Cleveland Clinic
Mercy Hospital

Community Health Needs Assessment

2025

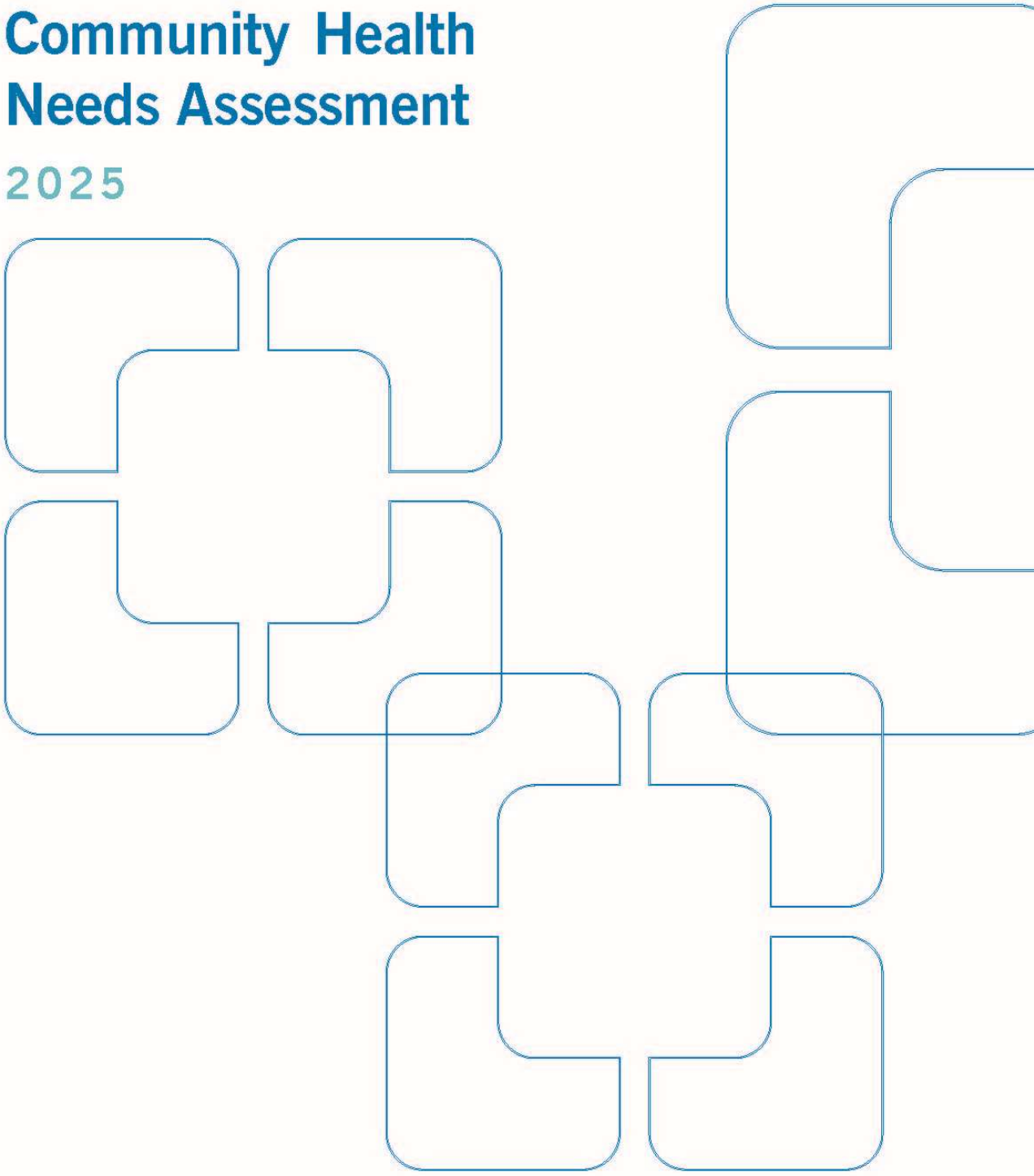


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Mercy Hospital 2025 Community Health Needs Assessment

Introduction

Cleveland Clinic Mercy Hospital (Mercy Hospital or "the hospital"), was founded in 1908 in Canton, Ohio, by the Sisters of Charity of St. Augustine. It is a 323-bed[1] hospital with outpatient locations in Alliance, Carroll County, Jackson Township, Lake Township, Louisville, Massillon, North Canton, Plain Township and Tuscarawas County. Mercy Hospital became a full member of the Cleveland Clinic health system on February 1, 2021 and is sponsored by the Sisters of Charity of St. Augustine.

As part of the broader Cleveland Clinic health system, Mercy Hospital 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 Mercy Hospital, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Mercy Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Mercy Hospital 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 equal access to care and reduction of barriers. 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, Mercy Hospital 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.

Mercy Hospital 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/mercy-hospital.

CHNA Background

As part of its mission to improve health and well-being in the communities it serves, Mercy Hospital 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.

Mercy Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Mercy Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Mercy Hospital 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: Mercy Hospital Community Definition

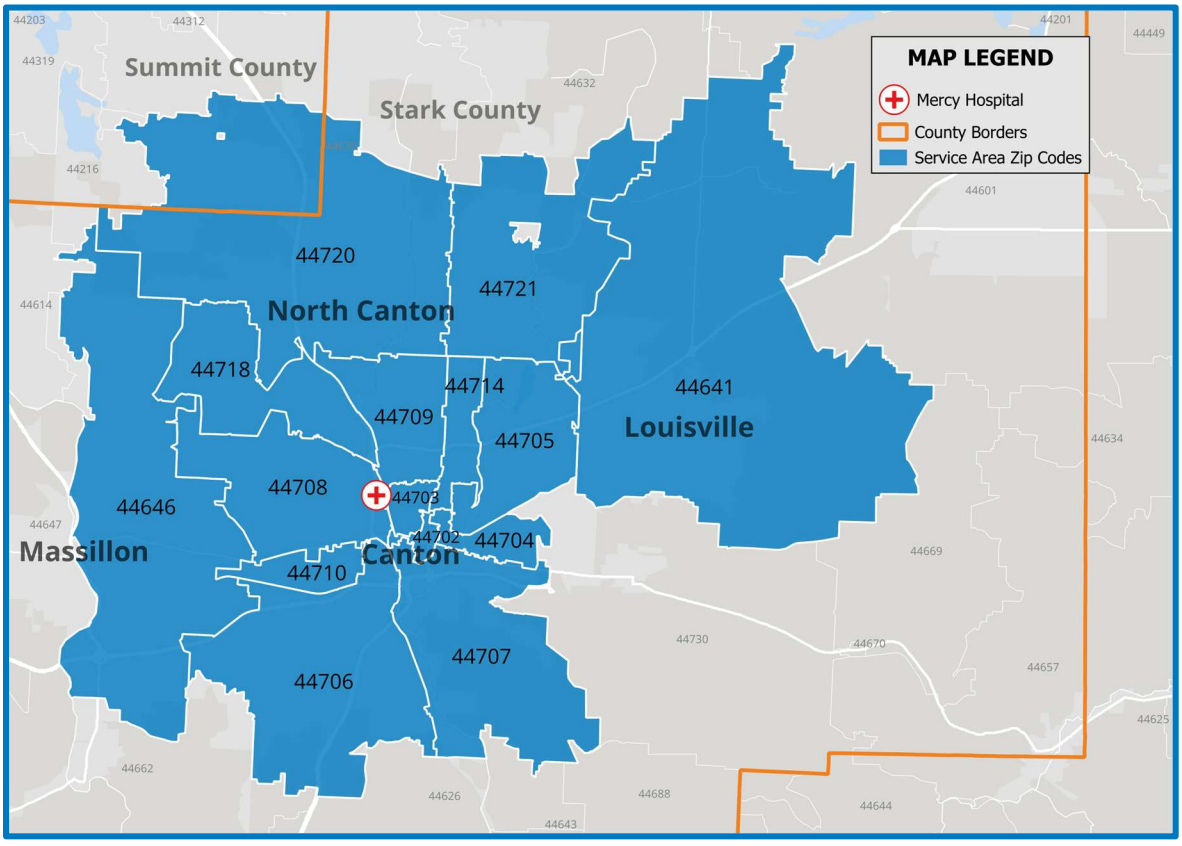


Table 1: Mercy Hospital Community Definition

Zip Code	Postal Name	Zip Code	Postal Name
44641	Louisville	44708	Canton
44646	Massillon	44709	North Canton
44702	Canton	44710	Canton
44703	Canton	44714	Canton
44704	Canton	44718	Canton
44705	Canton	44720	North Canton
44706	Canton	44721	North Canton
44707	Canton		

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 15-zip-code Mercy Hospital 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.

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 Mercy Hospital.

