Cleveland Clinic
Akron General

Community Health Needs Assessment

2025

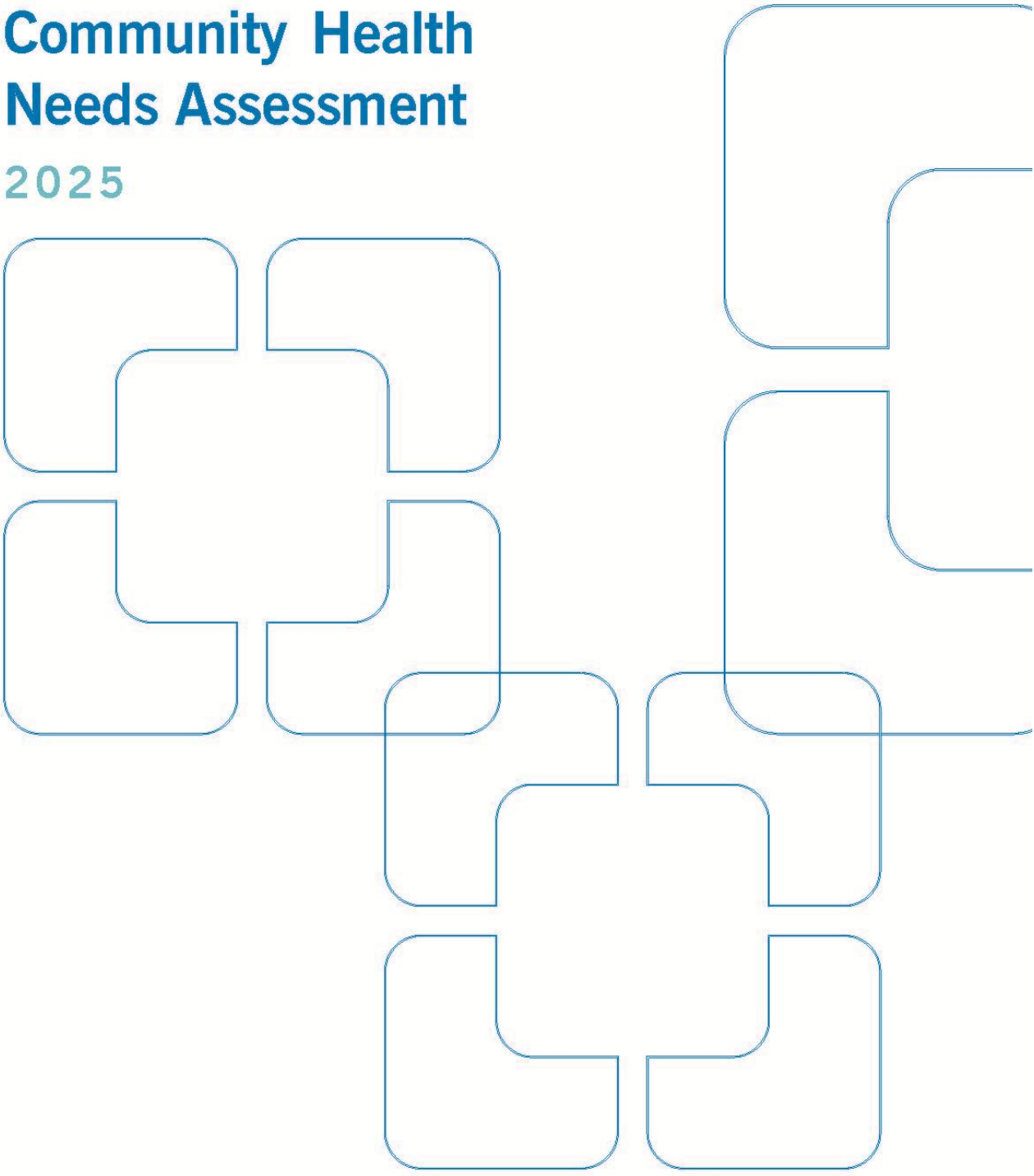


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Akron General 2025 Community Health Needs Assessment

Introduction

Cleveland Clinic Akron General (Akron General or "the hospital"), founded in 1914 as Peoples Hospital, is a 478-bed[1] teaching and research medical center that serves as the hub for Cleveland Clinic's Southern Region. The hospital is nationally recognized for its advanced specialty care, including stroke services, a Level I Trauma Center, and the McDowell Cancer Institute, which has earned the Commission on Cancer's Outstanding Achievement Award. Akron General has also been repeatedly recognized among America's Most Wired & Most Wireless Hospitals for its integration of technology in care delivery. With 24-hour access to trauma specialists, diagnostic services, and surgical teams, Akron General combines leading expertise and innovation with a commitment to providing comprehensive, high-quality care to the Akron community and beyond.

As part of the broader Cleveland Clinic health system, Akron General upholds the tripartite mission of clinical care, research, and education. Cleveland Clinic is a nonprofit, multispecialty academic medical center that integrates hospital-based services with innovative research and the training of future healthcare professionals. Currently, with more than 82,000 caregivers, 23 hospitals, and 280 outpatient facilities around the world, Cleveland Clinic is recognized as one of the world's leading healthcare systems. Its collaborative, patient-centered model of care promotes improved outcomes and enhances quality of life for patients both locally and internationally.

The Cleveland Clinic health system includes its flagship academic medical center near downtown Cleveland, fifteen regional hospitals in Northeast Ohio, a children's hospital and children's rehabilitation hospital, and additional hospitals and facilities in Florida and Nevada. Each hospital, including Akron General, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Akron General benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Akron General also plays a vital role within its immediate neighborhood, advancing the Cleveland Clinic's mission of improving community health. The hospital actively supports programs, partnerships, and services that address local health needs and promote health for all. It has received national recognition for excellence in patient safety and care quality, and remains committed to treating every patient with kindness, dignity, and respect.

The Cleveland Clinic's legacy as a pioneering institution began in 1921 as a multispecialty group practice, and it continues to lead through medical firsts, global expansion, and a commitment to community health. Today, Akron General exemplifies this vision by delivering high-quality care, supporting health-focused research, and fostering community partnerships that help address both medical and social drivers of health.

[1] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q3 2025) 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.

Akron General is a trusted part of the community and continues to grow and improve to meet the needs of its patients. To learn more, visit: my.clevelandclinic.org/locations/akron-general.

CHNA Background

As part of its mission to improve health and well-being in the communities it serves, Akron General led a Community Health Needs Assessment (CHNA) process to better understand the most important health issues facing residents. The Patient Protection and Affordable Care Act, enacted on March 23, 2010, requires not-for profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements of the Internal Revenue Code 501(r). Cleveland Clinic engaged Conduent Healthy Communities Institute (HCI) to guide the 2025 CHNA process using national, state, and local secondary data and qualitative community feedback.

Akron General Community Definition

The community definition describes the zip codes where approximately 75% of Akron General Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Akron General community that served as a guide for data collection and analysis for this CHNA. Table 1 lists zip codes and associated municipalities that comprise the community definition.

Figure 1: Akron General Community Definition

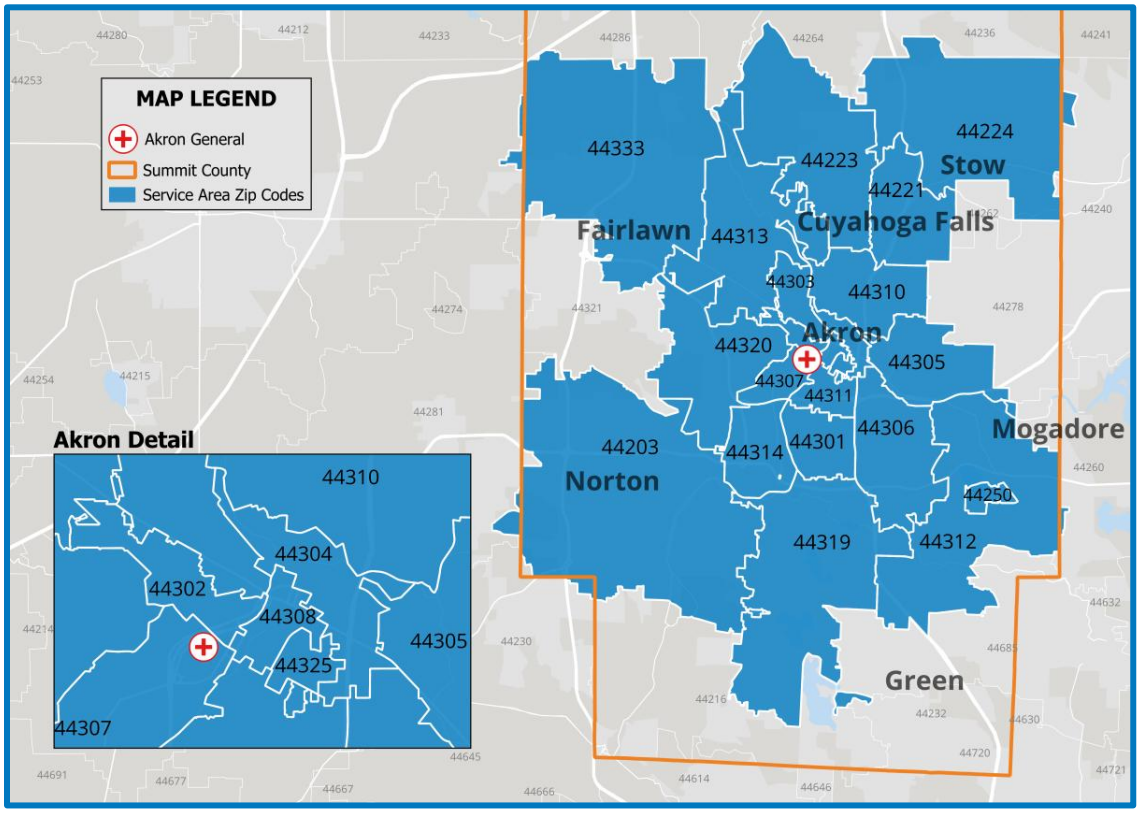


Table 1: Akron General Community Definition

Zip Code	Postal Name	Zip Code	Postal Name
44203	Barberton	44307	Akron (Lane-Wooster)
44221	Cuyahoga Falls	44308	Akron (Downtown)
44223	Cuyahoga Falls	44310	Akron (Chapel Hill)
44224	Stow	44311	Akron (Downtown)
44250	Lakemore	44312	Akron, Coventry
44301	Akron (Firestone Park)	44313	Akron (Merriman Valley)
44302	Akron (Highland Square)	44314	Akron (Kenmore)
44303	Akron (Elizabeth Park Valley)	44319	Akron, Coventry
44304	Akron (Elizabeth Park Valley)	44320	Akron (West Akron)
44305	Akron (Goodyear Heights)	44325	Akron (University)
44306	Akron (Ellet)	44333	Akron, Fairlawn

Secondary Data Methodology and Key Findings

Secondary Data Scoring

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, health-related social needs, and quality of life. The data are primarily derived from state and national public secondary data sources such as the U.S. Census American Community Survey (ACS Survey), Centers for Disease Control & Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), County Health Rankings, Feeding America, and the National Cancer Institute. These indicators were analyzed at both the county level and within a defined 22-zip-code Akron General community area. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced five key health priorities, Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, highlighting differences in outcomes by groups.

Other Community Assessment and Improvement Plans

An environmental scan was conducted to supplement quantitative data and further contextualize health needs across the hospital's defined community. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts, including reports from the nonprofits, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs prioritized in this 2025 CHNA process for Akron General.

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; behavioral health treatment gaps remain significant; chronic disease management is challenged by food insecurity and inadequate recreational infrastructure; differences in maternal and child health outcomes exist among

communities; and health-related social needs, particularly poverty, housing insecurity, and gun violence, impact all other areas of health.

Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations with community stakeholders were conducted across the Akron General community. Community stakeholders from 11 organizations provided feedback for the Akron General community. Participants represented sectors including public health, mental health, housing, food access, child and family services, and grassroots organizations. Feedback consistently reinforced the five identified health priorities and revealed community-specific challenges affecting health outcomes, such as long wait times for care, gaps in behavioral health support, housing-related health risks, and challenges of accessing culturally competent prenatal care. Economic hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and system-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

Akron General's 2025 Community Health Needs Assessment reaffirms its commitment to addressing five core health priorities based on a rigorous synthesis of primary data in the form of community stakeholder interviews, secondary indicators from national and state data sources, and a regional environmental scan. The following five prioritized health needs will help shape the hospital's Implementation Strategy Reports (ISR) for the subsequent three years:

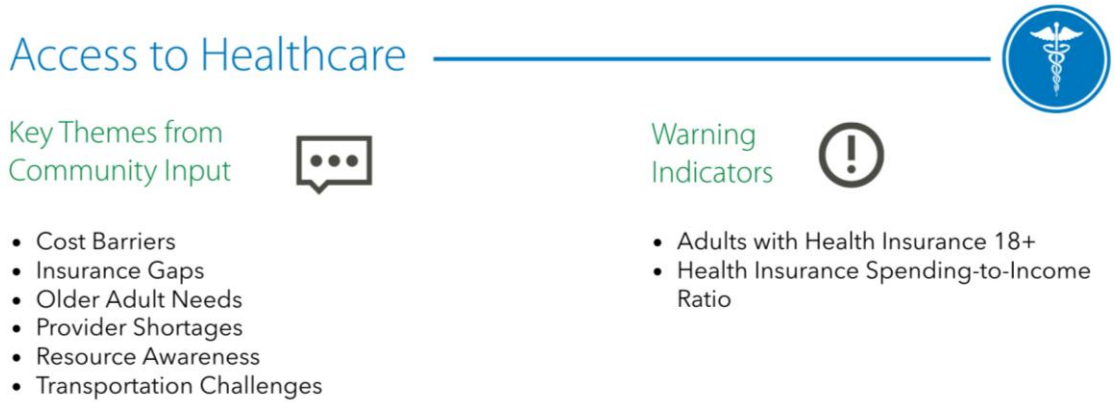


These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that the hospital's defined community continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to address reducing differences in health outcomes across populations in the community served by Akron General.

The five prioritized community health needs identified in this 2025 Akron General CHNA are summarized below. Within each summary, pertinent information pertaining to

secondary data findings, primary data findings and relevant demographics, social drivers of health, and differences in health outcomes are highlighted. Full data details are included in the appendices section at the end of this report.

Prioritized Health Need #1: Access to Healthcare



Stakeholder interviews from the 2025 CHNA highlighted persistent challenges in ensuring equal access to healthcare for residents in the Akron General community. Barriers related to cost, transportation, provider shortages, and system navigation were described as key obstacles, particularly for low-income households, older adults, and rural residents. Even when insurance coverage is available, out-of-pocket costs and copays often make follow-up care and specialty services unaffordable. Several participants also emphasized that navigating the healthcare system is confusing, leaving many without timely or appropriate care.

Transportation barriers were identified as particularly severe in rural areas of Summit County, where limited public transit options make it difficult for patients to reach appointments consistently. This concern was seen as especially pressing for older adults, people with disabilities, and families with limited financial resources. Stakeholders also underscored that workforce shortages, long wait times, and gaps in culturally and linguistically appropriate services limit the system's ability to meet growing needs.

Overall, stakeholders emphasized that improving access requires more integrated care models, expanded telehealth, and increased investment in local resources. Participants also noted the importance of building trust between providers and patients, strengthening patient education, and addressing the broader health-related social barriers that prevent residents from engaging fully with preventive and ongoing care.

About three-fourths of adults across Summit County (75.0%) have health insurance, and the lowest insured rates in the county are in the zip codes surrounding Akron General, including: 44311 (Downtown Akron), 44325 (University of Akron), 44307 (Akron, Lane-Wooster), and 44304 (Akron, Elizabeth Park Valley), all of which have an adult insured rate under 60%. Although the Akron General community has a higher median income than that of the U.S., the typical cost of health insurance in Summit County (6.8% of household income) is higher than that of the U.S. (5.9%).

Conduent HCI's Community Health Index (CHI) can help to estimate health risk for specific geographies based on health-related social needs. Across the Akron General community, there are seven zip codes with a CHI value greater than 90, indicating especially high health care needs, compared to other U.S. zip codes: 44308 (Downtown Akron), 44311 (Downtown Akron), 44304 (Akron, Elizabeth Park Valley), 44310 (Akron, Chapel Hill), 44306 (Akron, Ellet), 44250 (Lakemore), and 44307 (Akron, Lane-Wooster).

Prioritized Health Need #2: Behavioral Health



Behavioral Health emerged as one of the priorities for the Akron General community in the 2025 CHNA. Stakeholders consistently emphasized behavioral health as a top community concern. Mental health challenges, including rising rates of depression, anxiety, and trauma, were cited as particularly acute among youth, older adults, and marginalized populations. Substance use disorder was frequently mentioned alongside these concerns, with opioids, alcohol, and polysubstance use remaining significant drivers of poor health outcomes. Participants described the compounding impact of social isolation, poverty, and limited family support, which often intensify both mental health struggles and substance misuse.

A major barrier identified was limited access to behavioral health services, including shortages of providers, long wait times, and difficulties finding affordable or culturally competent care. Many stakeholders highlighted the shortage of mental health professionals willing to accept Medicaid or uninsured patients, leaving some populations with unmet needs. Stigma around seeking behavioral health care also persists, discouraging residents from accessing treatment when they need it most. Several participants connected these gaps to increased reliance on emergency departments for crises that could have been prevented with more consistent access to early intervention, counseling, and community-based support.

Stakeholders stressed the importance of expanding integrated and community-based behavioral health models that co-locate services, improve coordination, and address both

mental health and substance use disorders in tandem. They also highlighted the need for more prevention and education programs, particularly those targeting youth resilience and coping skills. Expanding peer support programs, crisis stabilization options, and school-based interventions were viewed as promising solutions to address growing behavioral health needs across the Akron General community.

Secondary data also indicate mental and behavioral health challenges for the Akron General community population, including high rates of depression and high rates of self-reported poor mental health that continue to rise. The Summit County rates of alcohol-involved driving deaths and deaths due to drug poisoning are both in the top quartile of all U.S. counties. The county's Black/African American population experiences a higher risk of drug poisoning death than the general population (60.8 vs. 42.8 deaths per 100,000). Although the county's rate of drug poisoning deaths is among the highest in the country, the Summit County rate is notably lower than the Ohio state-wide rate, suggesting that substance use is also a more wide-spread challenge across the state.

Conduent HCI's Mental Health Index (MHI) estimates differences in mental health needs between geographies, using health-related social need data. Across the Akron General community, there are seven zip codes with a MHI value greater than 95, indicating exceptionally high mental health needs, compared to other U.S. zip codes: 44307 (Akron, Lane-Wooster), 44306 (Akron, Ellet), 44320 (West Akron), 44311 (Downtown Akron), 44310 (Akron, Chapel Hill), 44314 (Akron, Kenmore).

Prioritized Health Need #3: Chronic Disease Prevention and Management

Chronic Disease Prevention & Management

Key Themes from Community Input

- Advanced-Stage Cancer Diagnoses
- Cost and Education Barriers
- Heart Disease and Stroke Burden
- High Diabetes Prevalence
- Limited Healthy Food Access
- Low Preventive Screening Rates
- Need for Coordinated Supports
- Obesity and Poor Nutrition
- Older Adult Vulnerabilities
- Transportation and Mobility Gaps

Warning Indicators

- People 65+ Living Alone
- Asthma: Medicare Population
- Depression: Medicare Population
- Chronic Kidney Disease: Medicare Population
- Adults who Frequently Cook Meals at Home
- Age-Adjusted Death Rate due to Alzheimer's Disease
- Oral Cavity and Pharynx Cancer Incidence Rate
- Age-Adjusted Death Rate due to Prostate Cancer
- COPD: Medicare Population
- Mammogram in Past 2 Years: 50 -74

Stakeholder interviews for the Akron General 2025 CHNA highlighted chronic disease prevention and management as a significant health concern for the community. Participants consistently identified high rates of conditions such as diabetes, hypertension, heart disease, and obesity as pressing health challenges. These conditions were described as strongly linked to lifestyle factors, including poor nutrition, limited access to affordable healthy food, and insufficient opportunities for physical activity. Stakeholders also noted that many community members struggle to maintain consistent

disease management due to fragmented care systems, cost barriers, and limited access to specialists.

Another key theme centered on the importance of preventive services and early detection. Several participants underscored the need for increased education around nutrition and wellness, more accessible preventive screenings, and better coordination between primary care and community-based programs. Stakeholders emphasized that targeted strategies for certain groups, particularly older adults, and low-income residents, are essential for reducing differences in health outcomes and supporting long-term wellness. The impact of social drivers, such as housing instability, transportation barriers, and financial stress, was described as a critical factor influencing both prevention and management of chronic conditions.

Finally, stakeholders called for broader system-level responses that bring medical, behavioral, and social support together in integrated care models. Suggestions included expanding mobile health units, improving chronic disease education within schools and workplaces, and developing community wellness initiatives that empower residents to adopt healthier behaviors. Stakeholders agreed that addressing chronic diseases requires a proactive, community-driven approach that combines clinical excellence with practical, accessible resources tailored to the community's population.

Primary and secondary data findings across topics such as nutrition, cancer, cardiovascular health, and aging consistently revealed differences in health outcomes influenced by income, location, and barriers in care delivery.

Nutrition, Healthy Eating, and Wellness

Stakeholders frequently pointed to poor nutrition and unhealthy lifestyle habits as major contributors to chronic disease burden in the community. Limited access to affordable, healthy foods was highlighted as an obstacle, particularly in lower-income neighborhoods. Participants also connected obesity and inactivity to preventable chronic conditions, noting that education on healthy eating and increased opportunities for physical activity would help support long-term wellness. Some emphasized the importance of community programs that combine nutrition, fitness, and mental health to foster more sustainable health improvements.

Secondary data show that across Summit County, residents are less likely to cook meals at home, more likely to use fast food, and are also more likely to be obese than nearly all other U.S. counties. Food insecurity is also a challenge. The child food insecurity rate in particular is higher in Summit County (21.0%) than most other Ohio counties, and both Black/African American and Hispanic/Latino residents are more likely than the general population to experience food insecurity across the county. The Conduent HCI Food Insecurity Index (FII) offers a more detailed geographic understanding of food access across the Akron General community, using sociodemographic data. In fact, there are seven zip codes across the community with FII scores above 95, indicating exceptionally high food access needs, compared to other U.S. zip codes: 44311 and 44308 (Downtown Akron), 44307 (Akron, Lane-Wooster), 44306 (Akron, Ellet), 44304 (Akron, Elizabeth Park Valley), 44320 (West Akron), and 44310 (Akron, Chapel Hill).

