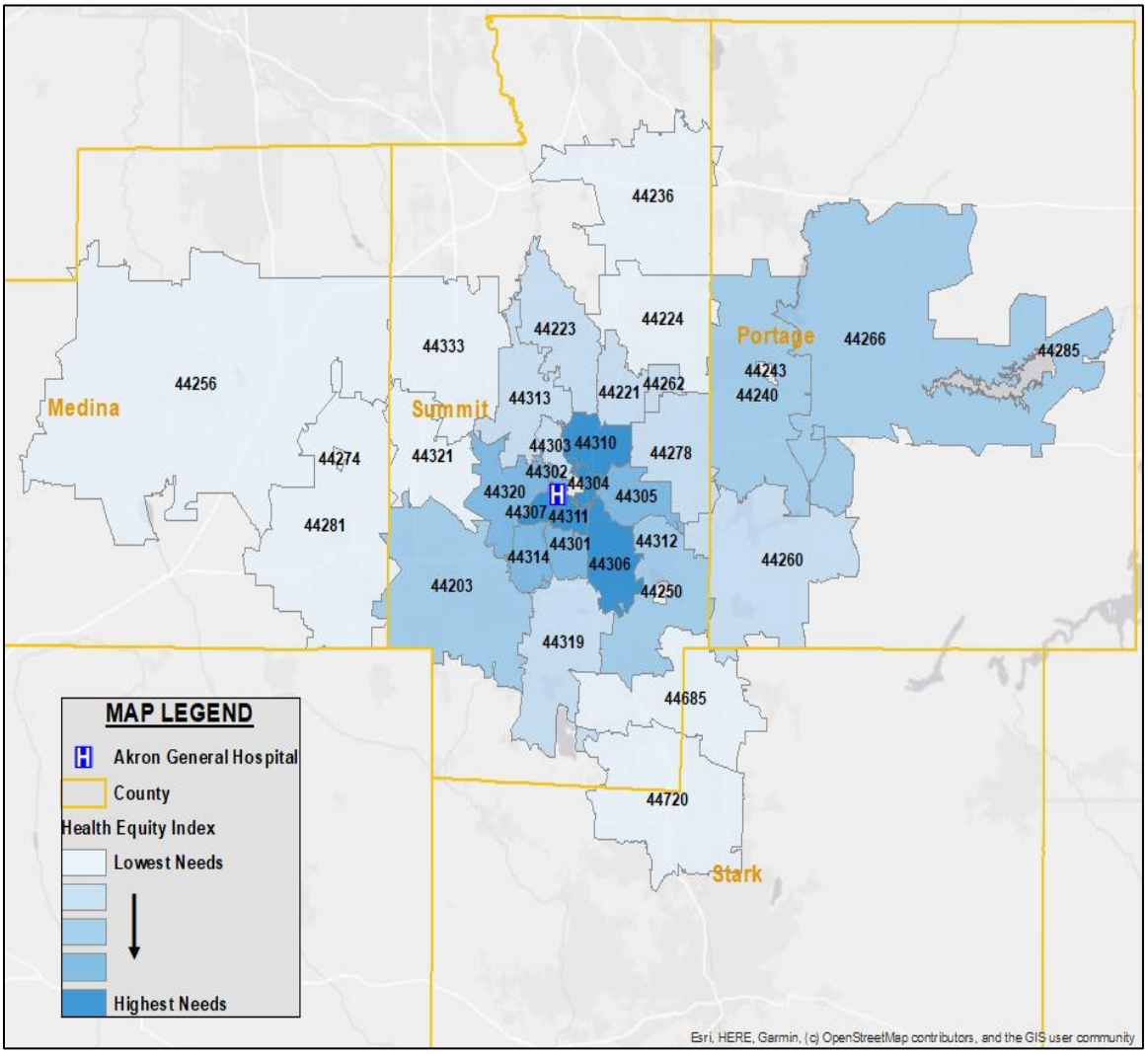
Geographic Disparities

In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific zip codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity and poor mental health. For all indices, counties, zip codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index (HEI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 21. The following zip codes in the Akron General Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44304, 44307, 44306, 44310, and 44311 in Summit County. Appendix A provides the index values for each zip code.

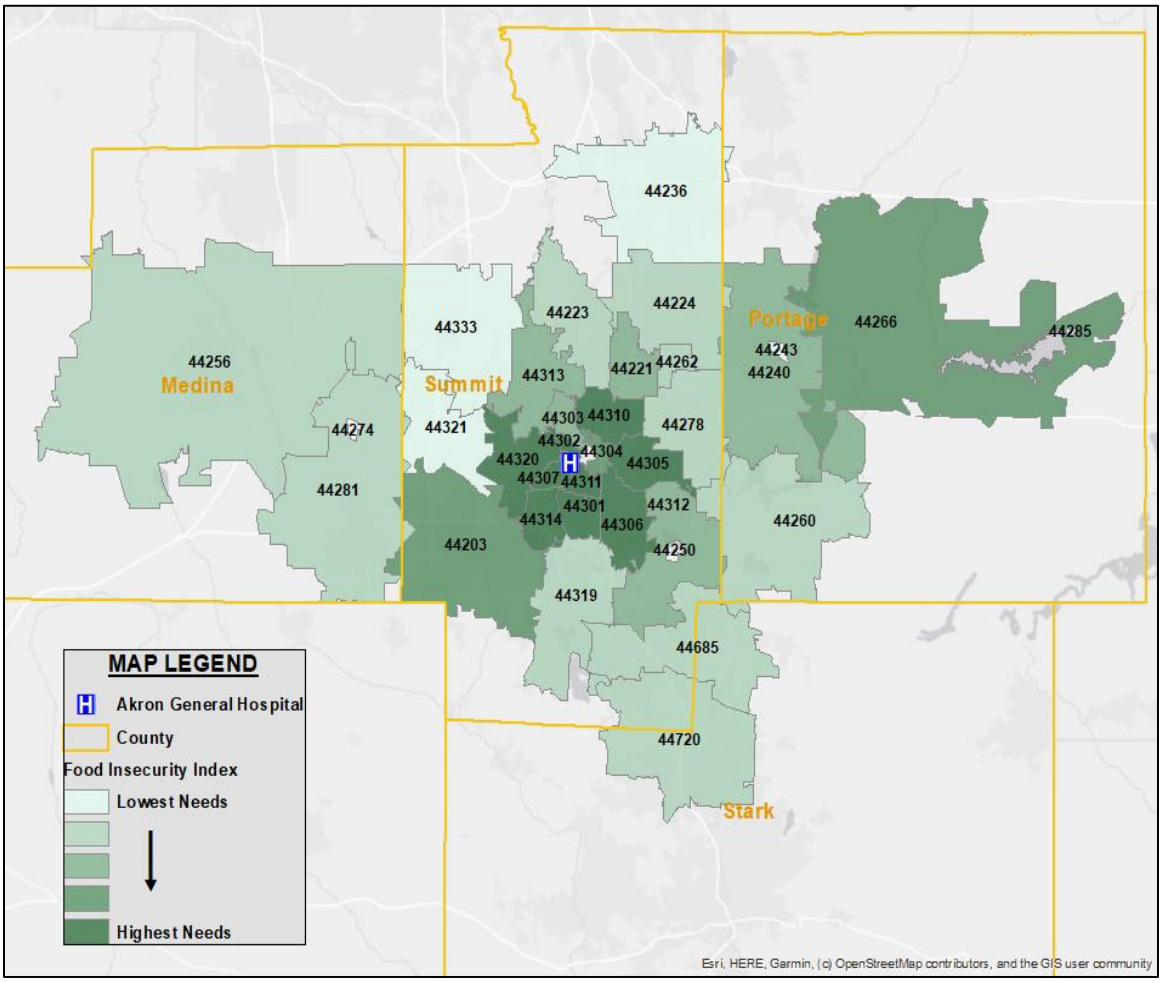
Figure 21: Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 44302, 44320, 44307, 44314, 44301, 44311, 44306, 44305, and 44310. These high needs zip codes are all within Summit County. Appendix A provides the index values for each zip code.

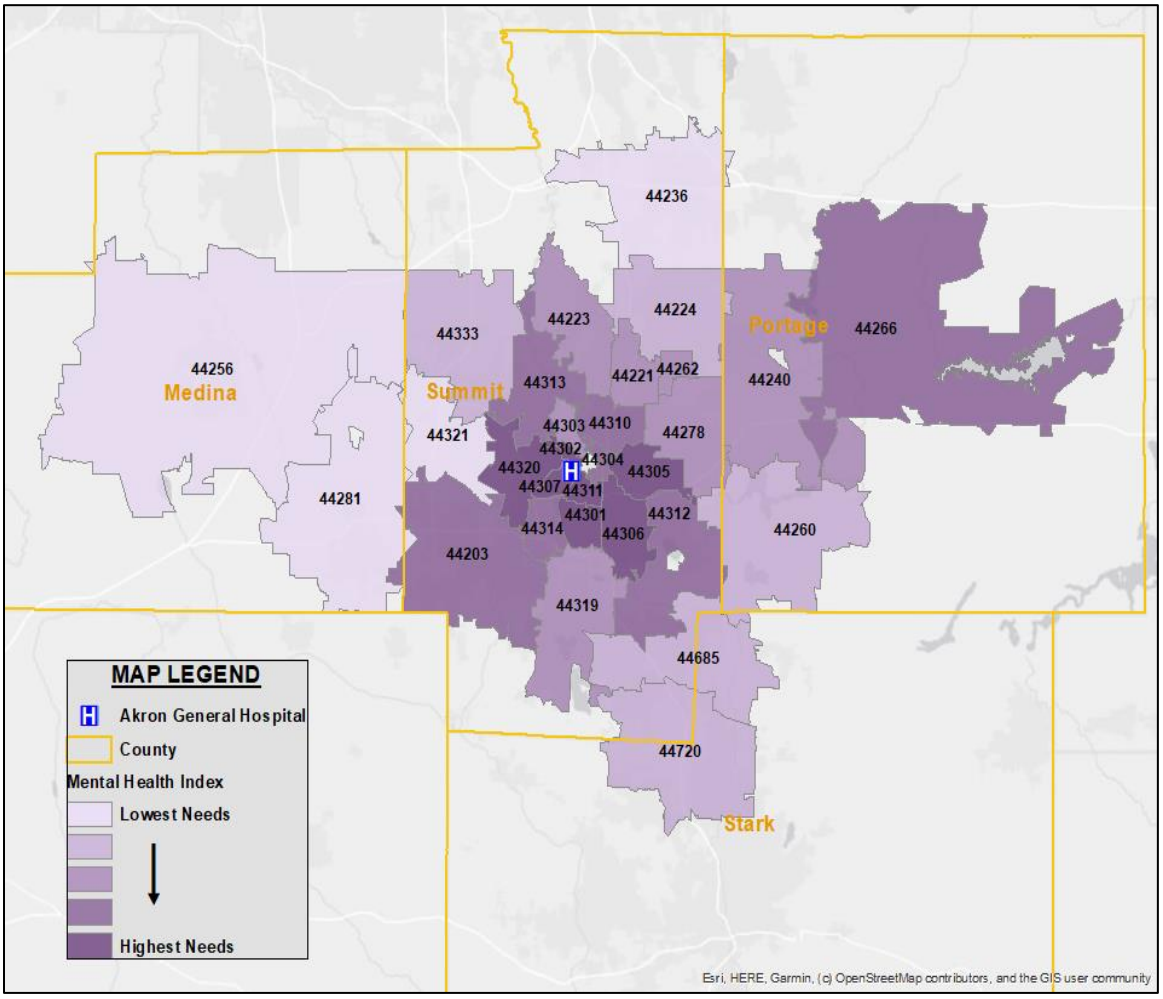
Figure 22: Food Insecurity Index



Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Zip codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 44307, 44320, 44306, 44311, 44302, 44301, and 44305 in Summit County and 44035 in Lorain County. Appendix A provides the index values for all zip codes within the Akron General Community.

Figure 23: Mental Health Index



Highlighted Demographics: COVID-19 Impacts Snapshot

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Province of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Later that month, stay-at-home orders were placed by the Ohio Governor and unemployment rates soared as companies were impacted and mass layoffs began.

At the time that the Akron General Community began its collaborative CHNA process, the community and the state of Ohio were in a period of the pandemic that was hoped to be in its final phases. Primary data was collected virtually to ensure the health and safety of those participating.

COVID-19 Pandemic

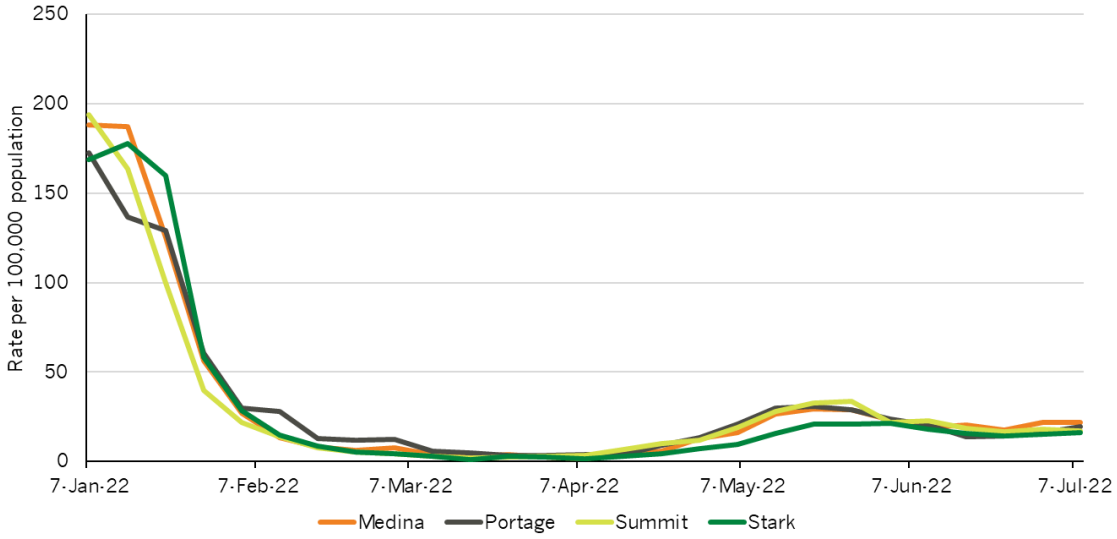
Community Input

Key stakeholder interviews and the Akron General Community Engagement Session served to assess the impact of the COVID-19 pandemic. Respondents were asked to describe how the pandemic has impacted community health. Top responses focused on mental health challenges that spanned all age groups. Older adult health suffered both because of isolation borne of the fear of exposure to the COVID-19 virus.

The COVID-19 Daily Average Case Incidence Rate by County

Figure 24 shows the daily average COVID-19 case incidence rate for Medina, Portage, Stark, and Summit counties from January 2022 through early July 2022. As shown, the incidence rate has declined since the beginning of 2022, although some small spikes in incidence rates have occurred.

Figure 24: Daily Average COVID-19 Case Incidence Rate by County



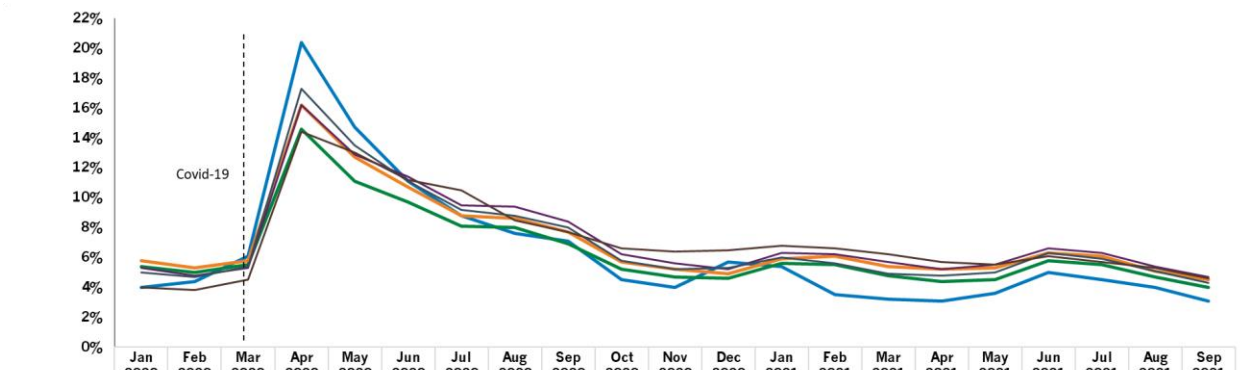
Vaccination Rates

As of June 2022, at least 55% of the population residing in counties within the Akron General Community Definition are fully vaccinated against COVID-19. Medina County has the highest vaccination rates (64.6%), followed by Summit County (64.0%), and Portage County (57.8%), and Stark County (55.3%).

Unemployment Rates

Unemployment rates rose between March and April 2020 for Medina, Portage, Stark, and Summit counties when stay-at-home orders were first announced. Illustrated in Figure 25 below, as counties began slowly reopening some businesses in late-2020, the unemployment rate gradually began to go down. As of late 2021, unemployment rates have stabilized but still exceed pre-pandemic rates. When unemployment rates rise, there is a potential impact on health insurance coverage and healthcare access if jobs lost include employer-sponsored healthcare.

Figure 25: Unemployment Rate After the Start of the COVID-19 Pandemic



	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Medina	4.0%	4.4%	6.1%	20.4%	14.7%	11.1%	8.8%	7.6%	7.1%	4.5%	4.0%	5.7%	5.4%	3.5%	3.2%	3.1%	3.6%	5.0%	4.5%	4.0%	3.1%
Portage	5.4%	5.0%	5.5%	14.6%	11.1%	9.7%	8.1%	8.0%	6.9%	5.2%	4.7%	4.6%	5.6%	5.5%	4.8%	4.4%	4.5%	5.8%	5.5%	4.7%	4.0%
Stark	5.8%	5.3%	5.8%	16.2%	12.7%	10.7%	8.8%	8.6%	7.7%	5.7%	5.2%	4.9%	5.9%	6.1%	5.4%	5.2%	5.3%	6.3%	6.1%	5.1%	4.5%
Summit	5.3%	4.8%	5.3%	16.2%	12.9%	11.4%	9.5%	9.4%	8.4%	6.2%	5.6%	5.2%	6.3%	6.2%	5.7%	5.2%	5.5%	6.6%	6.3%	5.4%	4.7%
Ohio	5.0%	4.7%	5.4%	17.3%	13.5%	11.1%	9.2%	8.8%	8.0%	5.8%	5.2%	5.3%	6.0%	5.6%	4.9%	4.8%	5.0%	6.3%	5.9%	5.1%	4.3%
U.S.	4.0%	3.8%	4.5%	14.4%	13.0%	11.2%	10.5%	8.5%	7.7%	6.6%	6.4%	6.5%	6.8%	6.6%	6.2%	5.7%	5.5%	6.1%	5.7%	5.3%	4.6%

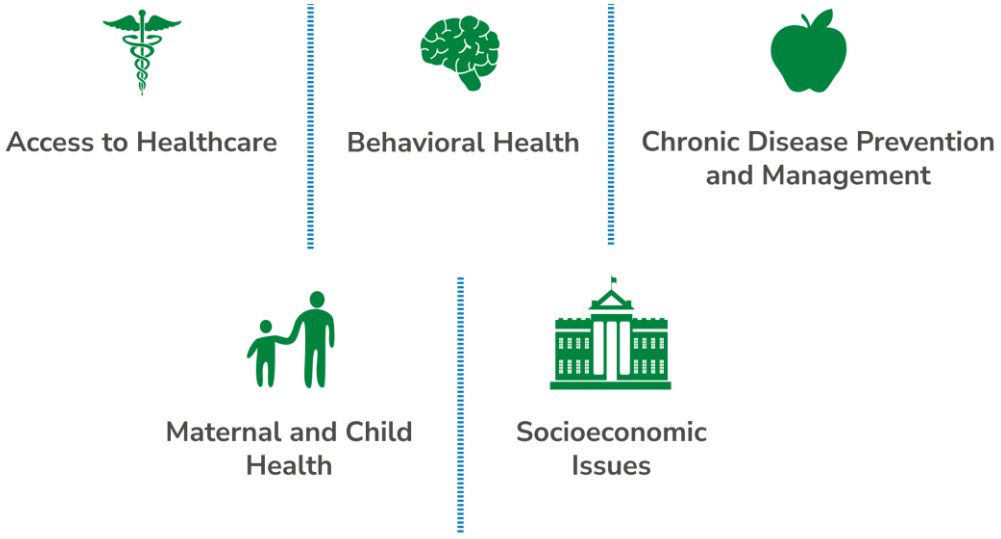
Synthesis and Prioritization

All forms of data may present strengths and limitations. Each data source used in this CHNA process was evaluated based on strengths and limitations and should be kept in mind when reviewing this report. Each health topic presented a varying scope and depth of quantitative data indicators and qualitative findings. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, community engagement session participants, and key stakeholders as possible. A full list of contributors can be found in the Primary Data Collection and Analysis description in Appendix A.

To gain a comprehensive understanding of the significant health needs for the Akron General Community, the findings from all three data sets were compared and studied simultaneously. The secondary data scores, community engagement session themes, and key stakeholder responses were considered equally important in understanding the health issues of the community. The top health needs identified from each of these data sources were analyzed for areas of overlap. Six health issues were identified as significant health needs across all three data sources and were used for further prioritization. To ensure alignment with state and local health department objectives, a working group analyzed these significant health needs alongside the Ohio State Health Improvement Plan (SHIP) as well as the Medina, Summit, Portage and Stark County Community Health Improvement Plans (CHIP) most recent findings. The prioritization process distilled the significant needs into five categories.

The five prioritized health needs are summarized in Figure 26. Each prioritized health topic includes the key findings from secondary data, the community engagement session discussions and key stakeholder interviews.

Figure 26: 2022 Prioritized Health Needs



Prioritized Health Topic #1: Access to Healthcare

Access to Healthcare

Secondary Data Score: 1.34

Key Themes from Community Input

- COVID-19 allowed for expansion of telehealth while exposing inequities in broadband/technology availability
- Gentrification/Built Environment reduces accessibility to services
- Healthcare systems are intimidating and overwhelming to navigate
- Issues of discrimination/bias create mistrust in healthcare: having doctors that look like the people they're serving, building a sustainable presence in the community, mobile health units, easily available translators, culturally responsive health care providers to implement trauma-informed care/gender-affirming care
- Lack of investment in local public health/preventive care
- Racial, economical, geographical, educational, environmental inequities all affect access to care, disproportionately impacting communities of color
- Red lined communities have decreased healthcare access
- Systemic inequities in payment structures: conditions that communities of color were experiencing are reimbursed at lower rates than the conditions that White people are reimbursed for

Warning Indicators

- Consumer Expenditures: Health Insurance
- Consumer Expenditures: Medical Services
- Consumer Expenditures: Medical Supplies
- Consumer Expenditures: Prescription and Non-Prescription Drugs

Primary Data: Key Stakeholder Interviews and Community Engagement Session

Access to Health Care was described as a top health need by the Akron Hospital Community Advisory Council members participating in the Community Engagement Session. Access, and access-related topics including transportation and resources, were described as among the top barriers to improving health.

> Certainly the people who are living with Long COVID have very direct health care issues that they're dealing with. The pandemic has definitely led to significant delays in care early on, so a lot of that preventative stuff got pushed off and I don't think we've caught up with all that.
>
> - Key Stakeholder

Key stakeholders noted a lack of investment in prevention practices including accessibility of primary services at a local level. Racial, economic, geographic, educational and environmental inequities all impact access to care and disproportionately affect communities of color. Three key themes surfaced from community discussions including systemic inequities in healthcare, the need to focus on preventative care, and barriers to healthcare.

Systemic inequities in healthcare included issues of discrimination and bias from providers which ultimately creates mistrust from communities experiencing this discrimination. Key informants suggested hiring providers that look like the people they are caring for, building a sustainable presence in the community, and ensuring providers are trained in trauma-informed care and gender-affirming care.

Preventative care included high utilization rates of the ER for minor health issues due to lack of primary care physician, and the need to strengthen the public health infrastructure. Furthermore, COVID-19 allowed for the expansion of telehealth which increased access to healthcare for many. However, it also exposed the inequities in broadband support due to infrastructure issues leaving residents unable to access telehealth.

Barriers to healthcare included transportation, navigating the difficulties of a fragmented healthcare system, ability to pay for services/insurance (lack of insurance, high co-pays/deductibles), and health literacy for providers to communicate with patients.

Secondary Data

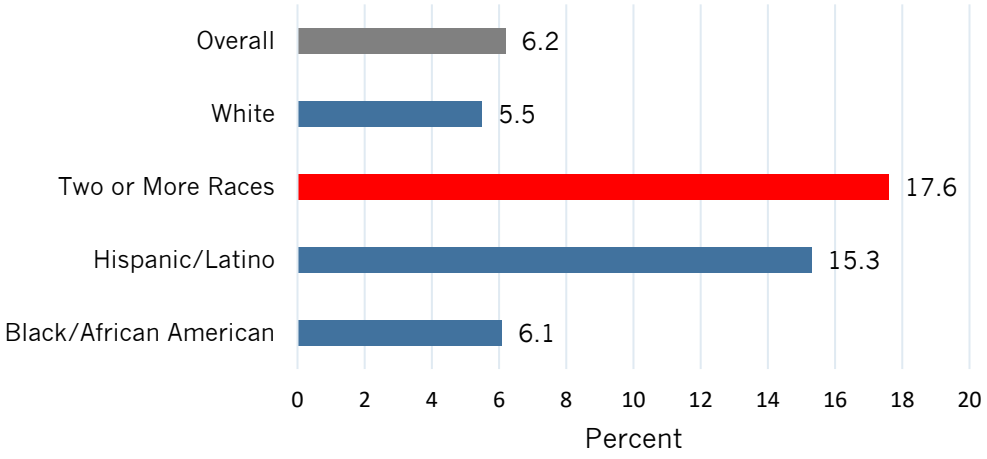
From the secondary data scoring results, Health Care Access & Quality ranked as the 13th highest scoring health need, with a score of 1.34. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

The average dollar amount per consumer unit for health insurance in Medina County is $5,410.8, which is higher than the average dollar amount spent on health insurance in the state of Ohio, where that amount is $4,371.7 dollars per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. For this indicator, Medina and Summit counties fell in the worst 25% of all counties in the nation. Medical costs in the United States are high. Therefore, people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. [24]Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.[25]

[24] Kaiser Family Foundation, 2020 and 2015
[25] The Commonwealth Fund, 2019

The rising costs of medical care and lack of insurance affects all races and ethnicities. However, in Stark County, people identifying as Two or More Races are disproportionately affected as seen in red in Figure 27.

Figure 27. Persons without Health Insurance by Race/Ethnicity in Stark County



Source: American Community Survey, 2019

Consumer Expenditures: Medical Services ranked poorly among Summit, Portage and Medina counties. This indicator measures the average dollar amount spent on medical services per consumer unit. This includes expenditures on eye care, dental care, physician care, non-physician care (e.g. chiropractors, naturopaths, psychologists, midwives), lab and blood tests, x-rays, hospital rooms and related services, nursing homes/convalescent care, and other medical services. In Medina County, the average dollar amount spent on medical services is $1,419.10 which is higher than in Summit ($1,153.1) and Portage ($1061.7) counties.

Prioritized Health Topic #2: Behavioral Health

Behavioral Health: Mental Health

Secondary Data Score: **1.62**

Key Themes from Community Input

- Closely linked with substance use as self-medication
- Lack of meaningful investment in true community health programming
- Lack of providers to meet the increasing mental health/behavioral health needs
- Mental health issues worsened for LGBTQ+ population, children, college students, teens & teachers as a result of COVID-19 isolation
- Need to expand provider network as the justice system works to divert folks with low-level violations to treatment and mental health care
- Resources needed to help develop coping strategies & resilience from trained/supportive professionals
- Second leading cause of death in kids 10-14 is suicide
- Social isolation worsened during pandemic leading to a spike in reports of depression, anxiety, suicide attempts or death by suicide
- Transgender patients have a much higher risk of suicide due to discrimination, bigotry & isolation

Warning Indicators

- Adults Ever Diagnosed with Depression
- Age-Adjusted Death Rate due to Alzheimer's Disease
- Age-Adjusted Death Rate due to Suicide
- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Poor Mental Health: 14+ Days
- Poor Mental Health: Average Number of Days

Primary Data: Key Stakeholder Interviews and Community Engagement Sessions (Mental Health)

Members of the Akron General Community Advisory Council, representing a range of organizations within the community, who attended the Community Engagement session ranked Mental Health the most important health problem in the community. Specifically, they described isolation, hopelessness and COVID-19 as contributors to mental health challenges in the community. Stigma around mental health was considered a key barrier to improving health in the community. Recommendations from community advisory council members for improving mental health centered on shielding children from COVID-19 restrictions impairing social interactions and school attendance as well as working to achieve mental health parity.