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

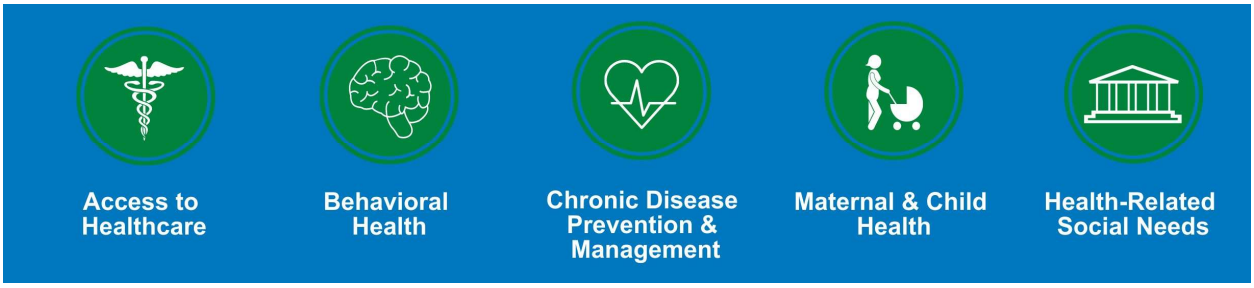
Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations with community stakeholders were conducted across the community. Stakeholders from 11 organizations provided feedback specifically for the Mercy Hospital 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 relevant 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

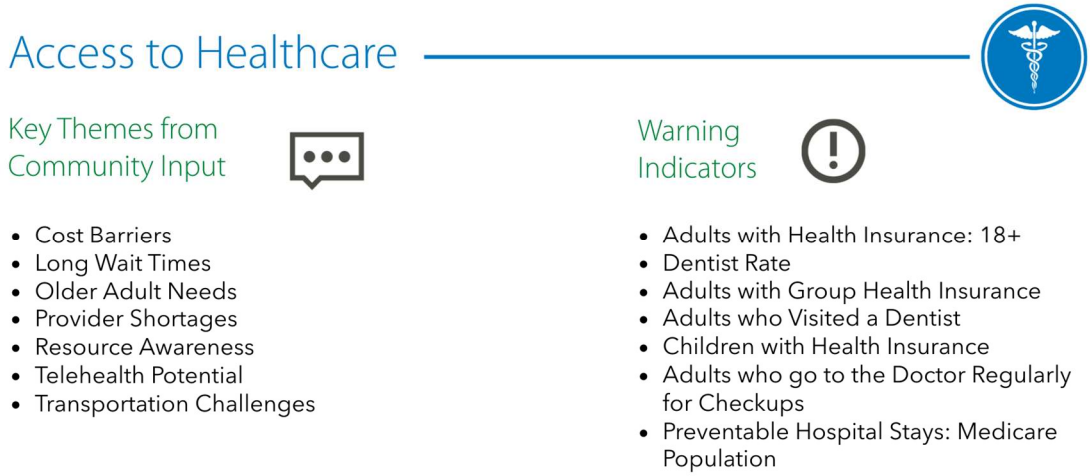
Mercy Hospital's 2025 Community Health Needs Assessment reaffirms its commitment to addressing five core health priorities based on a rigorous synthesis of primary data in the form of community stakeholder interviews, secondary indicators from national and state data sources, and a regional environmental 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 improve health outcomes across all populations in the community served by Mercy Hospital.

The five prioritized community health needs identified in this 2025 Mercy Hospital 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 for the Cleveland Clinic Mercy Hospital 2025 CHNA revealed consistent challenges in accessing timely, affordable, and comprehensive healthcare. Participants highlighted financial barriers as a central concern, particularly for uninsured and underinsured residents who struggle with high deductibles, copays, and prescription costs. Transportation challenges were also described as significant, especially for older adults and low-income households in rural parts of the community, where limited transit options contribute to delayed or missed care. Additionally, residents were said to encounter difficulty navigating a complex health system, which can deter them from seeking preventive care or necessary follow-up services.

Another theme was the shortage of providers, particularly in primary care and specialty services, which results in long wait times and delays in treatment. Stakeholders noted that limited availability of culturally responsive and linguistically accessible care further compounds issues for some populations. Despite Mercy's strong role in the community, many respondents emphasized that awareness of existing resources remains limited, and patients often lack guidance on how to connect to available programs or clinics.

Overall, stakeholders underscored that access to healthcare in the Mercy Hospital community is shaped by overlapping barriers of cost, availability, transportation, and system complexity. These challenges disproportionately impact low-income families, older adults, and under resourced populations, leading to delays in care and reliance on emergency services for conditions that could otherwise be addressed earlier. Stakeholders stressed the need for coordinated solutions such as expanded community outreach, improved integration of services, mobile health initiatives, and stronger patient navigation supports to ensure improved access across the community.

Secondary data demonstrate concerning rates of insured individuals across Stark County. Both the adult insured rate and the rate of children with health insurance are lower in Stark County than most other counties across the nation. In fact, some of the lowest rates of insured adults across all of Ohio are in the zip codes surrounding Mercy Hospital: 44702 (60.7%), 44704 (61.2%), and 44703 (62.0%).

Although insurance affordability has improved across Stark County overall, the cost of health insurance remains higher for the county's Black/African American population (9.3% vs. 7.0% of household income). Stark County's Black/African American population also experience a higher rate of preventable hospital stays than the overall county population (6,015 vs. 2,963 per 100,000 Medicare enrollees).

Conduent HCI's Community Health Index (CHI) can help to estimate health risk on a standardized scale of 0 to 100, based on health-related social heeds. Across the Mercy Hospital community, there are five zip codes—all located in Canton—with a CHI value above 90, indicating especially high health care needs compared to other U.S. zip codes: 44702, 44704, 44707, 44705, and 44703.

Prioritized Health Need #2: Behavioral Health

Behavioral Health: Mental Health & Substance Use Disorder

Key Themes from Community Input

- Crisis Access
- Cultural Gaps
- Provider Shortages
- Stigma Barriers
- Substance Misuse
- Youth Mental Health

Warning Indicators

- Age-Adjusted Death Rate due to Alzheimer's Disease
- Depression: Medicare Population
- Age-Adjusted Death Rate due to Suicide
- Tobacco Use: Medicare Population
- Alcohol-Impaired Driving Deaths
- Adults Ever Diagnosed with Depression
- Adults who Binge Drink
- Cigarette Spending-to-Income Ration
- Age-Adjusted Drug and Opioid-Involved
- Overdose Death Rate
- Mothers who Smoked During Pregnancy
- Self-Reported General Health Assessment: Good or Better

Behavioral Health emerged as one of the priorities for the Mercy Hospital community in the 2025 CHNA. Based on the stakeholder interviews for the Mercy Hospital community, behavioral health was consistently emphasized as a critical priority. Participants described how both mental health and substance use disorders are deeply affecting the community, with challenges cutting across all age groups. Provider shortages and long wait times were reported as significant barriers, especially for those seeking timely psychiatric or counseling services. The lack of accessible crisis intervention options leaves many residents without immediate support, resulting in over-reliance on emergency departments for behavioral health needs.

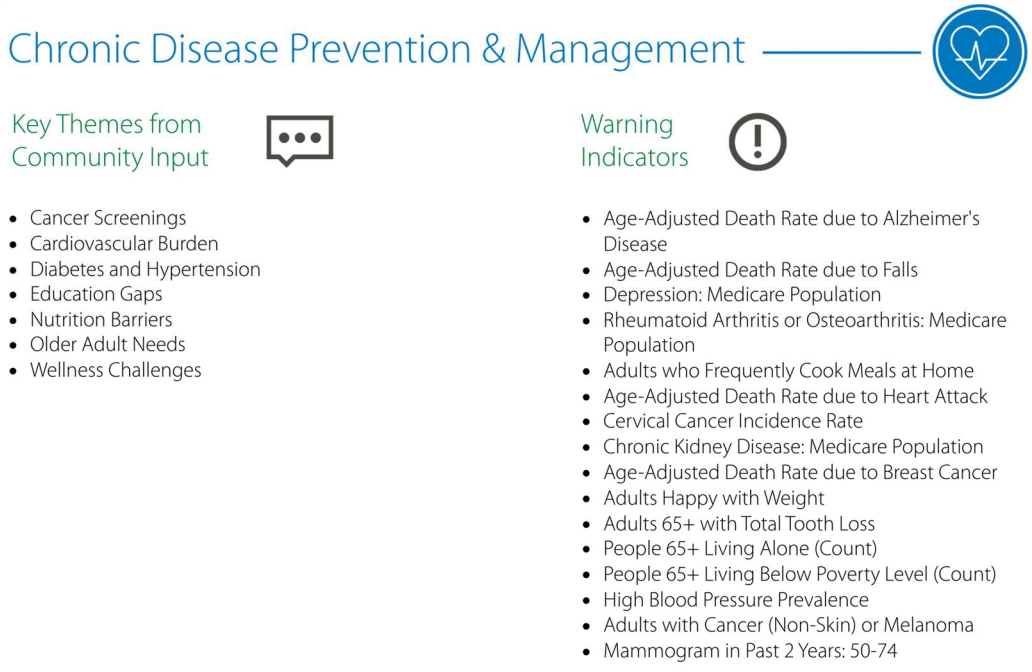
Stakeholders also highlighted the pervasive stigma associated with mental health and substance use, which discourages individuals from seeking care early. Youth and adolescents were described as experiencing rising risks of depression, anxiety, and trauma linked to family stressors, social media pressures, and the lingering impacts of the COVID-19 pandemic. Substance use, including opioid misuse, remains a major concern, with residents noting that treatment services are not only limited in number but often difficult to navigate due to insurance, cost, and transportation barriers.