Cancer
Concerns about cancer centered around delayed screenings, affordability of specialty care, and barriers to early detection. Several participants noted that limited awareness and transportation barriers prevent timely utilization of available resources. Stakeholders emphasized the need for better outreach, education, and access to affordable preventive screenings. Access to cancer specialists within the community was also flagged as a gap, reinforcing the importance of improving connections between primary care and specialty cancer care.

Data on the Summit County population indicate especially low levels of mammography screenings, as well as relatively high rates of breast cancer cases that continue to increase. Summit County residents also experience elevated risks of oral cancer. Although the county-wide prostate cancer rate is lower than state-wide and national benchmarks, this risk is higher for the county's Black/African American population (161.8 vs. 109.6 per 100,000 males).

Death rates due to cancer in Summit County are largely comparable to state-wide rates and continuing to decrease, but these rates still exceed Healthy People 2030 targets. Additionally, the death rate due to any cancer is significantly higher for the Black/African American population than the overall county rate (186.2 vs. 160.6 deaths per 100,000).

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions
Diabetes and cardiovascular diseases were consistently mentioned as highly prevalent and closely tied to nutrition, stress, and economic hardship. Stakeholders described challenges in accessing ongoing management services, medications, and consistent follow-up care. The financial burden of prescriptions and specialist visits was identified as a key barrier to disease control. Stakeholders also highlighted the importance of early intervention strategies, education, and screening programs for certain populations. Limited community-level resources for hypertension management and stroke prevention were noted as gaps that need strengthening.

Asthma, COPD, and other respiratory illnesses were also identified as areas of concern, often linked to environmental triggers, housing conditions, and smoking or vaping. Stakeholders highlighted that while resources exist, they are not always accessible or well-coordinated. Some participants emphasized that co-occurring chronic conditions further complicate care management, leading to higher costs and poorer outcomes when integrated services are not available.

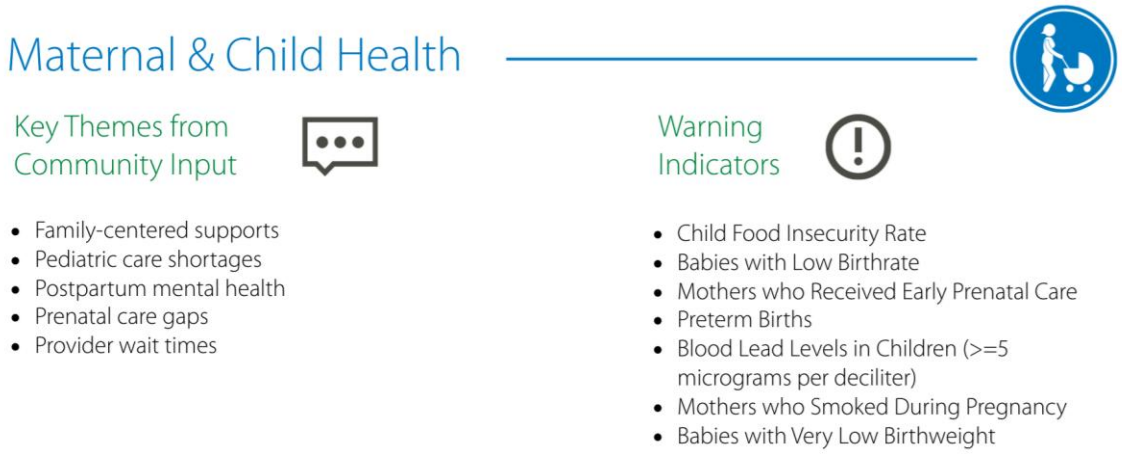
The rate of adults with diabetes in Summit County is in the highest quartile of all U.S. counties. Medicare data also indicate high levels of chronic kidney disease, a common complication of untreated diabetes. The rate of chronic kidney disease among the county's Medicare population (22.0%) is one of the highest in the state and nation, and this health outcome is more common among the county's Black/African Medicare population (31.0%).

The Summit County death rates due to coronary heart disease (88.0 per 100,000) and stroke (39.7 per 100,000) are both lower than the state-wide rate but still exceed their respective Healthy People 2030 targets (71.1 and 33.4 per 100,000, respectively).

Older Adult Health
Older adults were described by stakeholders as facing disproportionate challenges with chronic disease management due to mobility limitations, transportation barriers, and fixed incomes. Participants highlighted the struggles seniors experience in managing multiple conditions simultaneously, such as diabetes, heart disease, and arthritis, which place heavy demands on fragmented support systems. Social isolation and limited caregiver support were also identified as risks to both physical and mental health. Stakeholders underscored the need for community-based senior programs, improved coordination of care, and resources to support aging in place safely.

Social well-being and cognitive health are significant concerns for the Akron General community's older adult population. Despite rates of developing Alzheimer's disease that are comparable to state and national benchmarks, the county's death rate due to Alzheimer's disease (43.5 per 100,000) is among the highest across the state of Ohio and trending upward. The county's older adult population experience especially high rates of depression and high rates of living alone, compared to other counties.

Prioritized Health Need #4: Maternal and Child Health



Stakeholders participating in the 2025 CHNA for Akron General emphasized that reducing differences in health outcomes in prenatal and postpartum care remain significant, especially for low-income women. Access to affordable maternity services and culturally responsive providers was described as inconsistent, with many women struggling to navigate insurance barriers, transportation challenges, and limited local provider availability. Rising maternal mental health concerns, such as postpartum depression and anxiety, were noted as an area requiring urgent attention.

Participants also described substantial gaps in pediatric and adolescent care, particularly in mental and behavioral health services. Shortages of providers and long wait times were repeatedly cited as barriers that delay early intervention and place added strain on families. Stakeholders stressed that children and adolescents are increasingly facing challenges tied to trauma, family stressors, and financial instability, underscoring the need for holistic support.

Another theme centered on the importance of coordinated, family-centered care that extends beyond the clinical setting. Stakeholders highlighted the need for improved linkages between hospitals, schools, social services, and community-based organizations to provide comprehensive support for parents and children. Participants underscored that addressing maternal and child health challenges requires a combination of preventive health services, supportive environments, and expanded access to affordable childcare and developmental programs.

Secondary data indicate concerning trends regarding maternal and infant health for the Akron General community. Mothers in Summit County are relatively less likely to receive early prenatal care and are also about twice as likely as the overall U.S. population to smoke during their pregnancy (7.4% vs. 3.7%). Preterm births are also more common in Summit County (11.0%), especially among Black/African American mothers (33.3%), and the county-wide percentage of babies with low birthweight (9.4%) is one of the highest across the state.

Summit County has one of the highest rates of children living in single-parent households across Ohio, which can present health challenges for both the child and caretaker. Children across the county also experience a food insecurity rate that is higher than both the state-wide and national rates. Lead poisoning also remains a challenge in Summit County. County-wide, 1.7% of children have concerning levels of lead exposure, a rate which is higher than most other counties across Ohio.

Prioritized Health Need #5: Health-Related Social Needs



Stakeholders who participated in the 2025 CHNA process described how health-related social needs play a central role in shaping health outcomes for the Akron General community. Participants emphasized that poverty, unemployment, and underemployment remain persistent challenges that affect residents' ability to access

healthcare, maintain stable housing, and secure healthy food. Rising housing costs and limited affordable housing stock were described as barriers that force families into unstable or unsafe living conditions, further exacerbating health risks. In addition, transportation gaps and financial strain make it difficult for individuals, particularly low-income households, to attend medical appointments and sustain ongoing treatment.

Stakeholders also highlighted the connection between health-related social needs and other health priorities, noting that financial insecurity and lack of resources contribute to behavioral health challenges, substance use, and chronic disease management difficulties. Several participants pointed to the added burden of food insecurity and the lack of accessible healthy food options as compounding risk factors for diabetes, hypertension, and obesity. These conditions were seen as interconnected with broader neighborhood differences, including disinvestment in community resources and limited opportunities for workforce development.

Overall, stakeholders stressed the importance of addressing these social and economic barriers through coordinated cross-sector efforts. They underscored the need for policies and programs that expand affordable housing, improve food access, and strengthen workforce and educational opportunities as a foundation for healthier communities. Solutions that are community-driven, culturally tailored, and sustainable were viewed as essential to building long-term resilience.

Secondary data show that the Akron General community population has relatively lower levels of income and higher levels of poverty than Ohio and the U.S. overall. Despite these lower levels of wealth, housing costs in Summit County are among the highest in Ohio. Income inequality is high in Summit County, and is increasing. The median household income for Black/African American ($36,515) and Hispanic/Latino ($57,288) residents is significantly lower than the overall population.

Community violence is especially concerning across Summit County. The county population experiences elevated death rates due to firearms and homicide, exceeding state-wide rates and continuing to increase. The county's violent crime rate is one of the highest across the state, and the same is true for the rate of alcohol-impaired driving deaths.

Prioritized Health Needs in Context

Each of the five community health needs explored above reflect persistent and interconnected challenges shaped by broader social, economic, and environmental conditions. Together, these findings underscore the importance of place-based, needs-based approaches to improve health outcomes. The following sections provide an overview of the demographic and social factors influencing health in the Akron General community, offering additional context for understanding the differences and opportunities outlined in this report.

Secondary Data Overview

Demographics and Health-Related Social Needs

The demographics of a community significantly impact its health profile.[2] Different groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community served by Akron General, including the economic, environmental, and social drivers of health. The social drivers 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.[3] In addition to these highlights, detailed findings from the secondary data analysis can be found in Appendix B.

Geography and Data Sources

Data are presented at various geographic levels (county, zip code, and/or census tract) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data may mask issues 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 differences in health outcomes.

All estimates are sourced from Claritas Pop-Facts® (2024 population estimates) and American Community Survey one-year (2023) or five-year (2019-2023) estimates unless otherwise indicated.

Population Demographics of the Akron General Community

According to the 2024 Claritas Pop-Facts® population estimates, the Akron General community has an estimated population of 371,204 persons, making up approximately 69.4% of the Summit County population. The median age in the community is 41.2 years, which is older than that of Ohio (40.5 years). About a quarter of the population (26.2%) is between 25-44 years old.

The majority of the population is White (68.7%). Residents are more likely than the overall Ohio population to be Black/African American (18.5% vs. 12.8%) or Asian (4.6% vs. 2.7%), but less likely than the overall Ohio population to be Hispanic/Latino (3.2% vs. 5.0%).

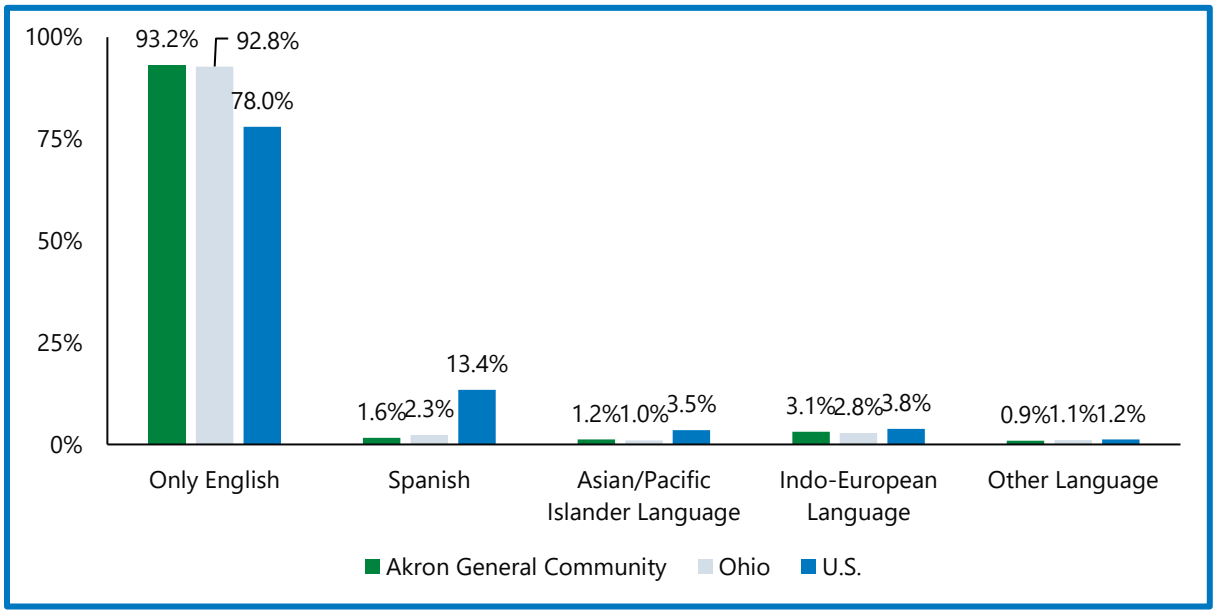
As shown in Figure 2, the vast majority of the Akron General population aged five and above speaks primarily English at home (93.2%). Very few residents speak Spanish at home (1.6%), and 3.1% speak another Indo-European language. Understanding

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

[3] Centers for Medicare and Medicaid (CMS) (2025). Social Drivers of Health and Health-Related Social Needs. https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs

countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

Figure 2: Population 5+ by Language Spoken at Home: Hospital Community, State, and Nation



Service area and state values: Claritas Pop-Facts® (2024 population estimates)

U.S. value: American Community Survey five-year (2019-2023) estimates

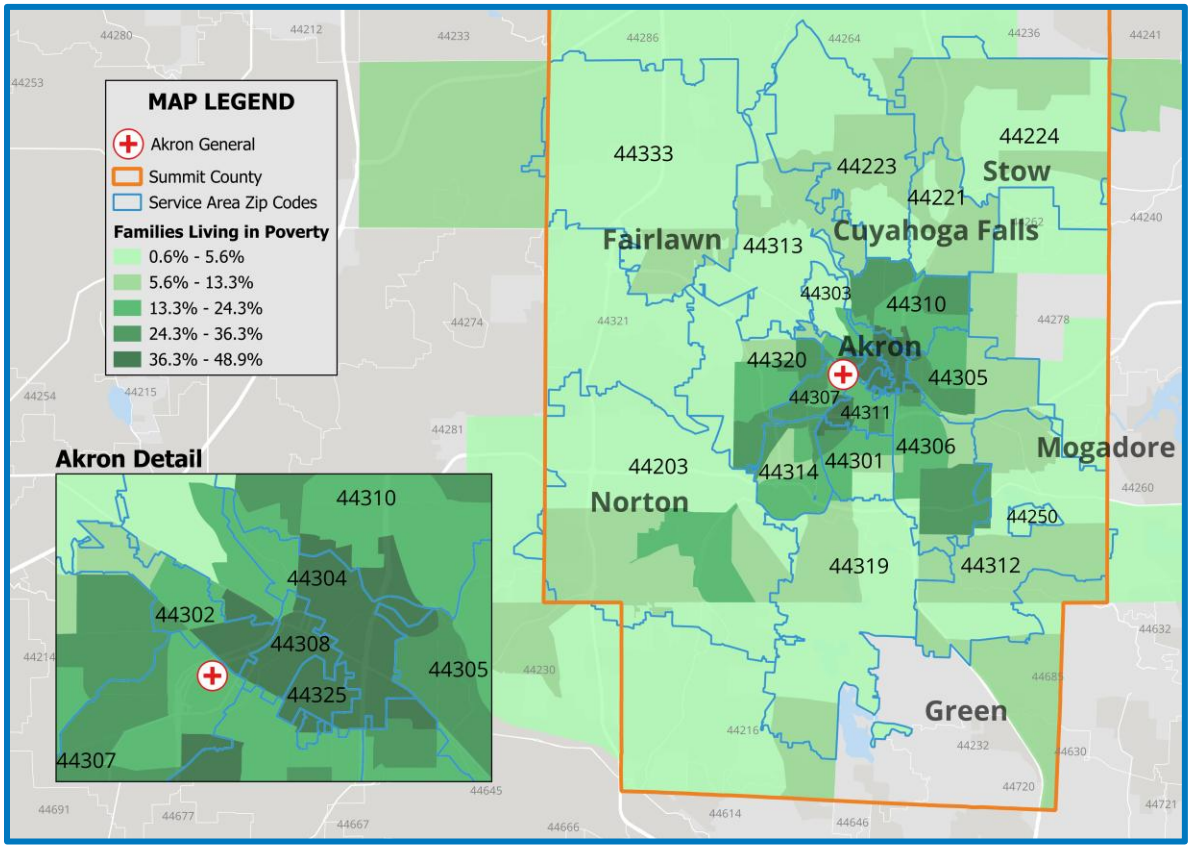
Income and Poverty

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.[4]

The median household income for the Akron General community is $60,982 which is lower than that of Ohio overall ($60,982). Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. In the Akron General community, 11.1% of families live below the poverty level. This is more than the state-wide and national poverty rates (9.4% and 8.8%, respectively). Poverty levels differ geographically across the Akron General community (Figure 3). At this zip code level, some of the highest levels of poverty across the region are in 44308 (Downtown Akron) and 44304 (Akron, Elizabeth Park Valley), with 59.6% and 38.3% of families living in poverty, respectively.

[4] 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 3: Families in Poverty by Census Tract, Akron General Community



Claritas Pop-Facts® (2024 population estimates)

Education and Employment

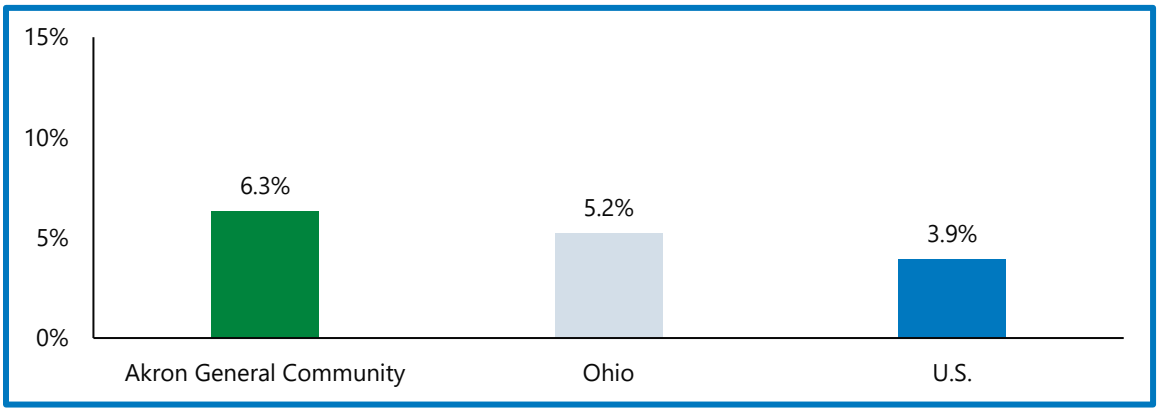
Education is an important indicator of health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health.[5] Higher levels of education may also lead to better job opportunities which, in turn, impact health. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes.[6]

The vast majority of the population within the Akron General community have a high school degree or higher (90.5%) and 29.4% have a bachelor's degree or higher. As seen in Figure 4, the unemployment rate (6.3%) is higher than that of Ohio and the U.S..

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

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

Figure 4: Population 16+ Unemployed: Hospital Community, State, and Nation



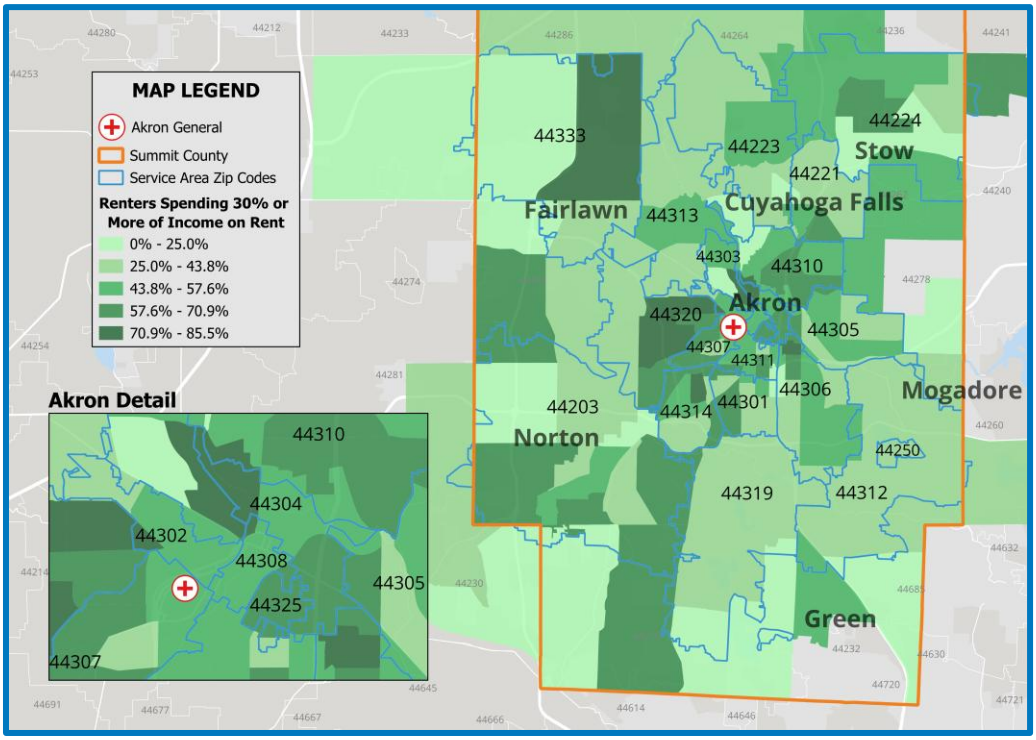
Service area and state values: Claritas Pop-Facts® (2024 population estimates)

U.S. value: American Community Survey five-year (2019-2023) estimates

Housing and Built Environment

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Across Summit County, 12.9% of households have severe housing problems, such as: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Additionally, 46.6% of renters in the county spend at least 30% of their income on rent (Figure 5).