> There's a pretty well documented shortage of behavioral health services and providers. Before the pandemic, we didn't have enough mental health providers. Post-pandemic or in the midst of the pandemic, because of the effect of isolation and trauma and all sorts of other things that got unearthed, that has really increased the demand for those services and it's been difficult for the whole system to keep up with that demand.
>
> - Key Stakeholder

Mental health resources, and the availability of mental health providers were frequently cited as disproportionate to community need. Overall, lack of mental health providers and resources, and navigation and/or knowledge about available services were all mentioned as barriers. Participants emphasized the need to examine the root causes leading to mental health issues within the community including poverty and an unequal playing field in terms of investment in education in low-income communities. Furthermore, LGBTQ+ community members experience disproportionate mental health issues. Stakeholders recommended an increase in meaningful investment in community health programming.

Secondary Data: Mental Health

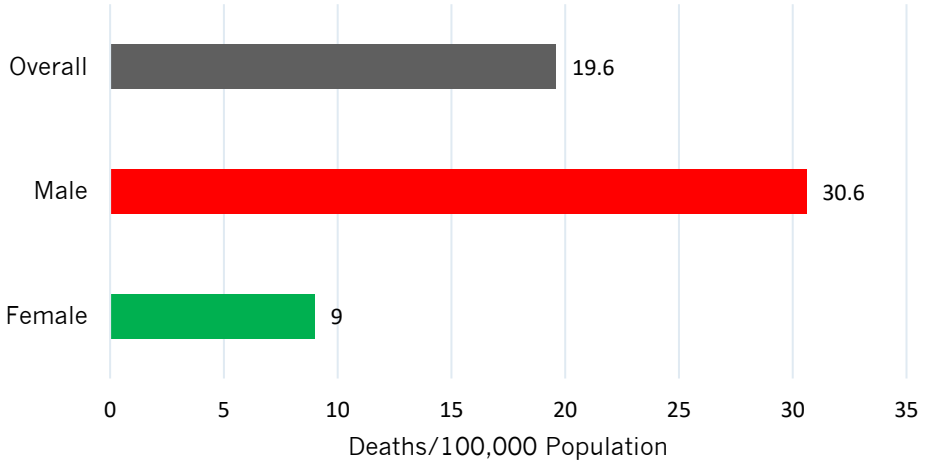
From the secondary data scoring results, Mental Health & Mental Disorders had the third highest data score of all topic areas, with a score of 1.62. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

According to the secondary data, depression and Alzheimer's, specifically within the Medicare population, are areas of great concern. 21.8% and 21.4% of Medicare beneficiaries in Summit and Portage counties, respectively, have been treated for depression. In Stark County, 21% of the Medicare population has been treated for depression and 12% have been treated for Alzheimer's.

Age-Adjusted Death Rate due to Suicide is also an area of concern in Medina County with a data value of 15.7 deaths due to suicide per 100,000 population. Depression in the Medicare Population is also of concern with 19% of Medicare beneficiaries in Medina County treated for depression. Both indicators are increasing significantly.

Disparities within the mental health topic area were also found for the Akron General community counties. As seen in Figure 28, in Stark County, the age-adjusted death rate due to suicide for males is 30.6 deaths per 100,000 population (see red in figure below). This rate is only nine deaths per 100,000 for females (see green below).

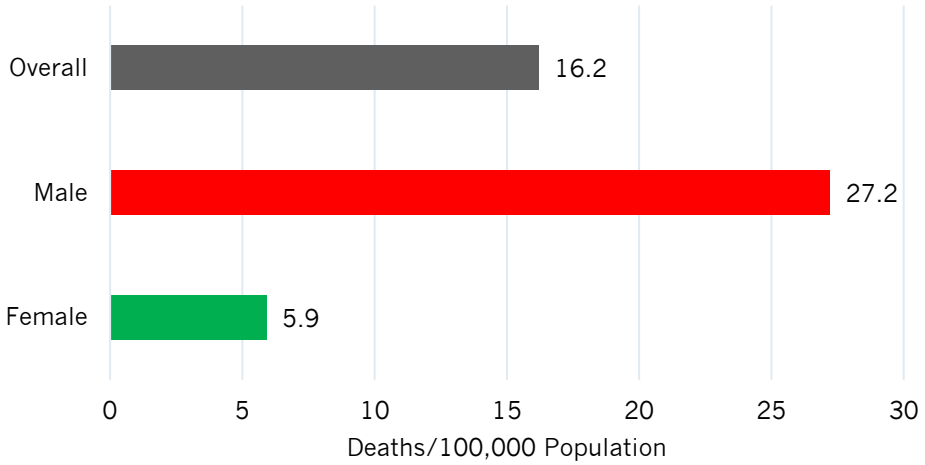
Figure 28. Age-Adjusted Death Rate due to Suicide by Gender in Stark County



Source: Centers for Disease Control and Prevention, 2017-2019

Summit County has a similar trend where there are 27.2 deaths due to suicide per 100,000 males (see red in figure below), and 5.9 deaths per 100,000 females (see green in figure below). This is shown in Figure 29.

Figure 29. Age-Adjusted Death Rate due to Suicide by Gender in Summit County

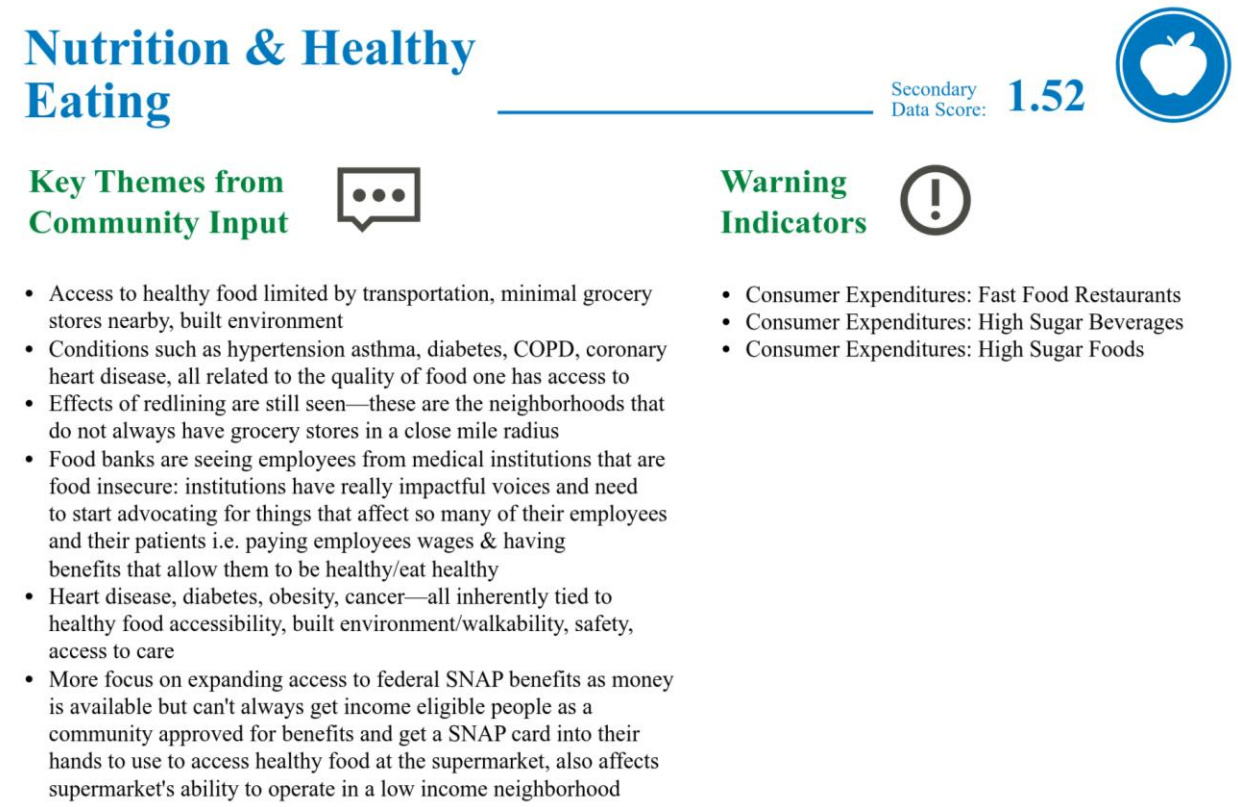


Source: Centers for Disease Control and Prevention, 2017-2019

Prioritized Health Topic #3: Chronic Disease Prevention and Management

Chronic Disease Prevention and Management is a health topic that is analyzed from four secondary data topics – Nutrition and Healthy Eating, Chronic Diseases, Older Adult Health and Cancer. An overview snapshot of each of these subtopics is provided below.

NUTRITION & HEALTHY EATING



Primary Data: Key Stakeholder Interviews and Community Engagement Session

Participants in the Akron General Community Engagement Session described rates of food insecurity in the community that increased proportionately with unemployment rates during the pandemic. A positive outcome of the pandemic for school-aged children was being able to access food packs that were broadly distributed through schools for children and their families.

Key stakeholders revealed that access to healthy food was often limited by a lack of either public or private transportation. There are only a few grocery stores in the community and few community members can access those by walking. The effects of redlining are evident as these neighborhoods do not always have grocery stores and therefore are limited to corner stores which often do not have fresh fruits and vegetables. Furthermore, key informants advised medical institutions to advocate for better pay for employees, as food

banks saw employees from these very institutions show up at their doors. Thus, these institutions are poised to prevent food insecurity within the walls of their hospital. Conditions such as hypertension, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease are all related to the quality of food community members have access to[26].

> To this day, the effects of redlining are still seen—these are the neighborhoods that do not always have grocery stores in a close mile radius. These are the neighborhoods where you're going to see lots of dollar stores around, where people are being forced to get their fruits and veggies because there hasn't been a historical investment in them.
>
> - Key Stakeholder

PHYSICAL ACTIVITY

Physical Activity

Secondary Data Score: **1.50**

Key Themes from Community Input

- Chronic conditions (i.e. heart disease, diabetes, obesity, cancer)—all inherently tied to healthy food accessibility, built environment/walkability, safety
- Environmental conditions can facilitate or hinder physical activity including:
  - air quality/climate change i.e. toxins, pollution,
  - built environment/infrastructure
  - gentrification
  - greenness
  - safety/violence
  - walkability
- Generational poverty, poor housing and lack of resources available to create healthy conditions for people to live, work, and play in
- Loss of green spaces in metro areas contributes to reduction in overall physical and mental health

Warning Indicators

- Children with Low Access to a Grocery Store
- Fast Food Restaurant Density
- Grocery Store Density
- Low-Income and Low Access to a Grocery Store
- People 65+ with Low Access to a Grocery Store
- SNAP Certified Stores
- WIC Certified Stores
- Workers who Walk to Work

In the Akron General Community Engagement Session, limited physical activity was associated with both poor overall health and chronic diseases as a top important health problem in the community. Populations most affected by limited physical activity include

[26] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm

homebound seniors and some low-income neighborhoods like Akron East and Akron South. Key recommendations from Community Advisory Council members were to promote healthy lifestyles—nutrition, healthy food and physical activity—and aim to incorporate chronic disease prevention measures into community member lifestyles.

Key stakeholders revealed that environmental conditions can either facilitate or hinder physical activity. For example, conditions including air quality, built environment and infrastructure, green space, safety/violence and walkability are all factors impacting the community's ability to exercise, and play. When asked what a community needs to be healthy, the above characteristics, which were attributed to key stakeholders understanding of social determinants, were discussed at length. They said that communities need to have opportunities to pursue healthy behaviors and need a healthy environment that allows for this.

OLDER ADULT HEALTH

Older Adult Health

Secondary Data Score: **1.50**

Key Themes from Community Input

- Affordable assisted living facilities in familiar neighborhoods are scarce
- Aging at home brings increased care requirements and isolation
- COVID-19 was a disruptor of programs for older adults leading to more social isolation and unhealthy coping habits
- Difficulties navigating health care system due to lack of broadband access/computer knowledge
- Lower income older adults disproportionately affected by chronic conditions, access to healthy food, poor housing conditions
- Mass vaccination sites were difficult for non-English speaking older adults to navigate (language barriers) and those not technologically savvy
- Older adults ranked #2 most underserved population (tied with children and refugees)
- Seniors are running out of money, living longer
- Social cohesion & connectedness:
  - Isolation in LGBTQ+ elderly patients because they come from a generation where they may have been rejected by family members, may have lost loved ones
  - Wasn't common for LGBT folks to have families, so they're really alone
  - Isolation is an independent risk factor for adverse outcomes

Warning Indicators

- Adults with Arthritis
- Age-Adjusted Death Rate due to Alzheimer's Disease
- Alzheimer's Disease or Dementia: Medicare Population
- Asthma: Medicare Population
- Atrial Fibrillation: Medicare Population
- Cancer: Medicare Population
- Chronic Kidney Disease: Medicare Population
- Depression: Medicare Population
- Hyperlipidemia: Medicare Population
- Osteoporosis: Medicare Population
- People 65+ Living Alone
- People 65+ with Low Access to a Grocery Store
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population

Community Engagement Session conversations centered on concerns for older home-bound adults particularly those with low-incomes and limited access to food, community services and other health needs including medications and prescriptions. Further, Community Advisory Council members noted that COVID-19 increased desires in the older adult population to age in place with the objective of avoiding high-risk nursing home and assisted living facilities.

> It is difficult to make sure that folks are safe in their homes and have adequate food, shelter and companionship or can get their medications. We see these folks that are choosing to and want to stay at home, which is perfectly OK, but don't have the adequate resources or support to stay in that home. After COVID-19 [older adult] people are very hesitant to go to any sort of assisted living. They don't want to be institutionalized.
>
> - Community Engagement Session Participant

Key stakeholders focused on lower income older adults who are disproportionately affected by chronic conditions, access to healthy food and poor housing conditions—supporting the conclusions drawn and assertions made during the Akron General Community Engagement Session. Furthermore, difficulties navigating telehealth services as well as arranging in-person visits are attributed to lack of broadband access or lack of comfort with technologies required to access services like smart phones, computers, and tablet devices in the older adult population. A main theme that arose in regard to older adult health was social cohesion and connectedness, especially amongst LGBTQ+ elderly patients that already experience isolation as a result of discrimination from their family and society.

> I think one of the challenges on the healthcare side of the equation is that it is not about the quality of the care that's available, it is about a population that for many people has had no experience being a healthcare consumer. And so at least one of the challenges for folks is they have no history of accessing the system. If they get a prescription written, do they know how to get it filled? Do they know how to navigate the system to get to the pharmacy again?
>
> - Key Stakeholder

Secondary Data

Nutrition & Healthy Eating had the fourth highest data score of all topic areas with a score of 1.52. The Older Adult health topic area had the sixth highest score at 1.50 and the Physical Activity health topic area has the fifth highest data score at 1.50. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

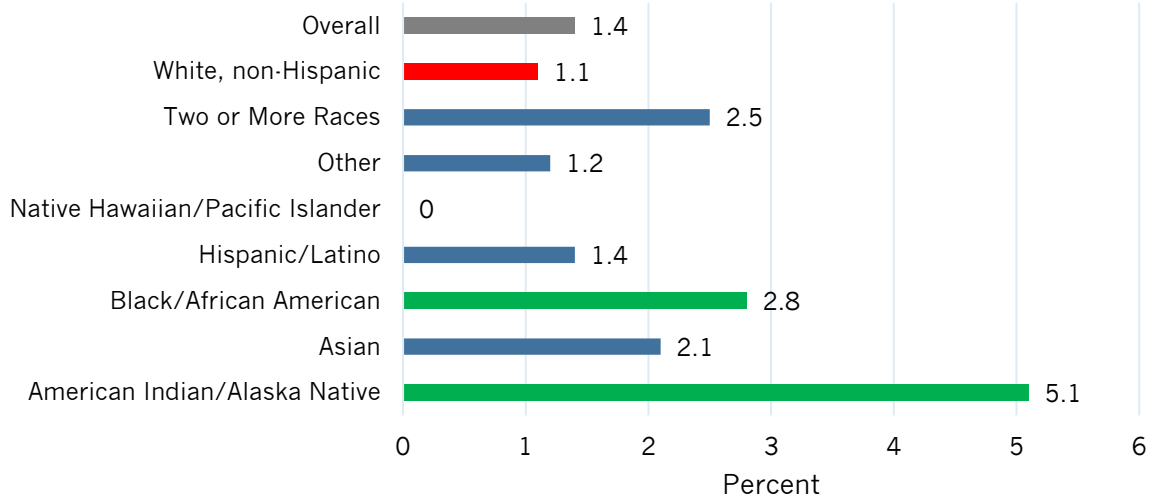
Consumer Expenditures: Fruits and Vegetables ranked highly in all three counties in the South Pointe service area. In Portage County, the average dollar amount per consumer unit spent on fruits and vegetables is $825.5, which is lower than the Ohio state value of $864.60 and the United States value of $1,002.1.

In Summit County, consumer expenditures related to high sugar foods was also identified as an area of concern where the average dollar spent per consumer unit on high sugar foods (cookies, ice cream, candy, gum, jams/jelly, etc.) is $531.5. This is higher than the Ohio value ($519) and U.S. value ($530.2).

Workers who Walk to Work is the worst scoring indicator under the Physical Activity topic area for Stark, Summit, and Medina Counties. In addition, disparities were found when looking at racial/ethnic subgroups.

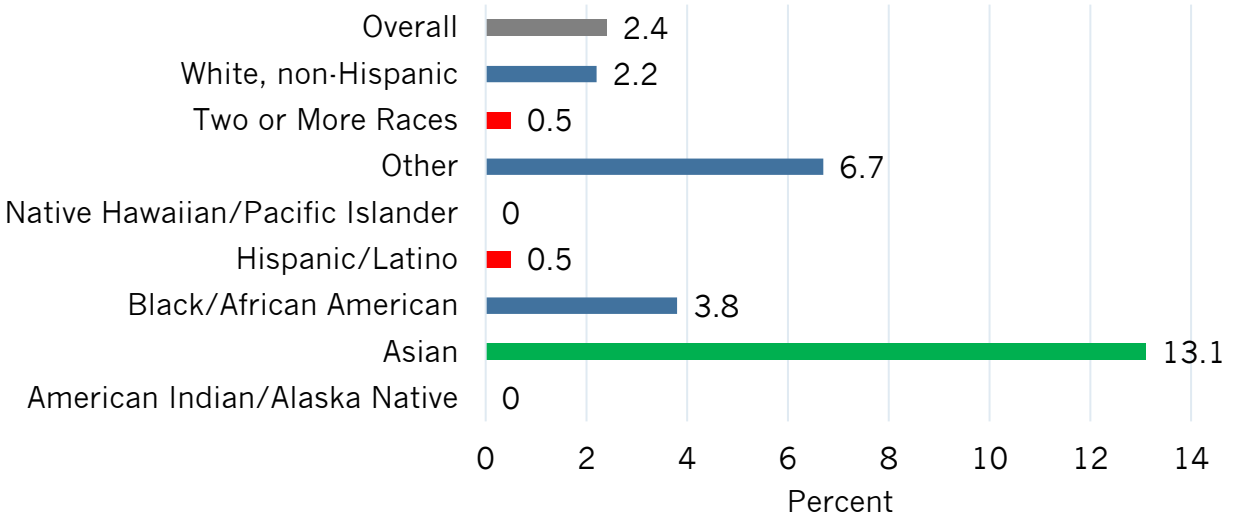
In Summit County, white residents walk to work the least at 1.1% according to Figure 30 (see red below). In Portage County, Hispanic/Latino residents and residents who identify as two or more races walk to work the least, both at 0.5% (see red in Figure 31). Asian residents in Portage County walk to work the most at 13.1% as shown on Figure 31 (see green). In Medina County, Black/African American and Hispanic/Latino residents walk to work the least at 0.1% (See red in Figure 32).

Figure 30 Workers who Walk to Work by Race/Ethnicity in Summit County



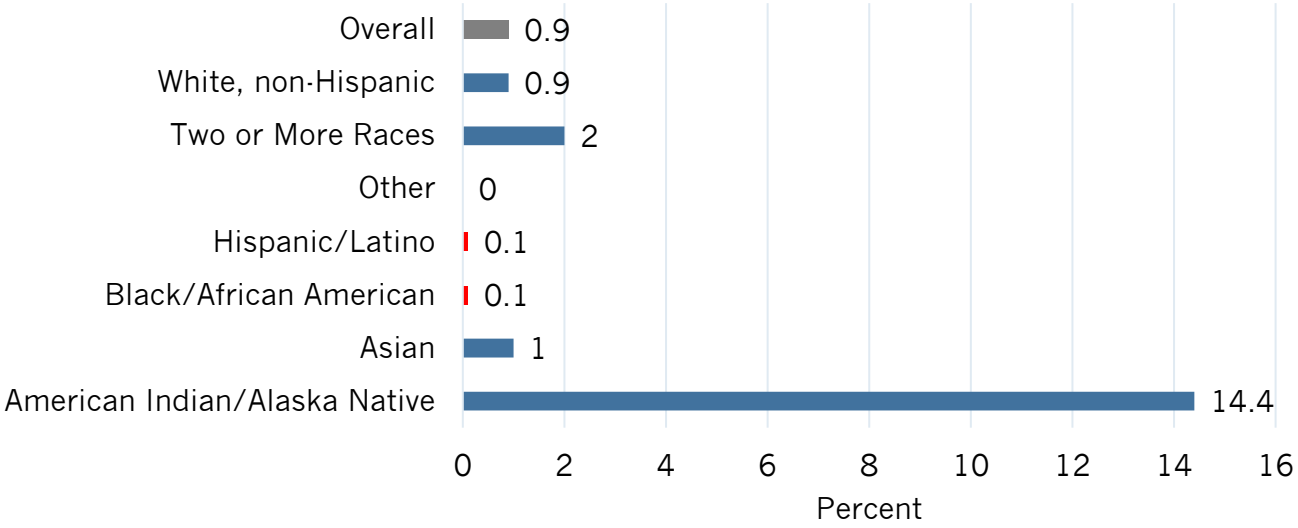
Source: American Community Survey, 2015-2019

Figure 31 Workers who Walk to Work by Race/Ethnicity in Portage County



Source: American Community Survey, 2015-2019

Figure 32 Workers who Walk to Work by Race/Ethnicity in Medina County



Source: American Community Survey, 2015-2019

Prioritized Health Topic #4: Maternal and Child Health

Maternal & Child Health

Secondary Data Score: **1.35**

Key Themes from Community Input

- All issues are disproportionately impacting poor children
- COVID-19 school closure impact on children:
  - Learning challenges- connection issues due to technology/broadband, learning loss
  - Children not eating- no access to nutritious school meals
- East Akron (44305, 44306, 44320) has highest infant mortality rates
- Infant mortality and premature births are major health issues, with large racial/ethnic disparities all a result of historic policies like redlining that create racial segregation
- Low quality housing & lead poisoning in children
- Many AAPI (Asian American and Pacific Islander) families made the decision that their kids were safer at home, not necessarily from COVID-19, but from physical, anti-Asian hostilities. So, they kept their kids at home and that's devastating because engagement in learning is extremely difficult in that remote setting
- Pregnant people with access to healthy foods leading to better outcomes in pregnancy: advocacy opportunity for payer community to pay for food for at risk pregnant people

Warning Indicators

- Babies with Low Birth Weight
- Babies with Very Low Birth Weight
- Children with Low Access to a Grocery Store
- Consumer Expenditures: Childcare
- Mothers who Smoked During Pregnancy

Primary Data: Key Stakeholder Interviews and Community Engagement Session

Although this health topic and themes related to it including Women's Health, Children's Health and Maternal, Fetal and Infant Health did not appear frequently enough in more than one data source to qualify this topic as a significant need for the Akron General Community, it did qualify for other hospital communities throughout the health system warranting inclusion in all regional hospital reports. Maternal and Child Health has dominated community discussions for multiple assessment cycles. High maternal and infant mortality rates across communities served by Cleveland Clinic hospitals have been of particular concern. Implementation strategies precipitated investments in community health focused on reducing maternal and infant mortality.

> In the infant mortality space, African American babies are almost 4 times more likely to die than White babies. So that is certainly a health disparity we are seeing.
>
> - Key Stakeholder

Key stakeholder interviews acknowledged the persistence of high infant mortality rates as well as the continuance of lead poisoning as a contributor to poor children's health outcomes. During the COVID-19 pandemic, long periods of time spent indoors increased exposures and worsened lead related incidents and outcomes. Children across the service area suffered some learning loss during the pandemic as classrooms went remote and parents were often unable to provide time away from work to attend to their child's educational needs. Parents identifying as Asian American and Pacific Islander (AAPI) reportedly opted to continue with remote options even after in-person learning resumed for fear of anti-Asian sentiment being expressed to their children by classmates. Related to learning loss and pandemic associated isolation, mental and behavioral health, including substance abuse has challenged children at increasingly younger ages. Isolation also kept parents from seeking primary care services for their children, including immunizations and well visits. Stakeholders considered nutrition for low-income families a key concern with risks to childhood obesity and juvenile diabetes as early life precursors to chronic diseases top of mind. Additionally, key stakeholders spoke about food insecurity amongst pregnant people, and the advocacy opportunity for the payer community to provide food for at risk pregnant people experiencing food insecurity. Finally, key stakeholders expressed disparities among low-income children that exacerbated nearly all health outcomes discussed.

Secondary Data

Maternal, Fetal and Infant Health ranked 12th with a score of 1.35. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Consumer Expenditures: Childcare is the worst-performing indicator in Medina County where residents spend an average of $403.8 per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. This data captures childcare, day care, nursery school, preschool, and non-institutional day camps. [27]Childcare is a major household expense for families with young children. Access to affordable and high-quality childcare is essential for parents to be able to provide sufficient income for their family while ensuring all their children's social and educational needs are met. In regions where

[27] Claritas Consumer Buying Power

childcare costs are high, family budgets are strained, and parents may be forced to sacrifice the quality of childcare arrangements they select for their children. [28]

Babies with Low Birth Weight and Babies with Very Low Birth Weight are some of the worst-performing indicators in Stark and Summit Counties. In Summit County, 9.4% of newborns weighed less than 2,500 grams (5 pounds, 8 ounces) whereas in Stark County 8.9% of newborns had a low birth weight.

[28] Center for American Progress, 2021

Prioritized Health Topic #5: Socioeconomic Issues

Prevention and Safety

Secondary Data Score: **1.21**

Key Themes from Community Input

- Food insecurity increased with unemployment during the pandemic
- Generational poverty, poor housing and lack of resources available to create healthy conditions for people to live, work, and play in
- Gun violence was a top community concern
- People without safe and affordable housing are an underserved population
- Transgender patients have a higher rate of victimization and murder

Warning Indicators

- Adults with Current Asthma
- Age-Adjusted Death Rate due to Unintentional Poisonings
- Asthma: Medicare Population
- Children with Low Access to a Grocery Store
- Fast Food Restaurant Density
- Grocery Store Density
- Low-Income and Low Access to a Grocery Store
- PBT Released
- People 65+ with Low Access to a Grocery Store
- SNAP Certified Stores
- WIC Certified Stores

Primary Data: Key Stakeholder Interviews and Community Engagement Session

During the Akron General Community Engagement Session safe and affordable housing was top of mind for community members. Evictions, homelessness and substandard housing options were considered chief among the most important health problems in the community. Employment opportunities where community members could earn a living wage were described as barriers to improving health in the community. Low-income neighborhoods require additional housing and food assistance during economic downturns as they are most impacted by rising prices of essential goods.

> "There's obviously issues with being a homeowner [like] maintenance, [etc.] but nothing can replace the fact that [your home is] your spot. The whole goal here with the homeownership piece is so that generational wealth can begin for the families. They're no longer stuck with having to deal with rent or landlords who don't care about the property or all those things that are compounded."
>
> - Community Engagement Session Participant

Key stakeholders couched discussions around specific health needs in the context of generational poverty, poor housing and historical red lining. Generally, there is a lack of resources individually and as a community to create healthy conditions for people to live, work and play. Finally, transgender patients have higher rates of victimization and murder.