Overall, the discussions reinforced that behavioral health in the Mercy Hospital community is shaped by both gaps in care delivery and broader health-related social needs. Stakeholders stressed the importance of expanding access to affordable, culturally responsive services, enhancing community-based supports, and strengthening prevention and early intervention efforts. Without addressing these barriers, they noted, the cycle of delayed treatment and worsening outcomes will persist, placing additional strain on families, providers, and the healthcare system as a whole.

Secondary data indicate high rates of depression in Stark County; rates of depression among Medicare recipients in particular are higher in Stark County than nearly all other U.S. counties. Rates of suicide are also especially high and have been trending upward.

Conduent HCI's Mental Health Index (MHI) similarly indicates high levels of mental health need across the Mercy Hospital community. The MHI estimates mental health risk based on local health-related social need indicators, on a standardized scale of 0 to 100. More than half of the zip codes (eight out of fifteen) in the Mercy Hospital community have an MHI value above 85, indicating especially high mental health needs compared to other U.S. zip codes. A more detailed breakdown of MHI values by census tract can be found in the *Prioritized Health Needs in Context* section below.

Prioritized Health Need #3: Chronic Disease Prevention and Management



Stakeholder interviews for the Mercy Hospital community highlighted that chronic disease prevention and management is one of the most pressing health challenges in the area. Participants pointed to high rates of conditions such as diabetes, hypertension, obesity, and heart disease, which continue to drive poor health outcomes and healthcare costs. These conditions were consistently tied to contributing factors like poor nutrition,

food insecurity, physical inactivity, and ongoing stress. Limited preventive screenings and gaps in patient education mean that many residents are not accessing care early enough, leading to more advanced disease at the time of diagnosis. Stakeholders also emphasized that low-income and under resourced groups are disproportionately affected due to barriers such as cost, insurance coverage, and inaccessible specialty care. Cancer was highlighted as another critical concern within chronic disease management. Interviewees noted that screening rates remain low, especially for breast, cervical, and colon cancers, and late-stage diagnosis is common. Access to affordable screenings, early detection programs, and community outreach were all identified as areas needing significant improvement. Stakeholders felt that promoting preventive health practices and expanding access to testing could help reduce cancer's burden.

Older adult health also emerged as a key theme. Many seniors in the Mercy Hospital community are managing multiple chronic conditions at once while dealing with transportation challenges, fixed incomes, and social isolation. These compounding factors make it harder for older residents to stay connected to care and manage their health effectively. Stakeholders stressed the importance of care coordination, affordable prescription programs, and community-based supports that allow older adults to age in place and avoid preventable hospitalizations. Overall, participants agreed that addressing chronic disease requires a multi-faceted approach that integrates preventive care, education, access to healthy foods, and stronger systems of support for at risk groups.

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

Nutrition, Healthy Eating, and Wellness

Stakeholders emphasized that poor nutrition and lack of affordable access to healthy food contribute significantly to chronic conditions such as obesity, diabetes, and heart disease. Limited availability of fresh food in some neighborhoods and financial constraints make it difficult for families to maintain healthy diets. Stress, sedentary lifestyles, and limited wellness programs were also cited as barriers to prevention. Participants highlighted the need for community-based education, affordable wellness initiatives, and accessible programs that encourage healthy eating and physical activity.

Secondary data illustrate that obesity impacts nearly a third of Medicare recipients (30.0%), one of the highest rates across all of Ohio. Stark County residents are also less likely to cook meals at home. The county's food insecurity rate (15.1%) is lower than most other Ohio counties, but is higher among the county's Black/African American and Hispanic/Latino populations (32.0% and 26.0%, respectively). The Conduent HCI Food Insecurity Index (FII) estimates food access challenges using widely available health-related social need data and can identify geographic differences across the Mercy Hospital community. In fact, there are five zip codes across the community, all located in Canton, with an FII score above 90, indicating especially high food access challenges: 44707, 44703, 44704, 44705, 44702.

Cancer
Cancer prevention and management were noted as critical concerns, particularly due to low screening rates and delayed detection. Stakeholders reported that residents often face financial and logistical barriers to timely screenings for breast, cervical, colon, and other cancers. This delay results in diagnoses at more advanced stages, complicating treatment, and outcomes. Participants stressed the importance of preventive education campaigns, community outreach, and accessible, low-cost screening opportunities.

Secondary data indicate that women experience elevated risks regarding breast cancer. Mammogram rates are in the lowest quartile of all Ohio counties, which may impact timely diagnosis and follow-up care. Although rates of breast cancer cases in Stark County are lower than state-wide and national rates, the death due to breast cancer (21.5 per 100,000) is higher than most other Ohio counties. Women in Stark County also face an elevated risk of cervical cancer, compared to state and national values.

Prostate cancer rates for Stark County's overall male population are similar to or lower than state-wide and national rates. However, the county's Black/African American male population experience higher risks of developing prostate cancer (197.5 vs. 105.3 per 100,000) and of dying due to prostate cancer (41.5 vs. 19.1 per 100,000).

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions
Stakeholders described widespread diabetes and hypertension, with many residents struggling to manage their conditions due to cost, lack of education, and difficulty maintaining long-term treatment regimens. Stroke and heart disease were cited as major contributors to mortality and morbidity in the community. Stakeholders emphasized that prevention through screenings, patient education, and accessible chronic care management is not being consistently achieved. Financial pressures and gaps in care coordination create further challenges, leaving many patients without the support needed for effective management.

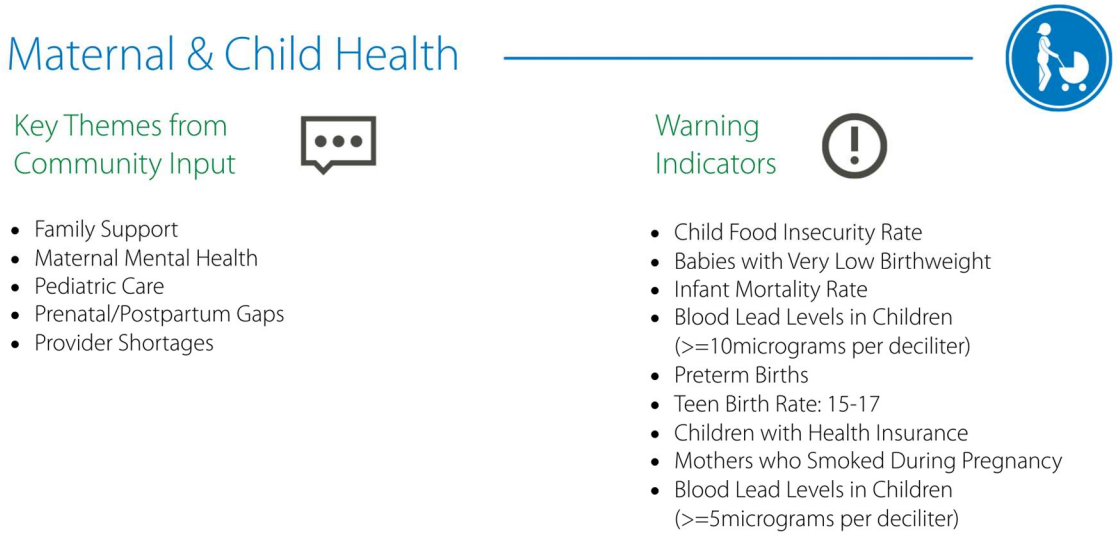
Based on secondary data, the risk of death due to heart attack in Stark County is substantially higher than the state-wide rate (70.8 vs. 60.9 deaths per 100,000 age 35+). In fact, there are multiple heart health risks that are greater in Stark County than most other U.S. counties, including: high blood pressure, hyperlipidemia, and heart failure.

About one in ten Stark County adults (9.8%) have diabetes, which is commensurate with other Ohio counties, but higher than most other U.S. counties. Likewise, the death rate due to diabetes is lower than the state-wide rate, but higher than the national rate. Stark County's Black/African American population has a higher risk of death due to diabetes complications than the general county population (47.4 vs. 25.1 per 100,000).

Older Adult Health
Older adults were described as particularly at risk, with many managing multiple chronic illnesses while also facing transportation limitations, fixed incomes, and social isolation. Stakeholders pointed out that seniors often encounter fragmented support systems, making it difficult to coordinate care. This population struggles with medication affordability, access to specialists, and barriers to aging in place. The need for better senior-focused services, improved coordination of care, and expanded community supports was repeatedly highlighted as a priority.