Figure 5: High Rent Burden by Census Tract, Akron General Community



American Community Survey five-year (2019-2023) estimates

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. The vast majority of Summit County households have internet access (90.4%). At the zip code level, the lowest levels of internet access in the Akron General community are in the zip code 44307 (Akron, Lane-Wooster), where only 75.0% of households have an internet subscription.

Community Health Indices

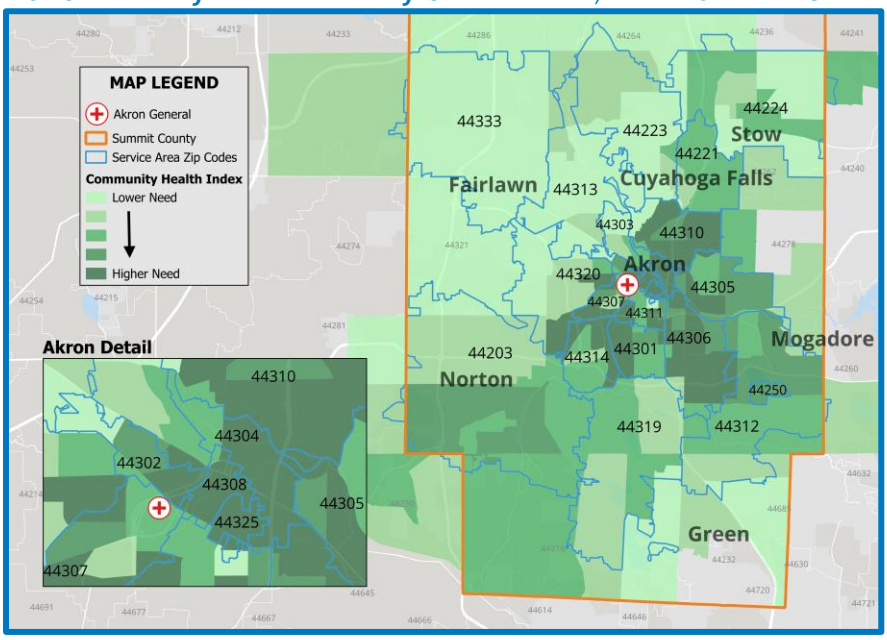
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the Akron General community at the zip code level.

Community Health Index

Conduent HCI's Community Health Index (CHI) can help to identify geographic differences in health outcomes across the county, down to the census tract level. The CHI uses health-related social need data that is strongly associated with poor health outcomes, such as preventable hospitalization or premature death, to estimate which geographic areas have the greatest health needs. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 6 illustrates which zip codes experience the greatest relative health needs in the Akron General community, as indicated by the darkest shade of green. At the zip code level, 44308 (Downtown Akron) and 44311 (Downtown Akron) have the highest index values, at 99.8 and 97.2, respectively. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the Akron General community.

Figure 6: Community Health Index by Census Tract, Akron General Community

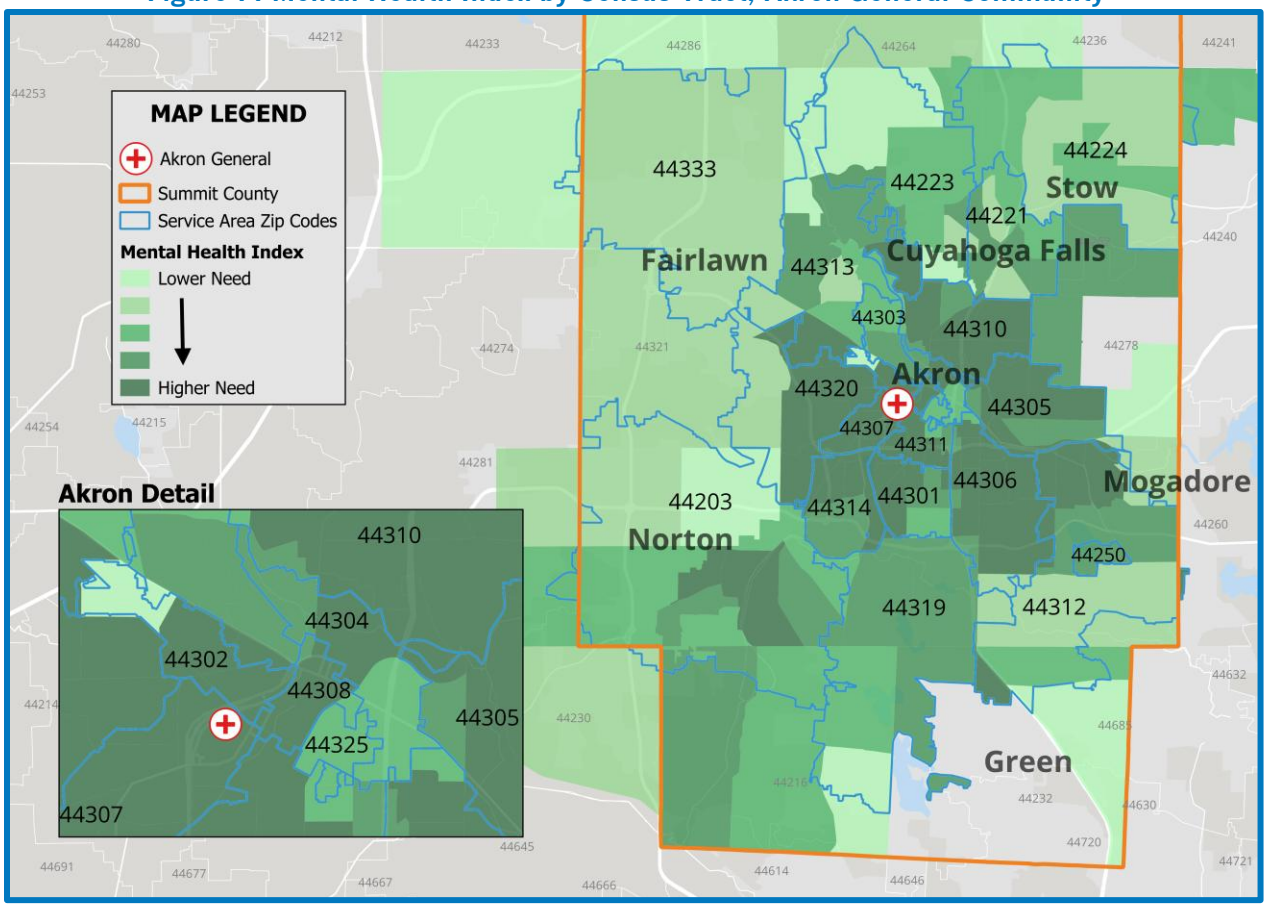


Mental Health Index

Conduent HCI's Mental Health Index (MHI) can help to identify geographic differences in mental health outcomes across the county, down to the census tract level. The MHI uses health-related social need data that is strongly associated with self-reported poor mental health to estimate which geographic regions have the greatest mental health needs. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 7 illustrates which zip codes experience the greatest relative need related to mental health in the Akron General Community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44307 (Akron, Lane-Wooster) and 44306 (Akron, Ellet) with MHI values of 99.6 and 99.4, respectively. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Akron General community.

Figure 7: Mental Health Index by Census Tract, Akron General Community

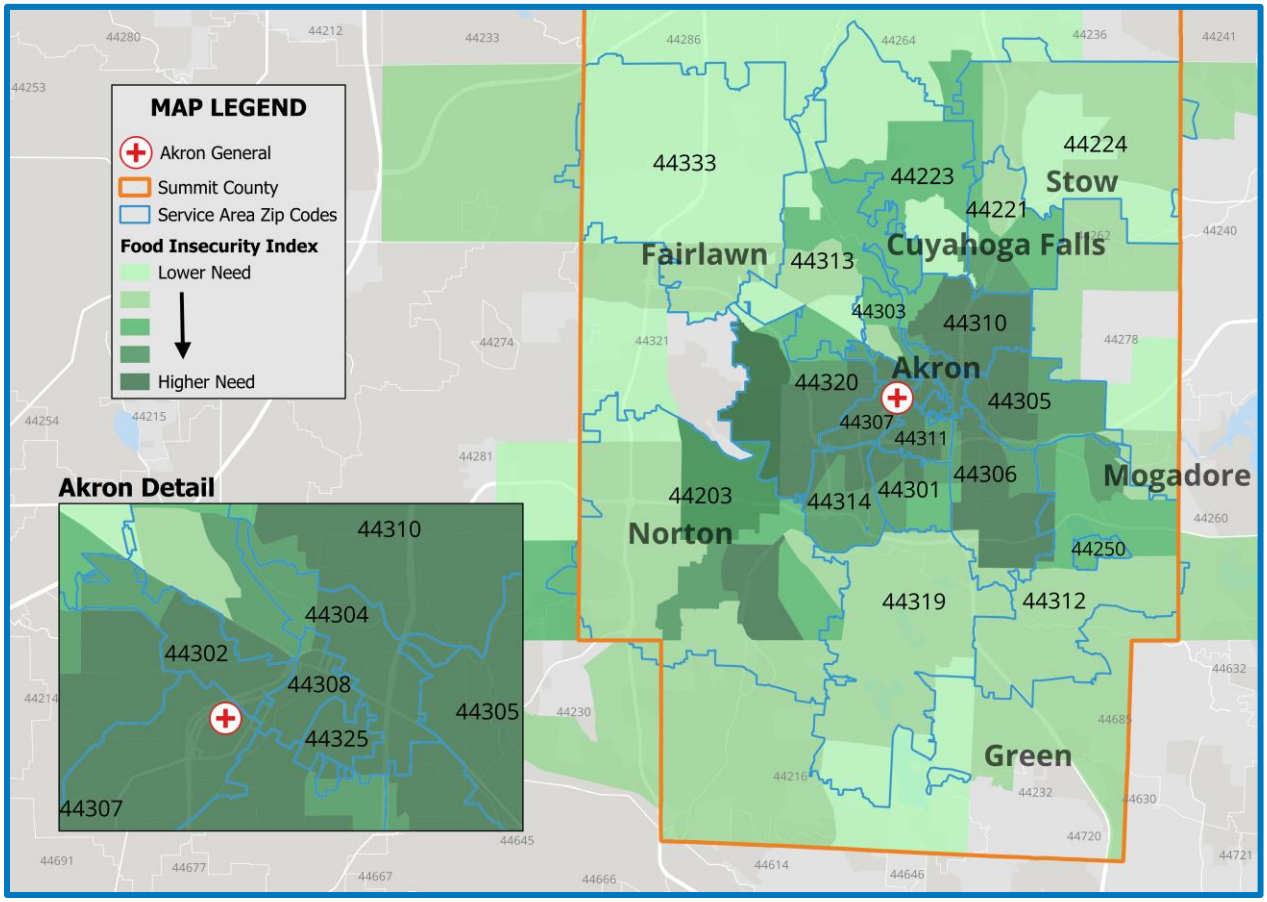


Food Insecurity Index

Conduent HCI's Food Insecurity Index (FII) can help to identify geographic differences in food access across the county, down to the census tract level. The FII uses health-related social need data that are strongly associated with poor food access to estimate which geographic regions have the greatest needs regarding food insecurity. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 8 illustrates which zip codes experience the greatest relative need related to food insecurity in the Akron General Community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44311 (Downtown Akron) and 44308 (Downtown Akron), with FII values of 99.7 and 99.3, respectively. See Appendix B for additional details about the FII and a table of FII values for each zip code in the Akron General community.

Figure 8: Food Insecurity Index by Census Tract, Akron General Community



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the Akron General community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the five prioritized health needs identified in Akron General's 2025 CHNA. Highlights of each of the relevant documents are provided below. The methodology for conducting the environmental scan is described in Appendix C.

2023 Ohio State Health Assessment[7]

The following points summarize the key alignment between the 2023 Ohio State Health Assessment and Akron General's prioritized health needs:

- Access to Healthcare:
    - There are widespread healthcare provider shortages, especially in primary care and mental health.
    - Many Ohioans face barriers such as limited insurance coverage, low health literacy, and lack of cultural and linguistically appropriate care.
- Behavioral Health:
    - Increased rates of depression, anxiety, and suicide among both youth and adults.
    - Significant unmet mental health needs and high levels of substance use, including youth drug use and adult overdose deaths.
- Chronic Disease Prevention and Management:
    - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
    - Obesity and poor nutrition are identified as key contributors to chronic conditions.
- Maternal and Child Health:
    - Stagnant or worsening maternal morbidity and infant mortality rates.
    - Persistent differences in health outcomes in birth outcomes, particularly for Black and low-income populations.
- Health-Related Social Needs:
    - Ongoing challenges related to poverty, housing affordability and quality, food insecurity, and transportation.
    - These social drivers of health are strongly linked to poor health outcomes across all priority areas.

[7] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.

2022 Community Health Needs Assessment (joint assessment conducted by Summa Health, Summit County Public Health, and the Summit Coalition for Community Health Improvement)[8]

Priority Areas Identified:

- Access and Barriers to Health Care
- Chronic Disease Prevention and Management
- Health for All
- Mental Health and Addiction
- Social Drivers of Health

2022 Akron Children's Hospital CHNA[9]

Priority Areas Identified:

- Mental and Behavioral Health (children's social and emotional health is urgent and critical need exacerbated by the COVID-19 pandemic and response, parents not satisfied with mental health services in the community for their child).
- Community Based Health and Wellness (encompasses basic health services, such as well visits and regular health screenings tailored to the needs of the community and in some cases located within it).
- Overarching commitments: Advancing Health for All, Improving Health Access, and Fostering Resiliency.

2022 Greater Akron LGBTQ+ Community Needs Assessment[10]

Healthcare Access

- Need for more accessible and LGBTQ+ affirming healthcare providers.
- Gaps in availability of primary care and preventative services.

Mental Health

- Strong demand for culturally competent therapists and mental health providers.
- Emphasis on reducing stigma and increasing access to mental health support.

Wellness & Prevention

- HIV prevention and sexual health education remain critical areas of focus.
- Broader wellness programs are recommended to promote holistic health.

Nutrition & Food Security

- Food insecurity is a barrier to well-being, particularly for LGBTQ+ youth and certain other groups.

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[8] Summa Health. (2022). *Summa Health Community Health Needs Assessment 2022* [PDF]. Summa Health. Retrieved from https://www.summahealth.org/about-us/about-summa/community-benefit-and-diversity/communityneedsassessments

[9] Akron Children's Hospital. (2022). *Community Health Needs Assessment.* Retrieved from https://www.akronchildrens.org/pages/Community_Health_Needs_Assessment.html?tab=sctabtwo

[10] Snyder, A. M., Roufael, J. S., DiDonato, A. E., Maikranz, N. E., & Alemagno, S. (2022). *Greater Akron LGBTQ+ community needs assessment.* Kent State University College of Public Health. Retrieved from https://www.lgbtqohio.org/news/lgbtq-community-needs-assessment-greater-akron

- More supportive food programs are needed to ensure access to healthy nutrition

United Way Community Needs Assessment: Summit & Medina Counties[11]

Priority Areas Identified (Medina County):

- Addiction/Substance Use: Gaps in treatment access and stigma around seeking help.
- Food Insecurity: Struggles with affordability and access to healthy food options.
- Housing: Difficulty finding affordable and available rental options.
- Mental Health: Limited accessibility, high costs, and stigma remain major barriers.
- Transit: Transportation access and affordability limit mobility and access to services.

Primary Data Overview

Community Stakeholder Conversations

Community stakeholders from 11 organizations provided feedback specifically for the Akron General community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

Individuals from the following organizations participated as key informants for the Akron General community:

- Akron Canton Regional Foodbank
- Akron Public Schools
- ASIA (Asian Services In Action)
- Boys and Girls Clubs of Northeast Ohio
- City of Akron
- Cleveland Clinic Children's
- Community Action Akron Summit Pathways Hub
- County of Summit ADM Board
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Minority Behavioral Health Group
- Summit County Public Health

Stakeholder discussions for the Akron General 2025 Community Health Needs Assessment affirmed Behavioral Health as the top community priority. Gaps in availability, affordability, and access to care were described as urgent challenges, particularly for youth, older adults, and low-income residents. Provider shortages, long wait times, and limited crisis response options restrict timely access to services. Stigma

[11] United Way of Summit & Medina County. *Understanding community needs in Summit & Medina counties.* United Way of Summit & Medina County. Retrieved from https://www.uwsummitmedina.org/united-way-of-summit-medina-names-in-summit-medina/

and the lack of culturally responsive care further prevent individuals from seeking treatment. Youth mental health, including depression, anxiety, and trauma, was repeatedly emphasized as an area of growing concern, often connected to family stress and the lingering effects of the COVID-19 pandemic.

Access to Healthcare and Chronic Disease Prevention and Management were also identified as pressing concerns. Stakeholders pointed to transportation barriers, high costs, and service shortages as significant obstacles to preventive and ongoing care. Chronic diseases such as diabetes, hypertension, obesity, heart disease, and stroke were described as widespread issues in Summit County, often linked to poor nutrition, physical inactivity, and stress. Participants emphasized expanding mobile health services, telehealth, and integrated care models as strategies to improve access, while also strengthening wellness, nutrition, and lifestyle supports that encourage prevention and healthier living.

Challenges specific to Older Adults were also raised in relation to chronic disease management. Seniors often face barriers with access to specialists, medication affordability, and coordinating multiple services. Limited transportation, fixed incomes, and social isolation further compound risks for this population. Stakeholders highlighted the need for more affordable senior care options, coordinated community-based programs, and supports that enable aging in place while reducing avoidable hospitalizations.

Finally, Health-Related Social Needs were described as fundamental drivers of differences in health outcomes in the Akron General community. Poverty, food insecurity, housing instability, unemployment, and financial stress affect residents across Summit County, limiting their ability to prioritize health and well-being. Stakeholders pointed to reduced investment in certain neighborhoods and gaps in social services as contributors to persistent differences in outcomes. They emphasized that progress would require cross-sector partnerships that address both clinical needs and upstream social drivers through sustainable, culturally responsive, and community-driven strategies.

The following quotes highlight key themes highlighted in community feedback:

Priority Area	Key Quote	Additional Context
Access to Healthcare	“Even with insurance, people cannot afford copays or prescriptions, so they delay care until it becomes an emergency.”	Highlights transportation and cost barriers that prevent timely access, especially in rural areas of Medina County.
Behavioral Health	“We do not have enough providers, and the wait for an appointment can be months, especially for kids and teens.”	Demonstrates ongoing shortages in behavioral health providers, especially impacting youth mental health.

Chronic Disease Prevention and Management	"We see a lot of diabetes and high blood pressure, but people do not always have the tools or resources to manage it."	Reflects the prevalence of chronic diseases like diabetes and hypertension and the challenges of consistent disease management.
Maternal and Child Health	"Moms are struggling with postpartum depression and do not know where to go for help."	Shows gaps in maternal mental health supports and limited awareness of available resources.
Health-Related Social Needs	"People are working but still cannot afford housing or healthy food, and that affects every aspect of their health."	Emphasizes the impact of poverty, food insecurity, and housing instability as upstream drivers of poor health outcomes.

Prioritization Methodology

Akron General's 2025 Community Health Needs Assessment (CHNA) reaffirmed its focus on the same five core health priorities identified in the previous assessment through a comprehensive and data-driven prioritization process. This decision was guided by a rigorous review of primary data, including stakeholder interviews with community leaders and subject matter experts, alongside secondary data analysis from national, state, and regional sources. An environmental scan further contextualized the findings, providing insight into persistent systemic and community-level challenges. The convergence of qualitative and quantitative findings demonstrated continued differences in areas such as access to care, behavioral health, and chronic disease. Consistent community feedback, coupled with county-level data showing outcomes that continue to exceed state and national benchmarks in these domains, reinforced the need for ongoing, coordinated efforts. As a result, Akron General has prioritized the same five health needs for its 2026-2028 Implementation Strategy Report, ensuring continuity in addressing longstanding health challenges and advancing equal outcomes for the populations it serves.

Collaborating Organizations

The fifteen regional hospitals within the Cleveland Clinic health system in Northeast Ohio collaborate to share community health data and resources throughout the CHNA and implementation strategy processes. Akron General is part of the Cleveland Clinic Southern Submarket which includes Akron General, Lodi, Medina, Mercy, and Union hospitals.

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 and Health Departments

Federally Qualified Health Centers (FQHCs)[12] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services. In Ohio, the Ohio Association of Community Health Centers (OACHC) represents 57 Community Health Centers operating at over 400 locations, including mobile units, and supports access to care through federal funding and enhanced Medicaid and Medicare reimbursement. Within the Akron General community, community health services are further supported by local public health agencies, including Summit County Public Health. The following FQHC clinics and networks operate in the Akron General community:

- AxessPointe Community Health Centers
- Community Support Services, Inc.
- Equitas Health
- Summit County Public Health

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
- Summa Health System – Akron Campus
- Western Reserve Hospital

Other Community Resources

A network of agencies, coalitions, and organizations provides a broad array of health and social services within the region served by Akron General. United Way 2-1-1 Ohio offers a comprehensive, statewide online resource directory that connects individuals to essential health and human services. This service, supported by the Ohio Department of Social Services in partnership with the Council of Community Services, The Planning Council, and local United Way chapters serves as a vital referral tool. United Way 2-1-1 contains information on organizations and resources in the following categories:

- Donations and Volunteering
- Education, Recreation, and the Arts
- Employment and Income Support
- Family Support and Parenting
- Food, Clothing, and Household Items
- Healthcare
- Housing and Utilities
- Legal Services and Financial Management
- Mental Health and Counseling
- Municipal and Community Services
- Substance Abuse and Other Addictions

Additional information is available at www.211oh.org.

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

Comments Received on Previous CHNA

Community Health Needs Assessment reports from 2022 were published on the Akron General and Cleveland Clinic websites. No community feedback has been received as of this report's drafting. For more information regarding Cleveland Clinic Community Health Needs Assessment and Implementation Strategy reports, please visit www.clevelandclinic.org/CHNAreports or contact CHNA@ccf.org

Request for Public Comment

Comments and feedback about this report are welcome. Please contact: chna@clevelandclinic.org.

Appendices Summary

A. Akron General Community Definition

B. Secondary Data Sources and Analysis

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

C. Environmental Scan and Key Findings

Environmental scan findings from the region comparing significant and prioritized health needs and identifying other relevant contextual data and associated programs and interventions.