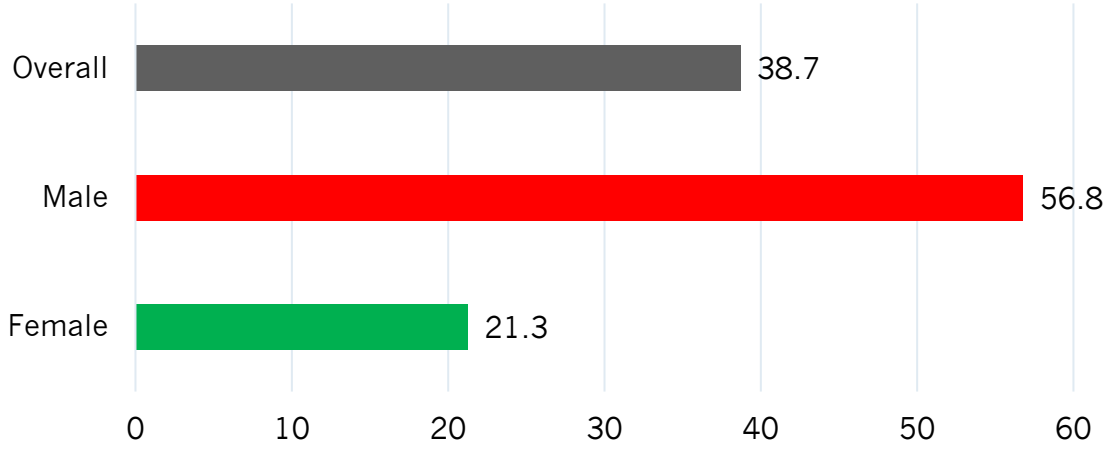
> If you don't have money to live in a safe community and clean home, that is certainly going to have an impact on health in addition to any stress that you might feel as a result of your environment or your conditions. And that's before if your basic needs aren't getting met. Then, you have additional challenges in terms of maybe potential trauma that's gonna impact your health greatly.
>
> - Key Stakeholder

Secondary Data

Prevention & Safety ranked 17th among all health topics with a score of 1.21. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. Portage and Medina Counties did not have any indicators of concern. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

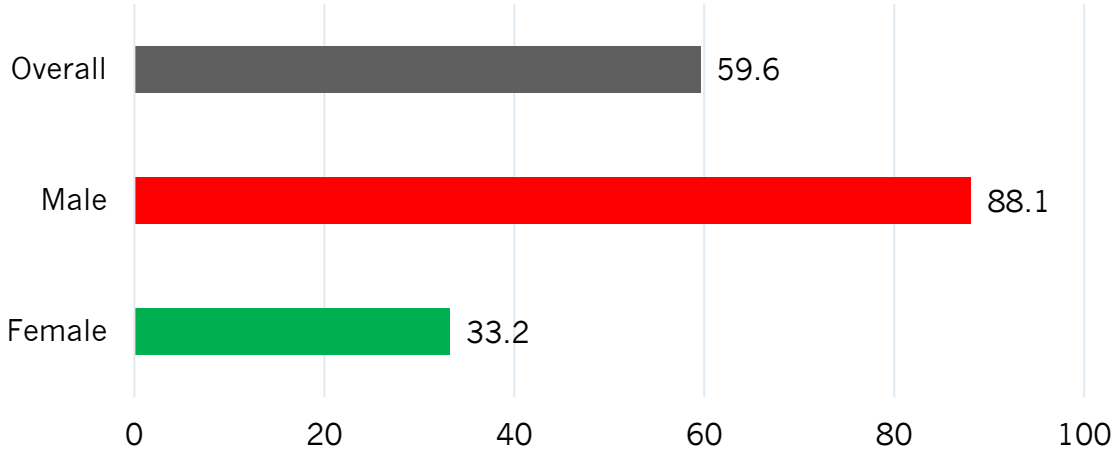
Age-Adjusted Death Rates due to Falls and Motor Vehicle Collisions are areas of concern in Stark County with data scores of 2.31 and 2.00, respectively. In Summit County, unintentional poisonings and injuries came up as concerns through the secondary data analysis. In addition, males in Summit County have higher values of age-adjusted death rates due to unintentional poisonings and injuries as shown in Figure 33 and Figure 34.

Figures 33. Age-Adjusted Death Rate due to Unintentional Poisonings by Gender in Summit County



Source: Centers for Disease Control and Prevention, 2017-2019

Figure 34. Age-Adjusted Death Rate due to Unintentional Injuries by Gender in Summit County



Source: Centers for Disease Control and Prevention, 2017-2019

2022 Akron General CHNA Alignment

The final prioritized health needs from this 2022 Akron General CHNA are in alignment with some of the top priorities and factors influencing health outcomes from the 2019 Ohio State Health Assessment/State Health Improvement Plan. They continue alignment with the 2019 Akron General CHNA priority areas. The check mark icon in Figure 35 indicates areas of alignment.

Figure 35. Akron General CHNA Alignment Matrix

2019 Ohio SHA/SHIP	2019 Akron General CHNA	2022 Akron General CHNA
Top Health Priorities: ☑ • Mental Health & Addiction ☑ • Chronic Disease ☑ • Maternal and Infant Health Top Priority Factors Influencing Health Outcomes: ☑ • Community Conditions ☑ • Health Behaviors ☑ • Access to Care	Priority Health Areas: ☑ • Access to Affordable Healthcare ☑ • Addiction and Mental Health ☑ • Chronic Disease Prevention and Management ☑ • Infant Mortality ☑ • Socioeconomic Concerns • Medical Research and Health Professions Education	Prioritized Health Needs: ☑ • Access to Healthcare ☑ • Behavioral health (Mental health and Substance Use Disorder) ☑ • Chronic disease prevention and management ☑ • Maternal and child health ☑ • Socioeconomic issues

Appendices Summary

A. Methodology

An overview of methods used to collect and analyze data from both secondary and primary sources.

B. Impact Evaluation

A detailed overview of progress made on the 2019 Implementation Strategy planning, development and roll-out as well as email and web contacts for more information on the 2022 CHNA.

C. Secondary Data Methodology and Scoring Tables

A detailed overview of the Conduent HCI data scoring methodology and indicator scoring results from the secondary data analysis.

D. Community Input Assessment Tools

Quantitative and qualitative community feedback data collection tools, stakeholders and organizations that were vital in capturing community feedback during this collaborative CHNA:

- Community Engagement Session Questions
- Key Stakeholder Interview Questions

E. Community Partners and Resources

The tables in this section acknowledge community partners and organizations who supported the CHNA process.

F. Acknowledgements

Appendix A: Methodology

Overview

Primary and secondary data were collected and analyzed to inform the 2022 CHNA. Primary data consisted of community engagement session discussions and key stakeholder interviews. The secondary data included indicators of health outcomes, health behaviors and social determinants of health. The methods used to analyze each type of data are outlined below. This analysis was conducted at the county-level and included data for Medina, Portage, Stark, and Summit counties. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of health needs in the Akron General Community.

Secondary Data Sources & Analysis

The main source for the secondary data, or data that have been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national sources used in the Akron General Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Buying Power
- Claritas Consumer Profiles
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Ohio Department of Education
- Ohio Department of Health, Infectious Diseases

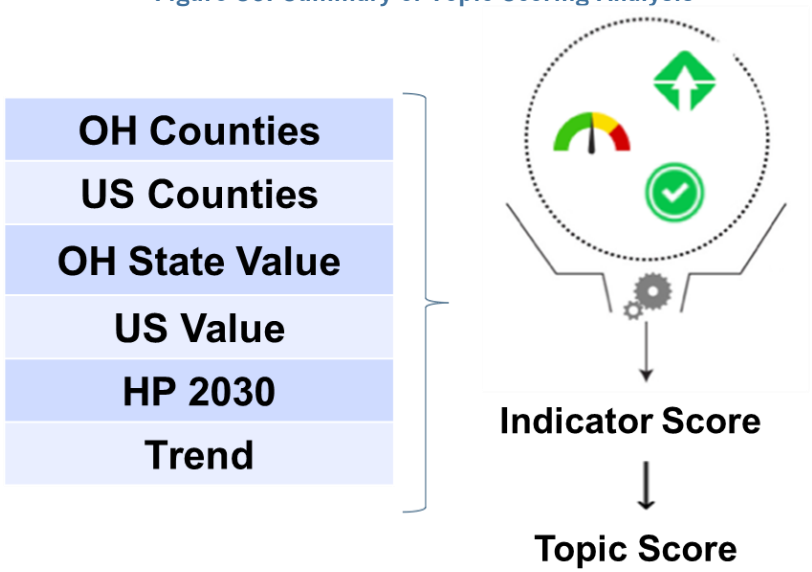
- Ohio Department of Health, Vital Statistics
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food Environment Atlas
- U.S. Environmental Protection Agency
- United For ALICE

Secondary data used for this assessment were collected and analyzed from HCI's community indicator database. This database, maintained by researchers and analysts at HCI, includes 300 community indicators from at least 25 state and national data sources. HCI carefully evaluates sources based on the following three criteria: the source has a validated methodology for data collection and analysis; the source has scheduled, regular publication of findings; and the source has data values for small geographic areas or populations.

Secondary Data Scoring

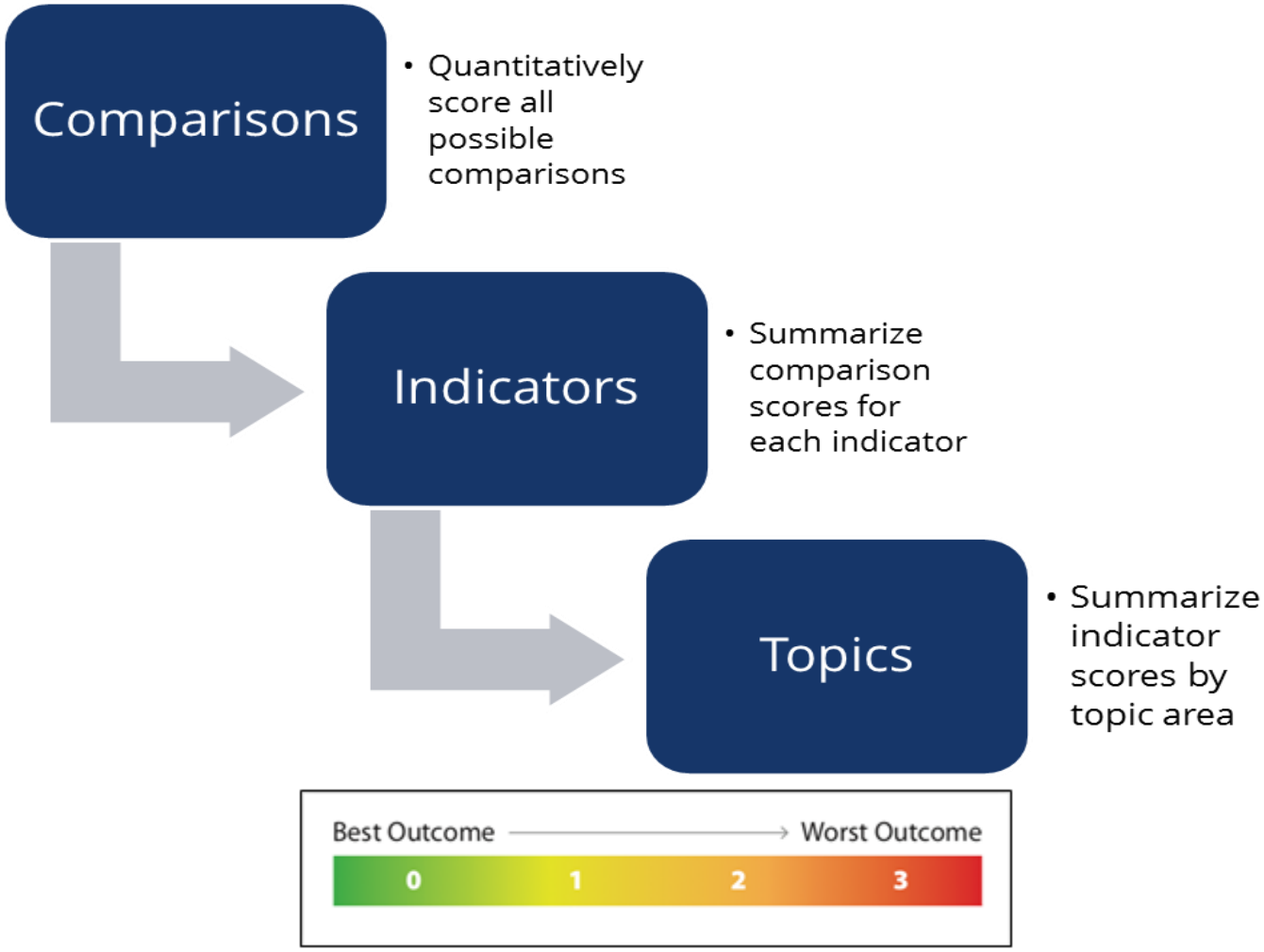
HCI's Data Scoring Tool (Figure 36) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs.

Figure 36: Summary of Topic Scoring Analysis



Secondary Data Scoring

Data scoring is done in three stages:



Each indicator available is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time.
Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.
This process was completed separately for the three counties within the Akron General Community: Medina, Portage, Stark, and Summit counties. To calculate the overall highest needs topic area scores, an average was taken for each topic area across the four counties. Each county's values were weighted the same. More details about topics scores and the average score for the Akron General Community, see Appendix C.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by the direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with

a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results. A full list of indicators and their scores can be seen in Appendix C.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. The resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.
Examples of the health and quality of life topic areas available through this analysis are described as follows:

Quality of Life	Health	
Community	Adolescent Health	Older Adults
Economy	Alcohol & Drug Use	Oral Health
Education	Cancer	Other Conditions
Environmental Health	Children's Health	Prevention & Safety
	Diabetes	Physical Activity
	Health Care Access and Quality	Respiratory Diseases
	Heart Disease & Stroke	Sexually Transmitted Infections
	Immunization & Infectious Diseases	Tobacco Use
	Maternal, Fetal & Infant Health	Women's Health
	Medications & Prescriptions	Wellness & Lifestyle
	Mental Health & Mental Disorders	Weight Status
	Nutrition & Healthy Eating	

Table 2 shows the health and quality of life topic scoring results for the Akron General Community, ranked in order of highest need. Medications & Prescriptions scored as the poorest performing topic area with a score of 1.94, followed by Other Conditions with a score of 1.63. Topics that received a score of 1.50 or higher were considered a significant health need. Six topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 2: Top Secondary Data Health Needs

Top Secondary Data Health Needs
Medications & Prescriptions
Other Conditions
Mental Health & Mental Disorders
Nutrition & Healthy Eating
Physical Activity
Older Adults

Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (ranging from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (ranging from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative need.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health

status, transportation, employment and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (ranging from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

Table 3 below lists each zip code within the Akron General Community and their respective HEI, FII, and MHI values.

Table 3: HEI, FII and MHI Values for Zip Codes within the Akron General Community

Zip Code	HEI Value	FII Value	MHI Value
44203	59	57.3	91.2
44221	33.6	47.3	62.5
44223	17.9	32.2	66.2
44224	11.7	22.9	57.6
44236	2.4	2.2	34.9
44240	45.8	47.5	75.2
44256	11.7	19.9	43.3
44260	26.7	30	53.9
44262	18.4	18	66.8
44266	56.4	58.1	89
44278	24.6	23	69
44281	14.6	24.3	40
44301	83.1	84.7	97.1
44302	84	93	97.4
44303	22.9	37.3	67.5
44304	97	72.2	87.3
44305	80.8	85.6	94.3
44306	96.2	97.3	99

44307	98.3	99.6	99.7
44310	91.5	85.3	90.8
44311	98.4	97.9	97.6
44312	49.7	51.2	84
44313	20.9	40.7	88.1
44314	81.7	86.2	92.9
44319	26.9	21	69.6
44320	86.7	91.7	99.1
44321	6.5	9.7	40.5
44333	6.2	7.5	53.3
44685	15.3	16.1	51.4
44720	14.9	20.5	56.8

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators.

Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or Ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or

cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Primary Data Collection & Analysis

Primary data used in this assessment consisted of a community engagement session and key stakeholder interviews. These findings expanded upon the information gathered from the secondary data analysis.

Community Engagement Session Methodology and Results

Akron General invited members of the hospital Community Advisory Council (CAC) to participate in a community engagement session. The session was held virtually on May 12, 2022. Participants answered four questions including:

1. What are the most important health problems in the community?
2. What barriers or challenges to improving health exist in your community?
3. What community groups, populations, or neighborhoods are underserved?
4. What can be done to improve the health in your community?

At the end of the session, participants were also asked to describe interventions or programs they are aware of that have been successful in improving health in the community.

The project team captured detailed records of the discussion through transcripts and a polling tool (Poll Everywhere®). Figure 37 shows the results from the analysis of inputs collected from these tools.

Figure 37: Community Engagement Session Findings

Table 4 shows the organizations that comprise the Cleveland Clinic Akron General Community Advisory Council.

Table 4: Akron General Community Advisory Council

Akron General Community Advisory Council	
• Akron Art Museum • Akron Canton Regional Foodbank • Akron Community Foundation • Akron Public Schools • Akron YMCA • Bober Markey Fedorovich CPA • Chase Bank • Child Guidance and Family Solutions • City of Akron	• Kent State University • NEOMED • One in Six Foundation • Mountain of the Lord • Pastoral Counseling Services • Portage Path Behavioral Health • Rubber City Radio Group • Stark and Knoll LPA • Stark State College • Stewart's Caring Place

• City of Green • City of Stow • County of Summit • Electric Impulse • Family Promise of Summit County • First Energy Corp. • First national Bank • GOJO Industries	• Summit County ADM Board • Summit County Community Partnership • Summit County Historical Society • Summit County Land Bank • The University of Akron • United Way of Summit and Medina

Key Stakeholder Interviews Methodology and Results

The project team also captured detailed transcripts of the key stakeholder interviews. Table 5 describes the key stakeholder organizations contributing to the primary data collection process.

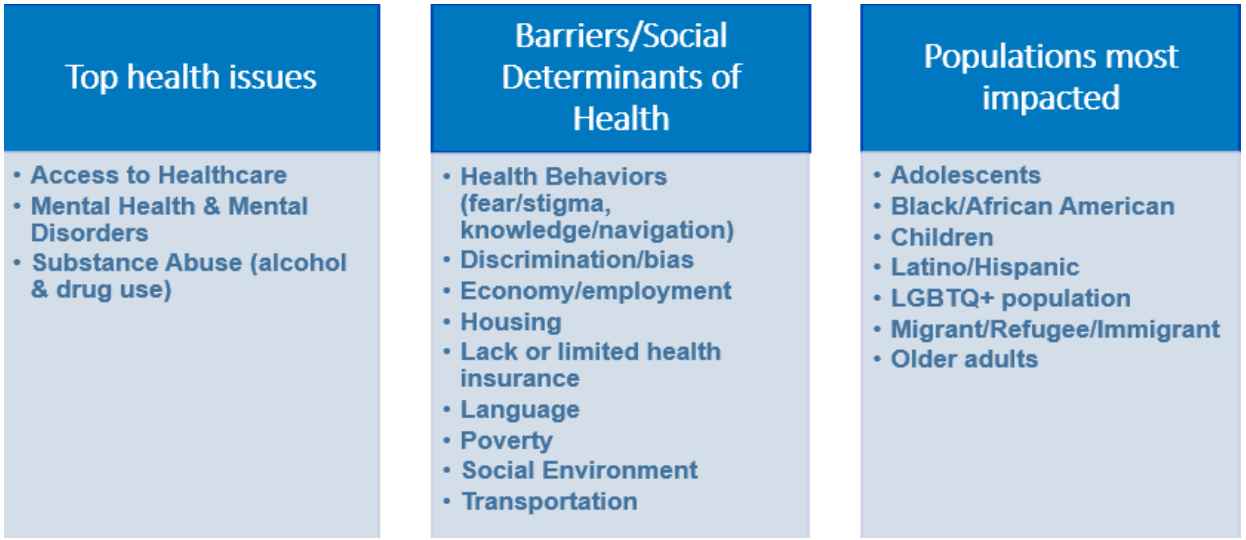
Table 5: Akron General Key Stakeholder Organizations

Key Stakeholder and Community Organizations	
• Akron General Community Advisory Council • Medina County Health Department • Summit County Public Health	• Neighborhood Family Practice • Birthing Beautiful Communities • Lead Safe Cleveland Coalition • Better Health Partnerships • NAMI Greater Cleveland • Asian Services in Action (ASIA) • Cleveland Clinic LGBTQ+ Care • Greater Cleveland Food Bank

	• The Gathering Place • Esperanza • The Centers for Families and Children

The transcripts were analyzed using the qualitative analysis program Dedoose 2®. Text was coded using a pre-designed codebook-organized by themes and analyzed for significant observations. Figure 38 shows key findings from community stakeholder interviews specific to the Akron General Community.

Figure 38: Key Stakeholder Findings



Findings from both the community engagement session and key stakeholder interview analyses were combined with findings from secondary data and incorporated into the Data Synthesis and Prioritized Health Needs.

Appendix B: Impact Evaluation

The CHNA process should be viewed as a three-year cycle to evaluate the impact of actions taken to address priority areas. This step affirms organizations focus and target efforts during the next CHNA cycle. The top health priorities for the Akron General Community from the 2019 CHNA were:

- Access to Affordable Healthcare
- Addiction and Mental Health
- Chronic Disease Prevention and Management
- Infant Mortality
- Socioeconomic Concerns
- Medical Research and Health Professions Education

Implementation strategies for these health topics shifted in response to the COVID-19 pandemic. Innovative strategies were adopted to continue building capacity for addressing the community health needs.

Actions Taken Since Previous CHNA

Akron General's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2019 CHNA: Addiction and Mental Health, Chronic Disease Prevention and Management, Infant Mortality, Socioeconomic Concerns, Access to Affordable Health Care, Medical Research and Health Professions Education.

The ISR was conducted before the onset of COVID 19, and therefore, does not reflect the pandemic's impact which dramatically affected community and hospital services. Many of our hospital services were paused or deferred as we navigated the emergent COVID 19 landscape. Caring for our community is essential, and part of that is sharing accurate, up-to-date information on health-related topics with our community. We provided COVID 19 education, vaccine distribution and collaborative services with government, health departments and community based organizations to keep our communities safe. As we continue to serve our communities we are committed to addressing the needs identified in the previous ISR.

Cleveland Clinic uses evidence-based approaches in the delivery of healthcare services and educational outreach with the aim of achieving healthy outcomes for the community it serves. It undertakes periodic monitoring of its programs to measure and determine their effectiveness and ensure that best practices continue to be applied. Given that the process for evaluating the impact of various services and programs on population health is longitudinal by nature, significant changes in health outcomes may not manifest for several community health needs assessment cycles. We continue to evaluate the cumulative impact.

The narrative below describes the strategies, modifications made to the action plans, and highlighted impacts for each health priority area.

Addiction and Mental Health

Actions and Highlighted Impacts:

a. Through Akron General's Alcohol and Drug Recovery Center, provided comprehensive care and developed individualized treatment plans with the support of skilled chemical dependency counselors and a multidisciplinary team as well as aftercare support groups for individuals in recovery.
b. Implemented the ERAS "Enhanced Recovery After Surgery" methodology for prescribing alternate medications to qualifying patients.
    - Launched Recovery's in Reach program in early 2022 to connect Emergency Department patients with substance disorder to community recovery services. Patients in Akron General's PATH Center which cares for victims of sexual assault and other types of abuse, are also referred to the program if they have substance abuse issues. The program began in the downtown Akron ED and has expanded to the satellite EDs in Green, Stow and Bath. Peer recovery coaches from our partner, Catholic Charities, ensure individuals receive post hospital treatment.
c. Participated as subject matter experts in Summit County's Opioid Abatement Advisory Council (SCOAAC) ensure settlement dollars are effectively used for programs serving residents impacted by the opioid epidemic
    - Pregnant women in Summit County who are affected by substance use disorder received increased access to prenatal care through Akron General's Centering Pregnancy Program, thanks to a grant from the SCOAAC.
d. In addition to direct patient care, Cleveland Clinic's Opioid Awareness Center, provided intervention and treatment for substance abuse disorders to Cleveland Clinic caregivers and their family members
    - Opioid misuse continues to be a public health emergency, contributing to over 50,000 U.S. deaths a year. About 40% of those deaths involve prescription opioids. Our comprehensive efforts to improve opioid prescribing have yielded reductions in these prescriptions by our providers for two years running, including a large improvement in 2021.
e. Through the Opioid Awareness Center, participated in the Northeast Ohio Hospital Opioid Consortium, the Summit County United Way Addiction Leadership Council, and Summit County Opiate Task Force. Akron General continues to provide preventative education and share evidence-based practices.
f. Collected unused medications through community-based drop boxes and a collection service.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

a. Improved management of chronic conditions through Chronic Care Clinics.
    - COVID 19 created a delay in treatment for many community members. We launched an effort to connect patients with care, proactively contacting over 300,000 patients and scheduling 57,000 appointments. This outreach is prompting more patients to complete recommended screening tests, allowing earlier detection of cancers and other diseases when they are most treatable. For example, 1,700 precancerous lesions of the colon have been detected earlier as a result — a key part of preventing colon cancer.
    - Many in-person community programs were paused by COVD 19. When COVID-19 vaccines became available, we co-led a nationwide campaign to encourage adults to get vaccinated. The coalition of 60 top hospitals and healthcare institutions communicated the vaccines' safety and effectiveness through diverse digital and traditional media. Throughout the years, our health experts explained and advocated the benefits of vaccination at every opportunity, from patient visits to national media appearances. In late 2021, when cases of the omicron variant surged and hospitals filled with unvaccinated patients, we joined with five other Northeast Ohio hospital systems in an advertising campaign urging the public to get vaccinated and take other precautions.
    - A panel of medical experts from Akron General served as a resource for community groups and organizations seeking to learn more about COVID and the safety and effectiveness of the vaccines.
    - Through the *Know COVID* education and awareness campaign, the hospital worked directly with neighborhood organizations to develop COVID and vaccine information and assembled COVID care kits for residents. Neighborhoods were identified in communities where COVID was especially prevalent through mapping data. Akron General caregivers provided vaccination information to three Akron neighborhoods – South Akron, Summit Lake and Sherbondy Hill – as part of a COVID Care-A-Van. A stream of vehicles made stops at each location, and Summit County Public Health administered vaccinations. Physicians spoke about the importance of vaccination and dispelled myths. We continue to operate a COVID testing location at our Broadway location downtown
b. Provided free cancer screenings, including mammograms, breast exams, and prostate cancer screenings, to the community.
    - Family Medicine providers and Cancer Center caregivers provided clinical breast exams and referrals for mammograms to underserved women at Open Ministries and women in the reentry

program at South Street Ministries. Services were also provided at a hospital-coordinated health fair in Akron's North Hill neighborhood, which is home to a significant number of resettled refugees.
    - Health Checks that included screenings to help detect prostate cancer early were provided to men in the reentry program at South Street.
    - A Health Risk Assessment tool was utilized at the Hispanic Health Fair held at St. Bernard's Catholic Church to help identify individuals at increased risk of disease.
c. Through the hospital's Lifestyles Department, implemented health promotion messaging, health education, and outreach programs related to reducing behavioral risk factors. Venues included Health and Wellness Centers in Summit County, local schools, and other community sites.
d. Through the Healthy Communities Initiative (HCI), partnered to fund programs designed to improve health outcomes in four core areas: physical activity, nutrition, smoking, and lifestyle management.
    - Prior to COVID 19, Healthy Communities Initiative provided in 23 programs in 59 NE Ohio zip codes with total participation of 2,813 community residents. Results indicated decreased blood pressure abnormality, increased physical activity and increased healthy eating behaviors.

Infant Mortality

Actions and Highlighted Impacts:

a. Provided expanded evidence-based health education to expecting mothers and families including information about safe sleep, other risk factors for infant mortality, and long-acting reversible contraception.
b. Co-led Summit County's Full Term First Birthday Greater Akron (FTFB), a collective impact collaborative advocating for policies, providing education, and informing the community of programs that promote healthy, full-term pregnancies. Donated support for the City of Akron's Health Equity Ambassador position.
c. Continued to offer the Centering Pregnancy group prenatal care model to expecting mothers at our Women's Health Clinic.
d. Screened patients for safe sleep procedures, assess home environments as needed, and ensure infants have access to safe cribs
    - A mom's support group, #MomLife, was launched to assist mothers keep in touch after delivery and discuss relevant topics in a group setting, including time management, stress management, budgeting and day/care/childcare expenses and breastfeeding. One-on-one breastfeeding support from the hospital's lactation department was offered.

e. Through grant funding in partnership with the Akron Community Foundation Women's Endowment Fund, OB/GYNs, educated and provided care to women of childbearing age living at the Joy Park and Summit Lake family housing sites. Through a partnership with Haven of Rest, OB/GYNs provided medical care to homeless women. In partnership with ACCESS Inc., family medicine providers care for homeless women and children.
f. Participating in a national quality project through the March of Dimes in collaboration with the U.S. Department of Health and Human Services. Project goal is to reduce maternal morbidity and mortality by establishing a culture that addresses racial inequities and the disparity gap in outcomes.