Secondary data demonstrate that falls are a major concern for Mercy Hospital's older adult population. The death rate due to falls across Stark County (12.3 per 100,000) is higher than both state-wide and national rates (10.8 and 9.8, respectively). The risk of death due to Alzheimer's disease is also especially high in Stark County (51.8 per 100,000), despite rates of Alzheimer's disease and dementia that are commensurate with the rest of the state and nation. Rates of arthritis are also especially high in Stark County (40% of Medicare recipients). These mobility issues and cognitive decline may also contribute to risks of fall-related injury and death across the county.

Prioritized Health Need #4: Maternal and Child Health



From the 2025 CHNA Mercy Hospital stakeholder interviews, Maternal and Child Health emerged as a critical concern shaped by barriers in prenatal, postpartum, and pediatric care. Stakeholders highlighted gaps in access to affordable maternal health services, especially for low-income and under resourced families. Limited prenatal and postpartum support, including difficulties accessing specialized providers, was seen as a significant contributor to disparities in maternal health outcomes. Participants also noted rising maternal mental health needs, particularly postpartum depression, and anxiety, which are compounded by stigma and limited availability of local behavioral health supports tailored for mothers.

Concerns regarding children's health centered on shortages of pediatric providers, long wait times for care, and insufficient behavioral health services for youth. Stakeholders emphasized that these gaps often result in delayed treatment and unmet developmental and mental health needs. Financial barriers, such as lack of insurance coverage or high out-of-pocket costs, further limit families' ability to access consistent care. The importance of coordinated, family-centered care models and stronger community support networks was repeatedly underscored as a way to address these issues and reduce preventable health disparities.

Overall, stakeholders identified Maternal and Child Health as a priority for the Mercy Hospital community. They stressed the need for expanded access to affordable maternal care, greater support for maternal mental health, improved pediatric behavioral health services, and integrated approaches that bring together healthcare providers, schools, and community organizations to support families. These efforts were viewed as essential for improving health outcomes for mothers, infants, children, and adolescents while reducing differences that disproportionately affect at risk populations.

Secondary data indicate concerning trends regarding birth risks for the Mercy Hospital community. Preterm births and teen births are more common in Stark County than most other Ohio counties, despite improvements in recent years. Likewise, the infant mortality rate in Stark County is higher than both state-wide and national rates. Mothers are also more likely to smoke during pregnancy in Stark County than state-wide or national rates.

Blood lead levels in Stark County children have shown some improvements in recent years but remain higher than most other Ohio counties. Child mortality, broadly, is relatively low in Stark County, compared to the rest of Ohio. However, the rate of death for the county's Black/African American children is higher than the overall county population of children (165.8 vs. 55.7 per 100,000).

Prioritized Health Need #5: Health-Related Social Needs



Based on the 2025 CHNA Mercy Hospital stakeholder interviews, health-related social needs emerged as deeply interconnected barriers to health that shape outcomes across the community. Participants consistently described how poverty, unemployment, and financial strain limit residents' ability to prioritize healthcare and wellness. Many families struggle with unstable housing, high rent burdens, and food insecurity, which create ongoing stress and prevent them from accessing preventive or consistent care. Stakeholders emphasized that even when services are available, residents' basic

economic challenges often make it difficult to afford medications, transportation, or follow-up appointments.

Housing instability and transportation limitations were noted as particularly significant drivers of differences. Residents facing eviction or inadequate housing conditions often experience higher rates of chronic disease and mental health challenges. At the same time, lack of affordable and reliable transportation restricts access to jobs, healthcare providers, and healthy food outlets. Stakeholders also pointed to differences in investment in certain neighborhoods could further widen differences in health outcomes.

Stakeholders also stressed that improving health in the Mercy Hospital community requires addressing these upstream social and economic drivers. They highlighted the importance of partnerships with community organizations, investment in affordable housing and transit, and expansion of support services such as food assistance and workforce development. These strategies were seen as critical for creating sustainable improvements in health and well-being, particularly for low-income families and under resourced populations who face the greatest barriers.

Overall, secondary data illustrate relatively lower levels of income, education, and employment across the Mercy Hospital community. Additional secondary data indicate that Stark County may broadly experience higher levels of social isolation, with high rates of youth disconnected from school and work, and low rates of internet access.

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, social, and economic factors influencing health in the Mercy Hospital 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 Mercy Hospital, 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

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

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 data 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 Mercy Hospital Community

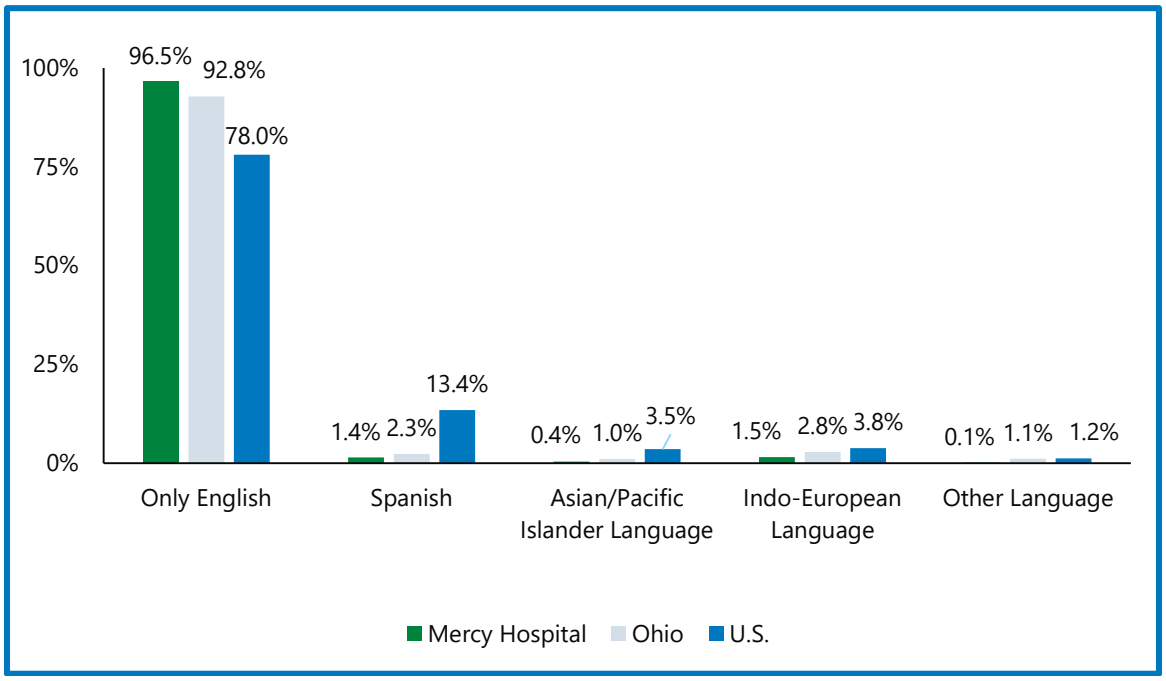
According to the 2024 Claritas Pop-Facts® population estimates, the Mercy Hospital community has an estimated population of 252,853 persons. The median age in the community is 42.2 years, which is older than that of Ohio (40.5 years). About a quarter of the population (24.5%) is between 45-64 years old.

The majority of the population is White (78.9%). Residents are less likely than the overall Ohio population to be Black/African American (10.5% vs. 12.8%), Asian (1.1% vs. 2.7%), or Hispanic/Latino (4.1% vs. 5.0%).

As shown in Figure 2, the vast majority of the Mercy Hospital population aged five and above speaks primarily English at home (96.5%). Very few residents speak Spanish at home (1.4%), and 1.5% speak another Indo-European language. Understanding 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.