D. Community Input Assessment Tools and Key Findings

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

- Key Stakeholder Interview Questions
- Summary Qualitative Findings

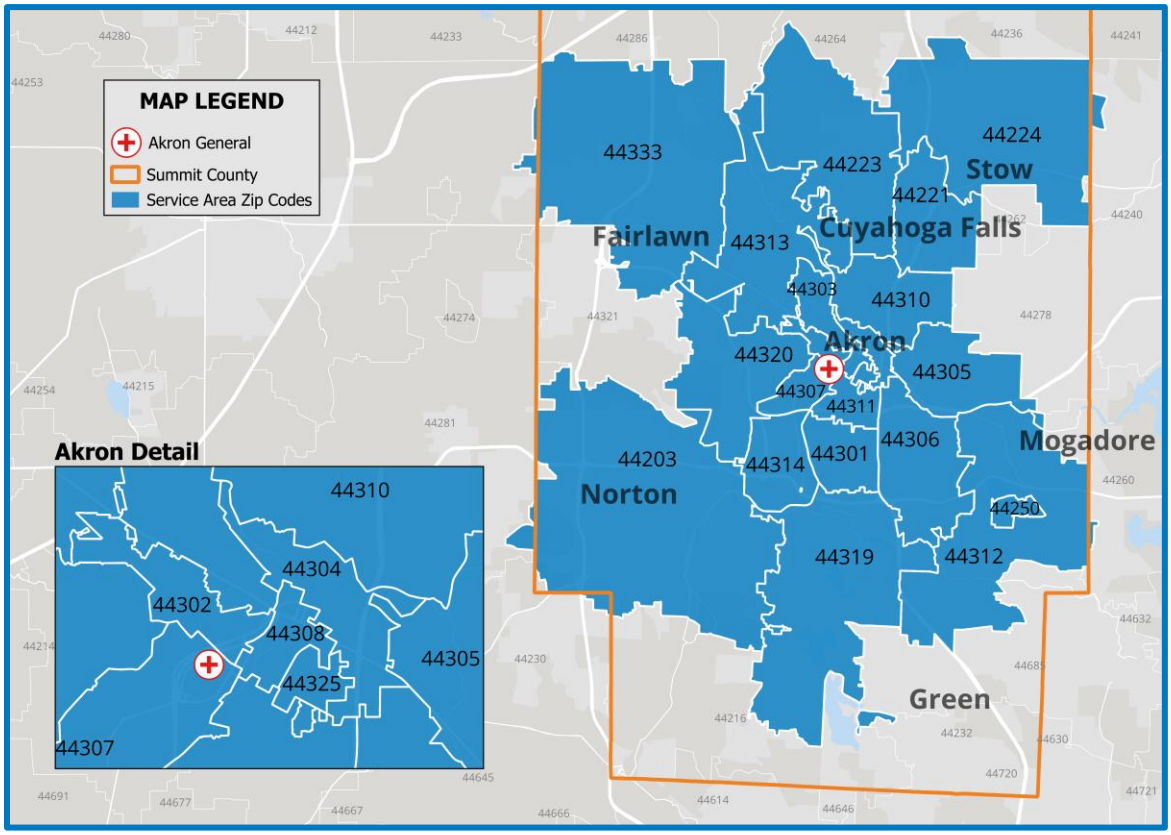
E. Impact Evaluation

F. Acknowledgements

Appendix A: Akron General Community Definition

The community definition describes the zip codes where approximately 75% of Akron General Emergency Department discharges originated in 2023. Figure 9 shows the specific geography for the Akron General community that served as a guide for data collection and analysis for this CHNA.

Figure 9: Akron General Community Definition



Appendix B: Secondary Data Sources and Analysis

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 (HCI). This database includes more than 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.

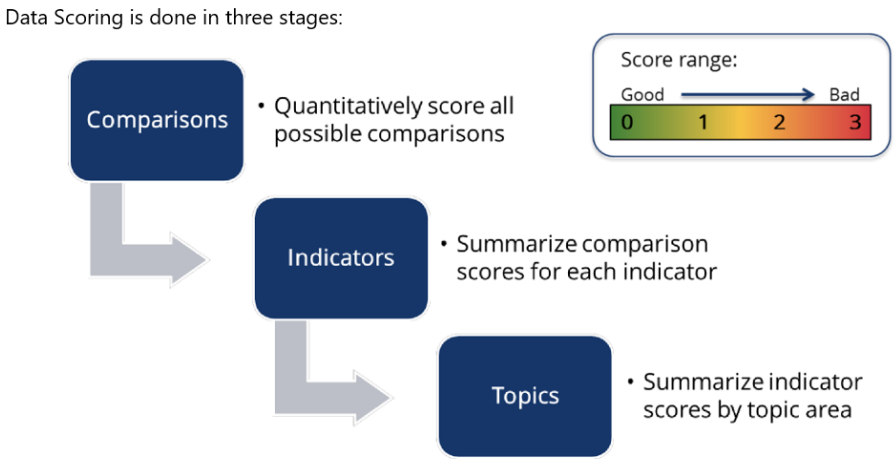
The following is a list of both local and national sources used in the Akron General Community Health Needs Assessment:

- 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 Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Feeding America
- 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
- Purdue Center for Regional Development
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Census Bureau - Small Area Health Insurance Estimates
- U.S. Environmental Protection Agency
- United For ALICE

Secondary Data Scoring

HCI's Data Scoring Tool was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. Due to restrictions regarding data availability, analysis was completed at the county level. For each indicator, the county value was compared to a distribution of other Ohio and U.S. counties, state and national values, targets defined by Healthy People 2030, and significant trends over time (see Figure 10). Based on these comparisons, each indicator is scored on a standardized scale ranging from 0 to 3, where 0 indicates least concern and 3 indicates greatest concern. Availability of each type of comparison depends on the indicator's data source, comparability with other communities, and changes in methodology over time. After scoring all available indicators, we grouped indicators into topic areas to assign summary scores for topic areas. Indicators may be categorized into more than one topic area, and topic areas with fewer than three indicators were not scored.

Figure 10: Summary of Topic Scoring Analysis



For the purposes of the Akron General Community, this analysis was completed for Summit County. A complete breakdown of topic and indicator scores can be found below.

Comparison to a Distribution of County Values: State and Nation

For ease of interpretation and analysis, distribution data for each indicator is visually represented as a green-yellow-red gauge illustrating how the county fares against a distribution of counties across either the state or across the nation. 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, and red) based on their order. Counties with the most concerning scores are "in the red" and those with the least concerning scores are "in the green."

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and the target value. Target values are defined by nation-wide Healthy People 2030 (HP2030) goals. HP2030 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 more or less concerning 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 90% confidence level. For each indicator with values available for four time periods, scoring was determined by 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, 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 found below.

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. Resulting scores range from 0 to 3, where a higher score indicates more concerning outcomes. A topic score is only calculated if it includes at least three indicators. See Figure 11 for a complete list of the potential health and quality of life topic areas examined in this analysis.

Figure 11: Health and Quality of Life Topic Areas



Topics that received a score of 1.50 or higher were considered a significant health need. Nine topics scored at or above this threshold in Summit County (see Tables 2 and 3).

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 2 and 3 below. The two highest scoring health needs in Summit County were *Sexually Transmitted Infections* and *Weight Status*, both with a score of 2.01.

Table 2: Health Topic Scores: Summit County

Health Topic	Score
Sexually Transmitted Infections	2.01
Weight Status	2.01
Other Conditions	1.83
Alcohol & Drug Use	1.68
Prevention & Safety	1.65
Older Adults	1.59
Mental Health & Mental Disorders	1.57
Physical Activity	1.56
Maternal, Fetal & Infant Health	1.51
Mortality Data	1.49
Diabetes	1.48
Wellness & Lifestyle	1.45
Respiratory Diseases	1.44
Women's Health	1.44
Nutrition & Healthy Eating	1.42
Cancer	1.40
Children's Health	1.33
Immunizations & Infectious Diseases	1.28
Heart Disease & Stroke	1.21
Oral Health	1.18
Tobacco Use	1.17

Health Care Access & Quality	1.05

Table 3: Quality of Life Topic Scores: Summit County

Quality of Life Topic	Score
Economy	1.47
Environmental Health	1.40
Education	1.36
Community	1.32

Conduent's SocioNeeds Index Suite®

Conduent HCI's SocioNeeds Index Suite® provides analytics around non-medical drivers of health to better understand how health outcomes differ by geography and identify areas for action. The suite includes the Community Health Index, Food Insecurity Index, and Mental Health Index. See Table 4 for a full list of index values for each zip code in the Akron General community.

Table 4: Community Health Index, Food Insecurity Index, and Mental Health Index Values for Akron General Community Zip Codes

Zip Code	CHI Value	FII Value	MHI Value
44203	64.0	72.8	91.3
44221	50.6	52.0	75.9
44223	13.2	20.0	59.3
44224	20.9	27.1	63.5
44250	93.0	51.9	62.8
44301	76.7	86.6	93.8
44302	51.5	87.4	91.9
44303	18.2	41.1	84.2
44304	95.6	97.2	81.2
44305	78.9	89.7	93.6
44306	95.2	97.3	99.4
44307	90.3	99.0	99.6
44308	99.8	99.3	--
44310	95.5	95.6	96.2
44311	97.2	99.7	97.2
44312	65.3	54.6	89.8
44313	9.5	43.7	85.3
44314	82.3	88.7	95.7
44319	33.2	27.4	76.2
44320	47.8	96.4	98.6

44325	--	--	--
44333	8.5	10.7	41.0

Census Tract Key

The figures and tables below should serve as a guide for identifying census tracts that are described in various maps throughout this report. Figure 12 and Table 5 show the census tracts for each zip code in the northern portion of the Akron General Community.

Figure 12: Census Tract Key (Akron General, North)

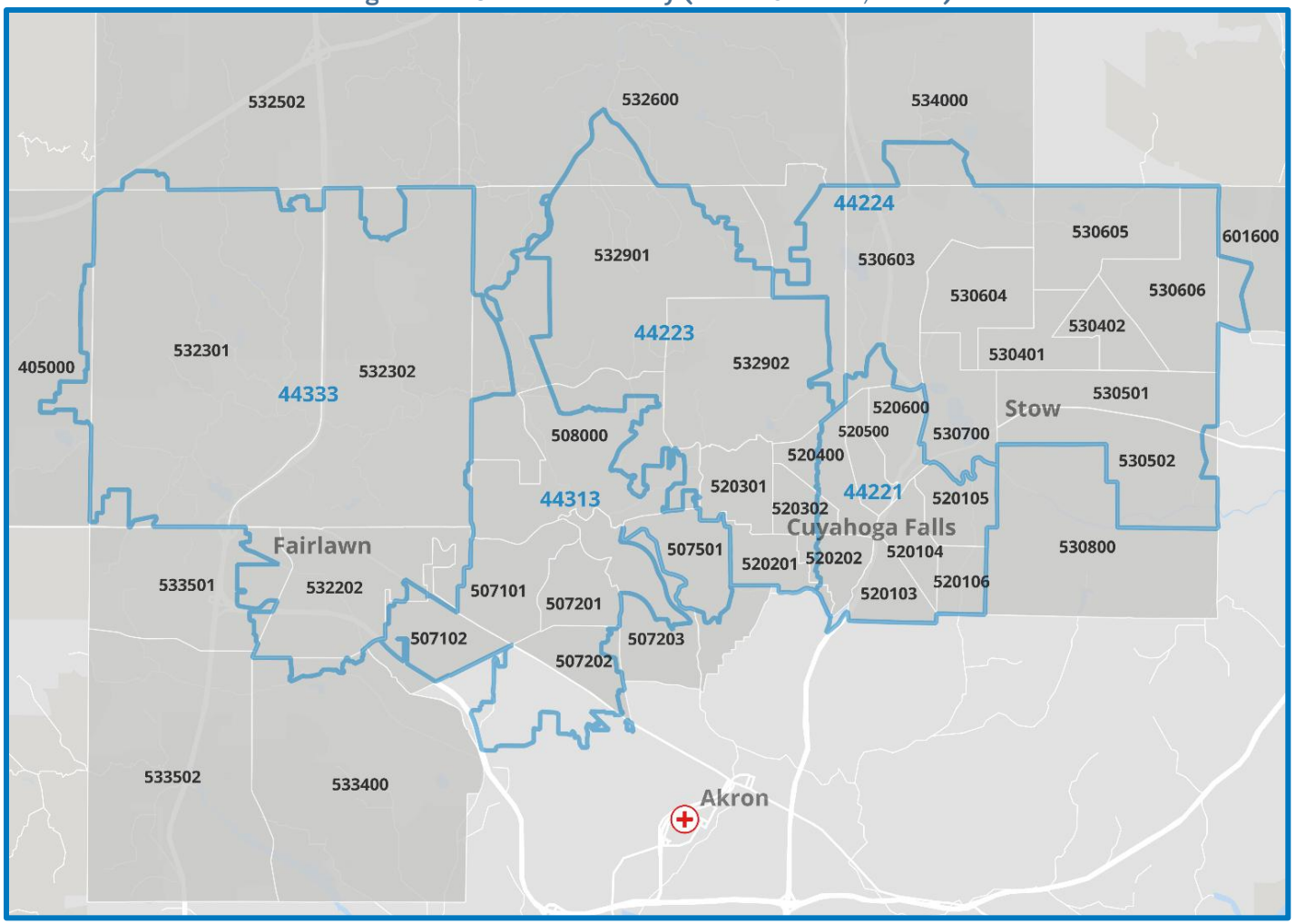


Table 5: Census Tracts by Zip Code (Akron General, North)

44221	44223	44224	44333	44313
507600	507501	520600	405000	506100
520103	508000	530401	507102	506400
520104	520201	530402	532202	507101
520105	520202	530501	532301	507102
520106	520301	530502	532302	507201
520201	520302	530603	532502	507202
520202	520400	530604	532901	507203
520302	532600	530605	533400	507501
520400	532901	530606	533501	508000
520500	532902	530700	533502	520301
520600		532600		532202
530603		532902		532302
530700		534000		532901
530800		601600		
532902				

Figure 13 and Table 6 show the census tracts for each zip code in the southern portion of the Akron General Community.

Figure 13: Census Tract Key (Akron General, South)

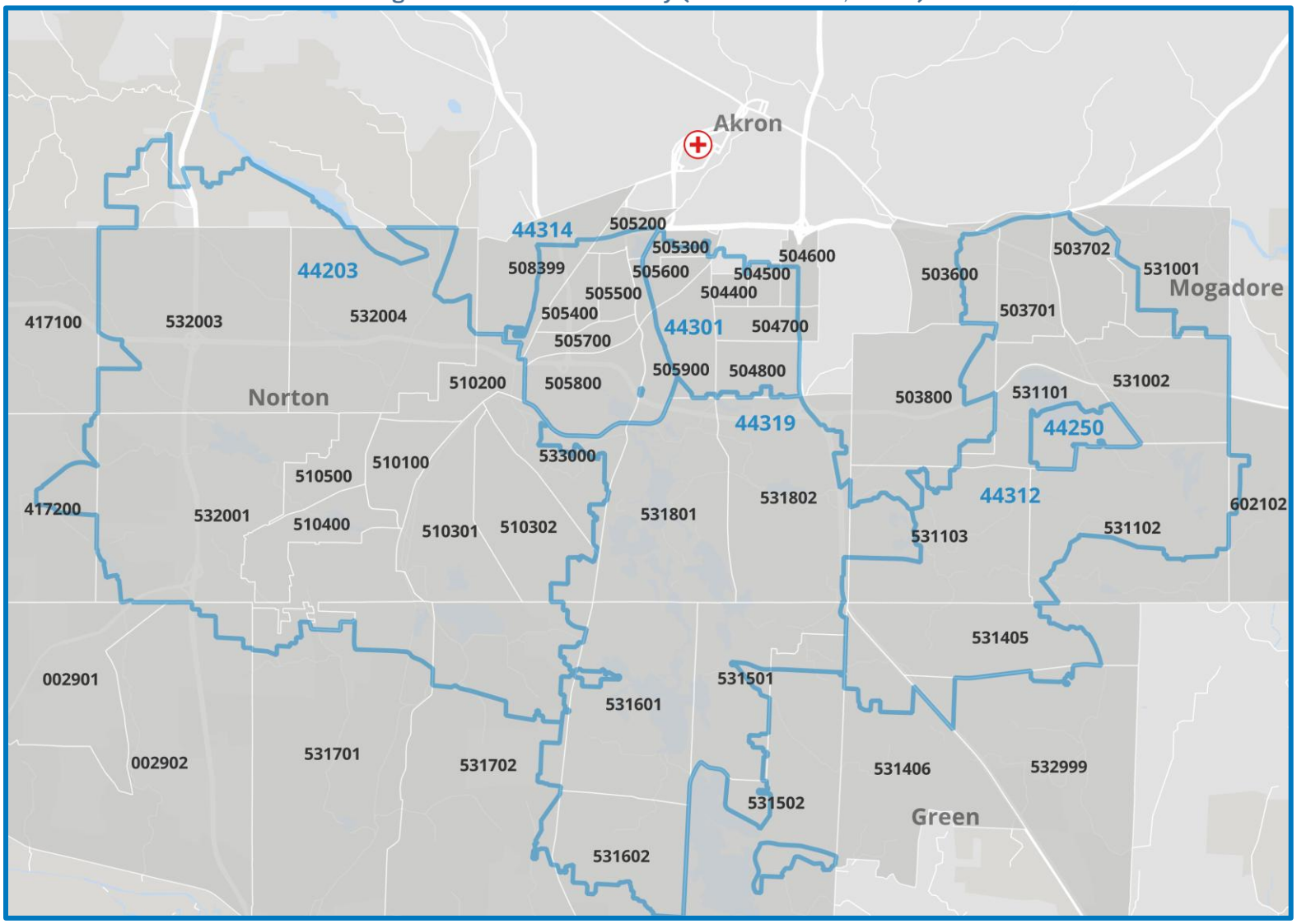


Table 6: Census Tracts by Zip Code (Akron General, South)

44203	44250	44301	44312	44314	44319
002901	531101	504400	503600	505200	504800
002902		504500	503701	505400	505800
417100		504600	503702	505500	505900
417200		504700	503800	505600	510302
510100		504800	531001	505700	531103
510200		505300	531002	505800	531501
510301		505600	531101	505900	531502
510302		505900	531102	508399	531601
510400		506800	531103	510200	531602
510500			531405		531702
531601			531406		531801
531701			531501		531802
531702			531502		533000
531801			531802		
532001			532999		
532003			602102		
532004					
533000					
533400					
533502					

Figure 14 and Table 7 show the census tracts for each zip code in the western portion of the Akron General Community.

Figure 14: Census Tract Key (Akron General, West)

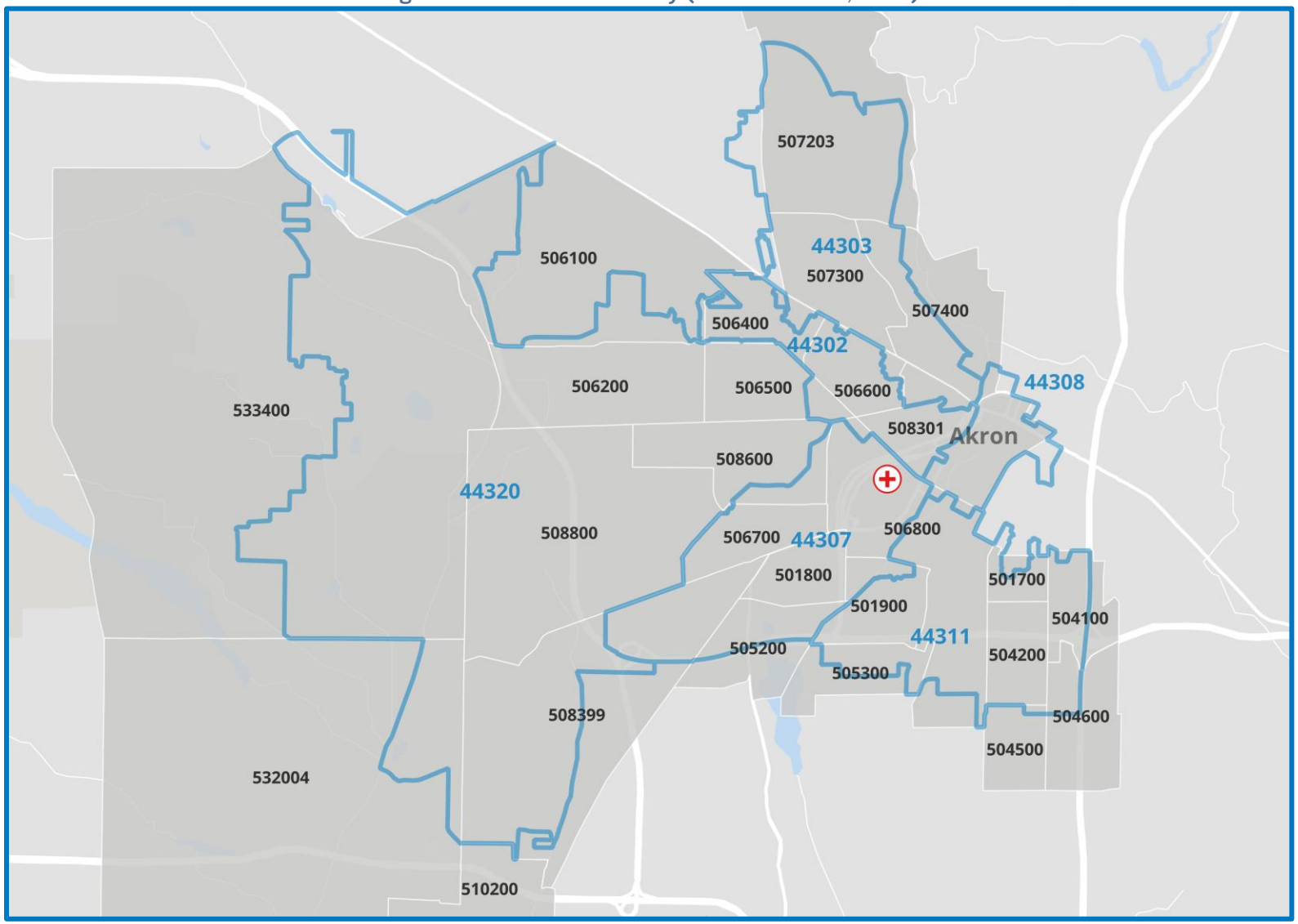


Table 7: Census Tracts by Zip Code (Akron General, West)

44302	44303	44307	44308	44311	44320
506100	506400	501800	501100	501700	506100
506400	506600	501900	506800	501900	506200
506500	507202	505200	507400	504100	506400
506600	507203	506700	508301	504200	506500
506800	507300	506800	508900	504500	506700
507202	507400	508399		504600	507102
508301	508301	508600		505200	508399
		508800		505300	508600
				506800	508800
				508900	510200
					532004
					533400

Figure 15 and Table 8 show the census tracts for each zip code in the eastern portion of the Akron General Community.