Socioeconomic Concerns

Actions and Highlighted Impacts:

a. Implemented a system-wide social determinants screening tool for adult patients.
b. Piloted patient navigation programming within a partnership pathway HUB model using community health workers and/or the co-location of community organizations with hospital facilities.
c. In partnership with Akron Public Schools College and Career Academies, supported student success at four Community Learning Centers (high schools) by participating in school-based career expos, providing in-classroom health speakers in alignment with curriculum, and giving guidance to the Academies through a steering committee and advisory councils
    - Established a food pantry at the hospital in collaboration with the Akron Canton Regional Foodbank and State Representative to meet the emergency needs of food insecure patients.
d. Through the PATH (Providing Access to Healing) Center, Akron's only sexual assault nurse examiner unit, provided care for victims of sexual assault, domestic violence, abuse, and neglect.
e. The Office of Diversity and Inclusion, provided sessions on Unconscious Bias, Bridges Out of Poverty, and LGBTQ allies training for medical providers and community members.
f. Provided workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders
    - Akron General created initiatives to develop a skilled community youth workforce in vulnerable communities aligning with Health Anchor Network (HAN) and Placed-based Initiatives.
    - Provided internships in women's health and primary care settings for Akron Public School students participating in Kent State University's Community Health Worker certification program.
    - In 2021, Cleveland Clinic, an anchor institution in the Cleveland Innovation District, collaborated with the state of Ohio to launch in 2021 an initiative to advance healthcare and digital technology, attract and create new businesses, and train the workforce of the future. The state of

Ohio and Cleveland Clinic pledged to contribute a combined $565 million for the district — the largest research investment in our history.
- In partnership with the city of Akron and the local community, planted fifty trees in Lane Field Park to improve the tree canopy and enhance the built environment, improving health.

g. Addressed diversity issues within the healthcare workforce.
- Cleveland Clinic is an inclusive organization that values diversity and equity. Our caregivers and leaders continue to become more diverse. Among newly hired or promoted leaders in 2021, 21% identify as an underrepresented minority. We will continue to make our caregiver family increasingly inclusive to better serve all our communities.

Access to Affordable Health Care

Highlighted Actions and Key Impacts:

a. Patient Financial Advocates assisted patients in evaluating eligibility for financial assistance or public health insurance programs
- Cleveland Clinic Akron General provided medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. The hospital has a financial assistance policy that is among the most generous in the region that covers both hospital services and physician services provided by physicians employed by the Cleveland Clinic. In 2021, Cleveland Clinic health system provided over $178 million in financial assistance to its communities in Ohio, Florida, and Nevada.

b. Provided walk-in care at Express Care Clinics and offer evening and weekend hours.
c. Utilized medically secure online and mobile platforms, connect patients with Cleveland Clinic providers for telehealth and virtual visits.
- In 2021, Cleveland Clinic provided 841,000 virtual visits.

d. In partnership with Akron Public Schools, Akron General Family Medicine physicians provided childhood immunizations to students of Helen Arnold Elementary.
- Provided blood pressure screenings, education and free blood pressures cuffs to residents at Akron's Vernon Odom branch of the Akron Summit County Public Library. Free physicals and blood pressure cuffs were also offered to residents at Akron's Firestone Park.

Medical Research and Health Professions Education

Highlighted Actions and Key Impacts:

a. Through medical research, advanced clinical techniques, devices and treatment protocols in the areas of cancer, heart disease, diabetes, and others.
    - Research into diseases and potential cures is an investment in people's long-term health.
    - In 2020, COVID-19 highlighted the significance of research in community health. Cleveland Clinic research findings increased knowledge about the virus and how best to respond to it. Our researchers developed the world's first COVID-19 risk-prediction model, enabling healthcare providers to calculate an individual patient's likelihood of testing positive for infection as well as their probable outcome from the disease.
    - For 2021, Cleveland Clinic's community benefit in support of research was $101 million.
b. Sponsored high-quality medical education including residency-training programs in emergency medicine, family medicine, internal medicine, general surgery, OB/GYN, orthopedics, and urology and fellowships in Breast Surgery Oncology and Vitreo-Retinal Surgery.
    - Welcomed the largest Graduate Medical Education class in 2021 including orthopedic and psychiatry residents and medical students from Ohio University Heritage College of Medicine participating in the innovative Transformative Care Continuum (TCC) program.
    - Sponsored training programs for nurses and allied health professionals through partnerships with several area colleges. AGMC continues to provide allied health internships in the areas of Biomedical Engineering, Radiation Therapy and Clinical Pastoral Education.
    - Akron General's EMT program was expanded to students at Akron's Ellet Community Learning Center. It was also expanded to Medina County.
    - As a partner with Akron Public Schools' College and Career Academies, advised teachers and mentored students on the skills needs for healthcare. Cleveland Clinic provided a wide range of high-quality medical education that includes accredited training programs for residents, physicians, nurses and allied health professionals. By educating medical professionals, we ensure that the public receives the highest level of medical care and will have access to highly trained health professionals in the future. For 2021, Cleveland Clinic's community benefit in support of education was $322 million.

Community Feedback

Community Health Needs Assessment reports from 2019 were published on the Akron General website. No community feedback has been received as of the drafting of this report. For more information regarding Cleveland Clinic Community Health Needs Assessments and Implementation Strategy reports, please visit www.clevelandclinic.org/CHNAreports or contact CHNA@ccf.org.

Appendix C: Secondary Data Scoring Tables

Table 5: Akron General Community Definition

Zip code	Postal Name
44203	Barberton
44221	Cuyahoga Falls
44223	Cuyahoga Falls
44224	Stow
44236	Hudson
44240	Kent
44243	Kent
44250	Lakemore
44256	Medina
44260	Mogadore
44262	Munroe Falls
44266	Ravenna
44278	Tallmadge
44281	Wadsworth
44301	Akron
44302	Akron
44303	Akron
44304	Akron
44305	Akron
44306	Akron
44307	Akron
44310	Akron
44311	Akron
44312	Akron
44313	Akron
44314	Akron
44319	Akron

44320	Akron
44321	Akron
44333	Akron
44685	Uniontown
44720	Cleveland
44203	Barberton
44221	Cuyahoga Falls

Table 6: Population Estimates for Each Zip Code

Zip code	City	Population
44203	Barberton	40,694
44221	Cuyahoga Falls	28,965
44223	Cuyahoga Falls	19,102
44224	Stow	39,855
44236	Hudson	25,338
44240	Kent	40,013
44243	Kent	4,343
44250	Lakemore	1,166
44256	Medina	66,686
44260	Mogadore	13,181
44262	Munroe Falls	4,956
44266	Ravenna	33,338
44278	Tallmadge	18,464
44281	Wadsworth	32,770
44301	Akron	14,307
44302	Akron	4,800
44303	Akron	7,040
44304	Akron	5,847
44305	Akron	21,088
44306	Akron	21,745
44307	Akron	7,869

44310	Akron	21,854
44311	Akron	8,161
44312	Akron	31,700
44313	Akron	24,560
44314	Akron	17,961
44319	Akron	22,526
44320	Akron	19,139
44321	Akron	17,022
44333	Akron	18,532
44685	Uniontown	30,033
44720	Cleveland	40,520

Table 7: Percentage of Families Living Below Poverty Level for Each Zip Code

Zip Code	City	Families Below Poverty Level (%)
44203	Barberton	9.55%
44221	Cuyahoga Falls	7.79%
44223	Cuyahoga Falls	4.73%
44224	Stow	5.16%
44236	Hudson	1.49%
44240	Kent	12.97%
44243	Kent	N/A
44250	Lakemore	7.57%
44256	Medina	4.43%
44260	Mogadore	3.89%
44262	Munroe Falls	4.25%
44266	Ravenna	9.11%
44274	Sharon Center	#N/A

44278	Tallmadge	4.55%
44281	Wadsworth	3.72%
44285	Wayland	#N/A
44301	Akron	14.46%
44302	Akron	25.90%
44303	Akron	10.45%
44304	Akron	38.89%
44305	Akron	16.62%
44306	Akron	29.40%
44307	Akron	42.53%
44310	Akron	24.41%
44311	Akron	38.69%
44312	Akron	7.26%
44313	Akron	7.66%
44314	Akron	16.17%
44319	Akron	4.76%
44320	Akron	20.26%
44321	Akron	2.11%
44333	Akron	3.98%
44685	Uniontown	5.17%
44720	Cleveland	4.18%

Table 8: Secondary Data Results by Health Topic—Medina, Portage, Stark and Summit Counties

HEALTH TOPICS	MEDINA	PORTAGE	STARK	SUMMIT	AVG
Alcohol & Drug Use	1.47	1.51	1.35	1.51	1.46
Cancer	1.34	1.52	1.52	1.51	1.47
Children's Health	1.34	1.41	1.35	1.41	1.38
Diabetes	0.89	1.13	1.24	1.29	1.14

Health Care Access & Quality	1.54	1.41	1.17	1.26	1.34
Heart Disease & Stroke	1.19	1.45	1.40	1.28	1.33
Immunizations & Infectious Diseases	0.82	0.86	1.11	1.27	1.02
Maternal, Fetal & Infant Health	1.03	1.32	1.41	1.63	1.35
Medications & Prescriptions	2.50	1.66	1.39	2.22	1.94
Mental Health & Mental Disorders	1.34	1.52	1.95	1.66	1.62
Nutrition & Healthy Eating	1.64	1.39	1.39	1.67	1.52
Older Adults	1.35	1.41	1.60	1.63	1.50
Oral Health	1.11	1.38	1.42	0.86	1.19
Other Conditions	1.53	1.38	1.77	1.83	1.63
Physical Activity	1.36	1.54	1.62	1.47	1.50
Prevention & Safety	1.00	1.07	1.54	1.24	1.21
Respiratory Diseases	0.96	1.19	1.40	1.38	1.23
Tobacco Use	1.11	1.56	1.52	1.36	1.39
Wellness & Lifestyle	1.10	1.33	1.54	1.33	1.33
Women's Health	1.22	1.34	1.73	1.58	1.47
QUALITY OF LIFE TOPIC		**SCORE**			
Community	1.09	1.17	1.43	1.30	1.25
Economy	0.74	1.10	1.45	1.28	1.14
Education	1.22	1.29	1.57	1.54	1.40
Environmental Health	1.19	1.41	1.46	1.43	1.37

Secondary Data Scoring Indicators of Concern

From the secondary data scoring results, Health Care Access & Quality ranked as the 13th highest scoring health need, with a score of 1.34. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 9 below. For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. The legend (Figure 39) on the right shows how to interpret the distribution gauges and trend icons used in the data scoring results for each health topic by county (Table 8).

Figure 39: Prioritized Health Needs

	If the needle is in the red, the county value is in the worst 25% (or worst quartile) of counties in the state or nation.
	If the needle is in the green, the county value is in the best 50% of counties in the state or nation.
	The indicator is trending down, significantly, and this is not the ideal direction.
	The indicator is trending down and this is not the ideal direction.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trendng up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction .
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.

Table 9. Data Scoring Results for Healthcare Access & Quality for the Akron General Community
Stark County

SCORE	HEALTH CARE ACCESS & QUALITY	Stark County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.56	Persons without Health Insurance	6.2		6.6		...	...	
1.50	Adults who Visited a Dentist	50.8		51.6	52.9			...
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	621.5		638.9	609.6			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	HEALTH CARE ACCESS & QUALITY	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.33	Consumer Expenditures: Medical Services	1153.1		1098.6	1047.4			...
2.17	Consumer Expenditures: Health Insurance	4543.8		4371.7	4321.1			...
2.17	Consumer Expenditures: Medical Supplies	213.4		204.8	194.9			...

2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	664.9		638.9	609.6			...
1.56	Persons without Health Insurance	6.5		6.6		...	...	...
1.50	Adults with Health Insurance	90		90.9	87.1	...	...	...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Portage County

SCORE	HEALTH CARE ACCESS & QUALITY	Portage County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.06	Primary Care Provider Rate	39.9		76.7				
1.83	Consumer Expenditures: Medical Services	1061.7		1098.6	1047.4			...
1.83	Consumer Expenditures: Medical Supplies	198.2		204.8	194.9			...
1.83	Non-Physician Primary Care Provider Rate	36.9		108.9				

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	HEALTH CARE ACCESS & QUALITY	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Consumer Expenditures: Health Insurance	5410.8		4371.7	4321.1			...
2.50	Consumer Expenditures: Medical Services	1419.1		1098.6	1047.4			...
2.50	Consumer Expenditures: Medical Supplies	259.4		204.8	194.9			...
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	781.2		638.9	609.6			...
1.72	Primary Care Provider Rate	60.3		76.7				
1.50	Non-Physician Primary Care Provider Rate	63.4		108.9				

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 10: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #2: Behavioral Health (Mental Health)

From the secondary data scoring results, Mental Health & Mental Disorders had the third highest data score of all topic areas, with a score of 1.62. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 10 below. Cuyahoga County did not have any indicators under Mental Health & Mental Disorders with a data score above 1.5.

Stark County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Stark County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.92	Age-Adjusted Death Rate due to Alzheimer's Disease	52.5		34	30.5			
2.64	Alzheimer's Disease or Dementia: Medicare Population	12		10.4	10.8			
2.58	Depression: Medicare Population	21		20.4	18.4			
2.39	Age-Adjusted Death Rate due to Suicide	19.6	12.8	15.1	14.1			
2.00	Poor Mental Health: Average Number of Days	5		4.8	4.1			...
1.75	Poor Mental Health: 14+ Days	16.1			13.6			...

1.50	Self-Reported General Health Assessment: Good or Better	84.7		85.6	86.5			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.75	Depression: Medicare Population	21.8		20.4	18.4			
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	41		34	30.5			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.3		10.4	10.8			
1.83	Poor Mental Health: Average Number of Days	4.8		4.8	4.1			...
1.61	Age-Adjusted Death Rate due to Suicide	16.2	12.8	15.1	14.1			
1.58	Poor Mental Health: 14+ Days	15.4			13.6			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Portage County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Portage County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.58	Depression: Medicare Population	21.4		20.4	18.4			
1.92	Poor Mental Health: 14+ Days	16.8			13.6			...
1.92	Adults Ever Diagnosed with Depression	22.3			18.8			...
1.50	Poor Mental Health: Average Number of Days	4.8		4.8	4.1			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.92	Depression: Medicare Population	19		20.4	18.4			
1.89	Age-Adjusted Death Rate due to Suicide	15.7	12.8	15.1	14.1			
1.58	Adults Ever Diagnosed with Depression	21.2			18.8			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 11: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #3: Chronic Disease Prevention & Management

Nutrition & Healthy Eating had the fourth highest data score of all topic areas with a score of 1.52. The Older Adult Health topic area had the sixth highest score at 1.50 and the Physical Activity topic area had the fifth highest data score at 1.50. All topic areas in this group demonstrate need per as they each scored above 1.5. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 11.

Stark County

SCORE	NUTRITION & HEALTHY EATING	Stark County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Consumer Expenditures: Fruits and Vegetables	805		864.6	1002.1			…
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	41.3		41.5	41.2			…

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	NUTRITION & HEALTHY EATING	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Consumer Expenditures: High Sugar Foods	531.5		519	530.2			…
2.00	Consumer Expenditures: Fast Food Restaurants	1508.4		1461	1638.9			…

1.83	Consumer Expenditures: High Sugar Beverages	324		319.7	357			...
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	41.2		41.5	41.2			...
1.50	Consumer Expenditures: Fruits and Vegetables	885.9		864.6	1002.1			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Portage County

SCORE	NUTRITION & HEALTHY EATING	Portage County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.67	Consumer Expenditures: Fruits and Vegetables	825.5		864.6	1002.1			...
1.50	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	81.5		80.9	80.4			...
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	41.3		41.5	41.2			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	NUTRITION & HEALTHY EATING	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Consumer Expenditures: Fast Food Restaurants	1814.2		1461	1638.9			...
2.50	Consumer Expenditures: High Sugar Foods	627		519	530.2			...
2.33	Consumer Expenditures: High Sugar Beverages	370		319.7	357			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Stark County

SCORE	OLDER ADULTS	Stark County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.92	Age-Adjusted Death Rate due to Alzheimer's Disease	52.5		34	30.5			
2.64	Alzheimer's Disease or Dementia: Medicare Population	12		10.4	10.8			
2.58	Depression: Medicare Population	21		20.4	18.4			

2.31	Age-Adjusted Death Rate due to Falls	11.7		10.5	9.5			
2.25	Chronic Kidney Disease: Medicare Population	25.8		25.3	24.5			
2.14	Hyperlipidemia: Medicare Population	51.7		49.4	47.7			
2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	35.9		36.1	33.5			
2.00	People 65+ with Low Access to a Grocery Store	4.6						...
1.81	Heart Failure: Medicare Population	14.8		14.7	14			...
1.75	Adults with Arthritis	31.5			25.1			...
1.67	Osteoporosis: Medicare Population	6.3		6.2	6.6			
1.64	Atrial Fibrillation: Medicare Population	8.7		9	8.4			

1.64	Cancer: Medicare Population	8.3		8.4	8.4			
1.64	People 65+ Living Alone	27.2		28.8	26.1			
1.58	Adults 65+ with Total Tooth Loss	16.2			13.5			...

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Summit County

SCORE	OLDER ADULTS	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.75	Depression: Medicare Population	21.8		20.4	18.4			
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	37.7		36.1	33.5			
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	41		34	30.5			
2.42	Cancer: Medicare Population	8.5		8.4	8.4			

2.36	Asthma: Medicare Population	5.8		4.8	5			
2.19	People 65+ Living Alone	30.1		28.8	26.1			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.3		10.4	10.8			
2.14	Osteoporosis: Medicare Population	6.6		6.2	6.6			
1.92	Chronic Kidney Disease: Medicare Population	24.7		25.3	24.5			
1.83	Colon Cancer Screening	62.2	74.4		66.4			...
1.83	People 65+ with Low Access to a Grocery Store	4.3						...
1.81	Atrial Fibrillation: Medicare Population	8.9		9	8.4			
1.81	Hyperlipidemia: Medicare Population	49.9		49.4	47.7			

1.58	Adults with Arthritis	29.8			25.1			...

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Portage County

SCORE	OLDER ADULTS	Portage County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.58	Depression: Medicare Population	21.4		20.4	18.4			
2.47	Atrial Fibrillation: Medicare Population	9.6		9	8.4			
2.31	Hyperlipidemia: Medicare Population	52.4		49.4	47.7			
2.25	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	36.3		36.1	33.5			
1.92	Osteoporosis: Medicare Population	6.2		6.2	6.6			
1.67	People 65+ with Low Access to a Grocery Store	3.6						...

1.64	Cancer: Medicare Population	8.3		8.4	8.4			

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	OLDER ADULTS	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.58	Cancer: Medicare Population	9		8.4	8.4			
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	37.2		36.1	33.5			
2.31	Atrial Fibrillation: Medicare Population	9.4		9	8.4			
2.14	Osteoporosis: Medicare Population	6.6		6.2	6.6			
1.92	Depression: Medicare Population	19		20.4	18.4			
1.81	Hyperlipidemia: Medicare Population	50		49.4	47.7			...

1.75	Adults with Arthritis	30			25.1			...
1.67	Consumer Expenditures: Eldercare	24.4		20.5	34.3			...
1.50	People 65+ with Low Access to a Grocery Store	2.5						...

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Stark County

SCORE	PHYSICAL ACTIVITY	Stark County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.31	Workers who Walk to Work	1.5		2.2	2.7			
2.14	Fast Food Restaurant Density	0.9						
2.00	People 65+ with Low Access to a Grocery Store	4.6						...
1.83	Children with Low Access to a Grocery Store	6.8						...

1.83	Low-Income and Low Access to a Grocery Store	8.1						...
1.67	Adults 20+ who are Obese	33.9	36					
1.58	Health Behaviors Ranking	46					...	...
1.53	Adults 20+ who are Sedentary	25.2						
1.53	Food Environment Index	7.4		6.8	7.8			
1.53	SNAP Certified Stores	0.7						...
1.50	Access to Exercise Opportunities	79.9		83.9	84			...
1.50	Grocery Store Density	0.2						...
1.50	WIC Certified Stores	0.1						...

HP2030 · Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	PHYSICAL ACTIVITY	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.31	Workers who Walk to Work	1.4		2.2	2.7			
2.00	Children with Low Access to a Grocery Store	7.2						...
1.83	People 65+ with Low Access to a Grocery Store	4.3						...
1.72	Adults 20+ who are Obese	32.2	36					
1.69	Fast Food Restaurant Density	0.8						
1.67	Grocery Store Density	0.2						...
1.67	Low-Income and Low Access to a Grocery Store	7.7						...
1.53	SNAP Certified Stores	0.8						

1.50	WIC Certified Stores	0.1						...

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Portage County

SCORE	PHYSICAL ACTIVITY	Portage County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.14	Fast Food Restaurant Density	0.9						
2.00	Grocery Store Density	0.1						
1.83	Children with Low Access to a Grocery Store	6.2						...
1.83	SNAP Certified Stores	0.6						...
1.67	Farmers Market Density	0				...	...	...
1.67	Low-Income and Low Access to a Grocery Store	7.8						...

1.67	People 65+ with Low Access to a Grocery Store	3.6						...
1.64	Workers who Walk to Work	2.4		2.2	2.7			
1.50	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	81.5		80.9	80.4			...
1.50	WIC Certified Stores	0.1						...

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Medina County

SCORE	PHYSICAL ACTIVITY	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.64	Workers who Walk to Work	0.9		2.2	2.7			
2.00	Grocery Store Density	0.1						
1.86	SNAP Certified Stores	0.6						

1.83	Children with Low Access to a Grocery Store	6.8						...
1.81	Fast Food Restaurant Density	0.7						
1.50	People 65+ with Low Access to a Grocery Store	2.5						...
1.50	WIC Certified Stores	0.1						...

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Table 12: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #4: Maternal, Fetal and Infant Health

Maternal, Fetal and Infant Health ranked 12th among all topic areas with a score of 1.35. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 12 below. See Appendix C for the full list of indicators categorized within this topic.

Stark County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Stark County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.25	Babies with Very Low Birth Weight	1.6		1.4	1.3		...	
1.89	Babies with Low Birth Weight	8.9		8.5	8.2		...	
1.58	Mothers who Smoked During Pregnancy	15	4.3	11.5	5.5		...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.67	Babies with Low Birth Weight	9.4		8.5	8.2		...	...
2.39	Babies with Very Low Birth Weight	1.7		1.4	1.3		...	...
1.97	Teen Birth Rate: 15-17	8		6.8			...	
1.83	Consumer Expenditures: Childcare	307		301.6	368.2			...
1.50	Preterm Births	9.9	9.4	10.3			...	

HP2030 · Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Portage County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Portage County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.22	Infant Mortality Rate	9.7	5	6.9		...	...	
1.86	Mothers who Smoked During Pregnancy	13.4	4.3	11.5	5.5		...	
1.83	Consumer Expenditures: Childcare	308.1		301.6	368.2			...
1.50	Preterm Births	9.8	9.4	10.3			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.33	Consumer Expenditures: Childcare	403.8		301.6	368.2			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 13: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #5: Socioeconomic Issues

Prevention & Safety ranked 17th among all health topics with a score of 1.21. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 13 below. Portage and Medina Counties did not have any indicators of concern. See Appendix C for the full list of indicators categorized within this topic.

Stark County

SCORE	PREVENTION & SAFETY	Stark County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.31	Age-Adjusted Death Rate due to Falls	11.7		10.5	9.5			
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.8		2.8	2.5	…	…	…
1.64	Death Rate due to Drug Poisoning	26.4		38.1	21			…

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	PREVENTION & SAFETY	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Age-Adjusted Death Rate due to Unintentional Poisonings	38.7		40.2	21.4			
1.86	Death Rate due to Drug Poisoning	36.7		38.1	21			

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 14: Secondary Data Scoring Results by Health Topic for The Akron General Community in Rank Order by Topic Score

HEALTH TOPICS	AVG
Medications & Prescriptions	1.94
Other Conditions	1.63
Mental Health & Mental Disorders	1.62
Nutrition & Healthy Eating	1.52
Physical Activity	1.50
Older Adults	1.50
Cancer	1.47
Women's Health	1.47
Alcohol & Drug Use	1.46
Tobacco Use	1.39
Children's Health	1.38
Maternal, Fetal & Infant Health	1.35
Health Care Access & Quality	1.34
Heart Disease & Stroke	1.33
Wellness & Lifestyle	1.33
Respiratory Diseases	1.23
Prevention & Safety	1.21
Oral Health	1.19
Diabetes	1.14
Immunizations & Infectious Diseases	1.02
QUALITY OF LIFE TOPIC	**SCORE**
Education	1.40
Environmental Health	1.37
Community	1.25
Economy	1.14

SCORE	ALCOHOL & DRUG USE	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	38.3	28.3	32.2	27	*2015-2019*	9
2.00	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	679.3		651.5	701.9	*2021*	7
1.86	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	36.7		38.1	21	*2017-2019*	9
1.75	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	40.1		42	22.8	*2017-2019*	5
1.42	Health Behaviors Ranking	*ranking*	27				*2021*	9
1.36	Mothers who Smoked During Pregnancy	*percent*	11.1	4.3	11.5	5.5	*2020*	17
1.17	Adults who Drink Excessively	*percent*	17.3		18.5	19	*2018*	9
1.08	Adults who Binge Drink	*percent*	15.4			16.7	*2019*	4
0.75	Liquor Store Density	*stores/ 100,000 population*	6.3		5.6	10.5	*2019*	22
SCORE	**CANCER**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.3		129.6	126.8	*2014-2018*	12
2.42	Cancer: Medicare Population	*percent*	8.5		8.4	8.4	*2018*	6
2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.8	15.3	21.6	19.9	*2015-2019*	12
2.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	20	16.9	19.4	18.9	*2015-2019*	12
1.83	Colon Cancer Screening	*percent*	62.2	74.4		66.4	*2018*	4
1.75	All Cancer Incidence Rate	*cases/ 100,000 population*	454.7		467.5	448.6	*2014-2018*	12

1.61	Mammogram in Past 2 Years: 50-74	*percent*	71.3	77.1		74.8	*2018*	4
1.58	Adults with Cancer	*percent*	8			7.1	*2019*	4
1.44	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	166.4	122.7	169.4	152.4	*2015-2019*	12
1.28	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	41	25.1	45	36.7	*2015-2019*	12
1.19	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.4		67.3	57.3	*2014-2018*	12
1.19	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	100.1		107.2	106.2	*2014-2018*	12
1.14	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	37.2		41.3	38	*2014-2018*	12
1.11	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.1	8.9	14.8	13.4	*2015-2019*	12
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.5	84.3		84.7	*2018*	4
0.69	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11		12.2	11.9	*2014-2018*	12
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5		7.9	7.7	*2014-2018*	12
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Children with Low Access to a Grocery Store	*percent*	7.2				*2015*	23
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.75	Projected Child Food Insecurity Rate	*percent*	19.1		18.5		*2021*	10
1.50	Child Food Insecurity Rate	*percent*	17.4		17.4	14.6	*2019*	10
1.33	Children with Health Insurance	*percent*	98		95.2	94.3	*2019*	1

1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.2		1.9		*2020*	19
0.78	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.1	8.7	6.8		*2020*	3
SCORE	**COMMUNITY**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.31	Workers who Walk to Work	*percent*	1.4		2.2	2.7	*2015-2019*	1
2.19	People 65+ Living Alone	*percent*	30.1		28.8	26.1	*2015-2019*	1
2.17	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	38.3	28.3	32.2	27	*2015-2019*	9
2.17	Single-Parent Households	*percent*	28.5		27.1	25.5	*2015-2019*	1
1.89	Violent Crime Rate	*crimes/ 100,000 population*	336.5		303.5	394	*2017*	18
1.86	Households without a Vehicle	*percent*	8.5		7.9	8.6	*2015-2019*	1
1.75	Workers who Drive Alone to Work	*percent*	85		82.9	76.3	*2015-2019*	1
1.67	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	123.1		121.7	148.8	*2021*	7
1.64	Linguistic Isolation	*percent*	1.4		1.4	4.4	*2015-2019*	1
1.58	Social and Economic Factors Ranking		47				*2021*	9
1.56	Workers Commuting by Public Transportation	*percent*	1.5	5.3	1.6	5	*2015-2019*	1
1.50	Households with One or More Types of Computing Devices	*percent*	88.6		89.1	90.3	*2015-2019*	1
1.42	Solo Drivers with a Long Commute	*percent*	29.2		31.1	37	*2015-2019*	9