[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

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

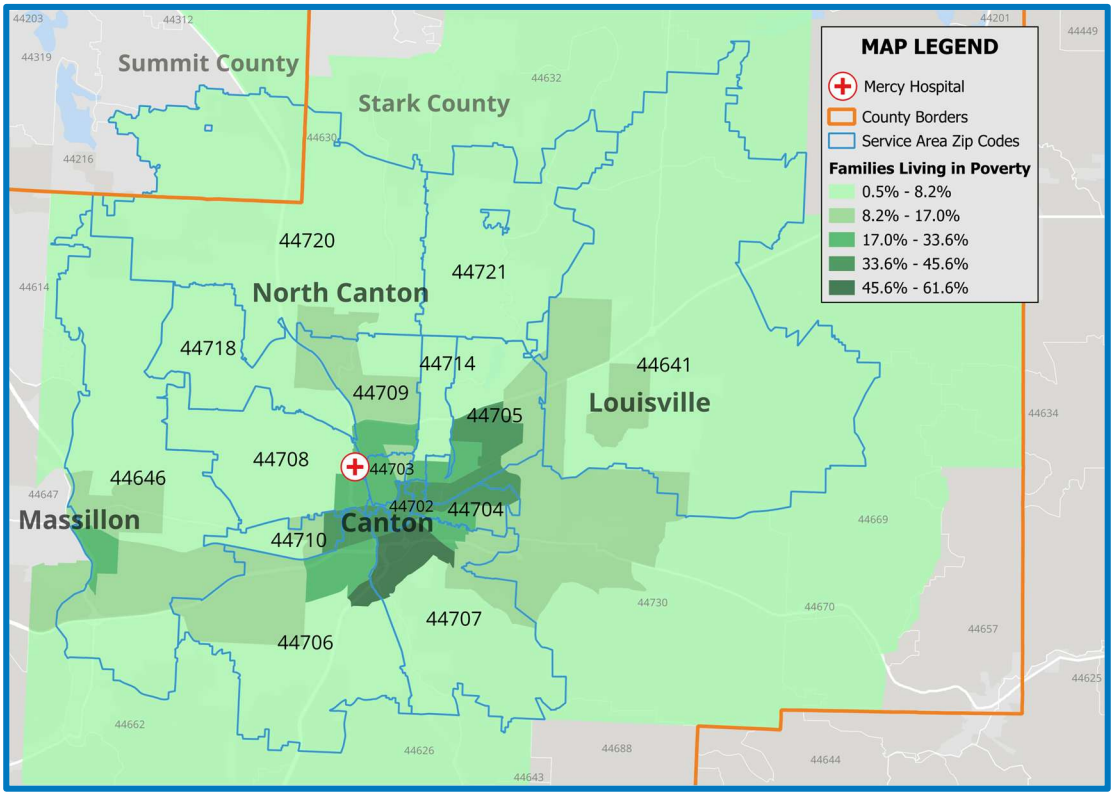
Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including 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 Mercy Hospital community is $63,168 which is less than that of Ohio overall ($68,488).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. In the Mercy Hospital community, 10.9% of families live below the poverty level. This is greater than the state-wide and national poverty rates (9.4% and 8.8%, respectively). Poverty levels differ geographically across the Mercy Hospital community (Figure 3), and poverty is most common in Canton, particularly in the zip codes 44702, where 42.2% of families live in poverty, followed by 44704, where 35.0% of families live in poverty.

[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, Mercy Hospital Community



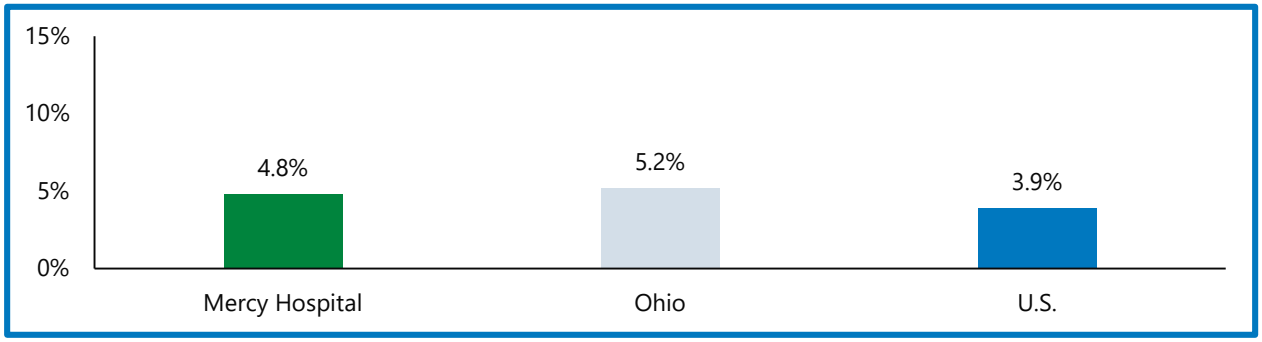
Service area, zip code, and state values: Claritas Pop-Facts® (2024 population estimates)

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

Education and Employment

The vast majority of the population within the Mercy Hospital community have a high school degree or higher (92.7%). About a quarter of the population (25.4%) have a bachelor's degree or higher, which is lower than the state-wide and national rates (30.2% and 35.0%, respectively). As seen in Figure 4, the Mercy Hospital community unemployment rate is less than that of Ohio (4.8% vs. 5.2%).

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



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

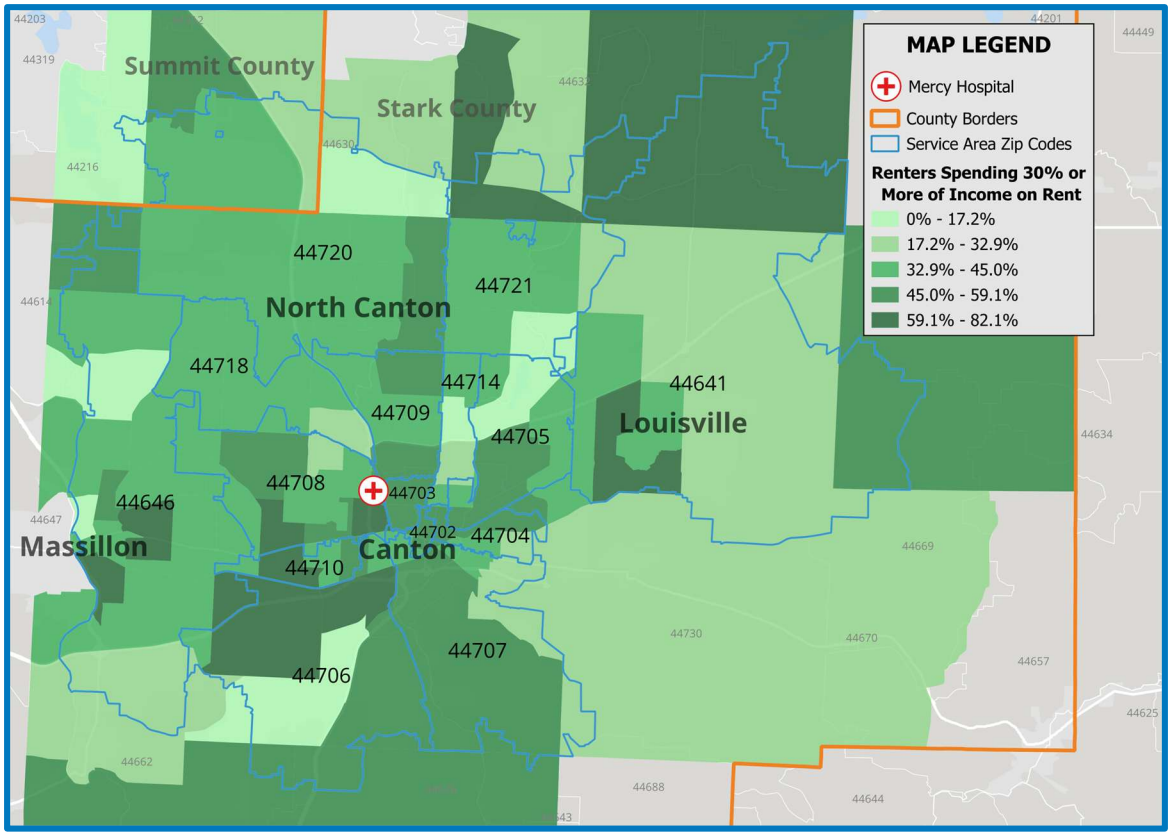
U.S. value: American Community Survey five-year (2019-2023) estimates

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]

Housing and Built Environment

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Across Stark County, 10.7% of households have severe housing problems, such as: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Additionally, 42.4% of renters in the county spend at least 30% of their income on rent (Figure 5).

Figure 5: High Rent Burden by Census Tract, Mercy Hospital 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 majority of Stark County households have internet access (86.1%). At the zip code level, the lowest levels of internet access in the Mercy Hospital

[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

community are in Canton, the zip codes 44702 and 44707 in Canton, where 40.8% and 71.6% of households have an internet subscription, respectively.