Figure 15: Census Tract Key (Akron General, East)

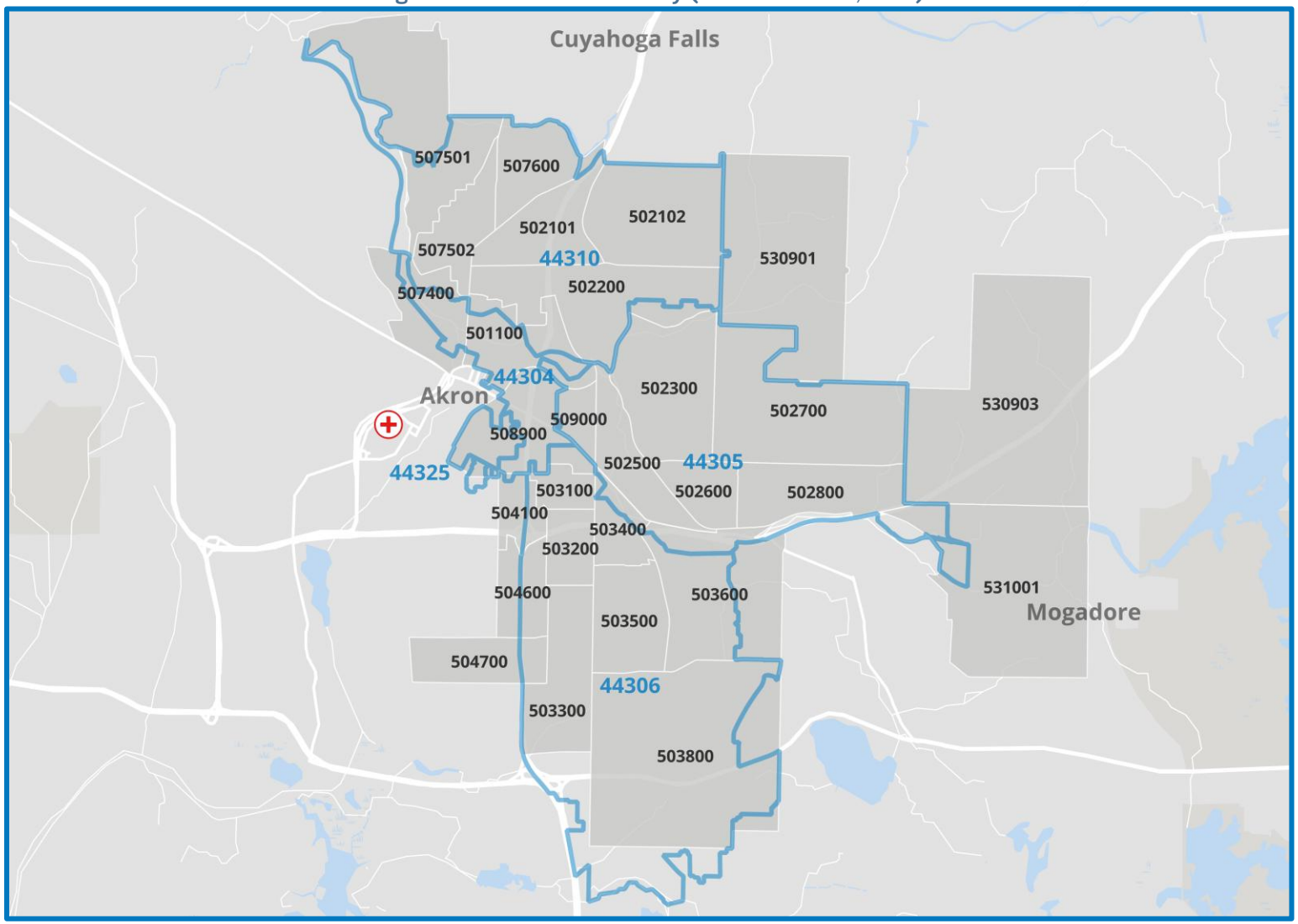


Table 8: Census Tracts by Zip Code (Akron General, East)

44304	44305	44306	44310	44325
501100	501100	503100	501100	508301
501700	502200	503200	502101	508900
503100	502300	503300	502102	
504100	502500	503400	502200	
507400	502600	503500	507400	
508301	502700	503600	507501	
508900	502800	503800	507502	
509000	503400	504100	507600	
	503600	504600		
	503701	504700		
	503702	508900		
	503800	531103		
	508900	531802		
	509000			
	530901			
	530903			
	531001			

Community Health Index (CHI)

Every community can be described by various demographic and economic factors that can contribute to differences in health outcomes. Conduent HCI's Community Health Index considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing concerning health outcomes.

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 nation. Communities with the highest index values are estimated to have the highest health-related social 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 CHI, with darker coloring associated with higher relative need.

Food Insecurity Index (FII)

Every community can be described by various demographic and economic factors that can contribute to differences in health outcomes. 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 nation. Communities with the highest index values are estimated to have the highest risk of food insecurity, which is correlated with correlated with household and community measures of food-related 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 FII, with darker coloring associated with higher relative need.

Mental Health Index (MHI)

Every community can be described by various demographic and economic factors that can contribute to differences in 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 mental health challenges.

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 nation. Communities with the highest index values are estimated to have the highest risk of 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 MHI, with darker coloring associated with higher relative need.

Data Considerations

Several data limitations 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 viability 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 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 health-related social 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 represent the population at large, these measures are subject to instability, especially for smaller populations.

Race or Ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present data using dissimilar naming conventions. 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 covers ZCTAs 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 sources from the U.S. 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.

Indicators of Concern for Prioritized Health Needs

Below are details regarding indicators of concern for all prioritized health needs discussed in this report. Each indicator includes a county-level value and standardized score, as well as the following comparison data, where available: state value, national value, state county distribution, national county distribution, and over-time trend. Table 9 describes how to interpret the icons used to describe county distributions and trend data.

Table 9: Icon Legend

Icon(s)	Definition
	If the needle is in the green, the county value is among the least concerning 50% of counties in the state or nation.
	If the needle is in the red, the county value is in the most concerning 25% (or worst quartile) of counties in the state or nation.
	The county value is significantly trending in a concerning direction.
	The county value is trending in a concerning direction, but not significantly.
	The county value is significantly trending in the ideal direction.
	The county value is trending in the ideal direction, but not significantly.

Indicators of Concern: Access to Healthcare

The topic *Health Care Access and Quality* was ranked as the twenty-second highest scoring health need, with a score of 1.05 out of 3. Those indicators scoring at or above 1.00 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
1.81	Adults with Health Insurance: 18+	*percent*	75.0	--	74.7	75.2			
1.53	Health Insurance Spending-to-Income Ratio	*percent*	6.8	--	6.6	5.9			
1.50	Adults who go to the Doctor Regularly for Checkups	*percent*	65.8	--	65.2	65.1			--
1.42	Adults who have had a Routine Checkup	*percent*	78.5	--	--	76.1			--
1.33	Adults With Group Health Insurance	*percent*	37.9	--	37.4	39.8			--
1.33	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	2872	--	3269	2769			--
1.31	Adults who Visited a Dentist	*percent*	45.3	--	44.3	45.3			
1.25	Children with Health Insurance	*percent*	97.4	--	95.1	94.6	--		
1.08	Adults without Health Insurance	*percent*	5.8	--	--	10.8			--

Indicators of Concern: Behavioral Health

The prioritized health topic *Behavioral Health* was captured under three health topic areas: *Mental Health and Mental Disorders*, *Alcohol and Drug Use*, and *Tobacco Use*. The most concerning of these topics was *Alcohol and Drug Use* (1.68), followed by *Mental Health and Mental Disorders* (Score: 1.57), and the least concerning was *Tobacco Use* (1.17). Indicators from these three topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.50	Depression: Medicare Population	*percent*	20	--	18	17			--
2.25	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	39.2	--	32.1	--			
2.17	Poor Mental Health: Average Number of Days	*days*	6.2	--	6.1	--			
2.14	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	43.5	--	33.8	--		--	
2.00	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	37.2	--	40.4	23.5			--
1.83	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.8	20.7	44.7	--			--
1.58	Adults Ever Diagnosed with Depression	*percent*	24.8	--	--	20.7			--
1.58	Poor Mental Health: 14+ Days	*percent*	17.7	--	--	15.8			--
1.58	Adults who Binge Drink	*percent*	16.9	--	--	16.6			--
1.50	Adults who Smoke	*percent*	16.0	6.1	--	12.9			--

Indicators of Concern: Chronic Disease Prevention and Management

The prioritized health topic *Chronic Disease Prevention and Management* was captured under the following health topics: *Nutrition and Healthy Eating*, *Wellness and Lifestyle*, *Cancer*, *Diabetes*, *Heart Disease and Stroke*, *Other Chronic Conditions*, and *Older Adults*. The most concerning of these topics was *Other Chronic Conditions* (Score: 1.83), followed by *Older Adults* (1.59), *Diabetes* (1.48), *Wellness and Lifestyle* (1.45), *Nutrition and Healthy Eating* (1.42), *Cancer* (1.40), and the least concerning topic was *Heart Disease and Stroke* (1.21). Indicators from these seven topic areas which scored at or above 1.70 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.75	People 65+ Living Alone	*percent*	30.9	--	30.2	26.5			
2.50	Asthma: Medicare Population	*percent*	8	--	7	7			--
2.50	Depression: Medicare Population	*percent*	20	--	18	17			--
2.50	Chronic Kidney Disease: Medicare Population	*percent*	22	--	19	18			--
2.17	Adults who Frequently Cook Meals at Home6	*Percent*	67	--	67.6	67.7			--
2.14	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	43.5	--	33.8	--		--	
2.08	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.4	--	12.8	12			
2.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	20.6	16.9	19.3	19	--		
2.00	COPD: Medicare Population	*percent*	14	--	13	11			--
2.00	Mammogram in Past 2 Years: 50-74	*percent*	71.7	80.3	--	76.5			--

1.92	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.5	--	15.1	--		--	
1.92	People 65+ Living Alone (Count)	*people*	31571	--	--	--	--	--	
1.92	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	28.7	--	28.4	--		--	
1.92	People 65+ Living Below Poverty Level (Count)	*people*	8502	--	--	--	--	--	
1.83	Hyperlipidemia: Medicare Population	*percent*	69	--	67	66			--
1.83	Adults Happy with Weight	*Percent*	41.8	--	42.1	42.6			--
1.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	39	--	39	36			--
1.75	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.4	--	--	8.2			--
1.75	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	38.6	--	38.1	38.2			
1.72	Poor Physical Health: Average Number of Days	*days*	4.5	--	4.3	--			

Indicators of Concern: Maternal and Child Health

The prioritized health topic *Maternal and Child Health* was captured under two health topic areas: *Maternal, Fetal, and Infant Health* and *Children's Health*. The more concerning of these topics was *Maternal, Fetal, and Infant Health*, with a score of 1.51, followed by *Children's Health*, with a score of 1.33. Indicators from these topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.14	Child Food Insecurity Rate	*percent*	21	--	20.1	18.4			
2.06	Babies with Low Birthweight	*percent*	9.4	--	8.7	8.6		--	
1.92	Mothers who Received Early Prenatal Care	*percent*	66.9	--	68.6	75.3		--	
1.89	Preterm Births	*percent*	11	9.4	10.8	--		--	
1.64	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.7	--	1.9	--		--	
1.53	Mothers who Smoked During Pregnancy	*percent*	7.4	4.3	7.9	3.7		--	
1.50	Babies with Very Low Birthweight	*percent*	1.4	--	1.5	--		--	

Indicators of Concern: Health-Related Social Needs

The prioritized health topic *Health-Related Social Needs* was captured under the quality of life topics *Community*, *Economy*, and *Education*, as well as the health topic *Prevention and Safety*. The topic *Prevention and Safety* was the fifth highest scoring health topic with a score of 1.65. The most concerning quality of life topic was *Economy* (Score: 1.47), followed by *Education* (1.36), and the least concerning topic was *Community* (1.32). Indicators from these four health and quality of life topic areas which scored at or above 2.00 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.75	People 65+ Living Alone	*percent*	30.9	--	30.2	26.5			
2.64	Workers who Walk to Work	*percent*	1.1	--	2	2.4			
2.64	Unemployed Veterans	*percent*	4.8	--	2.8	3.2			
2.58	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	16.1	10.7	13.5	12			
2.42	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	586	--	570	612			
2.36	Children in Single-Parent Households	*percent*	29.1	--	26.1	24.8			
2.36	Households with Cash Public Assistance Income	*percent*	4.7	--	2.5	2.7			
2.19	College Tuition Spending-to-Income Ratio	*percent*	13.3	--	12.6	11.9			
2.14	Child Food Insecurity Rate	*percent*	21	--	20.1	18.4			
2.08	Homeowner Spending-to-Income Ratio	*percent*	15.7	--	14.3	13.5			

2.25	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	11.7	5.5	9	--	--	--	
2.25	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	39.2	--	32.1	--			
2.08	Median Household Gross Rent	*dollars*	998	--	988	1348			
2.03	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.7	--	7.4	7.1			
2.00	Income Inequality	--	0.5	--	0.5	0.5			
2.00	Unemployed Workers in Civilian Labor Force	*percent*	5.6	--	5.4	4.5			
2.00	Workers Commuting by Public Transportation	*percent*	0.9	5.3	1.1	3.5		--	

All Indicator Scores by Topic Area

Below is a complete list of all indicators that were scored as part of the secondary data analysis. Indicators are grouped under their respective health and quality of life topic areas and include information about both the indicator data source and measurement period. Please refer to Table 10 below as a reference key for indicator data sources.

Table 10: Indicator Scoring Data Source Key

Key	Data Source
1	American Community Survey 1-Year
2	American Community Survey 5-Year
3	American Lung Association
4	Annie E. Casey Foundation
5	CDC - PLACES
6	Centers for Disease Control and Prevention
7	Centers for Medicare & Medicaid Services
8	Claritas Consumer Profiles
9	Claritas Consumer Spending Dynamix
10	County Health Rankings
11	Feeding America
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	Purdue Center for Regional Development
22	U.S. Bureau of Labor Statistics
23	U.S. Census - County Business Patterns
24	U.S. Census Bureau - Small Area Health Insurance Estimates
25	U.S. Environmental Protection Agency
26	United For ALICE

Table 11: All Summit County Secondary Data Indicators

SCORE	ALCOHOL & DRUG USE	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.25	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	39.2		32.1		*2018-2022*	10
2.00	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	37.2		40.4	23.5	*2018-2020*	6
1.83	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.8	20.7	44.7		*2020-2022*	10
1.58	Adults who Binge Drink	*percent*	16.9			16.6	*2022*	5
1.53	Mothers who Smoked During Pregnancy	*percent*	7.4	4.3	7.9	3.7	*2022*	17
1.39	Adults who Drink Excessively	*percent*	19.8		21.2		*2022*	10
1.17	Liquor Store Density	*stores/ 100,000 population*	6.2		5.6	10.9	*2022*	23

SCORE	CANCER	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.08	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.4		12.8	12	*2017-2021*	12
2.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	20.6	16.9	19.3	19	*2018-2022*	12
2.00	Mammogram in Past 2 Years: 50-74	*percent*	71.7	80.3		76.5	*2022*	5
1.75	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.4			8.2	*2022*	5
1.69	Breast Cancer Incidence Rate	*cases/ 100,000 females*	133.5		132.3	129.8	*2017-2021*	12
1.64	All Cancer Incidence Rate	*cases/ 100,000 population*	461.9		470	444.4	*2017-2021*	12
1.50	Cancer: Medicare Population	*percent*	12		12	12	*2023*	7

1.47	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	109.6		118.1	113.2	*2017-2021*	12
1.42	Cervical Cancer Screening: 21-65	*Percent*	81.1			82.8	*2020*	5
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	59.9		64.3	53.1	*2017-2021*	12
1.33	Mammography Screening: Medicare Population	*percent*	49		51	39	*2023*	7
1.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	19.9	15.3	20.2	19.3	*2018-2022*	12
1.17	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	38.1	25.1	39.8	32.4	*2018-2022*	12
1.00	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	160.6	122.7	161.1	146	*2018-2022*	12
0.92	Colon Cancer Screening: USPSTF Recommendation	*percent*	68.7			66.3	*2022*	5
0.89	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5.6		7.8	7.5	*2017-2021*	12
0.86	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	35.4		38.9	36.4	*2017-2021*	12
0.83	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	13.1	8.9	13.9	12.9	*2018-2022*	12

SCORE	**CHILDREN'S HEALTH**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**OH**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.14	Child Food Insecurity Rate	*percent*	21		20.1	18.4	*2023*	11
1.64	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.7		1.9		*2022*	19
1.25	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	54.3		59.2		*2019-2022*	10
1.25	Children with Health Insurance	*percent*	97.4		95.1	94.6	*2023*	1
1.08	Child Care Centers	*per 1,000 population under age 5*	8.6		8	7	*2022*	10
1.03	Home Child Care Spending-to-Income Ratio	*percent*	3.2		3.2	3.3	*2025*	9

0.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.4	8.7	6.9		*2021*	4

SCORE	COMMUNITY	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.75	People 65+ Living Alone	*percent*	30.9		30.2	26.5	*2019-2023*	2
2.64	Workers who Walk to Work	*percent*	1.1		2	2.4	*2019-2023*	2
2.58	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	16.1	10.7	13.5	12	*2018-2020*	6
2.42	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	586		570	612	*2019-2023*	2
2.36	Children in Single-Parent Households	*percent*	29.1		26.1	24.8	*2019-2023*	2
2.25	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	11.7	5.5	9		*2020-2022*	19
2.25	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	39.2		32.1		*2018-2022*	10
2.08	Median Household Gross Rent	*dollars*	998		988	1348	*2019-2023*	2
2.03	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.7		7.4	7.1	*2025*	9
2.00	Workers Commuting by Public Transportation	*percent*	0.9	5.3	1.1	3.5	*2019-2023*	2
1.97	Adults with Internet Access	*percent*	80.8		80.9	81.3	*2024*	8
1.92	Mortgaged Owners Median Monthly Household Costs	*dollars*	1438		1472	1902	*2019-2023*	2
1.92	People 65+ Living Alone (Count)	*people*	31571				*2019-2023*	2
1.86	Violent Crime Rate	*crimes/ 100,000 population*	432.3		331		*2024*	18
1.56	Voter Turnout: Presidential Election	*percent*	72.6	58.4	71.7		*2024*	20
1.50	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	85.2		84.9	85.1	*2024*	8
1.50	Social Vulnerability Index	*Score*	0.4				*2022*	6
1.42	Adult Day Care Spending-to-Income Ratio	*percent*	11.5		11.1	11.9	*2025*	9

1.39	Residential Segregation - Black/White	*Score*	58.9		69.6		*2025*	10
1.36	Children Living Below Poverty Level	*percent*	17.9		18	16.3	*2019-2023*	2
1.36	Linguistic Isolation	*percent*	1.4		1.5	4.2	*2019-2023*	2
1.33	Adults With Group Health Insurance	*percent*	37.9		37.4	39.8	*2024*	8
1.33	Total Employment Change	*percent*	3.8		2.9	5.8	*2021-2022*	23
1.28	People Living Below Poverty Level	*percent*	12.6	8	13.2	12.4	*2019-2023*	2
1.28	Social Associations	*membership associations/ 10,000 population*	11.1		10.8		*2022*	10
1.25	Young Children Living Below Poverty Level	*percent*	19.7		20	17.6	*2019-2023*	2
1.19	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3		3.3	3.1	*2025*	9
1.11	Solo Drivers with a Long Commute	*percent*	28.5		30.5		*2019-2023*	10
1.03	Households with a Computer	*percent*	86.2		85.2	86	*2024*	8
1.00	Digital Distress		1				*2022*	21
1.00	Mean Travel Time to Work	*minutes*	23.2		23.6	26.6	*2019-2023*	2
0.94	Grandparents Who Are Responsible for Their Grandchildren	*percent*	32.9		41.3	32	*2019-2023*	2
0.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.4	8.7	6.9		*2021*	4
0.92	Households with a Smartphone	*percent*	87.7		87.5	88.2	*2024*	8
0.92	Median Household Income	*dollars*	71016		69680	78538	*2019-2023*	2
0.92	Persons with Health Insurance	*percent*	93.4	92.4	92.9		*2022*	24
0.92	Workers who Drive Alone to Work	*percent*	76.7		76.6	70.2	*2019-2023*	2
0.86	Youth not in School or Working	*percent*	1.3		1.7	1.7	*2019-2023*	2
0.83	Adults With Individual Health Insurance	*percent*	20.8		20.5	20.2	*2024*	8
0.75	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	8.9		11.1		*2016-2022*	10
0.69	Female Population 16+ in Civilian Labor Force	*percent*	60.8		59.2	58.7	*2019-2023*	2

0.69	People 25+ with a High School Diploma or Higher	*percent*	92.9	91.6	89.4	*2019-2023*	2
0.58	Households with One or More Types of Computing Devices	*percent*	94.7	93.6	94.8	*2019-2023*	2
0.58	Per Capita Income	*dollars*	42749	39455	43289	*2019-2023*	2
0.50	Broadband Quality Score	*BQS Score*	68.6	53.4	50	*2022*	21
0.50	Digital Divide Index	*DDI Score*	15.3	40.1	50	*2022*	21
0.42	Households with an Internet Subscription	*percent*	90.4	89	89.9	*2019-2023*	2
0.42	Persons with an Internet Subscription	*percent*	93.1	91.3	92	*2019-2023*	2
0.42	Population 16+ in Civilian Labor Force	*percent*	61.4	60.1	59.8	*2019-2023*	2
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	35.3	30.9	35	*2019-2023*	2