1.36	Children Living Below Poverty Level	*percent*	19.2		19.9	18.5	*2015-2019*	1
1.33	Voter Turnout: Presidential Election	*percent*	74.7		74		*2020*	20
1.31	Social Associations	*membership associations/ 10,000 population*	11.3		11	9.3	*2018*	9
1.19	Young Children Living Below Poverty Level	*percent*	21.4		23	20.3	*2015-2019*	1
1.14	Mean Travel Time to Work	*minutes*	23.2		23.7	26.9	*2015-2019*	1
1.11	People Living Below Poverty Level	*percent*	13.2	8	14	13.4	*2015-2019*	1
1.00	Adults with Internet Access	*percent*	95		94.5	95	*2021*	8
1.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	1.4		2.8	2.5	*2015-2019*	5
1.00	Households with a Computer	*percent*	86.2		85.2	86.3	*2021*	8
1.00	Households with a Smartphone	*percent*	81.4		80.5	81.9	*2021*	8
1.00	Households with an Internet Subscription	*percent*	83		82.4	83	*2015-2019*	1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
1.00	Households with Wireless Phone Service	*percent*	97		96.8	97	*2020*	8
1.00	Persons with an Internet Subscription	*percent*	87.1		86.2	86.2	*2015-2019*	1
0.92	Homeownership	*percent*	60.1		59.4	56.2	*2015-2019*	1
0.92	Median Household Income	*dollars*	57181		56602	62843	*2015-2019*	1
0.78	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.1	8.7	6.8		*2020*	3
0.58	Per Capita Income	*dollars*	33606		31552	34103	*2015-2019*	1
0.42	Youth not in School or Working	*percent*	1.6		1.8	1.9	*2015-2019*	1

0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1
SCORE	**DIABETES**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.64	Adults 20+ with Diabetes	*percent*	9.5				*2019*	5
1.36	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	23.7		25.3	21.5	*2017-2019*	5
0.86	Diabetes: Medicare Population	*percent*	25.1		27.2	27	*2018*	6
SCORE	**ECONOMY**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.36	Households with Cash Public Assistance Income	*percent*	5.1		2.9	2.4	*2015-2019*	1
2.00	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	8092.4		7828	8900.1	*2021*	7
2.00	Income Inequality		0.5		0.5	0.5	*2015-2019*	1
1.75	Projected Child Food Insecurity Rate	*percent*	19.1		18.5		*2021*	10
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.7				*2015*	23
1.67	Renters Spending 30% or More of Household Income on Rent	*percent*	46.4		44.9	49.6	*2015-2019*	1
1.58	Persons with Disability Living in Poverty (5-year)	*percent*	30.2		29.5	26.1	*2015-2019*	1
1.58	Social and Economic Factors Ranking	*ranking*	47				*2021*	9
1.58	Unemployed Workers in Civilian Labor Force	*percent*	4.7		4.3	4.6	*Sep-21*	21

1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*	23
1.50	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.4		14.6	14.4	*2021*	8
1.50	Child Food Insecurity Rate	*percent*	17.4		17.4	14.6	*2019*	10
1.50	Food Insecurity Rate	*percent*	12.7		13.2	10.9	*2019*	10
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.36	Children Living Below Poverty Level	*percent*	19.2		19.9	18.5	*2015-2019*	1
1.36	Size of Labor Force	*persons*	264940				*Sept-21*	21
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	22.2		24.5		*2018*	25
1.25	Projected Food Insecurity Rate	*percent*	13.8		14.1		*2021*	10
1.19	Families Living Below Poverty Level	*percent*	9.4		9.9	9.5	*2015-2019*	1
1.19	Young Children Living Below Poverty Level	*percent*	21.4		23	20.3	*2015-2019*	1
1.17	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	66.1		61.6		*2018*	25
1.17	Households that are Below the Federal Poverty Level	*percent*	11.7		13.8		*2018*	25
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
1.11	People Living Below Poverty Level	*percent*	13.2	8	14	13.4	*2015-2019*	1
1.08	Severe Housing Problems	*percent*	13.6		13.7	18	*2013-2017*	9

0.97	People 65+ Living Below Poverty Level	*percent*	7.1		8.1	9.3	*2015-2019*	1
0.92	Homeownership	*percent*	60.1		59.4	56.2	*2015-2019*	1
0.92	Median Household Income	*dollars*	57181		56602	62843	*2015-2019*	1
0.86	Students Eligible for the Free Lunch Program	*percent*	15.4				*2019-2020*	13
0.83	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3632.3		3798.7	5460.2	*2021*	7
0.83	Households with a Savings Account	*percent*	70.4		68.8	70.2	*2021*	8
0.78	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.2		19.7	26.5	*2019*	1
0.75	People Living 200% Above Poverty Level	*percent*	69.9		68.8	69.1	*2015-2019*	1
0.58	Per Capita Income	*dollars*	33606		31552	34103	*2015-2019*	1
0.42	Youth not in School or Working	*percent*	1.6		1.8	1.9	*2015-2019*	1
SCORE	**EDUCATION**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.86	4th Grade Students Proficient in English/Language Arts	*percent*	56.5		63.3		*2018-2019*	15
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.83	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1208.5		1200.4	1492.4	*2021*	7
1.81	Student-to-Teacher Ratio	*students/ teacher*	16.8				*2019-2020*	13
1.69	4th Grade Students Proficient in Math	*percent*	67.4		74.3		*2018-2019*	15

1.58	8th Grade Students Proficient in English/Language Arts	*percent*	51.1		58.3		*2018-2019*	15
1.58	8th Grade Students Proficient in Math	*percent*	48.7		57.3		*2018-2019*	15
1.39	High School Graduation	*percent*	91.1	90.7	92		*2019-2020*	15
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.36	Asthma: Medicare Population	*percent*	5.8		4.8	5	*2018*	6
2.00	Children with Low Access to a Grocery Store	*percent*	7.2				*2015*	23
1.92	Adults with Current Asthma	*percent*	10.3			8.9	*2019*	4
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.75	Physical Environment Ranking	*ranking*	74				*2021*	9
1.72	Annual Ozone Air Quality		3				*2017-2019*	2
1.69	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*	23
1.67	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.7				*2015*	23
1.64	Number of Extreme Precipitation Days	*days*	32				*2019*	14
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23

1.44	Annual Particle Pollution		B				*2017-2019*	2
1.42	Houses Built Prior to 1950	*percent*	27		26.2	17.5	*2015-2019*	1
1.36	Food Environment Index	*index*	7.5		6.8	7.8	*2021*	9
1.36	Number of Extreme Heat Days	*days*	14				*2019*	14
1.36	Recognized Carcinogens Released into Air	*pounds*	97811.5				*2020*	24
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	1				*2020*	14
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
1.08	Severe Housing Problems	*percent*	13.6		13.7	18	*2013-2017*	9
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.2		1.9		*2020*	19
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
0.75	Liquor Store Density	*stores/ 100,000 population*	6.3		5.6	10.5	*2019*	22
0.50	Access to Exercise Opportunities	*percent*	94.1		83.9	84	*2020*	9
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1153.1		1098.6	1047.4	*2021*	7

2.17	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4543.8		4371.7	4321.1	*2021*	7
2.17	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	213.4		204.8	194.9	*2021*	7
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	664.9		638.9	609.6	*2021*	7
1.56	Persons without Health Insurance	*percent*	6.5		6.6		*2019*	1
1.50	Adults with Health Insurance	*percent*	90		90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	98		95.2	94.3	*2019*	1
1.25	Clinical Care Ranking	*ranking*	9				*2021*	9
1.00	Adults with Health Insurance: 18+	*percent*	90.9		90.2	90.6	*2021*	8
0.92	Adults who have had a Routine Checkup	*percent*	79.8			76.6	*2019*	4
0.83	Adults who Visited a Dentist	*percent*	53		51.6	52.9	*2021*	8
0.75	Adults without Health Insurance	*percent*	11.3			13	*2019*	4
0.75	Primary Care Provider Rate	*providers/ 100,000 population*	98		76.7		*2018*	9
0.67	Dentist Rate	*dentists/ 100,000 population*	64.1		64.2		*2019*	9
0.50	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	116.5		108.9		*2020*	9
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	292		261.3		*2020*	9
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

1.81	Atrial Fibrillation: Medicare Population	*percent*	8.9		9	8.4	*2018*	6
1.81	Hyperlipidemia: Medicare Population	*percent*	49.9		49.4	47.7	*2018*	6
1.58	Adults who Experienced a Stroke	*percent*	3.8			3.4	*2019*	4
1.56	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	39.1	33.4	42.5	37.2	*2017-2019*	5
1.42	Adults who Experienced Coronary Heart Disease	*percent*	7			6.2	*2019*	4
1.42	Cholesterol Test History	*percent*	85.6			87.6	*2019*	4
1.42	Stroke: Medicare Population	*percent*	3.9		3.8	3.8	*2018*	6
1.33	High Blood Pressure Prevalence	*percent*	34.7	27.7		32.6	*2019*	4
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.6			76.2	*2019*	4
1.17	Hypertension: Medicare Population	*percent*	57.3		59.5	57.2	*2018*	6
1.00	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	47.2		55.4		*2019*	14
0.92	Heart Failure: Medicare Population	*percent*	14.1		14.7	14	*2018*	6
0.92	High Cholesterol Prevalence: Adults 18+	*percent*	30.4			33.6	*2019*	4
0.86	Ischemic Heart Disease: Medicare Population	*percent*	24.8		27.5	26.8	*2018*	6
0.78	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	85.5	71.1	101.4	90.5	*2017-2019*	5

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.39	Chlamydia Incidence Rate	*cases/ 100,000 population*	640.8		561.9	551	*2019*	16
2.22	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.2	1.4	1.1		*2020*	16
2.08	Gonorrhea Incidence Rate	*cases/ 100,000 population*	241.2		224	187.8	*2019*	16
1.56	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	12.5	11.1	12.9		*2018*	16
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.1		0	0.5	*28-Jan-22*	11
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.4		48.6	49.4	*2021*	8
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	61.5				*28-Jan-22*	5
0.25	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.4		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	40		128.4	177.3	*28-Jan-22*	11
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.67	Babies with Low Birth Weight	*percent*	9.4		8.5	8.2	*2020*	17
2.39	Babies with Very Low Birth Weight	*percent*	1.7		1.4	1.3	*2020*	17
1.97	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	8		6.8		*2020*	17

1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.50	Preterm Births	*percent*	9.9	9.4	10.3		*2020*	17
1.36	Mothers who Smoked During Pregnancy	*percent*	11.1	4.3	11.5	5.5	*2020*	17
1.08	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	18.7		19.5		*2016*	17
1.00	Mothers who Received Early Prenatal Care	*percent*	71.7		68.9	76.1	*2020*	17
0.83	Infant Mortality Rate	*deaths/ 1,000 live births*	6	5	6.9		*2019*	17
SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1153.1		1098.6	1047.4	*2021*	7
2.17	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	213.4		204.8	194.9	*2021*	7
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	664.9		638.9	609.6	*2021*	7
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.75	Depression: Medicare Population	*percent*	21.8		20.4	18.4	*2018*	6
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	41		34	30.5	*2017-2019*	5
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.3		10.4	10.8	*2018*	6

1.83	Poor Mental Health: Average Number of Days	*days*	4.8		4.8	4.1	*2018*	9
1.61	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	16.2	12.8	15.1	14.1	*2017-2019*	5
1.58	Poor Mental Health: 14+ Days	*percent*	15.4			13.6	*2019*	4
1.25	Adults Ever Diagnosed with Depression	*percent*	19.5			18.8	*2019*	4
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	86.5		85.6	86.5	*2021*	8
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	292		261.3		*2020*	9
SCORE	**NUTRITION & HEALTHY EATING**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.17	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	531.5		519	530.2	*2021*	7
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1508.4		1461	1638.9	*2021*	7
1.83	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	324		319.7	357	*2021*	7
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.2		41.5	41.2	*2021*	8
1.50	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	885.9		864.6	1002.1	*2021*	7
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.6		80.9	80.4	*2021*	8

SCORE	OLDER ADULTS	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Depression: Medicare Population	*percent*	21.8		20.4	18.4	*2018*	6
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.7		36.1	33.5	*2018*	6
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	41		34	30.5	*2017-2019*	5
2.42	Cancer: Medicare Population	*percent*	8.5		8.4	8.4	*2018*	6
2.36	Asthma: Medicare Population	*percent*	5.8		4.8	5	*2018*	6
2.19	People 65+ Living Alone	*percent*	30.1		28.8	26.1	*2015-2019*	1
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.3		10.4	10.8	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6
1.92	Chronic Kidney Disease: Medicare Population	*percent*	24.7		25.3	24.5	*2018*	6
1.83	Colon Cancer Screening	*percent*	62.2	74.4		66.4	*2018*	4
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.81	Atrial Fibrillation: Medicare Population	*percent*	8.9		9	8.4	*2018*	6
1.81	Hyperlipidemia: Medicare Population	*percent*	49.9		49.4	47.7	*2018*	6
1.58	Adults with Arthritis	*percent*	29.8			25.1	*2019*	4
1.47	COPD: Medicare Population	*percent*	12.4		13.2	11.5	*2018*	6
1.42	Stroke: Medicare Population	*percent*	3.9		3.8	3.8	*2018*	6

1.25	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	33.7			32.4	*2018*	4
1.25	Adults 65+ with Total Tooth Loss	*percent*	14.8			13.5	*2018*	4
1.17	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	21.1		20.5	34.3	*2021*	7
1.17	Hypertension: Medicare Population	*percent*	57.3		59.5	57.2	*2018*	6
0.97	People 65+ Living Below Poverty Level	*percent*	7.1		8.1	9.3	*2015-2019*	1
0.92	Heart Failure: Medicare Population	*percent*	14.1		14.7	14	*2018*	6
0.86	Diabetes: Medicare Population	*percent*	25.1		27.2	27	*2018*	6
0.86	Ischemic Heart Disease: Medicare Population	*percent*	24.8		27.5	26.8	*2018*	6
0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	35.4			28.4	*2018*	4
0.08	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	6.9		10.5	9.5	*2017-2019*	5
SCORE	**ORAL HEALTH**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.25	Adults 65+ with Total Tooth Loss	*percent*	14.8			13.5	*2018*	4
0.83	Adults who Visited a Dentist	*percent*	53		51.6	52.9	*2021*	8
0.69	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11		12.2	11.9	*2014-2018*	12

0.67	Dentist Rate	*dentists/ 100,000 population*	64.1		64.2		*2019*	9
SCORE	**OTHER CONDITIONS**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.7		36.1	33.5	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6
1.92	Chronic Kidney Disease: Medicare Population	*percent*	24.7		25.3	24.5	*2018*	6
1.58	Adults with Arthritis	*percent*	29.8			25.1	*2019*	4
1.42	Adults with Kidney Disease	*Percent of adults*	3.2			3.1	*2019*	4
1.14	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	12.4		14.5	12.9	*2017-2019*	5
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.31	Workers who Walk to Work	*percent*	1.4		2.2	2.7	*2015-2019*	1
2.00	Children with Low Access to a Grocery Store	*percent*	7.2				*2015*	23
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.72	Adults 20+ who are Obese	*percent*	32.2	36			*2019*	5
1.69	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*	23
1.67	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23

1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.7				*2015*	23
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.42	Health Behaviors Ranking	*ranking*	27				*2021*	9
1.36	Adults 20+ who are Sedentary	*percent*	24.7				*2019*	5
1.36	Food Environment Index	*index*	7.5		6.8	7.8	*2021*	9
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.6		80.9	80.4	*2021*	8
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
0.50	Access to Exercise Opportunities	*percent*	94.1		83.9	84	*2020*	9
SCORE	**PREVENTION & SAFETY**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	38.7		40.2	21.4	*2017-2019*	5
1.86	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	36.7		38.1	21	*2017-2019*	9
1.44	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	59.6	43.2	68.8	48.9	*2017-2019*	5
1.08	Severe Housing Problems	*percent*	13.6		13.7	18	*2013-2017*	9

1.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	1.4		2.8	2.5	*2015-2019*	5
0.08	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	6.9		10.5	9.5	*2017-2019*	5
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.36	Asthma: Medicare Population	*percent*	5.8		4.8	5	*2018*	6
2.22	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.2	1.4	1.1		*2020*	16
1.92	Adults who Smoke	*percent*	23.3	5	21.4	17	*2018*	9
1.92	Adults with Current Asthma	*percent*	10.3			8.9	*2019*	4
1.83	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	483.4		487.9	422.4	*2021*	7
1.58	Adults with COPD	*Percent of adults*	8.9			6.6	*2019*	4
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.1		0	0.5	*28-Jan-22*	11
1.47	COPD: Medicare Population	*percent*	12.4		13.2	11.5	*2018*	6
1.36	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	44.8		47.8	39.6	*2017-2019*	5
1.28	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	41	25.1	45	36.7	*2015-2019*	12
1.19	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.4		67.3	57.3	*2014-2018*	12
1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.1		4.3	4.1	*2021*	8
0.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2		2.2	2	*2021*	8

0.25	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.4		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	40		128.4	177.3	*28-Jan-22*	11
SCORE	**TOBACCO USE**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Adults who Smoke	*percent*	23.3	5	21.4	17	*2018*	9
1.83	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	483.4		487.9	422.4	*2021*	7
1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.1		4.3	4.1	*2021*	8
0.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2		2.2	2	*2021*	8
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1508.4		1461	1638.9	*2021*	7
1.58	Insufficient Sleep	*percent*	38.6	31.4	40.6	35	*2018*	9
1.58	Morbidity Ranking	*ranking*	47				*2021*	9
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.2		41.5	41.2	*2021*	8
1.50	Life Expectancy	*years*	77.2		77	79.2	*2017-2019*	9
1.42	Poor Physical Health: 14+ Days	*percent*	14.2			12.5	*2019*	4
1.33	High Blood Pressure Prevalence	*percent*	34.7	27.7		32.6	*2019*	4
1.25	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.1			18.6	*2019*	4

1.17	Poor Physical Health: Average Number of Days	*days*	3.9		4.1	3.7	*2018*	9
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.6		80.9	80.4	*2021*	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.4		48.6	49.4	*2021*	8
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	86.5		85.6	86.5	*2021*	8
SCORE	**WOMEN'S HEALTH**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.3		129.6	126.8	*2014-2018*	12
2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.8	15.3	21.6	19.9	*2015-2019*	12
1.61	Mammogram in Past 2 Years: 50-74	*percent*	71.3	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.5	84.3		84.7	*2018*	4
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5		7.9	7.7	*2014-2018*	12

Summit Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

SCORE	ALCOHOL & DRUG USE	UNITS	STARK COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.64	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	26.4		38.1	21	*2017-2019*	9
1.58	Adults who Binge Drink	*percent*	16.6			16.7	*2019*	4
1.58	Health Behaviors Ranking	*ranking*	46				*2021*	9
1.58	Mothers who Smoked During Pregnancy	*percent*	15	4.3	11.5	5.5	*2020*	17
1.50	Adults who Drink Excessively	*percent*	18.8		18.5	19	*2018*	9
1.42	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	31.2		42	22.8	*2017-2019*	5
1.28	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	30.7	28.3	32.2	27	*2015-2019*	9
1.00	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	582.2		651.5	701.9	*2021*	7
0.58	Liquor Store Density	*stores/ 100,000 population*	5.7		5.6	10.5	*2019*	22
SCORE	**CANCER**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.39	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.2	15.3	21.6	19.9	*2015-2019*	12
2.06	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	170	122.7	169.4	152.4	*2015-2019*	12
2.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	19.7	16.9	19.4	18.9	*2015-2019*	12
1.75	Adults with Cancer	*percent*	8.2			7.1	*2019*	4
1.72	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8		7.9	7.7	*2014-2018*	12

1.67	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.9		12.2	11.9	*2014-2018*	12
1.64	Breast Cancer Incidence Rate	*cases/ 100,000 females*	124.5		129.6	126.8	*2014-2018*	12
1.64	Cancer: Medicare Population	*percent*	8.3		8.4	8.4	*2018*	6
1.47	All Cancer Incidence Rate	*cases/ 100,000 population*	453		467.5	448.6	*2014-2018*	12
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44.1	25.1	45	36.7	*2015-2019*	12
1.44	Cervical Cancer Screening: 21-65	*Percent*	84.2	84.3		84.7	*2018*	4
1.44	Mammogram in Past 2 Years: 50-74	*percent*	72.8	77.1		74.8	*2018*	4
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	64.9		67.3	57.3	*2014-2018*	12
1.33	Colon Cancer Screening	*percent*	66.3	74.4		66.4	*2018*	4
1.08	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	105.7		107.2	106.2	*2014-2018*	12
0.67	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	35.6		41.3	38	*2014-2018*	12
0.61	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	12.4	8.9	14.8	13.4	*2015-2019*	12
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Child Food Insecurity Rate	*percent*	18.2		17.4	14.6	*2019*	10
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.75	Projected Child Food Insecurity Rate	*percent*	19.4		18.5		*2021*	10

1.33	Children with Health Insurance	*percent*	95.7		95.2	94.3	*2019*	1
1.19	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.5		1.9		*2020*	19
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	235.6		301.6	368.2	*2021*	7
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
0.50	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.4	8.7	6.8		*2020*	3
SCORE	**COMMUNITY**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.31	Workers who Walk to Work	*percent*	1.5		2.2	2.7	*2015-2019*	1
2.31	Youth not in School or Working	*percent*	2.3		1.8	1.9	*2015-2019*	1
2.17	Single-Parent Households	*percent*	28.2		27.1	25.5	*2015-2019*	1
2.14	Children Living Below Poverty Level	*percent*	21.4		19.9	18.5	*2015-2019*	1
2.03	Workers who Drive Alone to Work	*percent*	85		82.9	76.3	*2015-2019*	1
2.03	Young Children Living Below Poverty Level	*percent*	25.8		23	20.3	*2015-2019*	1
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.8		2.8	2.5	*2015-2019*	5
1.75	Violent Crime Rate	*crimes/ 100,000 population*	345.5		303.5	394	*2017*	18

1.72	Workers Commuting by Public Transportation	*percent*	1.2	5.3	1.6	5	*2015-2019*	1
1.69	People 25+ with a Bachelor's Degree or Higher	*percent*	22.8		28.3	32.1	*2015-2019*	1
1.67	Households with a Smartphone	*percent*	78.3		80.5	81.9	*2021*	8
1.64	People 65+ Living Alone	*percent*	27.2		28.8	26.1	*2015-2019*	1
1.58	Social and Economic Factors Ranking	*ranking*	45				*2021*	9
1.50	Adults with Internet Access	*percent*	93.7		94.5	95	*2021*	8
1.50	Households with a Computer	*percent*	84		85.2	86.3	*2021*	8
1.50	Households with One or More Types of Computing Devices	*percent*	88.9		89.1	90.3	*2015-2019*	1
1.50	Households with Wireless Phone Service	*percent*	96.4		96.8	97	*2020*	8
1.42	Median Household Income	*dollars*	53860		56602	62843	*2015-2019*	1
1.28	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	30.7	28.3	32.2	27	*2015-2019*	9
1.25	Per Capita Income	*dollars*	29495		31552	34103	*2015-2019*	1
1.17	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	109.5		121.7	148.8	*2021*	7
1.17	Households with No Car and Low Access to a Grocery Store	*percent*	1.8				*2015*	23
1.17	People Living Below Poverty Level	*percent*	13.6	8	14	13.4	*2015-2019*	1
1.03	Homeownership	*percent*	62.8		59.4	56.2	*2015-2019*	1

1.03	Households without a Vehicle	*percent*	7		7.9	8.6	*2015-2019*	1
0.97	Mean Travel Time to Work	*minutes*	22.1		23.7	26.9	*2015-2019*	1
0.97	Social Associations	*membership associations/ 10,000 population*	12.2		11	9.3	*2018*	9
0.92	Voter Turnout: Presidential Election	*percent*	75.6		74		*2020*	20
0.86	Linguistic Isolation	*percent*	0.6		1.4	4.4	*2015-2019*	1
0.83	Households with an Internet Subscription	*percent*	83.3		82.4	83	*2015-2019*	1
0.83	Persons with an Internet Subscription	*percent*	87.8		86.2	86.2	*2015-2019*	1
0.81	Solo Drivers with a Long Commute	*percent*	26.3		31.1	37	*2015-2019*	9
0.50	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.4	8.7	6.8		*2020*	3
SCORE	**DIABETES**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.36	Adults 20+ with Diabetes	*percent*	9.4				*2019*	5
1.36	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	24.6		25.3	21.5	*2017-2019*	5
1.00	Diabetes: Medicare Population	*percent*	26		27.2	27	*2018*	6
SCORE	**ECONOMY**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.42	Persons with Disability Living in Poverty (5-year)	*percent*	30.4		29.5	26.1	*2015-2019*	1

2.36	Households with Cash Public Assistance Income	*percent*	6.2		2.9	2.4	*2015-2019*	1
2.31	Youth not in School or Working	*percent*	2.3		1.8	1.9	*2015-2019*	1
2.14	Children Living Below Poverty Level	*percent*	21.4		19.9	18.5	*2015-2019*	1
2.03	Young Children Living Below Poverty Level	*percent*	25.8		23	20.3	*2015-2019*	1
2.00	Child Food Insecurity Rate	*percent*	18.2		17.4	14.6	*2019*	10
2.00	Food Insecurity Rate	*percent*	13.4		13.2	10.9	*2019*	10
1.83	Low-Income and Low Access to a Grocery Store	*percent*	8.1				*2015*	23
1.75	Projected Child Food Insecurity Rate	*percent*	19.4		18.5		*2021*	10
1.69	Families Living Below Poverty Level	*percent*	10		9.9	9.5	*2015-2019*	1
1.58	Projected Food Insecurity Rate	*percent*	14.2		14.1		*2021*	10
1.58	Social and Economic Factors Ranking		45				*2021*	9
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.50	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.6		14.6	14.4	*2021*	8
1.50	Households that are Below the Federal Poverty Level	*percent*	13.6		13.8		*2018*	25
1.50	Households with a Savings Account	*percent*	67.7		68.8	70.2	*2021*	8
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.42	Median Household Income	*dollars*	53860		56602	62843	*2015-2019*	1

1.36	People Living 200% Above Poverty Level	*percent*	68.7		68.8	69.1	*2015-2019*	1
1.36	Size of Labor Force	*persons*	180742				*Sept-21*	21
1.33	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	63		61.6		*2018*	25
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	23.4		24.5		*2018*	25
1.33	Income Inequality		0.4		0.5	0.5	*2015-2019*	1
1.25	Per Capita Income	*dollars*	29495		31552	34103	*2015-2019*	1
1.25	Unemployed Workers in Civilian Labor Force	*percent*	4.5		4.3	4.6	*Sep-21*	21
1.17	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7332		7828	8900.1	*2021*	7
1.17	People Living Below Poverty Level	*percent*	13.6	8	14	13.4	*2015-2019*	1
1.14	Overcrowded Households	*percent of households*	0.9		1.4		*2015-2019*	1
1.03	Homeownership	*percent*	62.8		59.4	56.2	*2015-2019*	1
1.00	Renters Spending 30% or More of Household Income on Rent	*percent*	42.4		44.9	49.6	*2015-2019*	1
0.86	Students Eligible for the Free Lunch Program	*percent*	18.9				*2019-2020*	13
0.83	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3729.7		3798.7	5460.2	*2021*	7
0.69	People 65+ Living Below Poverty Level	*percent*	7.2		8.1	9.3	*2015-2019*	1