Community Health Indices

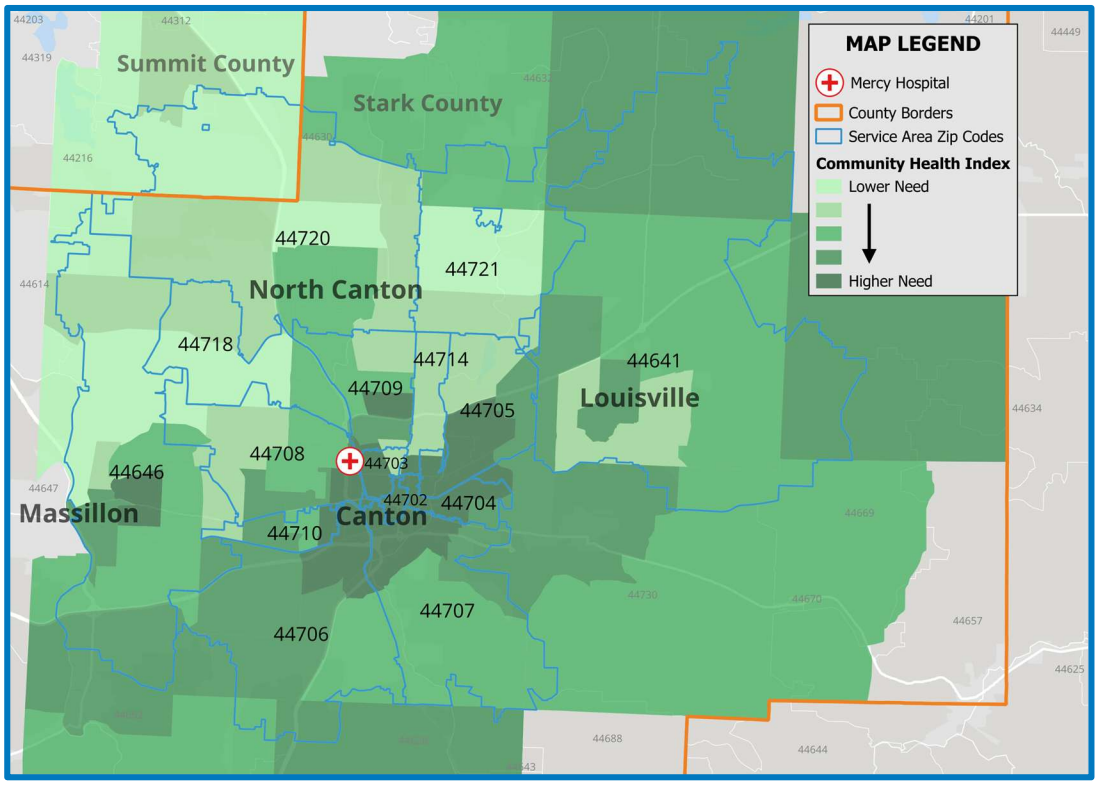
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the Mercy Hospital 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 zip code level. The CHI uses health-related social needs 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 Mercy Hospital community, as indicated by the darkest shade of green. At the zip code level, 44702 and 44704 in Canton have the highest index values, at 99.4 and 97.4, respectively. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the Mercy Hospital community.

Figure 6: Community Health Index by Census Tract, Mercy Hospital Community

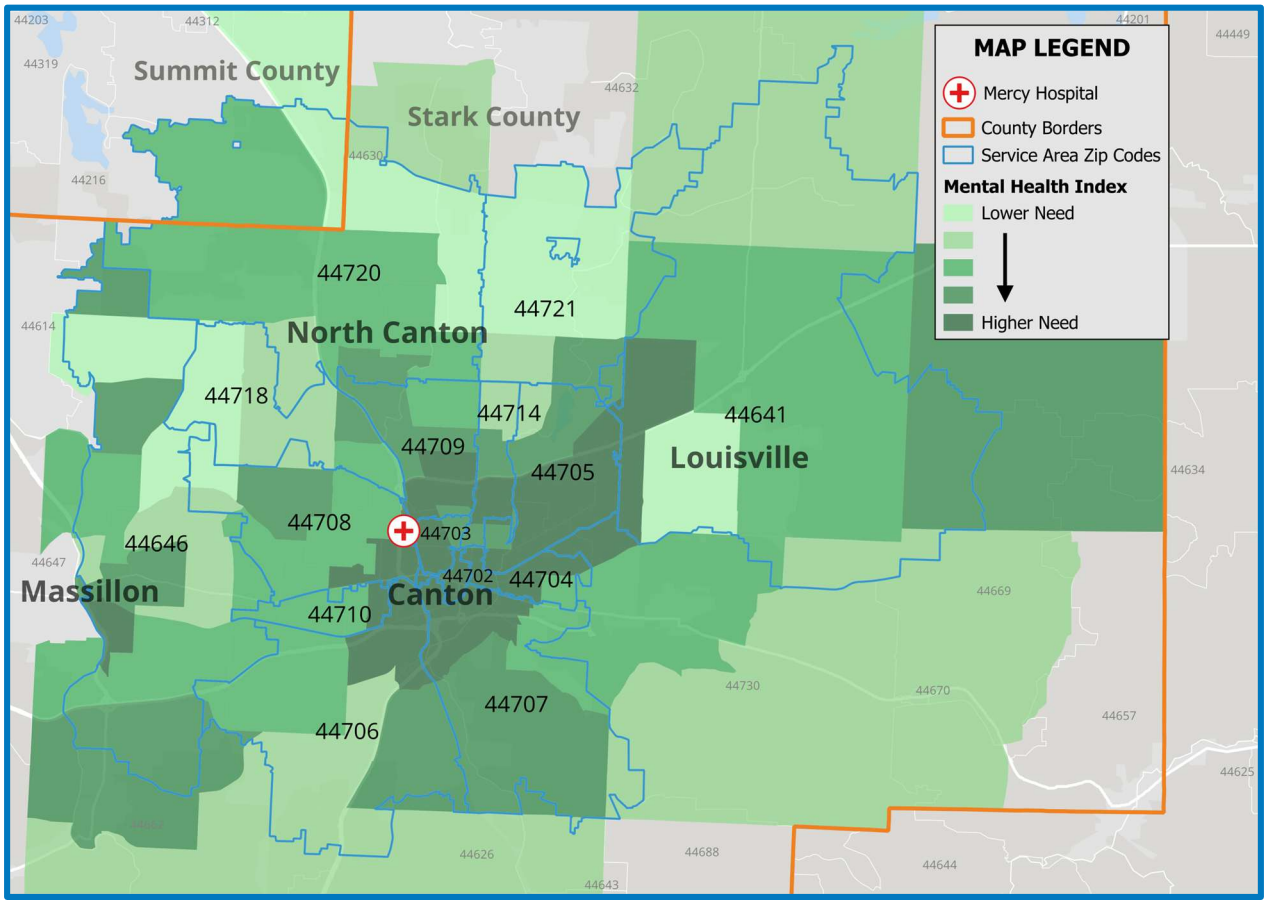


Mental Health Index

Conduent HCI's Mental Health Index (MHI) can help to identify geographic differences in mental health outcomes across the county, down to the zip code level. The MHI uses health-related social needs 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 Mercy Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44704 and 44702 in Canton have the highest levels of need, with MHI values of 98.4 and 95.8, respectively. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Mercy Hospital community.