SCORE	DIABETES	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.92	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	28.7		28.4		*2020-2022*	19
1.53	Adults 20+ with Diabetes	*percent*	9.5				*2021*	6
1.00	Diabetes: Medicare Population	*percent*	24		25	24	*2023*	7

SCORE	ECONOMY	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.64	Unemployed Veterans	*percent*	4.8		2.8	3.2	*2019-2023*	2
2.42	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	586		570	612	*2019-2023*	2
2.36	Households with Cash Public Assistance Income	*percent*	4.7		2.5	2.7	*2019-2023*	2
2.19	College Tuition Spending-to-Income Ratio	*percent*	13.3		12.6	11.9	*2025*	9
2.14	Child Food Insecurity Rate	*percent*	21		20.1	18.4	*2023*	11
2.08	Homeowner Spending-to-Income Ratio	*percent*	15.7		14.3	13.5	*2025*	9

2.08	Median Household Gross Rent	*dollars*	998		988	1348	*2019-2023*	2
2.03	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.7		7.4	7.1	*2025*	9
2.00	Income Inequality		0.5		0.5	0.5	*2019-2023*	2
2.00	Unemployed Workers in Civilian Labor Force	*percent*	5.6		5.4	4.5	*45748*	22
1.92	Children Living Below 200% of Poverty Level	*percent*	40.7		38.3	36.1	*2023*	1
1.92	Mortgaged Owners Median Monthly Household Costs	*dollars*	1438		1472	1902	*2019-2023*	2
1.92	People 65+ Living Below Poverty Level (Count)	*people*	8502				*2019-2023*	2
1.89	Renters Spending 30% or More of Household Income on Rent	*percent*	46.6	25.5	45.1	50.4	*2019-2023*	2
1.86	Adults with Disability Living in Poverty	*percent*	28.4		28.2	24.6	*2019-2023*	2
1.78	Severe Housing Problems	*percent*	12.9		12.7		*2017-2021*	10
1.69	Home Renter Spending-to-Income Ratio	*percent*	16.8		16.3	17	*2025*	9
1.58	Families Living Below 200% of Poverty Level	*Percent*	22.7		22.8	22.3	*2023*	1
1.58	Households with Student Loan Debt	*percent*	9.1		9.1	9.8	*2024*	8
1.58	People Living Below 200% of Poverty Level	*percent*	29.1		29.6	28.2	*2023*	1
1.56	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	25.9		25	29.4	*2023*	26
1.56	People 65+ Living Below 200% of Poverty Level	*percent*	28.1		28.4	28.1	*2023*	1
1.53	Health Insurance Spending-to-Income Ratio	*percent*	6.8		6.6	5.9	*2025*	9
1.53	Homeowner Vacancy Rate	*percent*	1		0.9	1	*2019-2023*	2
1.53	Student Loan Spending-to-Income Ratio	*percent*	4.7		4.6	4.5	*2025*	9

1.53	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.6		1.6	1.5	*2025*	9
1.47	Food Insecurity Rate	*percent*	14.8		15.3	14.5	*2023*	11
1.47	Households with a 401k Plan	*percent*	38.9		38.4	40.8	*2024*	8
1.47	Veterans Living Below Poverty Level	*percent*	7.3		7.4	7.2	*2019-2023*	2
1.44	Gender Pay Gap	*cents on the dollar*	0.7		0.7	0.8	*2023*	1
1.44	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	61.4		61.5	58	*2023*	26
1.42	Adult Day Care Spending-to-Income Ratio	*percent*	11.5		11.1	11.9	*2025*	9
1.42	People 65+ Living Below Poverty Level	*percent*	8.6		9.5	10.4	*2019-2023*	2
1.39	Residential Segregation - Black/White	*Score*	58.9		69.6		*2025*	10
1.36	Children Living Below Poverty Level	*percent*	17.9		18	16.3	*2019-2023*	2
1.36	Cigarette Spending-to-Income Ratio	*percent*	2.1		2.1	1.9	*2025*	9
1.36	Size of Labor Force	*persons*	274487				*45748*	22
1.33	Total Employment Change	*percent*	3.8		2.9	5.8	*2021-2022*	23
1.31	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	21.9	25.5	21.2	28.5	*2023*	1
1.28	Households Living Below Poverty Level	*percent*	12.8		13.5	12.7	*2023*	26
1.28	People Living Below Poverty Level	*percent*	12.6	8	13.2	12.4	*2019-2023*	2
1.25	Young Children Living Below Poverty Level	*percent*	19.7		20	17.6	*2019-2023*	2
1.19	Families Living Below Poverty Level	*percent*	9		9.2	8.7	*2019-2023*	2
1.19	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3		3.3	3.1	*2025*	9
1.19	Households with a Savings Account	*percent*	71.9		70.9	72	*2024*	8
1.08	Utilities Spending-to-Income Ratio	*percent*	6.1		6.1	5.6	*2025*	9

1.03	Home Child Care Spending-to-Income Ratio	*percent*	3.2	3.2	3.3	*2025*	9
0.92	Median Household Income	*dollars*	71016	69680	78538	*2019-2023*	2
0.92	Median Household Income: Householders 65+	*dollars*	51857	51608	57108	*2019-2023*	2
0.86	Youth not in School or Working	*percent*	1.3	1.7	1.7	*2019-2023*	2
0.83	Adults who Feel Overwhelmed by Financial Burdens	*percent*	32.9	34	33.6	*2024*	8
0.75	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	1.8	2	2	*2024*	8
0.69	Female Population 16+ in Civilian Labor Force	*percent*	60.8	59.2	58.7	*2019-2023*	2
0.64	Overcrowded Households	*percent*	0.9	1.4	3.4	*2019-2023*	2
0.58	Per Capita Income	*dollars*	42749	39455	43289	*2019-2023*	2
0.42	Population 16+ in Civilian Labor Force	*percent*	61.4	60.1	59.8	*2019-2023*	2
0.36	Students Eligible for the Free Lunch Program	*percent*	15.4	20.2	43.1	*2019-2020*	13

SCORE	EDUCATION	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.19	College Tuition Spending-to-Income Ratio	*percent*	13.3		12.6	11.9	*2025*	9
2.03	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.7		7.4	7.1	*2025*	9
1.97	8th Grade Students Proficient in Math	*percent*	41.9		46.3		*2023-2024*	15
1.81	8th Grade Students Proficient in English/Language Arts	*percent*	47.4		49.4		*2023-2024*	15
1.53	Student Loan Spending-to-Income Ratio	*percent*	4.7		4.6	4.5	*2025*	9
1.53	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.6		1.6	1.5	*2025*	9

1.42	4th Grade Students Proficient in Math	*percent*	65.8		67.2		*2023-2024*	15
1.36	4th Grade Students Proficient in English/Language Arts	*percent*	65.2		64.1		*2023-2024*	15
1.33	High School Graduation	*percent*	93.6	90.7	92.5		*2022-2023*	15
1.19	Veterans with a High School Diploma or Higher	*percent*	94.9		94.4	95.2	*2019-2023*	2
1.08	Child Care Centers	*per 1,000 population under age 5*	8.6		8	7	*2022*	10
1.03	Home Child Care Spending-to-Income Ratio	*percent*	3.2		3.2	3.3	*2025*	9
1.03	Student-to-Teacher Ratio	*students/ teacher*	15.1		16.6	15.2	*2023-2024*	13
0.69	People 25+ with a High School Diploma or Higher	*percent*	92.9		91.6	89.4	*2019-2023*	2
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	35.3		30.9	35	*2019-2023*	2

SCORE	ENVIRONMENTAL HEALTH	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.50	Asthma: Medicare Population	*percent*	8		7	7	*2023*	7
2.14	Houses Built Prior to 1950	*percent*	27.1		24.9	16.4	*2019-2023*	2
2.11	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	9.4		7.9		*2020*	10
1.78	Severe Housing Problems	*percent*	12.9		12.7		*2017-2021*	10
1.75	Adults with Current Asthma	*percent*	11			9.9	*2022*	5
1.75	Proximity to Highways	*percent*	6.2		7.2		*2020*	14
1.72	Annual Ozone Air Quality	*grade*	D				*2021-2023*	3
1.72	Annual Particle Pollution	*grade*	D				*2021-2023*	3
1.64	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.7		1.9		*2022*	19
1.64	PBT Released	*pounds*	906.7				*2023*	25
1.64	Weeks of Moderate Drought or Worse	*weeks per year*	5				*2021*	14

1.50	Social Vulnerability Index	*Score*	0.4			*2022*	6
1.47	Daily Dose of UV Irradiance	*Joule per square meter*	3379	3384		*2020*	14
1.36	Number of Extreme Heat Days	*days*	17			*2023*	14
1.36	Number of Extreme Heat Events	*events*	13			*2023*	14
1.36	Number of Extreme Precipitation Days	*days*	4			*2023*	14
1.19	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3	3.3	3.1	*2025*	9
1.17	Liquor Store Density	*stores/ 100,000 population*	6.2	5.6	10.9	*2022*	23
1.08	Utilities Spending-to-Income Ratio	*percent*	6.1	6.1	5.6	*2025*	9
0.94	Food Environment Index		7.7	7		*2025*	10
0.75	Access to Exercise Opportunities	*percent*	95.2	84.2		*2025*	10
0.75	Access to Parks	*percent*	79.7	59.6		*2020*	14
0.64	Overcrowded Households	*percent*	0.9	1.4	3.4	*2019-2023*	2
0.50	Broadband Quality Score	*BQS Score*	68.6	53.4	50	*2022*	21
0.50	Digital Divide Index	*DDI Score*	15.3	40.1	50	*2022*	21

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.81	Adults with Health Insurance: 18+	*percent*	75		74.7	75.2	*2024*	8
1.53	Health Insurance Spending-to-Income Ratio	*percent*	6.8		6.6	5.9	*2025*	9
1.50	Adults who go to the Doctor Regularly for Checkups	*percent*	65.8		65.2	65.1	*2024*	8
1.42	Adults who have had a Routine Checkup	*percent*	78.5			76.1	*2022*	5
1.33	Adults With Group Health Insurance	*percent*	37.9		37.4	39.8	*2024*	8
1.33	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	2872		3269	2769	*2023*	7

1.31	Adults who Visited a Dentist	*percent*	45.3		44.3	45.3	*2024*	8
1.25	Children with Health Insurance	*percent*	97.4		95.1	94.6	*2023*	1
1.08	Adults without Health Insurance	*percent*	5.8			10.8	*2022*	5
0.92	Persons with Health Insurance	*percent*	93.4	92.4	92.9		*2022*	24
0.83	Adults with Health Insurance	*percent*	92.5		91.6	89	*2023*	1
0.83	Adults With Individual Health Insurance	*percent*	20.8		20.5	20.2	*2024*	8
0.58	Dentist Rate	*dentists/ 100,000 population*	67.4		65.2	73.5	*2022*	10
0.58	Persons without Health Insurance	*percent*	5		6.1	7.9	*2023*	1
0.50	Mental Health Provider Rate	*providers/ 100,000 population*	379.5		349.4		*2024*	10
0.50	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	155.9		148.7		*2024*	10
0.50	Primary Care Provider Rate	*providers/ 100,000 population*	97.7		75.3	74.9	*2021*	10

SCORE	HEART DISEASE & STROKE	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.83	Hyperlipidemia: Medicare Population	*percent*	69		67	66	*2023*	7
1.42	Adults who Experienced Coronary Heart Disease	*percent*	7.8			6.8	*2022*	5
1.42	Cholesterol Test History	*percent*	84.5			86.4	*2021*	5
1.42	High Cholesterol Prevalence	*percent*	35.7			35.5	*2021*	5
1.33	Heart Failure: Medicare Population	*percent*	12		12	11	*2023*	7
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	80.9			78.2	*2021*	5
1.25	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	39.7	33.4	46		*2020-2022*	19
1.22	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	88	71.1	101.6		*2020-2022*	19

1.17	High Blood Pressure Prevalence	*percent*	34.9	41.9		32.7	*2021*	5
1.06	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	47.7		60.9		*2021*	14
1.00	Atrial Fibrillation: Medicare Population	*percent*	14		15	14	*2023*	7
1.00	Hypertension: Medicare Population	*percent*	65		67	65	*2023*	7
1.00	Ischemic Heart Disease: Medicare Population	*percent*	20		22	21	*2023*	7
0.92	Adults who Experienced a Stroke	*percent*	3.6			3.6	*2022*	5
0.83	Stroke: Medicare Population	*percent*	5		5	6	*2023*	7

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.67	Syphilis Incidence Rate	*cases/ 100,000 population*	31.4		16.4	15.8	*2023*	16
2.17	Tuberculosis Incidence Rate	*cases/ 100,000 population*	3	1.4	1.6	2.9	*2023*	16
1.94	Chlamydia Incidence Rate	*cases/ 100,000 population*	525.7		464.2	492.2	*2023*	16
1.83	Gonorrhea Incidence Rate	*cases/ 100,000 population*	199.3		168.8	179.5	*2023*	16
1.61	Age-Adjusted Death Rate due to HIV	*deaths/ 100,000 population*	1.4		0.9		*2020-2022*	19
1.19	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	12.3	11.5	13.8		*2023*	16
0.89	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5.6		7.8	7.5	*2017-2021*	12
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	61.1		59.8	60.4	*2024*	8
0.64	Overcrowded Households	*percent*	0.9		1.4	3.4	*2019-2023*	2
0.58	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	9.6		12.3		*2020-2022*	19
0.50	Flu Vaccinations: Medicare Population	*percent*	55		50	3	*2023*	7

0.50	Pneumonia Vaccinations: Medicare Population	*percent*	11		9	9	*2023*	7

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.06	Babies with Low Birthweight	*percent*	9.4		8.7	8.6	*2022*	17
1.92	Mothers who Received Early Prenatal Care	*percent*	66.9		68.6	75.3	*2022*	17
1.89	Preterm Births	*percent*	11	9.4	10.8		*2022*	17
1.53	Mothers who Smoked During Pregnancy	*percent*	7.4	4.3	7.9	3.7	*2022*	17
1.50	Babies with Very Low Birthweight	*percent*	1.4		1.5		*2022*	17
0.86	Infant Mortality Rate	*deaths/ 1,000 live births*	5.5	5	6.7	5.4	*2020*	17
0.78	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	4.6		6.1	5.6	*2022*	17

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.50	Depression: Medicare Population	*percent*	20		18	17	*2023*	7
2.17	Poor Mental Health: Average Number of Days	*days*	6.2		6.1		*2022*	10
2.14	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	43.5		33.8		*2020-2022*	19
1.58	Adults Ever Diagnosed with Depression	*percent*	24.8			20.7	*2022*	5
1.58	Poor Mental Health: 14+ Days	*percent*	17.7			15.8	*2022*	5
1.47	Self-Reported General Health Assessment: Good or Better	*percent*	85.9		85.4	86	*2024*	8
1.44	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	15.2	12.8	14.5		*2020-2022*	19
1.33	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6		6	6	*2023*	7

1.00	Adults who Feel Life is Slipping Out of Control	*Percent*	23.4		24.1	23.9	*2024*	8
0.50	Mental Health Provider Rate	*providers/ 100,000 population*	379.5		349.4		*2024*	10

SCORE	NUTRITION & HEALTHY EATING	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.17	Adults who Frequently Cook Meals at Home	*Percent*	67		67.6	67.7	*2024*	8
1.75	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	38.6		38.1	38.2	*2024*	8
0.94	Food Environment Index		7.7		7		*2025*	10
0.83	Adults who Drank Soft Drinks: Past 7 Days	*percent*	47.4		48.6	47.5	*2024*	8

SCORE	OLDER ADULTS	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.75	People 65+ Living Alone	*percent*	30.9		30.2	26.5	*2019-2023*	2
2.50	Asthma: Medicare Population	*percent*	8		7	7	*2023*	7
2.50	Chronic Kidney Disease: Medicare Population	*percent*	22		19	18	*2023*	7
2.50	Depression: Medicare Population	*percent*	20		18	17	*2023*	7
2.14	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	43.5		33.8		*2020-2022*	19
2.00	COPD: Medicare Population	*percent*	14		13	11	*2023*	7
1.92	People 65+ Living Alone (Count)	*people*	31571				*2019-2023*	2
1.92	People 65+ Living Below Poverty Level (Count)	*people*	8502				*2019-2023*	2
1.83	Hyperlipidemia: Medicare Population	*percent*	69		67	66	*2023*	7
1.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	39		39	36	*2023*	7
1.58	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	10.3		12.1		*2020-2022*	19

1.50	Cancer: Medicare Population	*percent*	12	12	12	*2023*	7
1.50	Osteoporosis: Medicare Population	*percent*	11	11	12	*2023*	7
1.47	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	109.6	118.1	113.2	*2017-2021*	12
1.42	Adult Day Care Spending-to-Income Ratio	*percent*	11.5	11.1	11.9	*2025*	9
1.42	People 65+ Living Below Poverty Level	*percent*	8.6	9.5	10.4	*2019-2023*	2
1.33	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6	6	6	*2023*	7
1.33	Heart Failure: Medicare Population	*percent*	12	12	11	*2023*	7
1.33	Mammography Screening: Medicare Population	*percent*	49	51	39	*2023*	7
1.00	Atrial Fibrillation: Medicare Population	*percent*	14	15	14	*2023*	7
1.00	Diabetes: Medicare Population	*percent*	24	25	24	*2023*	7
1.00	Hypertension: Medicare Population	*percent*	65	67	65	*2023*	7
1.00	Ischemic Heart Disease: Medicare Population	*percent*	20	22	21	*2023*	7
0.92	Median Household Income: Householders 65+	*dollars*	51857	51608	57108	*2019-2023*	2
0.83	Stroke: Medicare Population	*percent*	5	5	6	*2023*	7
0.75	Adults 65+ with Total Tooth Loss	*percent*	10.1		12.2	*2022*	5

SCORE	ORAL HEALTH	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.08	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.4		12.8	12	*2017-2021*	12
1.31	Adults who Visited a Dentist	*percent*	45.3		44.3	45.3	*2024*	8
0.75	Adults 65+ with Total Tooth Loss	*percent*	10.1			12.2	*2022*	5
0.58	Dentist Rate	*dentists/ 100,000 population*	67.4		65.2	73.5	*2022*	10

SCORE	OTHER CHRONIC CONDITIONS	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.50	Chronic Kidney Disease: Medicare Population	*percent*	22		19	18	*2023*	7
1.92	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.5		15.1		*2020-2022*	19
1.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	39		39	36	*2023*	7
1.50	Osteoporosis: Medicare Population	*percent*	11		11	12	*2023*	7
1.42	Adults with Arthritis	*percent*	30.3			26.6	*2022*	5

SCORE	PREVENTION & SAFETY	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.58	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	16.1	10.7	13.5	12	*2018-2020*	6
1.83	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.8	20.7	44.7		*2020-2022*	10
1.78	Severe Housing Problems	*percent*	12.9		12.7		*2017-2021*	10
1.64	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	43.3		46.5		*2020-2022*	19
1.58	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	10.3		12.1		*2020-2022*	19
1.42	Death Rate due to Injuries	*deaths/ 100,000 population*	95.9		100.7		*2018-2022*	10
0.75	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	8.9		11.1		*2016-2022*	10

SCORE	RESPIRATORY DISEASES	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.50	Asthma: Medicare Population	*percent*	8		7	7	*2023*	7
2.17	Tuberculosis Incidence Rate	*cases/ 100,000 population*	3	1.4	1.6	2.9	*2023*	16
2.00	COPD: Medicare Population	*percent*	14		13	11	*2023*	7
1.75	Adults with Current Asthma	*percent*	11			9.9	*2022*	5
1.75	Proximity to Highways	*percent*	6.2		7.2		*2020*	14

1.50	Adults who Smoke	*percent*	16	6.1		12.9	*2022*	5
1.42	Adults with COPD	*Percent of adults*	7.8			6.8	*2022*	5
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	59.9		64.3	53.1	*2017-2021*	12
1.19	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	41.3		42.8		*2020-2022*	19
1.17	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	38.1	25.1	39.8	32.4	*2018-2022*	12
1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.6		6.9	6.8	*2024*	8
0.58	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	9.6		12.3		*2020-2022*	19
0.36	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.7	1.6	*2024*	8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.67	Syphilis Incidence Rate	*cases/ 100,000 population*	31.4		16.4	15.8	*2023*	16
1.94	Chlamydia Incidence Rate	*cases/ 100,000 population*	525.7		464.2	492.2	*2023*	16
1.83	Gonorrhea Incidence Rate	*cases/ 100,000 population*	199.3		168.8	179.5	*2023*	16
1.61	Age-Adjusted Death Rate due to HIV	*deaths/ 100,000 population*	1.4		0.9		*2020-2022*	19

SCORE	TOBACCO USE	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.50	Adults who Smoke	*percent*	16	6.1		12.9	*2022*	5
1.42	Tobacco Use: Medicare Population	*percent*	7		7	6	*2023*	7
1.36	Cigarette Spending-to-Income Ratio	*percent*	2.1		2.1	1.9	*2025*	9
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	59.9		64.3	53.1	*2017-2021*	12
1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.6		6.9	6.8	*2024*	8

0.36	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.7	1.6	*2024*	8

SCORE	WEIGHT STATUS	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.28	Adults 20+ Who Are Obese	*percent*	37.7	36			*2021*	6
1.92	Obesity: Medicare Population	*percent*	26		25	20	*2023*	7
1.83	Adults Happy with Weight	*Percent*	41.8		42.1	42.6	*2024*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.17	Adults who Frequently Cook Meals at Home	*Percent*	67		67.6	67.7	*2024*	8
1.83	Adults Happy with Weight	*Percent*	41.8		42.1	42.6	*2024*	8
1.75	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	38.6		38.1	38.2	*2024*	8
1.72	Poor Physical Health: Average Number of Days	*days*	4.5		4.3		*2022*	10
1.67	Insufficient Sleep	*percent*	37.6	26.7		36	*2022*	5
1.47	Self-Reported General Health Assessment: Good or Better	*percent*	85.9		85.4	86	*2024*	8
1.25	Life Expectancy	*years*	75.3		75.2		*2020-2022*	10
1.25	Poor Physical Health: 14+ Days	*percent*	13.4			12.7	*2022*	5
1.25	Self-Reported General Health Assessment: Poor or Fair	*percent*	18.1			17.9	*2022*	5
1.17	High Blood Pressure Prevalence	*percent*	34.9	41.9		32.7	*2021*	5
1.00	Adults who Feel Life is Slipping Out of Control	*Percent*	23.4		24.1	23.9	*2024*	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	61.1		59.8	60.4	*2024*	8

SCORE	WOMEN'S HEALTH	UNITS	SUMMIT COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source

2.00	Mammogram in Past 2 Years: 50-74	*percent*	71.7	80.3		76.5	*2022*	5
1.69	Breast Cancer Incidence Rate	*cases/ 100,000 females*	133.5		132.3	129.8	*2017-2021*	12
1.42	Cervical Cancer Screening: 21-65	*Percent*	81.1			82.8	*2020*	5
1.33	Mammography Screening: Medicare Population	*percent*	49		51	39	*2023*	7
1.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	19.9	15.3	20.2	19.3	*2018-2022*	12
0.89	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5.6		7.8	7.5	*2017-2021*	12

Additional Demographic Data

The following tables detail the demographic, social, and economic characteristics of the Akron General Community described in the body of this CHNA report. All data are sourced from Claritas Pop-Facts® (2024 population estimates), unless otherwise noted.