0.50	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.4		19.7	26.5	*2019*	1
0.42	Severe Housing Problems	*percent*	11.8		13.7	18	*2013-2017*	9
SCORE	**EDUCATION**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.86	4th Grade Students Proficient in English/Language Arts	*percent*	47.8		63.3		*2018-2019*	15
1.86	8th Grade Students Proficient in English/Language Arts	*percent*	43.1		58.3		*2018-2019*	15
1.86	8th Grade Students Proficient in Math	*percent*	36.4		57.3		*2018-2019*	15
1.69	People 25+ with a Bachelor's Degree or Higher	*percent*	22.8		28.3	32.1	*2015-2019*	1
1.58	4th Grade Students Proficient in Math	*percent*	60.9		74.3		*2018-2019*	15
1.58	Student-to-Teacher Ratio	*students/ teacher*	18.2				*2019-2020*	13
1.33	High School Graduation	*percent*	92.4	90.7	92		*2019-2020*	15
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	235.6		301.6	368.2	*2021*	7
1.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	993.7		1200.4	1492.4	*2021*	7
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
2.08	Adults with Current Asthma	*percent*	10.6			8.9	*2019*	4
2.00	People 65+ with Low Access to a Grocery Store	*percent*	4.6				*2015*	23
1.86	Houses Built Prior to 1950	*percent*	28.8		26.2	17.5	*2015-2019*	1
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.83	Low-Income and Low Access to a Grocery Store	*percent*	8.1				*2015*	23
1.75	Physical Environment Ranking	*ranking*	80				*2021*	9
1.64	Number of Extreme Heat Events	*events*	11				*2019*	14
1.64	Number of Extreme Precipitation Days	*days*	32				*2019*	14
1.64	PBT Released	*pounds*	303331.9				*2020*	24
1.53	Food Environment Index	*index*	7.4		6.8	7.8	*2021*	9
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.50	Access to Exercise Opportunities	*percent*	79.9		83.9	84	*2020*	9
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.44	Annual Ozone Air Quality		C				*2017-2019*	2
1.42	Asthma: Medicare Population	*percent*	4.9		4.8	5	*2018*	6
1.36	Number of Extreme Heat Days	*days*	16				*2019*	14

1.36	Recognized Carcinogens Released into Air	*pounds*	24022.5				*2020*	24
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	3				*2020*	14
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.33	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.19	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.5		1.9		*2020*	19
1.17	Households with No Car and Low Access to a Grocery Store	*percent*	1.8				*2015*	23
1.14	Overcrowded Households	*percent of households*	0.9		1.4		*2015-2019*	1
1.11	Annual Particle Pollution		A				*2017-2019*	2
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
0.58	Liquor Store Density	*stores/ 100,000 population*	5.7		5.6	10.5	*2019*	22
0.42	Severe Housing Problems	*percent*	11.8		13.7	18	*2013-2017*	9
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.56	Persons without Health Insurance	*percent*	6.2		6.6		*2019*	1
1.50	Adults who Visited a Dentist	*percent*	50.8		51.6	52.9	*2021*	8
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	621.5		638.9	609.6	*2021*	7

1.33	Adults with Health Insurance	*percent*	91.1		90.9	87.1	*2019*	1
1.33	Adults with Health Insurance: 18+	*percent*	90.3		90.2	90.6	*2021*	8
1.33	Children with Health Insurance	*percent*	95.7		95.2	94.3	*2019*	1
1.33	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4213.3		4371.7	4321.1	*2021*	7
1.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1021.4		1098.6	1047.4	*2021*	7
1.33	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	191.1		204.8	194.9	*2021*	7
1.25	Clinical Care Ranking	*ranking*	16				*2021*	9
1.08	Adults without Health Insurance	*percent*	11.8			13	*2019*	4
0.92	Adults who have had a Routine Checkup	*percent*	79.3			76.6	*2019*	4
0.92	Dentist Rate	*dentists/ 100,000 population*	64.8		64.2		*2019*	9
0.83	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	99.3		108.9		*2020*	9
0.78	Primary Care Provider Rate	*providers/ 100,000 population*	79.4		76.7		*2018*	9
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	294.9		261.3		*2020*	9
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.33	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	41.4	33.4	42.5	37.2	*2017-2019*	5
2.14	Hyperlipidemia: Medicare Population	*percent*	51.7		49.4	47.7	*2018*	6
1.83	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	62.8		55.4		*2019*	14
1.81	Heart Failure: Medicare Population	*percent*	14.8		14.7	14	*2018*	6
1.75	Adults who Experienced Coronary Heart Disease	*percent*	8			6.2	*2019*	4
1.64	Atrial Fibrillation: Medicare Population	*percent*	8.7		9	8.4	*2018*	6
1.58	Adults who Experienced a Stroke	*percent*	4			3.4	*2019*	4
1.42	Cholesterol Test History	*percent*	85.5			87.6	*2019*	4
1.33	High Blood Pressure Prevalence	*percent*	34.6	27.7		32.6	*2019*	4
1.17	Hypertension: Medicare Population	*percent*	58.5		59.5	57.2	*2018*	6
1.08	Adults who Have Taken Medications for High Blood Pressure	*percent*	79.7			76.2	*2019*	4
0.92	High Cholesterol Prevalence: Adults 18+	*percent*	31.9			33.6	*2019*	4
0.86	Ischemic Heart Disease: Medicare Population	*percent*	25.6		27.5	26.8	*2018*	6
0.67	Stroke: Medicare Population	*percent*	3.3		3.8	3.8	*2018*	6

0.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	89.8	71.1	101.4	90.5	*2017-2019*	5
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	16.4	11.1	12.9		*2018*	16
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.1		0	0.5	*28-Jan-22*	11
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.3		48.6	49.4	*2021*	8
1.14	Overcrowded Households	*percent of households*	0.9		1.4		*2015-2019*	1
1.11	Chlamydia Incidence Rate	*cases/ 100,000 population*	483.8		561.9	551	*2019*	16
1.11	Gonorrhea Incidence Rate	*cases/ 100,000 population*	144.9		224	187.8	*2019*	16
0.92	Persons Fully Vaccinated Against COVID-19	*percent*	53.2				*28-Jan-22*	5
0.78	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	16
0.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.2		14.4	13.8	*2017-2019*	5
0.36	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	58.4		128.4	177.3	*28-Jan-22*	11
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.25	Babies with Very Low Birth Weight	*percent*	1.6		1.4	1.3	*2020*	17

1.89	Babies with Low Birth Weight	*percent*	8.9		8.5	8.2	*2020*	17
1.58	Mothers who Smoked During Pregnancy	*percent*	15	4.3	11.5	5.5	*2020*	17
1.36	Preterm Births	*percent*	9.9	9.4	10.3		*2020*	17
1.36	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	18.7		19.5		*2016*	17
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	235.6		301.6	368.2	*2021*	7
1.06	Infant Mortality Rate	*deaths/ 1,000 live births*	5.4	5	6.9		*2019*	17
1.03	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	5.9		6.8		*2020*	17
1.00	Mothers who Received Early Prenatal Care	*percent*	69.1		68.9	76.1	*2020*	17
SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	621.5		638.9	609.6	*2021*	7
1.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1021.4		1098.6	1047.4	*2021*	7
1.33	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	191.1		204.8	194.9	*2021*	7
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.92	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	52.5		34	30.5	*2017-2019*	5

2.64	Alzheimer's Disease or Dementia: Medicare Population	*percent*	12		10.4	10.8	*2018*	6
2.58	Depression: Medicare Population	*percent*	21		20.4	18.4	*2018*	6
2.39	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	19.6	12.8	15.1	14.1	*2017-2019*	5
2.00	Poor Mental Health: Average Number of Days	*days*	5		4.8	4.1	*2018*	9
1.75	Poor Mental Health: 14+ Days	*percent*	16.1			13.6	*2019*	4
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.7		85.6	86.5	*2021*	8
1.42	Adults Ever Diagnosed with Depression	*percent*	21.1			18.8	*2019*	4
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	294.9		261.3		*2020*	9
SCORE	**NUTRITION & HEALTHY EATING**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	805		864.6	1002.1	*2021*	7
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.3		41.5	41.2	*2021*	8
1.33	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	81.1		80.9	80.4	*2021*	8

1.33	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	490.4		519	530.2	*2021*	7
1.17	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1328.1		1461	1638.9	*2021*	7
1.00	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	300.8		319.7	357	*2021*	7
SCORE	**OLDER ADULTS**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.92	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	52.5		34	30.5	*2017-2019*	5
2.64	Alzheimer's Disease or Dementia: Medicare Population	*percent*	12		10.4	10.8	*2018*	6
2.58	Depression: Medicare Population	*percent*	21		20.4	18.4	*2018*	6
2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.7		10.5	9.5	*2017-2019*	5
2.25	Chronic Kidney Disease: Medicare Population	*percent*	25.8		25.3	24.5	*2018*	6
2.14	Hyperlipidemia: Medicare Population	*percent*	51.7		49.4	47.7	*2018*	6
2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.9		36.1	33.5	*2018*	6
2.00	People 65+ with Low Access to a Grocery Store	*percent*	4.6				*2015*	23
1.81	Heart Failure: Medicare Population	*percent*	14.8		14.7	14	*2018*	6
1.75	Adults with Arthritis	*percent*	31.5			25.1	*2019*	4

1.67	Osteoporosis: Medicare Population	*percent*	6.3		6.2	6.6	*2018*	6
1.64	Atrial Fibrillation: Medicare Population	*percent*	8.7		9	8.4	*2018*	6
1.64	Cancer: Medicare Population	*percent*	8.3		8.4	8.4	*2018*	6
1.64	People 65+ Living Alone	*percent*	27.2		28.8	26.1	*2015-2019*	1
1.58	Adults 65+ with Total Tooth Loss	*percent*	16.2			13.5	*2018*	4
1.42	Asthma: Medicare Population	*percent*	4.9		4.8	5	*2018*	6
1.33	Colon Cancer Screening	*percent*	66.3	74.4		66.4	*2018*	4
1.17	Hypertension: Medicare Population	*percent*	58.5		59.5	57.2	*2018*	6
1.08	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	31.6			28.4	*2018*	4
1.03	COPD: Medicare Population	*percent*	12.1		13.2	11.5	*2018*	6
1.00	Diabetes: Medicare Population	*percent*	26		27.2	27	*2018*	6
0.92	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	34			32.4	*2018*	4
0.86	Ischemic Heart Disease: Medicare Population	*percent*	25.6		27.5	26.8	*2018*	6
0.83	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	19.9		20.5	34.3	*2021*	7
0.69	People 65+ Living Below Poverty Level	*percent*	7.2		8.1	9.3	*2015-2019*	1

0.67	Stroke: Medicare Population	*percent*	3.3		3.8	3.8	*2018*	6
SCORE	**ORAL HEALTH**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.67	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.9		12.2	11.9	*2014-2018*	12
1.58	Adults 65+ with Total Tooth Loss	*percent*	16.2			13.5	*2018*	4
1.50	Adults who Visited a Dentist	*percent*	50.8		51.6	52.9	*2021*	8
0.92	Dentist Rate	*dentists/ 100,000 population*	64.8		64.2		*2019*	9
SCORE	**OTHER CONDITIONS**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.25	Chronic Kidney Disease: Medicare Population	*percent*	25.8		25.3	24.5	*2018*	6
2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.9		36.1	33.5	*2018*	6
1.75	Adults with Arthritis	*percent*	31.5			25.1	*2019*	4
1.67	Osteoporosis: Medicare Population	*percent*	6.3		6.2	6.6	*2018*	6
1.47	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	13.6		14.5	12.9	*2017-2019*	5
1.42	Adults with Kidney Disease	*Percent of adults*	3.3			3.1	*2019*	4
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.31	Workers who Walk to Work	*percent*	1.5		2.2	2.7	*2015-2019*	1
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
2.00	People 65+ with Low Access to a Grocery Store	*percent*	4.6				*2015*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.83	Low-Income and Low Access to a Grocery Store	*percent*	8.1				*2015*	23
1.67	Adults 20+ who are Obese	*percent*	33.9	36			*2019*	5
1.58	Health Behaviors Ranking	*ranking*	46				*2021*	9
1.53	Adults 20+ who are Sedentary	*percent*	25.2				*2019*	5
1.53	Food Environment Index	*index*	7.4		6.8	7.8	*2021*	9
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.50	Access to Exercise Opportunities	*percent*	79.9		83.9	84	*2020*	9
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.33	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	81.1		80.9	80.4	*2021*	8
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.33	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.17	Households with No Car and Low Access to a Grocery Store	*percent*	1.8				*2015*	23

SCORE	PREVENTION & SAFETY	UNITS	STARK COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.7		10.5	9.5	*2017-2019*	5
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.8		2.8	2.5	*2015-2019*	5
1.64	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	26.4		38.1	21	*2017-2019*	9
1.47	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	29.1		40.2	21.4	*2017-2019*	5
1.39	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	56.8	43.2	68.8	48.9	*2017-2019*	5
0.42	Severe Housing Problems	*percent*	11.8		13.7	18	*2013-2017*	9
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.42	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	52.8		47.8	39.6	*2017-2019*	5
2.25	Adults who Smoke	*percent*	24.1	5	21.4	17	*2018*	9
2.08	Adults with Current Asthma	*percent*	10.6			8.9	*2019*	4
1.83	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	475.7		487.9	422.4	*2021*	7
1.75	Adults with COPD	*Percent of adults*	9.7			6.6	*2019*	4

1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.1		0	0.5	*28-Jan-22*	11
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44.1	25.1	45	36.7	*2015-2019*	12
1.42	Asthma: Medicare Population	*percent*	4.9		4.8	5	*2018*	6
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	64.9		67.3	57.3	*2014-2018*	12
1.03	COPD: Medicare Population	*percent*	12.1		13.2	11.5	*2018*	6
1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.1		4.3	4.1	*2021*	8
1.00	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.2		2.2	2	*2021*	8
0.78	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	16
0.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.2		14.4	13.8	*2017-2019*	5
0.36	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	58.4		128.4	177.3	*28-Jan-22*	11
SCORE	**TOBACCO USE**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.25	Adults who Smoke	*percent*	24.1	5	21.4	17	*2018*	9
1.83	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	475.7		487.9	422.4	*2021*	7

1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.1		4.3	4.1	*2021*	8
1.00	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.2		2.2	2	*2021*	8
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Insufficient Sleep	*percent*	40.1	31.4	40.6	35	*2018*	9
1.75	Poor Physical Health: 14+ Days	*percent*	14.9			12.5	*2019*	4
1.67	Life Expectancy	*years*	77		77	79.2	*2017-2019*	9
1.67	Poor Physical Health: Average Number of Days	*days*	4.3		4.1	3.7	*2018*	9
1.58	Morbidity Ranking	*ranking*	57				*2021*	9
1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.1			18.6	*2019*	4
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.3		48.6	49.4	*2021*	8
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.3		41.5	41.2	*2021*	8
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.7		85.6	86.5	*2021*	8
1.33	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	81.1		80.9	80.4	*2021*	8

1.33	High Blood Pressure Prevalence	*percent*	34.6	27.7		32.6	*2019*	4
1.17	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1328.1		1461	1638.9	*2021*	7
SCORE	**WOMEN'S HEALTH**	**UNITS**	**STARK COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.39	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.2	15.3	21.6	19.9	*2015-2019*	12
1.72	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8		7.9	7.7	*2014-2018*	12
1.64	Breast Cancer Incidence Rate	*cases/ 100,000 females*	124.5		129.6	126.8	*2014-2018*	12
1.44	Cervical Cancer Screening: 21-65	*Percent*	84.2	84.3		84.7	*2018*	4
1.44	Mammogram in Past 2 Years: 50-74	*percent*	72.8	77.1		74.8	*2018*	4

Stark Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

SCORE	ALCOHOL & DRUG USE	UNITS	PORTAGE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.92	Adults who Binge Drink	*percent*	18.2			16.7	*2019*	4
1.86	Mothers who Smoked During Pregnancy	*percent*	13.4	4.3	11.5	5.5	*2020*	17
1.83	Adults who Drink Excessively	*percent*	19.2		18.5	19	*2018*	9
1.83	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	653.2		651.5	701.9	*2021*	7
1.67	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	29.2	28.3	32.2	27	*2015-2019*	9
1.25	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	26.4		42	22.8	*2017-2019*	5
1.25	Health Behaviors Ranking	*ranking*	7				*2021*	9
1.03	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	21.7		38.1	21	*2017-2019*	9
0.97	Liquor Store Density	*stores/ 100,000 population*	5.5		5.6	10.5	*2019*	22
SCORE	**CANCER**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.72	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	18.4	8.9	14.8	13.4	*2015-2019*	12
2.42	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	43.6		41.3	38	*2014-2018*	12
1.81	All Cancer Incidence Rate	*cases/ 100,000 population*	467.9		467.5	448.6	*2014-2018*	12
1.81	Breast Cancer Incidence Rate	*cases/ 100,000 females*	128.7		129.6	126.8	*2014-2018*	12
1.81	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.7		12.2	11.9	*2014-2018*	12
1.78	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	173	122.7	169.4	152.4	*2015-2019*	12
1.64	Cancer: Medicare Population	*percent*	8.3		8.4	8.4	*2018*	6
1.61	Cervical Cancer Screening: 21-65	*Percent*	83.7	84.3		84.7	*2018*	4
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44	25.1	45	36.7	*2015-2019*	12
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	64		67.3	57.3	*2014-2018*	12
1.33	Colon Cancer Screening	*percent*	65.4	74.4		66.4	*2018*	4
1.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20.4	15.3	21.6	19.9	*2015-2019*	12

1.25	Adults with Cancer	*percent*	7.4			7.1	*2019*	4
1.06	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.9	7.7	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	75.6	77.1		74.8	*2018*	4
0.92	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	98.2		107.2	106.2	*2014-2018*	12
0.61	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	16	16.9	19.4	18.9	*2015-2019*	12
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Children with Low Access to a Grocery Store	*percent*	6.2				*2015*	23
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	308.1		301.6	368.2	*2021*	7
1.33	Child Food Insecurity Rate	*percent*	15.7		17.4	14.6	*2019*	10
1.33	Children with Health Insurance	*percent*	96.9		95.2	94.3	*2019*	1
1.31	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.31	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.2		1.9		*2020*	19

1.25	Projected Child Food Insecurity Rate	*percent*	16.7		18.5		*2021*	10
1.11	Substantiated Child Abuse Rate	*cases/ 1,000 children*	6.4	8.7	6.8		*2020*	3
SCORE	**COMMUNITY**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.42	Solo Drivers with a Long Commute	*percent*	40		31.1	37	*2015-2019*	9
2.31	Social Associations	*membership associations/ 10,000 population*	8.7		11	9.3	*2018*	9
2.06	Workers Commuting by Public Transportation	*percent*	0.6	5.3	1.6	5	*2015-2019*	1
1.81	Mean Travel Time to Work	*minutes*	25.7		23.7	26.9	*2015-2019*	1
1.67	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	29.2	28.3	32.2	27	*2015-2019*	9
1.64	Workers who Walk to Work	*percent*	2.4		2.2	2.7	*2015-2019*	1
1.53	Workers who Drive Alone to Work	*percent*	83.6		82.9	76.3	*2015-2019*	1
1.50	Households with an Internet Subscription	*percent*	81.6		82.4	83	*2015-2019*	1
1.42	Social and Economic Factors Ranking	*ranking*	29				*2021*	9
1.33	Consumer Expenditures: Local Public Transportation	*average dollar amount per*	119.1		121.7	148.8	*2021*	7

		consumer unit						
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.3				*2015*	23
1.25	Per Capita Income	*dollars*	30054		31552	34103	*2015-2019*	1
1.19	Voter Turnout: Presidential Election	*percent*	76.7		74		*2020*	20
1.19	Young Children Living Below Poverty Level	*percent*	21.4		23	20.3	*2015-2019*	1
1.17	Households with Wireless Phone Service	*percent*	96.7		96.8	97	*2020*	8
1.14	Households without a Vehicle	*percent*	6.3		7.9	8.6	*2015-2019*	1
1.11	Substantiated Child Abuse Rate	*cases/ 1,000 children*	6.4	8.7	6.8		*2020*	3
1.03	Homeownership	*percent*	62.2		59.4	56.2	*2015-2019*	1
1.00	Persons with an Internet Subscription	*percent*	86.4		86.2	86.2	*2015-2019*	1
0.97	People 65+ Living Alone	*percent*	25.5		28.8	26.1	*2015-2019*	1
0.92	Median Household Income	*dollars*	57618		56602	62843	*2015-2019*	1
0.86	Linguistic Isolation	*percent*	0.9		1.4	4.4	*2015-2019*	1
0.83	Adults with Internet Access	*percent*	95.3		94.5	95	*2021*	8
0.83	Households with a Computer	*percent*	86.9		85.2	86.3	*2021*	8
0.83	Households with a Smartphone	*percent*	82.1		80.5	81.9	*2021*	8
0.83	Households with One or More Types of Computing Devices	*percent*	90.8		89.1	90.3	*2015-2019*	1
0.83	People Living Below Poverty Level	*percent*	12.8	8	14	13.4	*2015-2019*	1

0.78	Violent Crime Rate	*crimes/ 100,000 population*	90.8		303.5	394	*2017*	18
0.69	Single-Parent Households	*percent*	21.8		27.1	25.5	*2015-2019*	1
0.58	People 25+ with a Bachelor's Degree or Higher	*percent*	29		28.3	32.1	*2015-2019*	1
0.42	Children Living Below Poverty Level	*percent*	15.9		19.9	18.5	*2015-2019*	1
0.08	Youth not in School or Working	*percent*	0.3		1.8	1.9	*2015-2019*	1
SCORE	**DIABETES**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.36	Adults 20+ with Diabetes	*percent*	9				*2019*	5
1.03	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	23.1		25.3	21.5	*2017-2019*	5
1.00	Diabetes: Medicare Population	*percent*	25.4		27.2	27	*2018*	6
SCORE	**ECONOMY**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.47	Renters Spending 30% or More of Household Income on Rent	*percent*	53.2		44.9	49.6	*2015-2019*	1
1.83	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.67	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	26.6		24.5		*2018*	25

1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.8				*2015*	23
1.64	Income Inequality		0.5		0.5	0.5	*2015-2019*	1
1.50	Food Insecurity Rate	*percent*	12.7		13.2	10.9	*2019*	10
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.42	Social and Economic Factors Ranking	*ranking*	29				*2021*	9
1.36	Size of Labor Force	*persons*	84476				*Sept-21*	21
1.33	Child Food Insecurity Rate	*percent*	15.7		17.4	14.6	*2019*	10
1.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7482		7828	8900.1	*2021*	7
1.33	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	62.4		61.6		*2018*	25
1.25	Per Capita Income	*dollars*	30054		31552	34103	*2015-2019*	1
1.25	Projected Child Food Insecurity Rate	*percent*	16.7		18.5		*2021*	10
1.25	Projected Food Insecurity Rate	*percent*	13.5		14.1		*2021*	10
1.25	Severe Housing Problems	*percent*	14.4		13.7	18	*2013-2017*	9
1.19	Persons with Disability Living in Poverty (5-year)	*percent*	26.8		29.5	26.1	*2015-2019*	1
1.19	Young Children Living Below Poverty Level	*percent*	21.4		23	20.3	*2015-2019*	1

1.17	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.2		14.6	14.4	*2021*	8
1.17	Households that are Below the Federal Poverty Level	*percent*	11		13.8		*2018*	25
1.03	Homeownership	*percent*	62.2		59.4	56.2	*2015-2019*	1
0.92	Median Household Income	*dollars*	57618		56602	62843	*2015-2019*	1
0.86	Households with Cash Public Assistance Income	*percent*	2		2.9	2.4	*2015-2019*	1
0.86	Overcrowded Households	*percent of households*	0.8		1.4		*2015-2019*	1
0.83	Households with a Savings Account	*percent*	70.2		68.8	70.2	*2021*	8
0.83	People Living Below Poverty Level	*percent*	12.8	8	14	13.4	*2015-2019*	1
0.75	People Living 200% Above Poverty Level	*percent*	71		68.8	69.1	*2015-2019*	1
0.75	Students Eligible for the Free Lunch Program	*percent*	20.6				*2019-2020*	13
0.75	Unemployed Workers in Civilian Labor Force	*percent*	4		4.3	4.6	*Sep-21*	21
0.50	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3401.4		3798.7	5460.2	*2021*	7
0.50	People 65+ Living Below Poverty Level	*percent*	5.5		8.1	9.3	*2015-2019*	1
0.42	Children Living Below Poverty Level	*percent*	15.9		19.9	18.5	*2015-2019*	1

0.42	Families Living Below Poverty Level	*percent*	8.4		9.9	9.5	*2015-2019*	1
0.33	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	17.4		19.7	26.5	*2019*	1
0.08	Youth not in School or Working	*percent*	0.3		1.8	1.9	*2015-2019*	1
SCORE	**EDUCATION**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
0.86	4th Grade Students Proficient in English/Language Arts	*percent*	77.1		63.3		*2018-2019*	15
1.14	4th Grade Students Proficient in Math	*percent*	86		74.3		*2018-2019*	15
0.58	8th Grade Students Proficient in English/Language Arts	*percent*	77.4		58.3		*2018-2019*	15
1.00	8th Grade Students Proficient in Math	*percent*	72.6		57.3		*2018-2019*	15
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	308.1		301.6	368.2	*2021*	7
2.00	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1333.5		1200.4	1492.4	*2021*	7
1.78	High School Graduation	*percent*	91.6	90.7	92		*2019-2020*	15
0.58	People 25+ with a Bachelor's Degree or Higher	*percent*	29		28.3	32.1	*2015-2019*	1

1.81	Student-to-Teacher Ratio	*students/ teacher*	16.4				*2019-2020*	13
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.2				*2015*	23
1.83	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.75	Adults with Current Asthma	*percent*	10.2			8.9	*2019*	4
1.67	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.8				*2015*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.6				*2015*	23
1.64	Number of Extreme Precipitation Days	*days*	34				*2019*	14
1.64	PBT Released	*pounds*	154.8				*2020*	24
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.36	Number of Extreme Heat Days	*days*	13				*2019*	14

1.36	Weeks of Moderate Drought or Worse	*weeks per year*	0				*2020*	14
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.3				*2015*	23
1.33	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.31	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.31	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.2		1.9		*2020*	19
1.25	Annual Ozone Air Quality		A				*2017-2019*	2
1.25	Annual Particle Pollution		A				*2017-2019*	2
1.25	Physical Environment Ranking	*ranking*	12				*2021*	9
1.25	Severe Housing Problems	*percent*	14.4		13.7	18	*2013-2017*	9
1.17	Access to Exercise Opportunities	*percent*	83.8		83.9	84	*2020*	9
1.08	Asthma: Medicare Population	*percent*	4.8		4.8	5	*2018*	6
1.08	Recognized Carcinogens Released into Air	*pounds*	30276.6				*2020*	24
1.03	Food Environment Index		7.7		6.8	7.8	*2021*	9
1.03	Houses Built Prior to 1950	*percent*	17.8		26.2	17.5	*2015-2019*	1
0.97	Liquor Store Density	*stores/ 100,000 population*	5.5		5.6	10.5	*2019*	22
0.86	Overcrowded Households	*percent of households*	0.8		1.4		*2015-2019*	1

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	PORTAGE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.06	Primary Care Provider Rate	*providers/ 100,000 population*	39.9		76.7		*2018*	9
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1061.7		1098.6	1047.4	*2021*	7
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	198.2		204.8	194.9	*2021*	7
1.83	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	36.9		108.9		*2020*	9
1.44	Dentist Rate	*dentists/ 100,000 population*	47.4		64.2		*2019*	9
1.42	Adults who have had a Routine Checkup	*percent*	78			76.6	*2019*	4
1.42	Clinical Care Ranking	*ranking*	34				*2021*	9
1.33	Adults with Health Insurance	*percent*	92.4		90.9	87.1	*2019*	1
1.33	Adults with Health Insurance: 18+	*percent*	90.4		90.2	90.6	*2021*	8
1.33	Children with Health Insurance	*percent*	96.9		95.2	94.3	*2019*	1
1.33	Consumer Expenditures: Health Insurance	*average dollar*	4163.1		4371.7	4321.1	*2021*	7

		amount per consumer unit						
1.33	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	606.7		638.9	609.6	*2021*	7
1.17	Mental Health Provider Rate	*providers/ 100,000 population*	216.1		261.3		*2020*	9
1.11	Persons without Health Insurance	*percent*	5.5		6.6		*2019*	1
1.00	Adults who Visited a Dentist	*percent*	52.6		51.6	52.9	*2021*	8
0.75	Adults without Health Insurance	*percent*	10.7			13	*2019*	4
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.47	Atrial Fibrillation: Medicare Population	*percent*	9.6		9	8.4	*2018*	6
2.31	Hyperlipidemia: Medicare Population	*percent*	52.4		49.4	47.7	*2018*	6
2.08	Cholesterol Test History	*percent*	83.6			87.6	*2019*	4
1.75	Adults who Have Taken Medications for High Blood Pressure	*percent*	77.1			76.2	*2019*	4
1.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	105	71.1	101.4	90.5	*2017-2019*	5
1.47	Stroke: Medicare Population	*percent*	3.6		3.8	3.8	*2018*	6