Figure 7: Mental Health Index by Census Tract, Mercy Hospital Community

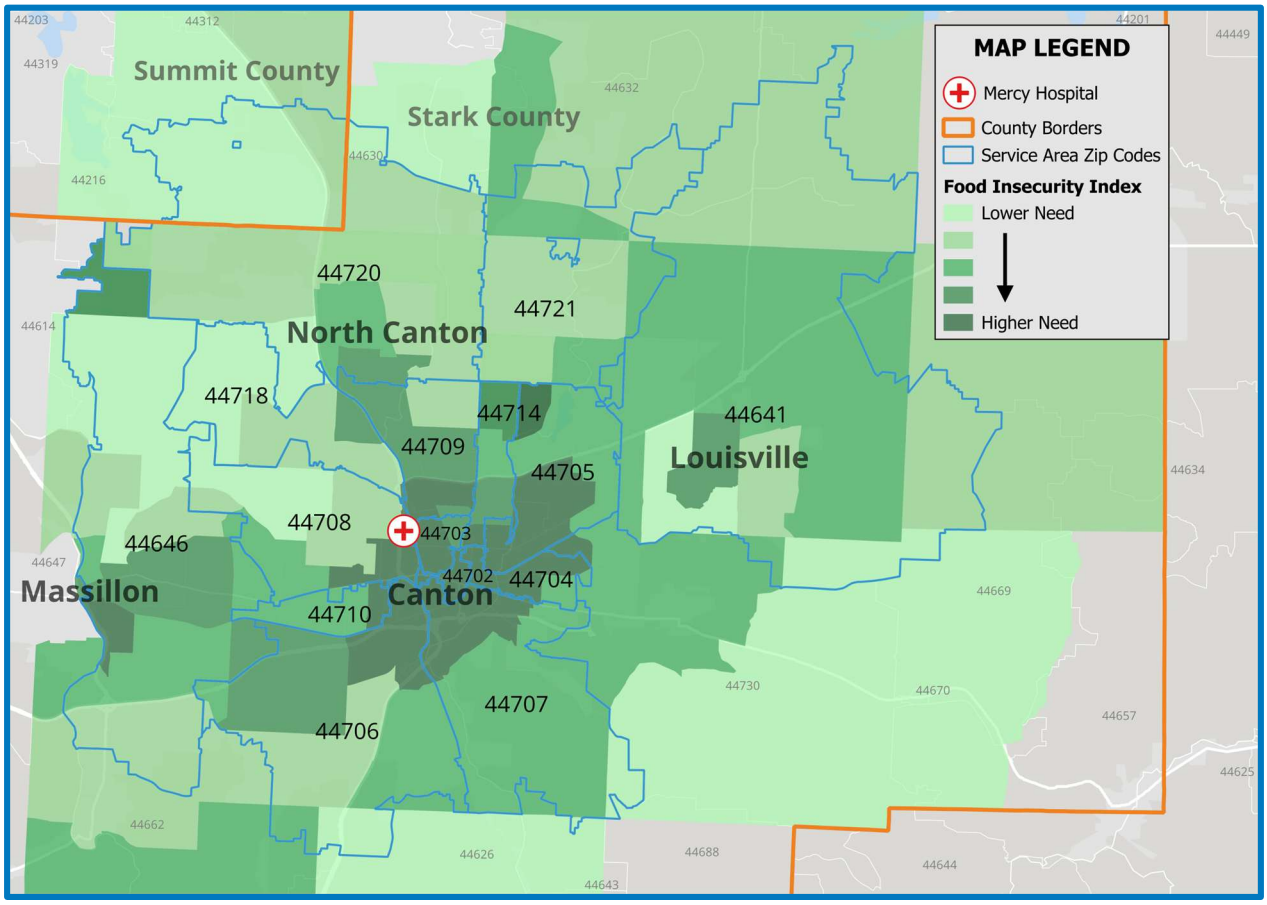


Food Insecurity Index

Conduent HCI's Food Insecurity Index (FII) can help to identify geographic differences in food access across the county, down to the zip code level. The FII uses health-related social needs 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 Mercy Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44707, 44703, and 44704 in Canton have the highest levels of need, with FII values of 98.8, 98.3, and 98.0, respectively. See Appendix B for additional details about the FII and a table of FII values for each zip code in the Mercy Hospital community.

Figure 8: Food Insecurity Index by Census Tract, Mercy Hospital Community



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the Mercy Hospital community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the five prioritized health needs identified in Mercy Hospital'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 Mercy Hospital'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 elevated 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 birth outcomes for some 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.

2025 Stark County Community Health Assessment[8]

Priority Areas Identified:

- Access to Health Care
- Community Conditions
- Chronic Disease
- Mental Health
- Substance Abuse

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 Equal 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 at risk groups.
- More supportive food programs are needed to ensure access to healthy nutrition

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[8] Stark County Health Department. (2025). *2025 Stark County Community Health Assessment*. Center for Marketing & Opinion Research, LLC. Retrieved from https://starkhealth.org/government/offices/public_health/community_health_assessment.php

[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

Primary Data Overview

Community Stakeholder Conversations

Community stakeholders from 11 organizations provided feedback specifically for the Mercy Hospital 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 Mercy Hospital community:

- Akron Canton Regional Foodbank
- Beacon Charitable Pharmacy
- Canton City Schools- Patrick Elementary School
- Cleveland Clinic Children's
- Cleveland Clinic Mercy
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Stark County Community Action Agency Pathways HUB
- Stark County Health Department
- Stark County Mental Health & Addiction Recovery
- Stark Metropolitan Housing Authority
- United Way of Greater Stark County

Stakeholder discussions for the Mercy Hospital 2025 Community Health Needs Assessment consistently identified Behavioral Health as the leading community priority. Participants highlighted limited availability of services, affordability barriers, and long wait times as major challenges. Youth mental health was described as an area of urgent need, with rising rates of depression, anxiety, and trauma often linked to family instability and lingering impacts of the COVID-19 pandemic. Stigma and the absence of culturally responsive resources were also emphasized as factors that discourage residents from seeking care.

Access to Healthcare was also a significant concern. Transportation barriers, workforce shortages, and high out-of-pocket costs were cited as obstacles to both preventive and ongoing care. Stakeholders noted that chronic diseases such as diabetes, heart disease, obesity, hypertension, and stroke remain widespread in Stark County and are often associated with poor nutrition, limited physical activity, and financial stress. Interviewees stressed the importance of strategies such as telehealth, mobile health units, and integrated care approaches to reach under resourced populations while also strengthening nutrition and lifestyle supports.

Older Adults were highlighted as a particularly at risk group within the community. Many seniors struggle to manage multiple chronic illnesses while facing fixed incomes, transportation gaps, and social isolation. Stakeholders expressed concern that these barriers limit access to specialty care and medication adherence, underscoring the need for expanded community-based senior services and supports that allow aging in place.

Finally, health-related social needs were consistently described as root causes shaping health outcomes. Poverty, unstable housing, food insecurity, unemployment, and financial strain were identified as persistent drivers of health differences. Stakeholders emphasized that lasting progress would require collaboration across healthcare, social services, and community organizations to address both medical needs and the broader social and economic conditions affecting health.

The following quotes highlight key themes highlighted in community feedback:

Priority Area	Key Quote	Additional Context
Access to Healthcare	"It is difficult for families to find affordable care close to home, and transportation just makes it worse."	Access challenges were consistently tied to transportation barriers, excessive costs, and limited local service availability, making preventive and ongoing care difficult for residents.
Behavioral Health	"Mental health services are stretched thin, and people wait months before getting help."	Chronic conditions like diabetes and heart disease were linked to poor nutrition, lack of preventive care, and financial strain in the community.
Chronic Disease Prevention and Management	"Obesity, diabetes, and high blood pressure are everywhere, and people do not have the resources to manage them."	Reflects the prevalence of chronic diseases like diabetes and hypertension and the challenges of consistent disease management.
Maternal and Child Health	"There are not enough supports for new mothers, especially those struggling with postpartum depression."	Participants pointed to gaps in prenatal, postpartum, and pediatric behavioral health services, noting increased maternal mental health concerns.
Health-Related Social Needs	"Housing and food insecurity affect everything. If you cannot meet basic needs, your health is always going to suffer."	Poverty, housing instability, and food insecurity were described as root causes driving disparities in health outcomes for families across Stark County.

Prioritization Methodology

Mercy Hospital's 2025 Community Health Needs Assessment (CHNA) identified five core health priorities 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, chronic disease, and health-related social needs. 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, Mercy Hospital has prioritized the same five health needs for its 2026–2028 Implementation Strategy Report, ensuring continuity in addressing longstanding health challenges and advancing improved 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. Mercy Hospital 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 Mercy Hospital available to address community health needs.

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[11] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services in medically under resourced areas. 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 Mercy Hospital community, community health services are further supported by local public health agencies, including the Stark County Health Department. The following FQHC clinics and networks operate in the Mercy Hospital community:

- Alliance Family Health Center, Inc.
- Community Health Care, Inc. (CHCI)

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

- Lifecare Family Health & Dental Center

Hospitals

In addition to several Cleveland Clinic hospitals in Northeast Ohio, the following is a list of other hospital facilities located in the Mercy Hospital community:

- Aultman Alliance Community Hospital
- Aultman Hospital
- Aultman Massillon

Other Community Resources

A network of agencies, coalitions, and organizations provides a broad array of health and social services within the region served by Mercy Hospital. 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.

Comments Received on Previous CHNA

Community Health Needs Assessment reports from 2022 were published on the Mercy Hospital 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 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. Mercy Hospital 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