Table 12: Population Size of Hospital Community by Zip Code

Zip Code	Population
44203	39,160
44221	29,140
44223	19,442
44224	38,555
44250	1,117
44301	13,638
44302	4,698
44303	6,972
44304	5,295
44305	20,852
44306	20,531
44307	7,313
44308	848
44310	24,796
44311	7,051
44312	30,771
44313	24,854
44314	17,294
44319	21,327
44320	18,552
44325	7
44333	18,991
Akron General Community (Total)	371,204

Table 13: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Akron General Community	Ohio
0-4	5.3%	5.6%
5-9	5.5%	5.7%
10-14	5.6%	6.1%
15-17	3.5%	3.8%
18-20	4.0%	4.4%
21-24	5.0%	5.3%
25-34	13.7%	12.4%
35-44	12.5%	12.2%
45-54	11.4%	11.7%
55-64	13.2%	13.0%
65-74	12.1%	11.6%
75-84	6.0%	6.1%
85+	2.2%	2.2%
Median Age	41.6 years	40.5 years

Table 14: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	Akron General Community	Ohio	U.S.
White	68.7%	75.7%	63.4%
Black/African American	18.5%	12.8%	12.4%
American Indian/Alaskan Native	0.3%	0.3%	0.9%
Asian	4.6%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.1%	0.2%
Another Race	1.3%	2.1%	6.6%
Two or More Races	6.7%	6.4%	10.7%
Hispanic or Latino (any race)	3.2%	5.0%	19.0%

U.S. value: American Community Survey (2019-2023)

Table 15: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	Akron General Community	Ohio	U.S.
Only English	93.2%	92.8%	78.0%
Spanish	1.6%	2.3%	13.4%
Asian/Pacific Islander Language	1.2%	1.0%	3.5%
Indo-European Language	3.1%	2.8%	3.8%
Other Language	0.9%	1.1%	1.2%

U.S. value: American Community Survey (2019-2023)

Table 16: Household Income of Hospital Community and Surrounding Geographies

Income Category	Akron General Community	Ohio
Under $15,000	12.1%	9.5%
$15,000 - $24,999	9.0%	7.8%
$25,000 - $34,999	9.2%	8.0%
$35,000 - $49,999	13.9%	12.2%
$50,000 - $74,999	17.6%	17.0%
$75,000 - $99,999	12.8%	13.0%
$100,000 - $124,999	8.7%	9.9%
$125,000 - $149,999	5.5%	7.0%
$150,000 - $199,999	5.2%	7.2%
$200,000 - $249,999	2.4%	3.5%
$250,000 - $499,999	2.4%	3.4%
$500,000+	1.2%	1.6%
Median Household Income	$60,982	$68,488

Table 17: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Akron General Community	11.1%
Ohio	9.4%
U.S.	8.8%
Akron General Zip Codes	-
44203	9.3%
44221	7.7%
44223	2.5%
44224	5.4%
44250	5.1%
44301	12.5%
44302	15.9%
44303	5.5%
44304	38.3%
44305	15.3%
44306	22.9%
44307	31.7%
44308	59.6%
44310	26.0%
44311	34.6%
44312	6.9%
44313	5.6%
44314	15.9%
44319	4.5%
44320	17.3%
44325	100.0%
44333	4.3%

U.S. value: American Community Survey (2019-2023)

Table 18: Educational Attainment of Hospital Community and Surrounding Geographies

	Akron General Community	Ohio	U.S.
Less than High School Graduate	5.3%	8.6%	10.6%
High School Graduate	31.8%	32.8%	26.2%
Some College, No Degree	20.8%	19.6%	19.4%
Associate Degree	8.5%	8.9%	8.8%
Bachelor's Degree	19.4%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	10.0%	11.5%	13.7%

U.S. value: American Community Survey (2019-2023)

Table 19: High Rent Burden in Hospital Community and Surrounding Geographies

	Renters Spending 30% or More of Income on Rent
Summit County	46.6%
Ohio	45.1%
U.S.	50.4%
Akron General Zip Codes	-
44203	43.6%
44221	40.1%
44223	42.4%
44224	45.9%
44250	0.7%
44301	41.0%
44302	48.8%
44303	39.5%
44304	59.8%
44305	48.3%
44306	46.1%
44307	57.1%
44308	46.7%
44310	57.9%
44311	53.9%
44312	42.4%
44313	36.3%
44314	52.1%
44319	36.9%
44320	70.2%
44325	--
44333	48.6%

All values: American Community Survey (2019-2023)

Table 20: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Summit County	90.4%
Ohio	89.0%
U.S.	89.9%
Akron General Zip Codes	-
44203	87.7%
44221	89.1%
44223	91.0%
44224	94.2%
44250	95.9%
44301	86.6%
44302	83.7%
44303	91.1%
44304	85.2%
44305	89.4%
44306	87.1%
44307	75.0%
44308	86.1%
44310	82.8%
44311	84.1%
44312	92.0%
44313	93.4%
44314	87.4%
44319	92.1%
44320	86.8%
44325	--
44333	93.8%

All values: American Community Survey (2019-2023

Appendix C: Environmental Scan and Key Findings

An environmental scan was conducted to supplement quantitative data and further contextualize health needs across Summit County. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts, including reports from the latest Ohio State Health Assessment and Summit County Community Health Assessment (CHA) corroborated the relevance of the five prioritized needs in this 2025 CHNA process for Akron General.

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; behavioral health treatment gaps remain significant; chronic disease management is challenged by food insecurity and inadequate recreational infrastructure; differences in maternal and child health outcomes persist among various communities; and health-related social needs particularly poverty, housing insecurity, and gun violence, impact all other areas of health.

The following reports were reviewed. The full reports can be accessed via the hyperlinks in the footnotes:

- 2023 Ohio State Health Assessment[13]
- 2022 Community Health Needs Assessment (joint assessment conducted by Summa Health, Summit County Public Health, and the Summit Coalition for Community Health Improvement)[14]
- 2022 Akron Children's Hospital CHNA[15]
- 2022 Greater Akron LGBTQ+ Community Needs Assessment[16]
- United Way Community Needs Assessment: Summit & Medina Counties[17]

[13] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[14] Summa Health. (2022). *Summa Health Community Health Needs Assessment 2022* [PDF]. Summa Health. Retrieved from https://www.summahealth.org/about-us/about-summa/community-benefit-and-diversity/communityneedsassessments
[15] Akron Children's Hospital. (2022). *Community Health Needs Assessment.* Retrieved from https://www.akronchildrens.org/pages/Community_Health_Needs_Assessment.html?tab=sctabtwo
[16] Snyder, A. M., Roufael, J. S., DiDonato, A. E., Maikranz, N. E., & Alemagno, S. (2022). *Greater Akron LGBTQ+ community needs assessment.* Kent State University College of Public Health. Retrieved from https://www.lgbtqohio.org/news/lgbtq-community-needs-assessment-greater-akron
[17] United Way of Summit & Medina County. *Understanding community needs in Summit & Medina counties.* United Way of Summit & Medina County. Retrieved from https://www.uwsummitmedina.org/united-way-of-summit-medina-names-in-summit-medina/

Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

WELCOME: Cleveland Clinic is in the process of conducting our 2025 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 in [XXXX] County. During this interview, we will ask a series of questions related to health issues in your community. Our goal is to gain various perspectives on the major issues affecting the population that your organization 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 accessible 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 Questions and Probes

- **From your perspective, what does a community need to be healthy?**
    - What are your community's strengths?

- **What are the top health-related issues that residents are facing in your community that you would change or improve?**
    - What makes them the most important health issues?

- What do you think is the cause of these problems in your community?

- **From the health issues and challenges we've just discussed, which do you think are the most difficult to overcome?**
    - Which of these issues are more urgent or important than others?
    - Which groups in your community face particular health issues or challenges?
    - What health challenges are different if the person is a particular age, or gender, race, or ethnicity?

- **What do you think causes residents to be healthy or unhealthy in your community?**
    - What types of things influence their health, to make it better or worse?
    - What might prevent someone from accessing care for these health challenges? Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.

- **What could be done to promote health for all? (Health for all is the idea that everyone should have the same chance to be healthy, regardless of their circumstances)**

- **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?
    - What specific community organizations or agencies can you see taking a strong leadership role in improving the health of your community?
    - What resources does your community have that can be used to improve community health?

- **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 the progress organizations are making to improve health and quality of life?

- **What community health changes have you seen over the past three years (since 2022)?**

- **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.

Community Input Key Findings

Community stakeholders from 11 organizations provided feedback specifically for the Akron General community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

Individuals from the following organizations participated as key informants for the Akron General community:

- Akron Canton Regional Foodbank
- Akron Public Schools
- ASIA (Asian Services In Action)
- Boys and Girls Clubs of Northeast Ohio
- City of Akron
- Cleveland Clinic Children's
- Community Action Akron Summit Pathways Hub
- County of Summit ADM Board
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Minority Behavioral Health Group
- Summit County Public Health

The following are summary findings for each of the five prioritized health needs identified in the 2025 Community Health Needs Assessment.

Access to Healthcare

Stakeholder conversations for the Akron General community highlighted significant barriers to accessing healthcare, especially for low-income residents, older adults, and marginalized populations. Participants noted that financial challenges, transportation limitations, and provider shortages continue to limit access to both preventive and specialized care. Even insured residents struggle with high out-of-pocket costs, while long wait times and difficulty navigating a fragmented system exacerbate delays in treatment. Stakeholders consistently emphasized the importance of improving affordability, expanding local services, and increasing care coordination to reduce differences in health outcomes.

The following are highlights of participant feedback regarding access to healthcare:

- Cost barriers: High deductibles, copays, and prescription costs limit consistent access.
- Insurance gaps: Uninsured and underinsured populations face severe obstacles.

- Transportation challenges: Lack of reliable and affordable options affects rural and urban residents.
- Provider shortages: Wait times and limited availability, especially for specialists, remain common.
- Resource awareness: Many residents are unaware of existing programs and services.
- Older adult needs: Seniors face challenges in affording care and managing chronic conditions.

The following are a few select quotes illustrating feedback about healthcare access by key informants:

"Even people with insurance cannot afford the deductibles and end up avoiding care until it becomes an emergency."

"Transportation is a huge barrier. People miss appointments because they simply cannot get there."

"We have long wait times for specialists, especially mental health, and people give up trying to get care."

"Older adults on fixed incomes often have to choose between medications and groceries."

Overall, access to healthcare remains a pressing challenge for the Akron General community. Financial and insurance barriers continue to limit residents' ability to seek timely care, while transportation and provider shortages further differences in outcomes. Older adults and populations with unmet needs experience disproportionate impacts, reflecting gaps in both affordability and service availability. Stakeholders underscored the need for innovative solutions, including mobile clinics, telehealth expansion, and integrated care models, alongside stronger community outreach to ensure residents are aware of and can navigate available resources. Addressing these issues holistically will be critical to improving access and advancing equal health outcomes.

Behavioral Health: Mental Health and Substance Use Disorder

Behavioral health, including both mental health and substance use disorder, was consistently identified as a top priority by stakeholders in the Akron General community. Persistent gaps in access, affordability, and availability of services remain a critical concern, particularly for certain groups such as youth, older adults, and those experiencing financial hardship. Provider shortages, long wait times, and limited crisis services were viewed as urgent barriers that prevent timely treatment. Stigma, cultural barriers, and lack of integrated care further complicate access, while youth mental health issues such as depression, anxiety, and trauma were repeatedly noted as pressing needs linked to social stressors, family instability, and lingering effects of the COVID-19 pandemic.

The following are highlights of participant feedback regarding behavioral health:

- Provider shortages: Insufficient behavioral health professionals and long wait times.
- Youth mental health: Increasing concerns about depression, anxiety, and trauma.
- Substance use: Ongoing opioid epidemic and barriers to treatment.
- Crisis care gaps: Limited options for immediate, intensive intervention.
- Stigma and barriers: Cultural and social stigma discouraging treatment.
- Integrated services: Need for behavioral health embedded in primary care.
- Affordability: High costs and inadequate insurance coverage limiting access.

The following are a few select quotes illustrating feedback about behavioral health by key informants:

"It can take months to get an appointment with a psychiatrist, and families just cannot wait that long."

"Youth are struggling more than ever with depression and anxiety, and many do not know where to turn for help."

"Addiction services are still too hard to access, especially for those without good insurance."

"We need crisis stabilization options that do not involve the emergency room."

Stakeholders emphasized that behavioral health remains a deeply entrenched issue in the Akron General community, with far-reaching impacts on individuals, families, and neighborhoods. Addressing these challenges will require investments in workforce development, crisis intervention resources, and culturally responsive, integrated care models that reduce stigma and meet people where they are. Community-driven strategies, particularly those focused on youth, affordability, and substance use, were seen as essential to improving behavioral health outcomes and reducing preventable crises.

Chronic Disease Prevention & Management

Stakeholders in the Akron General community emphasized that chronic disease prevention and management remain a pressing issue, particularly given the high prevalence of conditions such as diabetes, hypertension, heart disease, obesity, and stroke. Many participants linked these conditions to social and lifestyle factors, including poor nutrition, limited access to healthy foods, physical inactivity, and stress. Preventive care was described as underutilized, with barriers such as cost, limited access to specialists, and gaps in patient education contributing to delayed detection and treatment. Older adults were seen as a particular population to focus on, as they often manage multiple chronic illnesses while also facing transportation challenges, social isolation, and financial strain.

Primary and secondary data findings across topics such as nutrition, cancer, cardiovascular health, and aging consistently revealed differences in health outcomes influenced by income, location, and barriers in care delivery.

Nutrition & Healthy Eating and Wellness & Lifestyle
The following are highlights of participant feedback regarding nutrition and healthy eating and wellness and lifestyle:

- Limited access to affordable healthy foods.
- Obesity and poor nutrition are strong contributors to chronic disease.
- Stress and physical inactivity compound chronic health risks.

The following are a few select quotes illustrating feedback about nutrition and healthy eating and wellness and lifestyle by key informants:

"Obesity and poor nutrition are driving so many of the health issues we see, and healthy food is not affordable for many families."

"Wellness is often overlooked, but it is at the root of preventing so many chronic conditions."

Cancer
The following are highlights of participant feedback regarding cancer:

- Screening rates are low, particularly for breast, cervical, and colon cancers.
- Late detection is common, leading to advanced disease at diagnosis.
- Preventive education and accessible testing opportunities are needed.

The following are a few select quotes illustrating feedback about cancer by key informants:

"People are not getting screened early enough, and by the time they do, their conditions are already advanced."

"We need more outreach to promote cancer screenings in the community."

Diabetes, Heart Disease, & Stroke
The following are highlights of participant feedback regarding diabetes, heart disease, stroke, and other chronic conditions:

- Diabetes and hypertension remain widespread across the community.
- Stroke and heart disease are major causes of morbidity and mortality.
- Preventive screenings and regular management are not consistently accessed.
- Cost and lack of patient education create barriers to long-term management.

The following are select quotes about diabetes, heart disease, stroke, and other chronic conditions:

"Diabetes is rampant, but many people cannot afford the care they need to manage it."

"Heart disease and stroke continue to take a toll on families in this county."

Older Adult Health

The themes related to the 65 and older population center around access to care, environmental supports, health behaviors, and social factors that directly impact older adults' ability to manage chronic conditions such as diabetes, hypertension, and dementia.

The following are highlights of participant feedback regarding older adult health:

- Seniors often face multiple chronic conditions at once.
- Barriers include transportation challenges, limited mobility, and fixed incomes.
- Social isolation and fragmented support systems worsen outcomes.
- Need for better coordination of senior care and community support.

The following are a selection of quotes illustrating feedback about Older Adult Health by key informants:

"Older adults are juggling multiple chronic diseases and often cannot get to the care they need."

"Social isolation is a huge problem for seniors, and it directly impacts their health."

Chronic disease prevention and management emerged as a top concern for stakeholders in the Akron General community. Challenges such as poor nutrition, physical inactivity, limited preventive screenings, and financial barriers contribute to the persistence of conditions like cancer, diabetes, heart disease, and stroke. Older adults are especially at risk due to multiple chronic conditions and compounding social factors. Stakeholders stressed the importance of holistic and community-based strategies that include patient education, preventive care, access to affordable nutrition, and integrated support.

Maternal and Child Health

Stakeholder discussions for the Akron General 2025 Community Health Needs Assessment identified maternal and child health as an area of ongoing concern. Participants emphasized that while there are strong healthcare providers in Summit County, persistent gaps exist in prenatal, postpartum, and pediatric care, particularly for low-income families, women in rural areas or neighborhoods with fewer resources, and communities of color. Rising maternal mental health concerns, including postpartum depression and anxiety, were noted, as well as shortages of pediatric and adolescent behavioral health providers. Stakeholders consistently called for more coordinated, family-centered services that address both medical and social needs across the maternal and child health continuum.

The following are highlights of participant feedback regarding maternal and child health:

- Limited prenatal and postpartum care for low-income communities.
- Rising maternal mental health needs, especially postpartum depression, and anxiety.
- Gaps in pediatric care access, particularly behavioral and mental health services.
- Provider shortages and long wait times for children's services.
- Need for coordinated family-centered care and supportive community networks.

The following are a selection of quotes illustrating feedback about Maternal and Child Health by key informants:

"Moms in rural areas still have to travel far for OB care, and transportation is a huge barrier."

"Postpartum depression is underdiagnosed and undertreated here. Women are struggling in silence."

"We need more providers who understand children's behavioral health. Wait times are months long."

"Family-centered care makes all the difference. Parents want support, not just for the baby, but for themselves too."

Maternal and child health remains deeply tied to broader access and opportunity challenges. Stakeholders highlighted that barriers in transportation, provider shortages, and affordability exacerbate gaps in prenatal, pediatric, and maternal mental health care. Families are particularly impacted by long wait times for pediatric behavioral health and by the lack of coordinated, culturally responsive services. Stakeholders underscored the importance of strengthening family-centered care models, expanding access to maternal mental health support, and improving resource networks for children and families. Addressing these gaps will be critical to improving long-term outcomes for mothers, infants, and children across the Akron General community.

Health-Related Social Needs

Stakeholder discussions for the Akron General 2025 Community Health Needs Assessment highlighted health-related social needs as fundamental drivers of health outcomes in the community. Residents described how poverty, unemployment, housing instability, and food insecurity create significant barriers to maintaining wellness and accessing necessary services. These issues are compounded by limited transportation options, gaps in workforce development, and systemic challenges. Stakeholders emphasized that addressing these root causes is essential to improving overall community health and reducing differences in health outcomes.

The following highlights key insights from stakeholder interviews regarding health-related social needs in the community Akron General serves.

- Housing instability: Shortages of affordable, safe housing remain a widespread concern.
- Food insecurity: Residents face limited access to affordable, healthy food, especially in lower-income neighborhoods.

- Employment barriers: Job opportunities and workforce training are insufficient, particularly for low-income families.
- Transportation challenges: Lack of reliable, affordable public transit restricts access to jobs, healthcare, and other services.
- Financial stress: Poverty and rising costs of living undermine residents' ability to prioritize health.
- Community differences: Structural barriers and underinvestment in certain neighborhoods contribute to persistent differences in outcomes.

The following are a selection of quotes illustrating feedback about health-related social needs:

"Housing is such a big issue. If people don't have stable housing, it affects every part of their health and wellbeing."

"There are too many families making choices between food, rent, and medical bills. That's not sustainable."

"Transportation is a constant barrier. If you can't get to work or to the doctor, everything else falls apart."

"We see whole communities that have been overlooked for decades, and the health outcomes show it."

Health-related social needs are deeply interconnected with health outcomes in the Akron General community. Stakeholders consistently linked poverty, housing, transportation, and food insecurity to broader challenges in accessing healthcare and sustaining wellness. Addressing these conditions requires cross-sector collaboration that prioritizes community-led strategies, increased investment in social infrastructure, and sustainable solutions that meet both immediate needs and long-term barriers. Improving stability related to health-related social needs was viewed as a prerequisite for advancing more fair health outcomes across the community.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

Akron General's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2022 CHNA: Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-related Social Needs.

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

Access to Affordable Healthcare

Actions and Highlighted Impacts:

A. Cleveland Clinic 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 2024, Cleveland Clinic health system provided over $337 million in financial assistance to its communities in Ohio, Florida, and Nevada.

B. Utilizing medically secure online and mobile platforms, Akron General connected patients with Cleveland Clinic providers for telehealth and virtual visits. In 2024, Cleveland Clinic provided 1.1 million virtual visits.

C. The Transformative Care Continuum (TCC) program, a partnership between Akron General's Center for Family Medicine and the Ohio University Heritage College of Osteopathic Medicine, graduated their inaugural class in 2024. The cohort of TCC students continues to grow each year and consistently supports community outreach. Community projects are focused on food insecurity, the Intellectual & Developmental Disability (IDD) population (specifically transitions from pediatrics to adult medicine), Refugees (from North Hill, etc.), and the Unhoused/Housing insecure (includes ACCESS Inc.) in Akron.