1.42	Heart Failure: Medicare Population	*percent*	15.1		14.7	14	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	58		59.5	57.2	*2018*	6
1.25	Adults who Experienced Coronary Heart Disease	*percent*	6.8			6.2	*2019*	4
1.17	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	36.5	33.4	42.5	37.2	*2017-2019*	5
1.17	High Blood Pressure Prevalence	*percent*	32.7	27.7		32.6	*2019*	4
1.14	Ischemic Heart Disease: Medicare Population	*percent*	25.9		27.5	26.8	*2018*	6
0.92	Adults who Experienced a Stroke	*percent*	3.4			3.4	*2019*	4
0.92	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	50.3		55.4		*2019*	14
0.92	High Cholesterol Prevalence: Adults 18+	*percent*	32.1			33.6	*2019*	4
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.67	Chlamydia Incidence Rate	*cases/ 100,000 population*	433.2		561.9	551	*2019*	16
1.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.5		14.4	13.8	*2017-2019*	5

1.22	Gonorrhea Incidence Rate	*cases/ 100,000 population*	80.6		224	187.8	*2019*	16
1.00	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.1		48.6	49.4	*2021*	8
0.86	Overcrowded Households	*percent of households*	0.8		1.4		*2015-2019*	1
0.78	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	9.8	11.1	12.9		*2018*	16
0.78	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	16
0.75	Persons Fully Vaccinated Against COVID-19	*percent*	55.9				*28-Jan-21*	5
0.08	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-21*	11
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	60.6		128.4	177.3	*28-Jan-21*	11
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.06	Babies with Low Birth Weight	*percent*	7.3		8.5	8.2	*2020*	17
0.78	Babies with Very Low Birth Weight	*percent*	1		1.4	1.3	*2020*	17
1.83	Consumer Expenditures: Childcare	*average dollar amount per*	308.1		301.6	368.2	*2021*	7

		consumer unit						
2.22	Infant Mortality Rate	*deaths/ 1,000 live births*	9.7	5	6.9		*2019*	17
0.94	Mothers who Received Early Prenatal Care	*percent*	75.9		68.9	76.1	*2020*	17
1.86	Mothers who Smoked During Pregnancy	*percent*	13.4	4.3	11.5	5.5	*2020*	17
1.50	Preterm Births	*percent*	9.8	9.4	10.3		*2020*	17
0.86	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	2.4		6.8		*2020*	17
0.86	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	14.9		19.5		*2016*	17
SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1061.7		1098.6	1047.4	*2021*	7
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	198.2		204.8	194.9	*2021*	7

1.33	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	606.7		638.9	609.6	*2021*	7
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Adults Ever Diagnosed with Depression	*percent*	22.3			18.8	*2019*	4
1.14	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	30.4		34	30.5	*2017-2019*	5
1.17	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	13.9	12.8	15.1	14.1	*2017-2019*	5
1.31	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.9		10.4	10.8	*2018*	6
2.58	Depression: Medicare Population	*percent*	21.4		20.4	18.4	*2018*	6
1.17	Mental Health Provider Rate	*providers/ 100,000 population*	216.1		261.3		*2020*	9
1.92	Poor Mental Health: 14+ Days	*percent*	16.8			13.6	*2019*	4
1.50	Poor Mental Health: Average Number of Days	*days*	4.8		4.8	4.1	*2018*	9
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	86.2		85.6	86.5	*2021*	8

SCORE	NUTRITION & HEALTHY EATING	UNITS	PORTAGE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.67	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	825.5		864.6	1002.1	*2021*	7
1.50	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	81.5		80.9	80.4	*2021*	8
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.3		41.5	41.2	*2021*	8
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1439.5		1461	1638.9	*2021*	7
1.33	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	490.7		519	530.2	*2021*	7
1.00	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	299.9		319.7	357	*2021*	7
SCORE	**OLDER ADULTS**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.58	Depression: Medicare Population	*percent*	21.4		20.4	18.4	*2018*	6
2.47	Atrial Fibrillation: Medicare Population	*percent*	9.6		9	8.4	*2018*	6
2.31	Hyperlipidemia: Medicare Population	*percent*	52.4		49.4	47.7	*2018*	6
2.25	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.3		36.1	33.5	*2018*	6
1.92	Osteoporosis: Medicare Population	*percent*	6.2		6.2	6.6	*2018*	6
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.6				*2015*	23
1.64	Cancer: Medicare Population	*percent*	8.3		8.4	8.4	*2018*	6
1.47	Stroke: Medicare Population	*percent*	3.6		3.8	3.8	*2018*	6
1.42	Adults with Arthritis	*percent*	28.6			25.1	*2019*	4
1.42	Heart Failure: Medicare Population	*percent*	15.1		14.7	14	*2018*	6
1.36	COPD: Medicare Population	*percent*	12.5		13.2	11.5	*2018*	6
1.33	Colon Cancer Screening	*percent*	65.4	74.4		66.4	*2018*	4
1.31	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.9		10.4	10.8	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	58		59.5	57.2	*2018*	6
1.25	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	33.8			32.4	*2018*	4
1.25	Adults 65+ with Total Tooth Loss	*percent*	14.4			13.5	*2018*	4

1.25	Chronic Kidney Disease: Medicare Population	*percent*	22.6		25.3	24.5	*2018*	6
1.14	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	30.4		34	30.5	*2017-2019*	5
1.14	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.3		10.5	9.5	*2017-2019*	5
1.14	Ischemic Heart Disease: Medicare Population	*percent*	25.9		27.5	26.8	*2018*	6
1.08	Asthma: Medicare Population	*percent*	4.8		4.8	5	*2018*	6
1.00	Diabetes: Medicare Population	*percent*	25.4		27.2	27	*2018*	6
0.97	People 65+ Living Alone	*percent*	25.5		28.8	26.1	*2015-2019*	1
0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	34.3			28.4	*2018*	4
0.67	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	19.4		20.5	34.3	*2021*	7
0.50	People 65+ Living Below Poverty Level	*percent*	5.5		8.1	9.3	*2015-2019*	1
SCORE	**ORAL HEALTH**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.81	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.7		12.2	11.9	*2014-2018*	12

1.44	Dentist Rate	*dentists/ 100,000 population*	47.4		64.2		*2019*	9
1.25	Adults 65+ with Total Tooth Loss	*percent*	14.4			13.5	*2018*	4
1.00	Adults who Visited a Dentist	*percent*	52.6		51.6	52.9	*2021*	8
SCORE	**OTHER CONDITIONS**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.25	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.3		36.1	33.5	*2018*	6
1.92	Osteoporosis: Medicare Population	*percent*	6.2		6.2	6.6	*2018*	6
1.42	Adults with Arthritis	*percent*	28.6			25.1	*2019*	4
1.25	Chronic Kidney Disease: Medicare Population	*percent*	22.6		25.3	24.5	*2018*	6
0.92	Adults with Kidney Disease	*Percent of adults*	2.9			3.1	*2019*	4
0.50	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	11.5		14.5	12.9	*2017-2019*	5
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23

1.83	Children with Low Access to a Grocery Store	*percent*	6.2				*2015*	23
1.83	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.67	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.8				*2015*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.6				*2015*	23
1.64	Workers who Walk to Work	*percent*	2.4		2.2	2.7	*2015-2019*	1
1.50	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	81.5		80.9	80.4	*2021*	8
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.42	Adults 20+ who are Obese	*percent*	31.8	36			*2019*	5
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.3				*2015*	23
1.33	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.25	Health Behaviors Ranking	*ranking*	7				*2021*	9
1.19	Adults 20+ who are Sedentary	*percent*	23.3				*2019*	5
1.17	Access to Exercise Opportunities	*percent*	83.8		83.9	84	*2020*	9
1.03	Food Environment Index	*index*	7.7		6.8	7.8	*2021*	9

SCORE	PREVENTION & SAFETY	UNITS	PORTAGE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.14	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.3		10.5	9.5	*2017-2019*	5
0.72	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	47.4	43.2	68.8	48.9	*2017-2019*	5
1.19	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	24.7		40.2	21.4	*2017-2019*	5
1.03	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	21.7		38.1	21	*2017-2019*	9
1.25	Severe Housing Problems	*percent*	14.4		13.7	18	*2013-2017*	9
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.6		4.3	4.1	*2021*	8
1.75	Adults with Current Asthma	*percent*	10.2			8.9	*2019*	4
1.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.7		2.2	2	*2021*	8
1.58	Adults who Smoke	*percent*	21.4	5	21.4	17	*2018*	9
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44	25.1	45	36.7	*2015-2019*	12
1.42	Adults with COPD	*Percent of adults*	8.4			6.6	*2019*	4

1.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.5		14.4	13.8	*2017-2019*	5
1.36	COPD: Medicare Population	*percent*	12.5		13.2	11.5	*2018*	6
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	64		67.3	57.3	*2014-2018*	12
1.17	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	443.7		487.9	422.4	*2021*	7
1.08	Asthma: Medicare Population	*percent*	4.8		4.8	5	*2018*	6
0.86	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	41.9		47.8	39.6	*2017-2019*	5
0.78	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	16
0.08	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-21*	11
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	60.6		128.4	177.3	*28-Jan-21*	11
SCORE	**TOBACCO USE**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.6		4.3	4.1	*2021*	8

1.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.7		2.2	2	*2021*	8
1.58	Adults who Smoke	*percent*	21.4	5	21.4	17	*2018*	9
1.17	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	443.7		487.9	422.4	*2021*	7
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Insufficient Sleep	*percent*	40	31.4	40.6	35	*2018*	9
1.67	Poor Physical Health: Average Number of Days	*days*	4.4		4.1	3.7	*2018*	9
1.50	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	81.5		80.9	80.4	*2021*	8
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.3		41.5	41.2	*2021*	8
1.42	Morbidity Ranking	*ranking*	34				*2021*	9
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1439.5		1461	1638.9	*2021*	7
1.25	Poor Physical Health: 14+ Days	*percent*	13.2			12.5	*2019*	4
1.17	High Blood Pressure Prevalence	*percent*	32.7	27.7		32.6	*2019*	4

1.17	Life Expectancy	*years*	78		77	79.2	*2017-2019*	9
1.08	Self-Reported General Health Assessment: Poor or Fair	*percent*	18.1			18.6	*2019*	4
1.00	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.1		48.6	49.4	*2021*	8
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	86.2		85.6	86.5	*2021*	8
SCORE	**WOMEN'S HEALTH**	**UNITS**	**PORTAGE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.81	Breast Cancer Incidence Rate	*cases/ 100,000 females*	128.7		129.6	126.8	*2014-2018*	12
1.61	Cervical Cancer Screening: 21-65	*Percent*	83.7	84.3		84.7	*2018*	4
1.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20.4	15.3	21.6	19.9	*2015-2019*	12
1.06	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.9	7.7	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	75.6	77.1		74.8	*2018*	4

Portage County Data Sources

Key	Data Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

SCORE	ALCOHOL & DRUG USE	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	40.7	28.3	32.2	27	*2015-2019*	9
2.50	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	821.2		651.5	701.9	*2021*	7
1.92	Adults who Binge Drink	*percent*	17.6			16.7	*2019*	4
1.33	Adults who Drink Excessively	*percent*	18.5		18.5	19	*2018*	9
1.25	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	25.1		42	22.8	*2017-2019*	5
1.25	Health Behaviors Ranking		4				*2021*	9
1.19	Mothers who Smoked During Pregnancy	*percent*	6.9	4.3	11.5	5.5	*2020*	17
1.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.1		38.1	21	*2017-2019*	9
0.08	Liquor Store Density	*stores/ 100,000 population*	1.7		5.9	10.6	*2018*	22
SCORE	**CANCER**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	135.8		107.2	106.2	*2014-2018*	12

2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.7		129.6	126.8	*2014-2018*	12
2.58	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.25	All Cancer Incidence Rate	*cases/ 100,000 population*	486.3		467.5	448.6	*2014-2018*	12
1.92	Adults with Cancer	*percent*	8.3			7.1	*2019*	4
1.42	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.4		12.2	11.9	*2014-2018*	12
1.25	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	18.6	16.9	19.4	18.9	*2015-2019*	12
1.03	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	38.8		41.3	38	*2014-2018*	12
0.94	Colon Cancer Screening	*percent*	68.2	74.4		66.4	*2018*	4
0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.8	77.1		74.8	*2018*	4
0.89	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5.1		7.9	7.7	*2014-2018*	12
0.89	Cervical Cancer Screening: 21-65	*Percent*	86.8	84.3		84.7	*2018*	4
0.86	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	57.4		67.3	57.3	*2014-2018*	12
0.78	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.2	15.3	21.6	19.9	*2015-2019*	12
0.78	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	149	122.7	169.4	152.4	*2015-2019*	12

0.61	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	36.5	25.1	45	36.7	*2015-2019*	12
0.44	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	11.4	8.9	14.8	13.4	*2015-2019*	12
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.72	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.4	8.7	6.8		*2020*	3
1.33	Children with Health Insurance	*percent*	95.4		95.2	94.3	*2019*	1
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	19
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2020*	19
0.75	Projected Child Food Insecurity Rate	*percent*	11.7		18.5		*2021*	10
0.50	Child Food Insecurity Rate	*percent*	10.6		17.4	14.6	*2019*	10

SCORE	COMMUNITY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Workers who Walk to Work	*percent*	0.9		2.2	2.7	*2015-2019*	1
2.58	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	40.7	28.3	32.2	27	*2015-2019*	9
2.36	Solo Drivers with a Long Commute	*percent*	43.4		31.1	37	*2015-2019*	9
2.22	Workers Commuting by Public Transportation	*percent*	0.3	5.3	1.6	5	*2015-2019*	1
2.19	Workers who Drive Alone to Work	*percent*	86.9		82.9	76.3	*2015-2019*	1
2.17	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	134.3		121.7	148.8	*2021*	7
2.14	Social Associations	*membership associations/ 10,000 population*	9.4		11	9.3	*2018*	9
2.03	Mean Travel Time to Work	*minutes*	27.3		23.7	26.9	*2015-2019*	1
1.72	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.4	8.7	6.8		*2020*	3
1.25	Social and Economic Factors Ranking	*ranking*	6				*2021*	9
1.19	People 65+ Living Alone	*percent*	26.3		28.8	26.1	*2015-2019*	1

1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Households with Wireless Phone Service	*percent*	97		96.8	97	*2020*	8
0.97	Linguistic Isolation	*percent*	0.5		1.4	4.4	*2015-2019*	1
0.83	Adults with Internet Access	*percent*	95.8		94.5	95	*2021*	8
0.83	Households with a Computer	*percent*	88.7		85.2	86.3	*2021*	8
0.83	Households with a Smartphone	*percent*	82.9		80.5	81.9	*2021*	8
0.83	Households with an Internet Subscription	*percent*	87.6		82.4	83	*2015-2019*	1
0.83	Households with One or More Types of Computing Devices	*percent*	93.4		89.1	90.3	*2015-2019*	1
0.83	Persons with an Internet Subscription	*percent*	90.5		86.2	86.2	*2015-2019*	1
0.64	Young Children Living Below Poverty Level	*percent*	11.3		23	20.3	*2015-2019*	1
0.61	Violent Crime Rate	*crimes/ 100,000 population*	41.6		303.5	394	*2017*	18
0.58	Voter Turnout: Presidential Election	*percent*	82		74		*2020*	20
0.53	Youth not in School or Working	*percent*	0.6		1.8	1.9	*2015-2019*	1

0.36	Children Living Below Poverty Level	*percent*	8.1		19.9	18.5	*2015-2019*	1
0.36	Homeownership	*percent*	76.1		59.4	56.2	*2015-2019*	1
0.36	Households without a Vehicle	*percent*	4.1		7.9	8.6	*2015-2019*	1
0.36	Single-Parent Households	*percent*	16		27.1	25.5	*2015-2019*	1
0.28	People Living Below Poverty Level	*percent*	6	8	14	13.4	*2015-2019*	1
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	33.9		28.3	32.1	*2015-2019*	1
0.08	Median Household Income	*dollars*	76600		56602	62843	*2015-2019*	1
0.08	Per Capita Income	*dollars*	37788		31552	34103	*2015-2019*	1
SCORE	**DIABETES**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.50	Adults 20+ with Diabetes	*percent*	9.2				*2019*	5
0.81	Diabetes: Medicare Population	*percent*	23.9		27.2	27	*2018*	6
0.36	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	18.8		25.3	21.5	*2017-2019*	5
SCORE	**ECONOMY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	9561.5		7828	8900.1	*2021*	7
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.64	Size of Labor Force	*persons*	93296				*Sept-21*	21
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.2				*2015*	23
1.25	Social and Economic Factors Ranking	*ranking*	6				*2021*	9
1.03	Overcrowded Households	*percent of households*	1.1		1.4		*2015-2019*	1
1.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	73.7		61.6		*2018*	25
1.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	19.3		24.5		*2018*	25
1.00	Households that are Below the Federal Poverty Level	*percent*	7		13.8		*2018*	25

0.83	Adults who Feel Overwhelmed by Financial Burdens	*percent*	13.2		14.6	14.4	*2021*	8
0.83	Households with a Savings Account	*percent*	74.1		68.8	70.2	*2021*	8
0.83	Renters Spending 30% or More of Household Income on Rent	*percent*	39.1		44.9	49.6	*2015-2019*	1
0.75	Projected Child Food Insecurity Rate	*percent*	11.7		18.5		*2021*	10
0.75	Projected Food Insecurity Rate	*percent*	10.1		14.1		*2021*	10
0.67	Income Inequality		0.4		0.5	0.5	*2015-2019*	1
0.64	People 65+ Living Below Poverty Level	*percent*	5.2		8.1	9.3	*2015-2019*	1
0.64	Young Children Living Below Poverty Level	*percent*	11.3		23	20.3	*2015-2019*	1
0.58	Students Eligible for the Free Lunch Program	*percent*	15.8				*2019-2020*	13
0.53	Youth not in School or Working	*percent*	0.6		1.8	1.9	*2015-2019*	1
0.50	Child Food Insecurity Rate	*percent*	10.6		17.4	14.6	*2019*	10
0.50	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3057.8		3798.7	5460.2	*2021*	7
0.50	Food Insecurity Rate	*percent*	9.3		13.2	10.9	*2019*	10

0.50	Persons with Disability Living in Poverty (5-year)	*percent*	16.4		29.5	26.1	*2015-2019*	1
0.36	Children Living Below Poverty Level	*percent*	8.1		19.9	18.5	*2015-2019*	1
0.36	Families Living Below Poverty Level	*percent*	4.1		9.9	9.5	*2015-2019*	1
0.36	Homeownership	*percent*	76.1		59.4	56.2	*2015-2019*	1
0.36	Households with Cash Public Assistance Income	*percent*	1.2		2.9	2.4	*2015-2019*	1
0.33	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	16.4		19.7	26.5	*2019*	1
0.28	People Living Below Poverty Level	*percent*	6	8	14	13.4	*2015-2019*	1
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9
0.25	Unemployed Workers in Civilian Labor Force	*percent*	3.1		4.3	4.6	*Sep-21*	21
0.08	Median Household Income	*dollars*	76600		56602	62843	*2015-2019*	1
0.08	People Living 200% Above Poverty Level	*percent*	82.8		68.8	69.1	*2015-2019*	1
0.08	Per Capita Income	*dollars*	37788		31552	34103	*2015-2019*	1
SCORE	**EDUCATION**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
2.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1490.7		1200.4	1492.4	*2021*	7
1.58	Student-to-Teacher Ratio	*students/ teacher*	18.3				*2019-2020*	13
1.50	8th Grade Students Proficient in Math	*percent*	62.1		57.3		*2018-2019*	15
1.00	4th Grade Students Proficient in Math	*percent*	86.3		74.3		*2018-2019*	15
0.86	4th Grade Students Proficient in English/Language Arts	*percent*	79		63.3		*2018-2019*	15
0.72	High School Graduation	*percent*	96.3	90.7	92		*2019-2020*	15
0.58	8th Grade Students Proficient in English/Language Arts	*percent*	74		58.3		*2018-2019*	15
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	33.9		28.3	32.1	*2015-2019*	1
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23

1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	23
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.5				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.36	Number of Extreme Heat Days	*days*	14				*2019*	14
1.36	Number of Extreme Precipitation Days	*days*	28				*2019*	14
1.36	PBT Released	*pounds*	676.8				*2020*	24
1.36	Recognized Carcinogens Released into Air	*pounds*	447				*2020*	24
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	1				*2020*	14
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.2				*2015*	23
1.25	Adults with Current Asthma	*percent*	9.4			8.9	*2019*	4

1.25	Physical Environment Ranking	*ranking*	10				*2021*	9
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	19
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2020*	19
1.11	Annual Ozone Air Quality		A				*2017-2019*	2
1.11	Annual Particle Pollution		A				*2017-2019*	2
1.03	Overcrowded Households	*percent of households*	1.1		1.4		*2015-2019*	1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.83	Access to Exercise Opportunities	*percent*	92.1		83.9	84	*2020*	9
0.53	Houses Built Prior to 1950	*percent*	12.5		26.2	17.5	*2015-2019*	1
0.36	Food Environment Index	*index*	8.6		6.8	7.8	*2021*	9
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9

0.08	Liquor Store Density	*stores/ 100,000 population*	1.7		5.9	10.6	*2018*	22
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	5410.8		4371.7	4321.1	*2021*	7
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1419.1		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	259.4		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	781.2		638.9	609.6	*2021*	7
1.72	Primary Care Provider Rate	*providers/ 100,000 population*	60.3		76.7		*2018*	9
1.50	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	63.4		108.9		*2020*	9
1.44	Dentist Rate	*dentists/ 100,000 population*	53.4		64.2		*2019*	9
1.39	Persons without Health Insurance	*percent*	4.3		6.6		*2019*	1
1.33	Adults with Health Insurance	*percent*	94.4		90.9	87.1	*2019*	1

1.33	Children with Health Insurance	*percent*	95.4		95.2	94.3	*2019*	1
1.33	Mental Health Provider Rate	*providers/ 100,000 population*	140.8		261.3		*2020*	9
1.25	Clinical Care Ranking	*ranking*	4				*2021*	9
0.92	Adults who have had a Routine Checkup	*percent*	79.5			76.6	*2019*	4
0.83	Adults who Visited a Dentist	*percent*	56.6		51.6	52.9	*2021*	8
0.83	Adults with Health Insurance: 18+	*percent*	92.4		90.2	90.6	*2021*	8
0.75	Adults without Health Insurance	*percent*	9.5			13	*2019*	4
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.4		9	8.4	*2018*	6
1.81	Hyperlipidemia: Medicare Population	*percent*	50		49.4	47.7	*2018*	6
1.42	Adults who Have Taken Medications for High Blood Pressure	*percent*	78			76.2	*2019*	4
1.33	High Blood Pressure Prevalence	*percent*	33.7	27.7		32.6	*2019*	4
1.31	Hypertension: Medicare Population	*percent*	57.5		59.5	57.2	*2018*	6

1.28	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	34.1	33.4	42.5	37.2	*2017-2019*	5
1.25	Cholesterol Test History	*percent*	87.1			87.6	*2019*	4
1.08	Adults who Experienced Coronary Heart Disease	*percent*	6.6			6.2	*2019*	4
1.08	High Cholesterol Prevalence: Adults 18+	*percent*	32.8			33.6	*2019*	4
1.03	Stroke: Medicare Population	*percent*	3.5		3.8	3.8	*2018*	6
0.92	Adults who Experienced a Stroke	*percent*	3.2			3.4	*2019*	4
0.86	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	45.4		55.4		*2019*	14
0.78	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	83.7	71.1	101.4	90.5	*2017-2019*	5
0.69	Heart Failure: Medicare Population	*percent*	12.9		14.7	14	*2018*	6
0.69	Ischemic Heart Disease: Medicare Population	*percent*	24.7		27.5	26.8	*2018*	6
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	16.2	11.1	12.9		*2018*	16

1.72	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.1	1.4	1.1		*2020*	16
1.03	Overcrowded Households	*percent of households*	1.1		1.4		*2015-2019*	1
0.89	Gonorrhea Incidence Rate	*cases/ 100,000 population*	43		224	187.8	*2019*	16
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	50.9		48.6	49.4	*2021*	8
0.75	Chlamydia Incidence Rate	*cases/ 100,000 population*	216.8		561.9	551	*2019*	16
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	62.5				*28-Jan-22*	5
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	8		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-22*	11
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	56.4		128.4	177.3	*28-Jan-22*	11
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
1.19	Mothers who Smoked During Pregnancy	*percent*	6.9	4.3	11.5	5.5	*2020*	17

1.11	Mothers who Received Early Prenatal Care	*percent*	74.7		68.9	76.1	*2020*	17
0.86	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	1.6		6.8		*2020*	17
0.86	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	13.4		19.5		*2016*	17
0.78	Infant Mortality Rate	*deaths/ 1,000 live births*	1.8	5	6.9		*2019*	17
0.78	Preterm Births	*percent*	7.6	9.4	10.3		*2020*	17
0.75	Babies with Low Birth Weight	*percent*	5.7		8.5	8.2	*2020*	17
0.61	Babies with Very Low Birth Weight	*percent*	0.6		1.4	1.3	*2020*	17
SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1419.1		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	259.4		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	781.2		638.9	609.6	*2021*	7
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

1.92	Depression: Medicare Population	*percent*	19		20.4	18.4	*2018*	6
1.89	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	15.7	12.8	15.1	14.1	*2017-2019*	5
1.58	Adults Ever Diagnosed with Depression	*percent*	21.2			18.8	*2019*	4
1.33	Mental Health Provider Rate	*providers/ 100,000 population*	140.8		261.3		*2020*	9
1.25	Poor Mental Health: 14+ Days	*percent*	14.3			13.6	*2019*	4
1.17	Poor Mental Health: Average Number of Days	*days*	4.4		4.8	4.1	*2018*	9
1.14	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.4		10.4	10.8	*2018*	6
0.97	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	28.8		34	30.5	*2017-2019*	5
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	88.2		85.6	86.5	*2021*	8
SCORE	**NUTRITION & HEALTHY EATING**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1814.2		1461	1638.9	*2021*	7

2.50	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	627		519	530.2	*2021*	7
2.33	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	370		319.7	357	*2021*	7
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.2		41.5	41.2	*2021*	8
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.67	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	1043.8		864.6	1002.1	*2021*	7
SCORE	**OLDER ADULT HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.2		36.1	33.5	*2018*	6
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.4		9	8.4	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6

1.92	Depression: Medicare Population	*percent*	19		20.4	18.4	*2018*	6
1.81	Hyperlipidemia: Medicare Population	*percent*	50		49.4	47.7	*2018*	6
1.75	Adults with Arthritis	*percent*	30			25.1	*2019*	4
1.67	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	24.4		20.5	34.3	*2021*	7
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.5				*2015*	23
1.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.7		10.5	9.5	*2017-2019*	5
1.42	Chronic Kidney Disease: Medicare Population	*percent*	23		25.3	24.5	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	57.5		59.5	57.2	*2018*	6
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
1.19	People 65+ Living Alone	*percent*	26.3		28.8	26.1	*2015-2019*	1
1.14	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.4		10.4	10.8	*2018*	6
1.03	Stroke: Medicare Population	*percent*	3.5		3.8	3.8	*2018*	6
0.97	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	28.8		34	30.5	*2017-2019*	5

0.97	COPD: Medicare Population	*percent*	10.8		13.2	11.5	*2018*	6
0.94	Colon Cancer Screening	*percent*	68.2	74.4		66.4	*2018*	4
0.81	Diabetes: Medicare Population	*percent*	23.9		27.2	27	*2018*	6
0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	36.5			28.4	*2018*	4
0.75	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	38.5			32.4	*2018*	4
0.75	Adults 65+ with Total Tooth Loss	*percent*	11			13.5	*2018*	4
0.69	Heart Failure: Medicare Population	*percent*	12.9		14.7	14	*2018*	6
0.69	Ischemic Heart Disease: Medicare Population	*percent*	24.7		27.5	26.8	*2018*	6
0.64	People 65+ Living Below Poverty Level	*percent*	5.2		8.1	9.3	*2015-2019*	1
SCORE	**ORAL HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.44	Dentist Rate	*dentists/ 100,000 population*	53.4		64.2		*2019*	9
1.42	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.4		12.2	11.9	*2014-2018*	12