Behavioral Health

Actions and Highlighted Impacts:

A. Through the Opioid Awareness Center, the hospital participated 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, Akron General continued to provide preventative education and share evidence-based practices.

B. Similar to CPR training, which helps a person without medical training assist an individual experiencing a heart attack, Cleveland Clinic offered Mental Health First Aid (MHFA) training to all US caregivers. MHFA is an 8-hour virtual training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis.

C. Akron General's Alcohol and Drug Recovery Center (ADRC) continued to provide comprehensive care and develop individualized treatment plans with the support of skilled chemical dependency counselors and a multidisciplinary team. The ADRC experienced bed reduction, but still provided comprehensive treatment programs including full assessment, intensive outpatient substance use treatment, aftercare treatment, medication assisted treatment for substance use disorder and/or co-occurring mental health issues.

D. Akron General received funding from Summit County's Opioid Abatement Advisory Council to continue its *Recovery's In Reach* program. Akron General staff continues to be an active member of the Summit County Opioid Abatement Advisory Council.

E. The hospital collected and disposed of unused medications through community-based drop boxes and drop boxes at Akron General. Deterra pouches for medication deactivation and disposal were distributed through the hospital's pharmacy.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. Health and Wellness Centers caregivers provided health screenings, wellness education lectures and other seminars. Dietitians provided one-on-one nutrition consultations and personalized meal planning in addition to *NuFit, KickStart* and other weight management programs. More than 12,000 individuals met their wellness goals.

B. In partnership with Akron's Pathways Community Hub, Akron General's Community Health Workers continued to provide health education and care coordination during in-home visits to assist with disease management and improved their quality of life.

C. The hospital's *Neighbor to Neighbor* campaign continued to support community health initiatives. The Integrating Clinical and Resource Evaluations (ICARE) program assisted community members obtain

medications, access food and transportation, and meet other health-related social needs.

Maternal and Child Health

Actions and Highlighted Impacts:

A. Akron General continued to participate in 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.

B. Through Cleveland Clinic's Center for Infant and Maternal Health, the hospital continued to provide services for pregnant women to improve their health and support babies reaching their first birthday. Cleveland Clinic's Community Health Workers (CHWs) provided education on safe sleep, diet, nutrition, and screened for social drivers of health. CHWs connected families to resources and reinforced healthcare access. If eligible, mothers received food vouchers.

C. The hospital continued to support *Centering Pregnancy* group prenatal care model to expecting mothers and increased the number of families who participate in evidence-based home visiting programs.

D. Akron General Women's Health Center collaborated with Community Action Akron Pathways Hub and Akron Metropolitan Housing Authority (AMHA) and *Full Term First Birthday* to ensure optimal access to care, programming offered by AMHA for pregnant clients/clients with young children and community support services.

Health-Related Social Needs

Actions and Highlighted Impacts:

A. Akron General participated in Cleveland Clinic community referral data platform (Unite Us) to coordinate health services and ensure optimal communication among social service providers. The hospital employed a system-wide health-related social needs screening tool for adult patients to identify categories of community support, including alcohol abuse, depression, financial strain, food insecurity, intimate partner violence, and stress. Collaborating hospitals included University Hospitals and Metro Health. Cleveland Clinic Unite Us referrals from January 2023 to July 2025 reflected a gap closure of 41%.

B. In partnership with the Akron Canton Regional Foodbank, Akron General opened the hospital NOURISH Pantry to address the needs of community members struggling to obtain food for themselves and their families. The pantry provided nutrition guidance as well as fresh and staple food items. Since 2022, over 6,000 households received food assistance through these initiatives.

C. The hospital conducted *Stop the Bleed* classes and educated 4,000 community residents on administering life saving measures. Conducted

Matter of Balance and *Stepping On* classes to reduce risk of traumatic falls among older adults.

D. Provided education classes to community members regarding motor vehicle collision and motorcycle safety.

E. Through the PATH (Providing Access to Healing) Center, the hospital provided trauma-informed, compassionate care for victims of intimate partner violence. . In January 2025, services of the PATH Center expanded to the Emergency Departments in Bath, Stow and Green.

F. Akron General caregivers engaged with students at North High School, East and Buchtel Community Learning Centers, and the LeBron James I Promise School to provide career building skills in Radiology and Imaging, Surgery, Information Technology, Respiratory Therapy, Sterile Processing and Orthopedics.

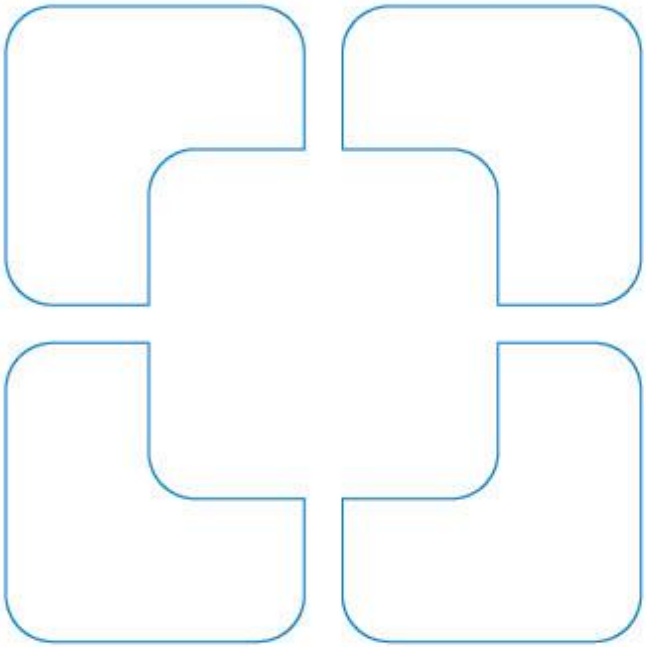
G. Cleveland Clinic's Center for Youth and College Education provided youth and college learners with career exploration opportunities in a healthcare environment, offering programming that prepares the next generation of caregivers to join the healthcare workforce.

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

2025

AKRON GENERAL
2025 Community Health Needs Assessment
Implementation Strategy Report for Years 2026 – 2028

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Akron General Implementation Strategy Report

I. Introduction and Purpose

This written plan is intended to satisfy the requirements set forth in 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 Akron General findings of the Community Health Needs Assessment (CHNA). The Implementation Strategy Report (ISR) includes the priority community health needs identified during the 2025 CHNA for Akron General. This report includes strategies for years 2026 through 2028.

The ISR serves as the foundational framework for each hospital's community health efforts and guides how Cleveland Clinic translates identified community needs into coordinated action. The ISR aligns hospital-level strategies with enterprise-wide community priorities, including food security, maternal and child health, and lead safety, ensuring that local initiatives contribute to broader system goals.

Community engagement is embedded throughout the Community Health Needs Assessment process, from the data collection and prioritization of needs to the design, implementation, and evaluation of strategies, so that community voice meaningfully informs decision-making at every stage. Cleveland Clinic recognizes that healthy communities are achieved through collective action and that sustained improvements require strong partnerships among hospitals, public health agencies, community-based organizations, and community members. These strategies reflect a shared commitment to collaborative, cross-sector approaches, recognizing that no single organization can address complex community health challenges alone.

A. Description of Hospital

Cleveland Clinic Akron General (Akron General or "the hospital"), founded in 1914 as Peoples Hospital, is a 478-bed[18] teaching and research medical center that serves as the hub for Cleveland Clinic's Southern Region. The hospital is nationally recognized for its advanced specialty care, including stroke services, a Level I Trauma Center, and the McDowell Cancer Institute, which has earned the Commission on Cancer's Outstanding Achievement Award. Akron General has also been repeatedly recognized among America's Most Wired & Most Wireless Hospitals for its integration of technology in care delivery. With 24-hour access to trauma specialists, diagnostic services, and surgical teams, Akron General combines leading expertise and innovation with a commitment to providing comprehensive, high-quality care to the Akron community and beyond.

[18] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q3 2025) 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.

As part of the broader Cleveland Clinic health system, Akron General upholds the tripartite mission of caring for life, researching for health, and educating those who serve. Cleveland Clinic is a nonprofit, multispecialty academic medical center that integrates hospital-based services with innovative research and the training of future healthcare professionals. Currently, with more than 83,000 caregivers, 23 hospitals, and 280 outpatient facilities around the world, Cleveland Clinic is recognized as one of the world's leading healthcare systems. Its collaborative, patient-centered model of care promotes improved outcomes and enhances quality of life for patients both locally and internationally.

The Cleveland Clinic health system includes its flagship academic medical center in Cleveland, regional hospitals in Northeast Ohio, a children's rehabilitation hospital, and additional hospitals and facilities in Florida and Nevada. Each hospital, including Akron General, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Akron General benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Akron General also plays a vital role within its immediate neighborhood, advancing the Cleveland Clinic's mission of improving community health. The hospital actively supports programs, partnerships, and services that address local health needs and promote health for all. It has received national recognition for excellence in patient safety and care quality, and remains committed to treating every patient with kindness, dignity, and respect.

Cleveland Clinic's legacy as a pioneering institution began in 1921 as a multispecialty group practice, and it continues to lead through medical firsts, global expansion, and a commitment to community health. Today, Akron General exemplifies this vision by delivering high-quality care, supporting health-focused research, and fostering community partnerships that help address both medical and social drivers of health.

Akron General is a trusted part of the community and continues to grow and improve to meet the needs of its patients. To learn more, visit: my.clevelandclinic.org/locations/akron-general.

II. Akron General Community Definition

The community definition describes the zip codes where approximately 75% of Akron General Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Akron General community that served as a guide for data collection and analysis for this CHNA. Table 1 lists zip codes and associated municipalities that comprise the community definition.

Figure 1: Akron General Community Definition

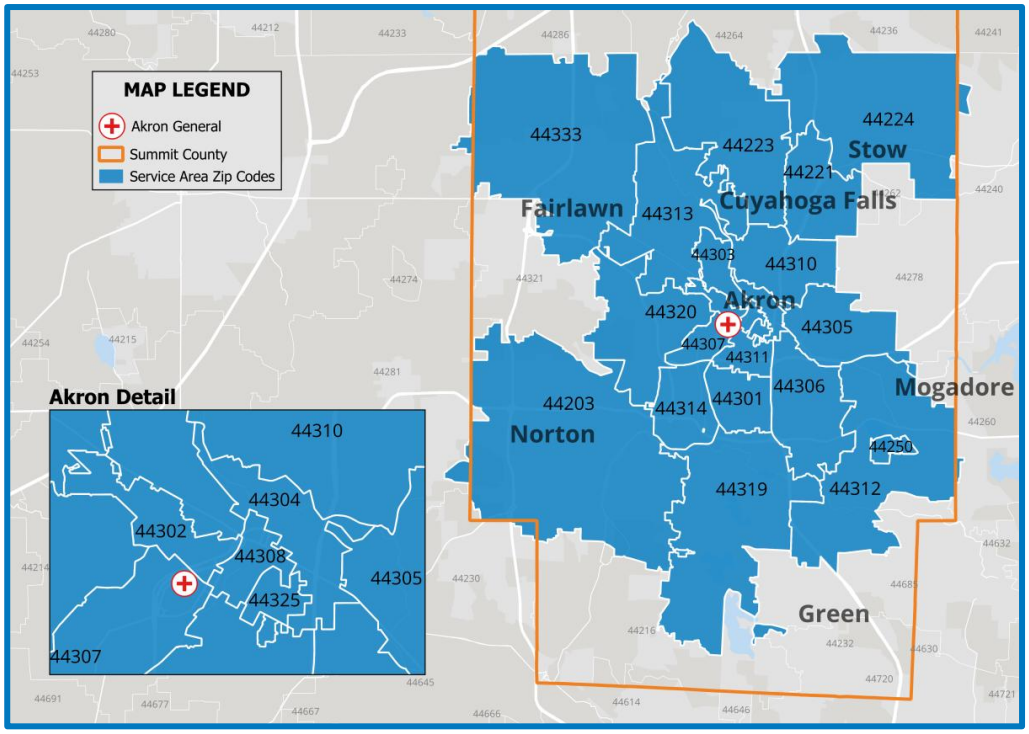


Table 1: Akron General Community Definition

Zip Code	Postal Name	Zip Code	Postal Name
44203	Barberton	44307	Akron (Lane-Wooster)
44221	Cuyahoga Falls	44308	Akron (Downtown)
44223	Cuyahoga Falls	44310	Akron (Chapel Hill)
44224	Stow	44311	Akron (Downtown)
44250	Lakemore	44312	Akron, Coventry
44301	Akron (Firestone Park)	44313	Akron (Merriman Valley)
44302	Akron (Highland Square)	44314	Akron (Kenmore)
44303	Akron (Elizabeth Park Valley)	44319	Akron, Coventry
44304	Akron (Elizabeth Park Valley)	44320	Akron (West Akron)
44305	Akron (Goodyear Heights)	44325	Akron (University)
44306	Akron (Ellet)	44333	Akron, Fairlawn

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of leadership at Akron General representing several departments of the organization, including clinical administration, medical operations, nursing, and community health. This team incorporated input from the hospital's community and local nonprofit organizations to prioritize selected strategies and determine possible collaborations. 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 from the 2025 CHNA include:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health
- Health-Related Social Needs

These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that the hospital's defined community continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to address reducing differences in health outcomes across populations in the community served by Akron General.

V. Needs Hospital Will Address

Each Cleveland Clinic hospital has adopted and is implementing an Implementation Strategy to address the significant community health needs identified through the 2025 CHNA, in accordance with the requirements of Internal Revenue Service (IRS) Section 501(r). This Implementation Strategy outlines the hospital's planned actions for the 2026–2028 implementation period and describes how identified community health needs will be addressed through hospital-led programs, services, and partnerships.

Implementation efforts focus on addressing underlying structural and social factors that influence health; strengthening and sustaining trust with community members, partners, and stakeholders; incorporating community input into the development and implementation of strategies; and monitoring and evaluating the effectiveness of programs and initiatives over time.

The strategies included in this ISR reflect collaborative efforts between Akron General and local nonprofit, public health, and community-based organizations. These coordinated initiatives are intended to improve health outcomes within the community the hospital serves.

A. Access to Healthcare

Access to healthcare remains a significant challenge for the Akron General community, as identified in the 2025 CHNA. Stakeholders cited barriers such as cost, transportation, provider shortages, and system navigation, particularly for low-income households, older adults, and rural residents. Even insured individuals face high out-of-pocket costs and copays, limiting follow-up and specialty care. Transportation challenges are severe in rural areas, while long wait times and lack of culturally responsive services further restrict access. Recommended strategies include integrated care models, expanded telehealth, and improved patient education. Secondary data show high uninsured rates in several Akron neighborhoods and high health risk scores in seven zip codes, underscoring concentrated needs.

Access to Healthcare Initiatives for 2026-2028 include:

Access to Healthcare Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Continue to provide Patient Financial Advocates to support patients in evaluating eligibility for financial assistance or public health insurance programs.

   Anticipated Impacts: Increase the proportion of eligible individuals who are enrolled in assistance programs, increase access to healthcare.

B. **Initiative:** Collaborate with Federally Qualified Health Centers (FQHCs), community-based organizations, area hospitals, and local health departments to provide access and continuum of healthcare services.

   Anticipated Impacts: Improve healthcare access and connect individuals with community resources.

C. **Initiative:** Continue to build a pipeline of primary care physicians 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.

   Anticipated Impacts: Improve community health, reduce access gaps.

B. Behavioral Health

Behavioral health, encompassing mental health and substance use, is a top priority for the Akron General community, as identified in the 2025 CHNA. Stakeholders reported rising rates of depression, anxiety, trauma, and substance use disorders, particularly opioids and alcohol, affecting youth, older adults, and marginalized populations. Barriers include provider shortages, long wait times, affordability issues, and lack of care that is culturally aware, with stigma further deterring treatment. Participants stressed the need for integrated, community-based models, school-based interventions, crisis stabilization,

and peer support programs. Data show high rates of depression, alcohol-related driving deaths, and drug poisoning mortality, and high Mental Health Index scores in certain neighborhoods, indicating exceptionally high behavioral health needs.

Behavioral Health Initiatives for 2026-2028 include:

Behavioral Health Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Collaborate with community-based organizations, schools, and local healthcare providers to educate and understand behavioral health issues, available resources, and treatment options for mental health and substance misuse issues.

   Anticipated Impacts: Increase awareness of treatment, reduce stigma, and improve early identification of behavioral health conditions.

B. **Initiative:** Continue violence prevention community programming and trauma informed care for patients.

   Anticipated Impacts: Ensure safe services at the hospital for patients experiencing violence.

C. Chronic Disease Prevention and Management



Chronic Disease Prevention and Management is a major concern for the Akron General community, as identified in the 2025 CHNA. Stakeholders reported high rates of diabetes, hypertension, heart disease, and obesity, driven by poor nutrition, limited access to healthy food, and insufficient physical activity opportunities. Barriers such as cost, fragmented care, and transportation challenges hinder consistent disease management, especially for older adults and low-income residents. Data show high obesity and food insecurity rates, and low Cancer screening rates, while breast and oral cancer risks remain elevated. Diabetes and chronic kidney disease rates are among the highest nationally, underscoring the need for integrated, community-based prevention strategies.

Chronic Disease Prevention and Management Initiatives for 2026-2028 include:

Chronic Disease Prevention and Management Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Provide community health education and screenings regarding chronic diseases and conditions for community-based organizations, residents, and faith-based organizations.

Anticipated Impacts: Address chronic disease issues of diabetes, heart disease, cancer, hypertension, chronic obstructive pulmonary disease, obesity. Improve screening follow-up rates and therefore reduce behavioral risk factors.

B. **Initiative:** Through the hospital's Health and Wellness Centers, continue to provide community classes and resources focused on physical and emotional health.

Anticipated Impacts: Improve physical activity, increase nutrition education.

D. Maternal and Child Health 

Maternal and Child Health is a critical priority for the Akron General community, as identified in the 2025 CHNA. Stakeholders reported barriers to affordable prenatal and postpartum care, culturally responsive providers, and mental health support, with rising concerns about postpartum depression and anxiety. Pediatric and adolescent care gaps, especially in behavioral health, were noted, driven by provider shortages and long wait times. Participants emphasized the need for coordinated, family-centered care linking hospitals, schools, and social services, alongside expanded childcare and developmental programs. Data show concerning trends: low early prenatal care rates, high smoking during pregnancy, elevated preterm births and low birthweight. Child health risks include high food insecurity, lead exposure, and single-parent households.

Maternal and Child Health Initiatives for 2026-2028 include:

Maternal and Child Health Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Continue Cleveland Clinic services of Community Health Workers and/or the co-location of community organizations with hospital facilities, providing assistance for families from pregnancy throughout baby's first year of life.

Anticipated Impacts: Ensure connection to obstetric/pediatric medical services, improve health and birth outcomes for pregnant patients, and support families with community resources.

B. **Initiative:** Co-Design strategies with community-based organizations to connect mothers with essential resources.

Anticipated Impacts: Gather data, align programs, and coordinate a systemic approach to improving infant mortality in communities, increase the number of babies that reach their first birthday, improve health and well-being of mother and baby.

E. Health-Related Social Needs

Health-related social needs are a major driver of health outcomes for the Akron General community, as identified in the 2025 CHNA. Stakeholders cited poverty, unemployment, rising housing costs, and limited affordable housing as persistent barriers that force families into unstable living conditions and restrict access to care. Transportation gaps and financial strain further hinder appointment attendance and treatment continuity. These challenges intersect with other priorities, contributing to behavioral health issues, substance use, and chronic disease risks. Food insecurity and lack of healthy options were highlighted as compounding factors. Data show high poverty and differences in incomes and health outcomes, alongside elevated violent crime, firearm-related deaths, and alcohol-impaired driving fatalities, underscoring the need for coordinated, cross-sector solutions.

Health-Related Social Needs Initiatives for 2026-2028 include:

Health-Related Social Needs Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. Initiative: Continue Cleveland Clinic referral data platform, Unite Us, to coordinate services and ensure optimal communication, connecting residents with essential community resources.

Anticipated Impacts: Enables gap closure, ensuring that social needs such as food assistance, family support, housing assistance, and mental health services are resolved.

B. Initiative: Expand a multi-pronged strategy to address food security through education and healthy food access options. Integrate hospital food pantries with school and community resources. Support key partnership with Akron-Canton Regional Foodbank.

Anticipated Impacts: Improve self-efficacy associated with healthy eating, improve nutrition education, reduce childhood hunger.

C. Initiative: Strengthen the hospital's Community Advisory Council with continued integration of community voice and aligned strategic planning.

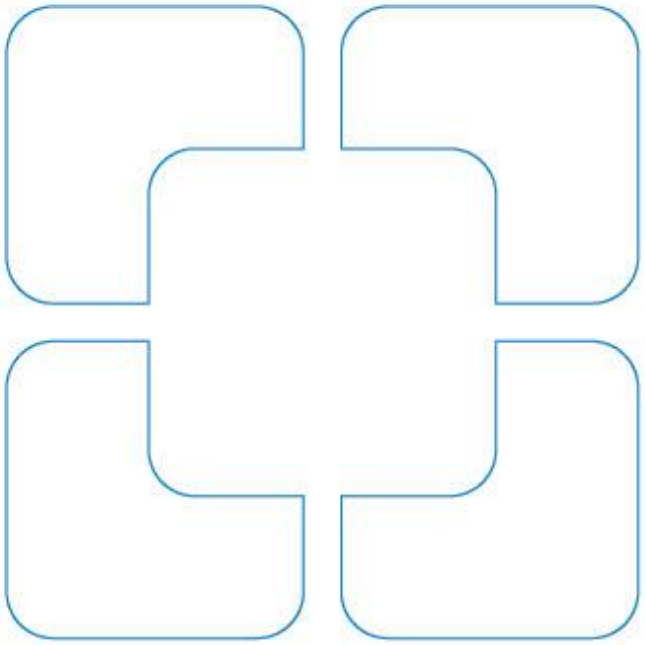
Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives. Improve community awareness of available resources, develop a resource guide, and improve access to social supports.

D. Initiative: Provide workforce development and training opportunities for K-12 students in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders.

Anticipated Impacts: Improve local employment opportunities, improve poverty rates.

While this ISR outlines specific strategies and programs identified to address the 2025 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, it does not reflect all the work being done by Akron General 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 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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