0.83	Adults who Visited a Dentist	*percent*	56.6		51.6	52.9	*2021*	8
0.75	Adults 65+ with Total Tooth Loss	*percent*	11			13.5	*2018*	4
SCORE	**OTHER CONDITIONS**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.2		36.1	33.5	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6
1.75	Adults with Arthritis	*percent*	30			25.1	*2019*	4
1.42	Chronic Kidney Disease: Medicare Population	*percent*	23		25.3	24.5	*2018*	6
0.92	Adults with Kidney Disease	*Percent of adults*	2.8			3.1	*2019*	4
0.36	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	8.7		14.5	12.9	*2017-2019*	5
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Workers who Walk to Work	*percent*	0.9		2.2	2.7	*2015-2019*	1
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23

1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	23
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.5				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.2				*2015*	23
1.25	Health Behaviors Ranking		4				*2021*	9
1.03	Adults 20+ who are Sedentary	*percent*	21.1				*2019*	5
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.94	Adults 20+ who are Obese	*percent*	27.8	36			*2019*	5

0.83	Access to Exercise Opportunities	*percent*	92.1		83.9	84	*2020*	9
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.36	Food Environment Index		8.6		6.8	7.8	*2021*	9
SCORE	**PREVENTION & SAFETY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.7		10.5	9.5	*2017-2019*	5
1.47	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	23.6		40.2	21.4	*2017-2019*	5
1.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.1		38.1	21	*2017-2019*	9
0.67	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	43.8	43.2	68.8	48.9	*2017-2019*	5
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.72	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.1	1.4	1.1		*2020*	16

1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	472.9		487.9	422.4	*2021*	7
1.47	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	43.7		47.8	39.6	*2017-2019*	5
1.42	Adults with COPD	*Percent of adults*	7.9			6.6	*2019*	4
1.33	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.3		2.2	2	*2021*	8
1.25	Adults with Current Asthma	*percent*	9.4			8.9	*2019*	4
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
0.97	COPD: Medicare Population	*percent*	10.8		13.2	11.5	*2018*	6
0.92	Adults who Smoke	*percent*	17.9	5	21.4	17	*2018*	9
0.86	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	57.4		67.3	57.3	*2014-2018*	12
0.61	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	36.5	25.1	45	36.7	*2015-2019*	12
0.50	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.7		4.3	4.1	*2021*	8
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	8		14.4	13.8	*2017-2019*	5

0.08	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-22*	11
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	56.4		128.4	177.3	*28-Jan-22*	11
SCORE	**TOBACCO USE**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	472.9		487.9	422.4	*2021*	7
1.33	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.3		2.2	2	*2021*	8
0.92	Adults who Smoke	*percent*	17.9	5	21.4	17	*2018*	9
0.50	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.7		4.3	4.1	*2021*	8
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1814.2		1461	1638.9	*2021*	7
1.42	Insufficient Sleep	*percent*	37.5	31.4	40.6	35	*2018*	9
1.33	High Blood Pressure Prevalence	*percent*	33.7	27.7		32.6	*2019*	4

1.25	Morbidity Ranking	*ranking*	4				*2021*	9
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.2		41.5	41.2	*2021*	8
0.92	Poor Physical Health: 14+ Days	*percent*	12.5			12.5	*2019*	4
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	50.9		48.6	49.4	*2021*	8
0.83	Life Expectancy	*years*	80.1		77	79.2	*2017-2019*	9
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	88.2		85.6	86.5	*2021*	8
0.75	Self-Reported General Health Assessment: Poor or Fair	*percent*	16.5			18.6	*2019*	4
0.67	Poor Physical Health: Average Number of Days	*days*	3.6		4.1	3.7	*2018*	9
SCORE	**WOMEN'S HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.7		129.6	126.8	*2014-2018*	12

0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.8	77.1		74.8	*2018*	4
0.89	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5.1		7.9	7.7	*2014-2018*	12
0.89	Cervical Cancer Screening: 21-65	*Percent*	86.8	84.3		84.7	*2018*	4
0.78	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.2	15.3	21.6	19.9	*2015-2019*	12

Medina County Data Sources

Key	Data Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

Appendix D: Community Input Assessment Tools

CCF identified key community stakeholders to provide vital perspectives and context around important community health issues. CCF and HCI worked to develop a questionnaire to determine what a community needs to be healthy, what barriers to health exist in the community, how COVID-19 has impacted health in the community and how the challenges identified might be addressed in the future. Below is the complete Key Stakeholder Interview Guide:

WELCOME: Cleveland Clinic ***{hospital name}*** is in the process of conducting our 2022 comprehensive Community Health Needs Assessment (CHNA) to understand and plan for the current and future health needs of our community.
You have been invited to take part in this interview because of your experience working ***{at organization}*** in the community. During this interview, we will ask a series of questions related to health issues in your community. Our ultimate goal is to gain various perspectives on the major issues affecting the population that your organizations serves and how to improve health in your community. We hope to get through as many questions as possible and hear your perspective as much as time allows.

TRANSCRIPTION: For today's call we are using the transcription feature in MS Teams. This feature produces a live transcript and makes meetings more inclusive for those who are deaf, hard of hearing, or have different levels of language proficiency. Our primary purpose for using this feature is to assist with note taking.

CONFIDENTIALITY: For this conversation, I will invite you to share as much or little as you feel comfortable sharing. The results of this assessment will be made available to the public. Although we will take notes on your responses, your name will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

FORMAT: We anticipate that this conversation will last ~45 minutes to an hour.

Section #1: Introduction

- What community, or geographic area, does your organization serve (or represent)?
    - How does your organization serve the community?

Section #2: Community Health and Well-being

- From your perspective, what does a community need to be healthy?

- What do you believe are the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

Section #3: Barriers to Health

- What health disparities appear most prevalent in your community?
- What are the barriers or challenges to improving health in the community?
    - What makes some people healthy in the community while others experience poor health?
    - What particular parts of the community or geographic areas that are underserved or under-resourced?
    - What services are most difficult to access?
- What could be done to promote health equity?

Section #4: COVID-19

- How has COVID-19 impacted health in your community?
    - What were the most significant health concerns prior to the pandemic vs now?
    - What populations have been most affected by COVID-19?
- How has COVID-19 impacted access to care in the community?
    - What about access to mental health or substance use treatment in the community?
    - What about emergency and preventative care services?

Section #5: Addressing the Challenges & Solutions

- What are some possible solutions to the problems that we have discussed?
    - How can organizations such as hospitals, health departments, government, and community-based organizations work together to address some of the problems that have been mentioned?
- How can we make sure that community voices are heard when decisions are made that affect their community?
    - What would be the best way to communicate with community members about progress organizations are making to improve health and quality of life?
- What resources does your community have that can be used to improve community health?

Section #6: Conclusion

- Is there anything else that you think would be important for us to know as we conduct this community health needs assessment?

CLOSURE SCRIPT: Thank you again for taking time out of your busy day to share your experiences with us. We will include the key themes from today's discussion in our assessment. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Appendix E: Community Partners and Resources

This section identifies other facilities and resources available in the community served by Akron General that are available to address community health needs.

Federally Qualified Health Centers

Ohio's Association of Community Health Centers (OACHC) is a not-for-profit membership association representing Federally Qualified Health Centers (FQHCs).[29] FQHCs are established to promote access to ambulatory care in areas designated as medically underserved. These clinics provide primary care, mental health, and dental services for lower-income members of the community. FQHCs receive enhanced reimbursement for Medicaid and Medicare services and most also receive federal grant funds under Section 330 of the Public Health Service Act. OACHC represents Ohio's 57 Community Health Centers at 400 locations, including multiple mobile units The following FQHC clinics and networks operate in the Akron General Community:

- Asian Services in Action, Inc.
- Axesspointe Community Health Center, Inc.
- Community Support Services, Inc.
- Lifecare Family Health & Dental Center
- Medina County Health Department
- My Community Health Center

Hospitals

In addition to several Cleveland Clinic hospitals in Northeast Ohio, the following is a list of other hospital facilities located in the Akron General Community:

- Akron Children's Hospital
- Crystal Clinic Orthopaedic Center
- Select Specialty Hospital- Akron
- Summa Health System – Akron Campus

[29] Ohio Association of Community Health Centers, https://www.ohiochc.org/page/178

- University Hospitals (Multiple Locations)
- Western Reserve Hospital

Other Community Organizations

- Akron Canton Regional Foodbank
- Akron Community Foundation
- City of Akron Fire Department
- City of Green Fire Department
- Child Guidance and Family Solutions
- Family Promise of Summit County
- Summit County Alcohol, Drug Addiction, and Mental Health Services Board (ADM Board)
- Summit County Public Health
- Synthomer Foundation

Other Community Resources

A wide range of agencies, coalitions, and organizations that provide health and social services is available in the region served by Akron General. United Way of Summit and Medina Counties 2-1-1 service is available 24/7 to provide free confidential information on thousands of services for residents. These include:

- Clothing and Household Items
- Education Program
- Housing and Shelter
- Mental Health Services
- Prenatal Care
- Supplemental food and nutrition programs
- Utilities and Transportation

Appendix F: Acknowledgements

Conduent Healthy Communities Institute (HCI) supported report preparation. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. To learn more about Conduent HCI, please visit www.conduent.com/community-population-health.

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Cleveland Clinic
Akron General

Implementation Strategy Report

2022

AKRON GENERAL 2022 IMPLEMENTATION STRATEGY REPORT

2022 Community Health Needs Assessment
Implementation Strategy Report for Years 2023 – 2025

TABLE OF CONTENTS

AKRON GENERAL 2022 IMPLEMENTATION STRATEGY REPORT

I. INTRODUCTION AND PURPOSE

This written plan is intended to satisfy the requirements set forth in the Internal Revenue Code Section 501(r)(3) regarding community health needs assessments and implementation strategies. The overall purpose of the Implementation Strategy is to align the hospital's limited resources, program services, and activities with the findings of the 2022 Akron General Community Health Needs Assessment ("CHNA"). The Implementation Strategy Report (ISR) includes the priority community health needs identified during the 2022 CHNA and hospital-specific strategies to address those needs from 2023 through 2025.

A. Description of Hospital

Founded in 1914 as Peoples Hospital, Cleveland Clinic Akron General is a not-for-profit healthcare organization that serves as the hub for Cleveland Clinic's Southern Region. In addition to a 485 staffed bed[30] teaching and research medical center in downtown Akron, the Cleveland Clinic Akron General system includes a critical access hospital and health and wellness centers. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/akron-general.

The hospital is part of the Cleveland Clinic health system, which includes an academic medical center near downtown Cleveland, fourteen regional hospitals in northeast Ohio, a children's hospital, a children's rehabilitation hospital, five southeast Florida hospitals, and several other facilities and services across Ohio, Florida, and Nevada. Additional information about Cleveland Clinic is available at https://my.clevelandclinic.org/.

Cleveland Clinic Akron General's mission statement is:

Caring for life, researching for health, and educating those who serve.

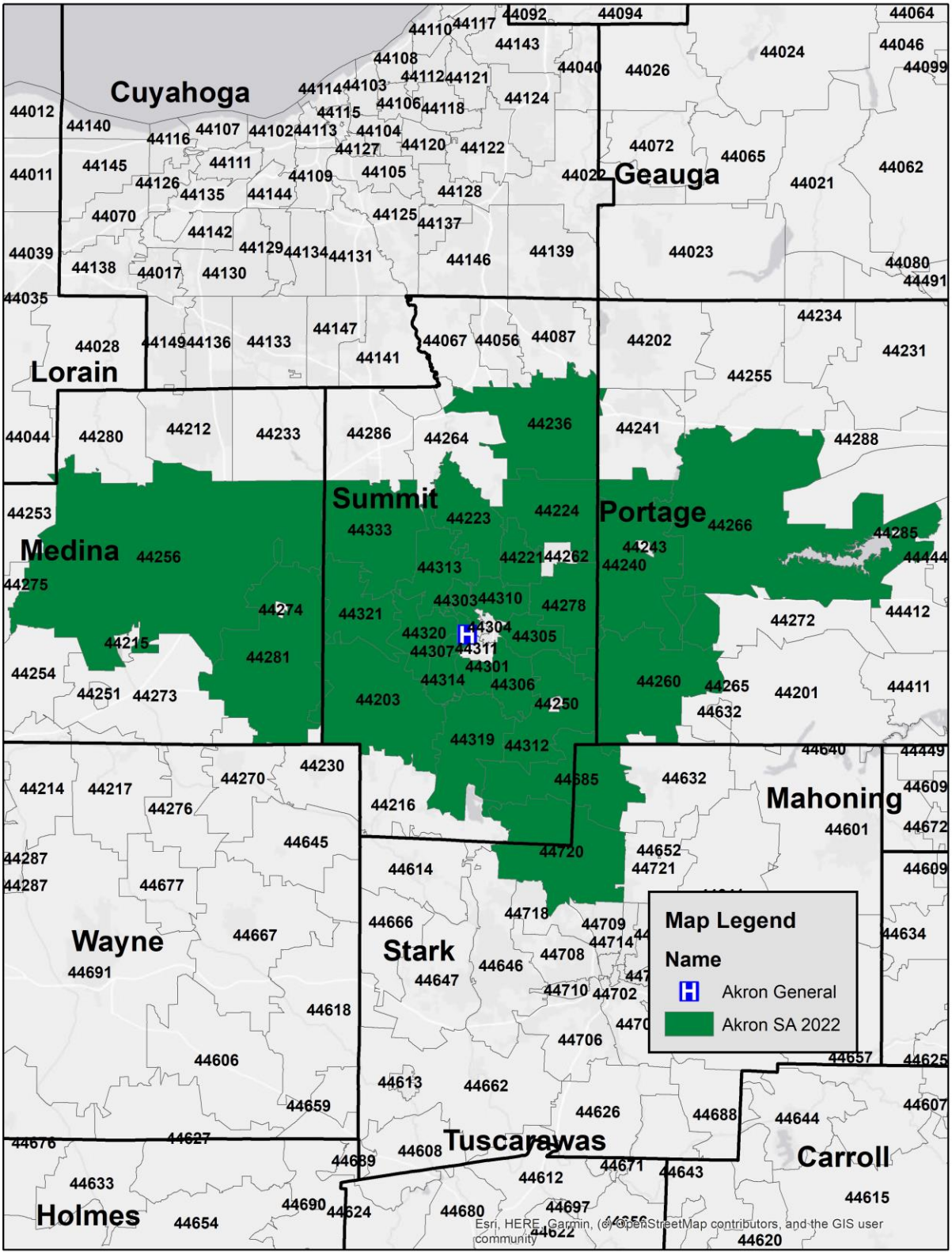
II. COMMUNITY DEFINITION

For purposes of this report, the Akron General's CHNA community definition is an aggregate of 34 zip codes in Medina, Summit, Portage, and Stark Counties comprising approximately 75% of inpatient, outpatient, and emergency department visits in 2021 (Figure 1).

In order to have the most impact on the health of our community we have further defined our focus area for community outreach to the six Akron zip codes surrounding our main hospital campus where residents have the highest needs. These zip codes include 44306, 44307, 44310, 44311, 44314, and 44320.

[30] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) interim financial statement is referenced for official bed count. We acknowledge that staffed bed count may fluctuate and may differ from registered or licensed bed counts reflected in other descriptions.

Figure 1: Akron General Hospital Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of leadership at Akron General and Cleveland Clinic representing several departments of the organizations, including clinical administration, medical operations, nursing, finance, population health, and community relations. This team incorporated input from the hospital's community and local non-profit organizations to prioritize selected strategies and determine possible collaborations. Alignment with county Community Health Assessments (CHA) as well as the State Health Assessment (SHA), was also considered. Leadership at Akron General will utilize this Implementation Strategy to determine whether changes should be made to better address the health needs of its communities.

IV. SUMMARY OF THE COMMUNITY HEALTH NEEDS IDENTIFIED

Akron General's prioritized community health needs as determined by analyses of quantitative and qualitative data include:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health
- Socioeconomic Issues

In addition to the prioritized community health needs, themes of health equity, social determinants of health, and medical research and education are intertwined in all community health components and impact multiple areas of community health strategies and delivery. Cleveland Clinic is committed to promoting health equity and healthy behaviors in our communities. The hospital addresses these overarching themes through a variety of services and initiatives including cross-sector health and economic improvement collaborations, local hiring for the hospital workforce, mentoring of community residents, in-kind donation of time and sponsorships, anchor institution commitment, and caregiver training for inclusion and diversity.

COVID-19 Considerations

The COVID-19 global pandemic declared in early 2020 has caused extraordinary challenges for healthcare systems across the world including Akron General. Keeping front line workers and patients safe, securing protective equipment, developing testing protocols, and helping patients and families deal with the isolation needed to stop the spread of the virus all took priority as the pandemic took hold.

Many of the community benefit strategies noted in the previous 2019 implementation strategy were temporarily paused or adjusted to comply with current public health guidelines to ensure the health and safety of patients, staff, and other participants. Many of the strategies included in the 2023-2025 implementation strategy are a continuation or renewal of those that were paused during the pandemic as the community needs identified in the 2022 CHNA did not change greatly from those identified in the 2019 CHNA.

See the 2022 Akron General and other Cleveland Clinic CHNAs for more information:
www.clevelandclinic.org/CHNAReports

V. NEEDS HOSPITAL WILL ADDRESS

Each Cleveland Clinic hospital provides numerous services and programs in effort to address the health needs of the community. Implementation of our services focuses on addressing structural factors important for community health, strengthening trust with residents and stakeholders, ensuring community voice in developing strategies, and evaluating our strategies and programs.

Strategies within the ISRs are included according to the prioritized list of needs developed during the 2022 CHNA. These hospitals' community health initiatives combine Cleveland Clinic and local non-profit organizations' resources in unified efforts to improve health and health equity for our community members, especially low-income, underserved, and vulnerable populations.

A. Access to Healthcare

Access to Healthcare data analysis results describe community needs related to consumer expenditures for insurance, medical expenses, medicines, and other supplies. More expansive parameters include limitations to accessing healthcare described in terms of transportation challenges, resource limitations, and availability of primary care and other prevention services in local neighborhoods.

Cleveland Clinic continues to evaluate methods to improve patient access to care. All Cleveland Clinic hospitals will continue to provide medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. The financial assistance policy can be accessed here: Cleveland Clinic Financial Assistance.

Access to Healthcare Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Patient Financial Advocates assist patients in evaluating eligibility for financial assistance or public health insurance programs	Increase the proportion of eligible individuals who are enrolled in various assistance programs
B Address digital equity, utilize medically secure online and mobile platforms, connect patients with Cleveland Clinic providers for telehealth and virtual visits	Overcome geographical and transportation barriers, improve access to specialized care
C Build a pipeline of primary care physicians skilled at managing patient populations and addressing patients' social determinants of health needs through the Transformative Care Continuum program, a partnership between Akron General's Center for Family Medicine and the Ohio University Heritage College of Osteopathic Medicine	Improve the health of the community, reduce racial gaps

Access to Healthcare (continued)

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
D Expand the number of Community Health Workers at Akron General who serve as trusted members of the health care team	Ensure connection to medical, social, and behavioral services; improve health equity and outcomes

B. Behavioral Health

Akron General's 2022 CHNA also identified Behavioral Health as a prioritized need area. Behavioral Health encompasses Mental Health and Substance Use Disorders. Mental Health includes suicide, depression, and self-reported poor mental health rates. Substance Use Disorder relates to alcohol and drug use including drug overdoses. Community members described mental health challenges in the community, exacerbated by COVID-19 related stressors, resulting in increased alcohol and drug use starting in adolescence as a means of coping.

Behavioral Health Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Continue Akron General's Alcohol and Drug Recovery Center to provide comprehensive care and develop individualized treatment plans with the support of skilled chemical dependency counselors and a multidisciplinary team; proceeding with a full renovation of our inpatient Behavioral Health units to provide an updated healing environment for patients Continue the Recovery in Reach program in Emergency Departments in Akron, Bath, Stow, and Green to provide emergency treatment and care for patients with a substance use disorder and connect them to long-term treatment with support from a peer recovery coach Provide medication-assisted treatment through the inpatient outreach program and treat patients at the Center for Family Medicine's Suboxone Clinic	Improve access to inpatient and outpatient treatment services
B Implement the ERAS "Enhanced Recovery After Surgery" methodology for prescribing alternate medications to qualifying patients Educate providers within the Emergency Department to reduce the number of opioid prescriptions exceeding 3 days by 50 percent	Reduce the prescription of opioids, reduce patient exposure to opioids

Behavioral Health (continued)

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
C	Continue participation in Summit County's Opioid Abatement Advisory Council and ensure settlement dollars are effectively used for programs serving residents impacted by the opioid epidemic	Funding for evidence-based opioid addiction treatment and support services
D	Through the Opioid Awareness Center, participation in the Northeast Ohio Hospital Opioid Consortium, the Summit County United Way Addiction Leadership Council, and Summit County Opioid Task Force, and community-based classes and presentations, Cleveland Clinic will provide preventative education and share evidence-based practices	Reduce the number of individuals with opioid addiction and dependence
E	Collect unused medications through community-based drop boxes and a collection service In collaboration with the Summit County Community Partnership, distribute Deterra pouches for medication deactivation and disposal to inpatients via the hospital pharmacy	Reduce the availability of unused prescription opioids within the community

C. Chronic Disease Prevention & Management

Akron General's CHNA identified chronic disease and other health conditions as prevalent in the community (ex. heart disease, stroke, diabetes, respiratory diseases, hypertension, obesity, cancer, COVID-19). Prevention and management of chronic disease initiatives seek to increase healthy behaviors in nutrition, physical activity, and tobacco cessation.

Chronic Disease Prevention & Management Initiatives for 2023-2025 include:

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Through the hospital's Lifestyles Department, implement health promotion messaging, health education, and outreach programs related to reducing behavioral risk factors at venues including Health and Wellness Centers in Summit County, businesses, local schools, and other community sites	Decrease smoking, improve physical activity, improve nutrition, decrease stress levels, increase the number of individuals with a regular source of care
B	Provide free cancer screenings, including mammograms, breast exams, prostate, and skin cancer screenings to the community	Increase cancer screening rates

Chronic Disease Prevention & Management (continued)

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
C	In partnership with Akron's Pathways Community Hub, our Community Health Workers will continue to provide health education and care coordination during in-home visits; Social Determinants of Health needs will be identified and addressed by connecting individuals to community social services and other resources	Increase continuum of care services and community referrals, improve health equity
D	Continue to promote the Neighbor to Neighbor campaign of the Akron General Foundation which provides philanthropic support for community health initiatives that help shrink the access gap and address the medical complications of racial and socioeconomic disparities for those living in zip codes surrounding the hospital	Increase continuum of care services and community referrals, improve health equity

D. Maternal & Child Health

Akron General's 2022 CHNA continued to identify Maternal and Child Health as a prioritized health need in the community. Secondary data indicators include a range of children's health needs from babies with low birth weight to consumer expenditures on childcare. Primary data describes disparities among low-income and ethnic minority populations and link access to healthcare with prenatal care. Infant mortality rates at the local, state, and national levels have been particularly high for Black infants.

Maternal & Child Health Initiatives for 2023-2025 include:

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Continue evidence-based health education for expecting mothers and families including information about safe sleep, other risk factors for infant mortality, and long-acting reversible contraception	Improve the number of mothers who receive adequate prenatal care, reduce infant mortality rates, improve breastfeeding rates, increase pregnancy spacing
B	Serve in leadership capacity with Summit County's Full Term First Birthday collaborative, a collective impact collaborative advocating for policies, providing education, and informing the community of programs that promote healthy, full-term pregnancies	Improve the preterm birth inequity and reduce deaths due to unsafe sleep practices

Maternal & Child Health (continued)

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
C	Expand number of Community Health Workers who serve as the liaison between health care providers and expecting mothers, and who connect them to needed social services and other resources.	Improve the preterm birth inequity and continuum of care
D	Screen patients for safe sleep procedures, assess home environments as needed, and ensure infants have access to safe cribs.	Reduce SIDS cases, decrease infant mortality
E	Educate and provide screenings and care for women of childbearing age living at subsidized family housing sites and being served by community agencies. In partnership with ACCESS Inc. homeless shelter, family medicine team provides onsite medical care for women and children	Improve the number of mothers who receive adequate prenatal care, reduce infant mortality inequity, reduce maternal mortality inequity, increase birth spacing, reduce smoking during pregnancy, improve the preterm birth rate
F	Continue the Centering Pregnancy group prenatal care model for expecting mothers at Akron General's Women's Health Clinic and offer the program to community members Continue #MomLife support group for postpartum mothers from Centering Pregnancy to connect with each other and share issues such as child care, work life balance, baby's health needs, and immunization	Improve the preterm birth rate, increase pregnancy spacing, reduce preterm birth inequity, reduce SIDS cases, decrease infant mortality

E. Socioeconomic Issues

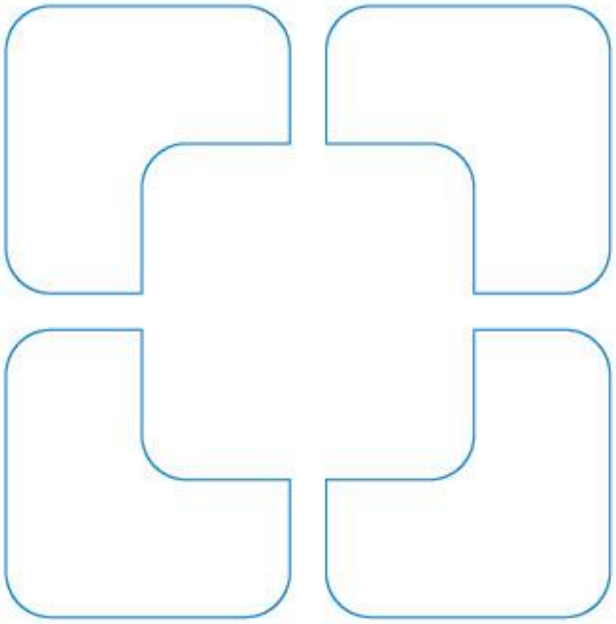
Akron General's 2022 CHNA demonstrated that health needs are multifaceted, involving medical as well as socioeconomic concerns. The assessment identified food security, affordable housing, employment, transportation, health literacy, structural racism, poverty, and environmental risk factors as significant concerns. Further, the primary and secondary impacts of COVID-19 have exacerbated many health disparities and barriers that were present before the pandemic. Socioeconomic Issues for this report are defined as a subset of social determinants of health (SDOH). Prevention & Safety, Affordable Housing, Violence, Falls, and Environmental Issues were prioritized socioeconomic issues described by primary and secondary data.

Socioeconomic Issues Initiatives for 2023-2025 include:

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Through the ICARE program, continue to work with patients who are at risk for hospital readmissions due to challenges like housing, food insecurity, and transportation and connect them with community resources to get them back on their feet	Increase continuum of care through community referrals and support services
B	Through lifesaving programs offered by the Level I Trauma Team: provide Stop the Bleed training at areas schools, businesses, and groups; provide Matter of Balance classes to help seniors avoid falls; and to prevent traumatic brain injuries and maximize recovery, conduct bike helmet giveaways; host programs to promote safe driving and motorcycle safety, encourage seat belt use, and discourage drinking and texting while driving	Increase community safety, decrease injuries related falls, motor vehicle accidents, and alcohol/drug use
C	Through the PATH (Providing Access to Healing) Center, Akron's only sexual assault nurse examiner unit, provides trauma-informed, compassionate care for victims of sexual assault, domestic violence, abuse and neglect, and other traumas	Minimize the impact of trauma and violence on overall health
D	In partnership with Akron Public Schools College and Career Academies, support student success at two Community Learning Centers (high schools) by participating in school-based career expos, providing in-classroom health speakers in alignment with curriculum, and giving guidance to the Academies through a steering committee and advisory councils	Improve graduation rates, increase the number of individuals earning a living wage
E	Provide workforce development and training opportunities for youth in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders	Increase diversity within the healthcare workforce, improve trust in providers, improve local provider shortages
F	In partnership with the Akron Canton Regional Foodbank, operate an onsite Food Pantry at Akron General to provide emergency food for patients and the community	Meet essential nutrition needs and reduce food insecurity

While this ISR outlines specific strategies and programs identified to address the 2022 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Socioeconomic Issues, it does not reflect all the work being done by Akron General Hospital to improve community health. Through this iterative process, opportunities are identified to grow and expand existing work in prioritized areas as well as implement additional programming in new areas. These ongoing strategic conversations will allow Akron General Hospital to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

For more information regarding Cleveland Clinic Community Health Needs Assessments and Implementations Strategy Reports, please visit www.clevelandclinic.org/CHNAReports or contact CHNA@ccf.org.



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