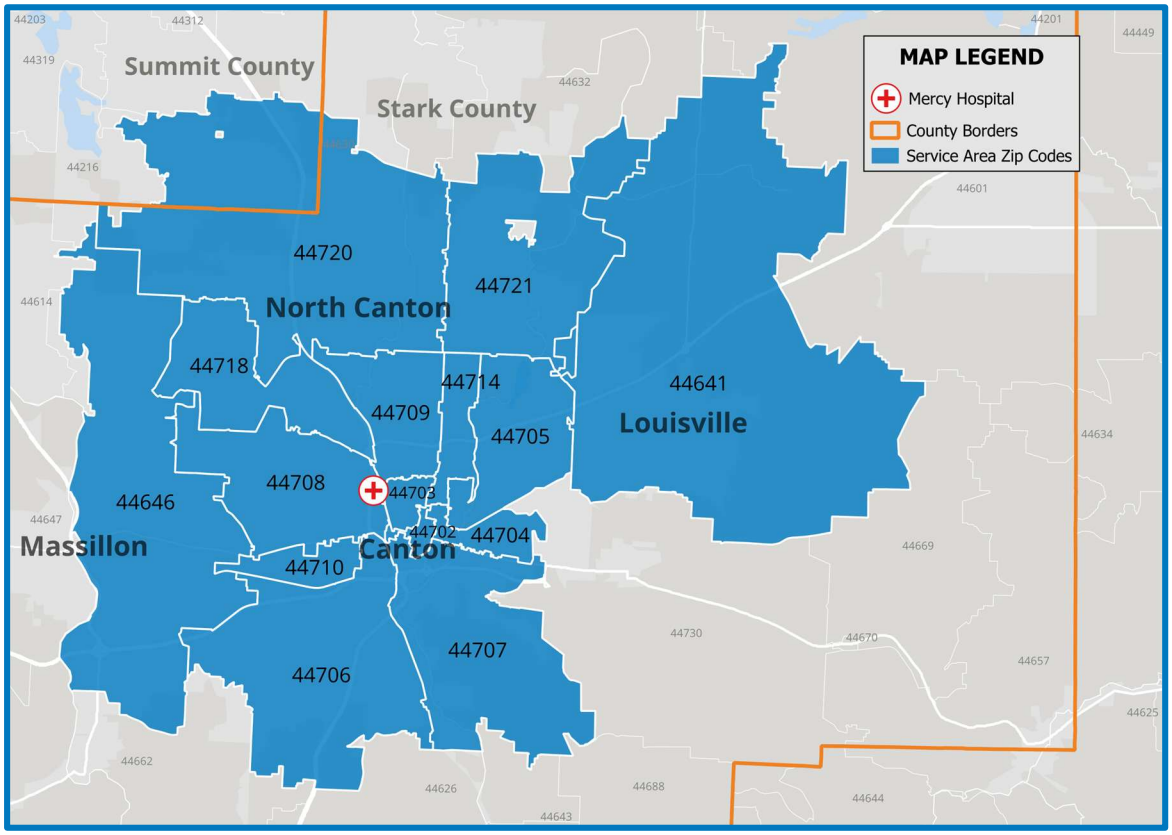
E. Impact Evaluation

F. Acknowledgements

Appendix A: Mercy Hospital Community Definition

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

Figure 9: Mercy Hospital 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.

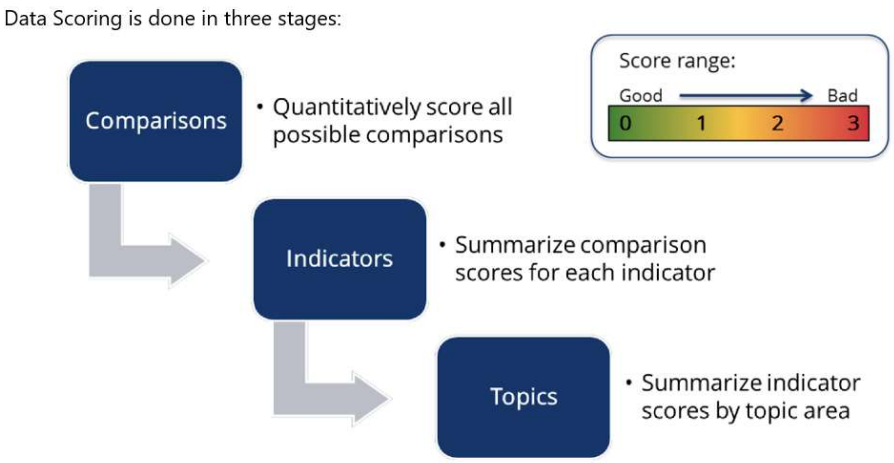
The following is a list of both local and national sources used in the Mercy Hospital Community Health Needs Assessment:

- 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 Mercy Hospital Community, this analysis was completed for Stark 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.

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. Twelve topics scored at or above this threshold in Stark 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 highest scoring health need in Stark County was *Weight Status* with a score of 2.17.

Table 2: Health Topic Scores: Stark County

Health Topic	Score
Weight Status	2.17
Women's Health	1.74
Maternal, Fetal & Infant Health	1.73
Other Chronic Conditions	1.70
Oral Health	1.68
Physical Activity	1.61
Older Adults	1.58
Sexually Transmitted Infections	1.58
Mortality Data	1.56
Nutrition & Healthy Eating	1.55
Mental Health & Mental Disorders	1.51
Prevention & Safety	1.51
Wellness & Lifestyle	1.49
Heart Disease & Stroke	1.46
Children's Health	1.40
Cancer	1.40
Diabetes	1.34
Alcohol & Drug Use	1.32
Respiratory Diseases	1.29

Immunizations & Infectious Diseases	1.28
Tobacco Use	1.28
Health Care Access & Quality	1.25

Table 3: Quality of Life Topic Scores: Stark County

Quality of Life Topic	Score
Community	1.41
Economy	1.38
Environmental Health	1.36
Education	1.35

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 Mercy Hospital community.

Table 4: Community Health Index, Food Insecurity Index, and Mental Health Index Values for Mercy Hospital Community Zip Codes

Zip Code	CHI Value	FII Value	MHI Value
44641	37.9	47.7	57.7
44646	28.0	65.3	70.2
44702	99.4	94.7	95.8
44703	90.1	98.3	93.0
44704	97.4	98.0	98.4
44705	93.7	97.0	94.9
44706	86.5	86.6	89.1
44707	95.0	98.8	94.0
44708	41.5	65.7	81.5
44709	63.5	84.9	87.5
44710	69.0	81.0	80.3
44714	34.0	75.5	90.3
44718	16.0	27.8	46.2
44720	15.4	33.4	49.1
44721	11.2	21.6	16.4

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 Mercy Hospital Community.

Figure 12: Census Tract Key (Mercy Hospital, North)

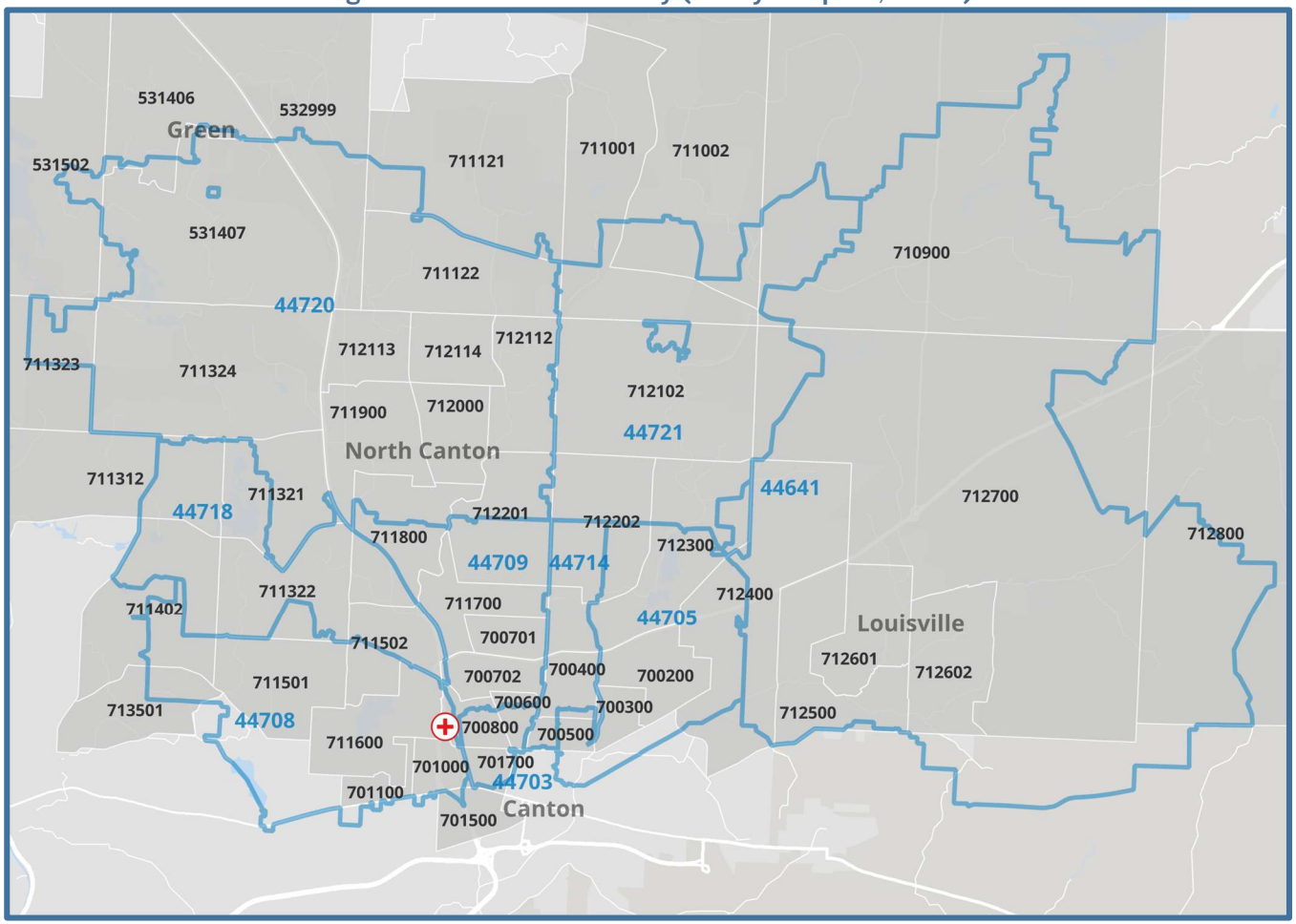


Table 5: Census Tracts by Zip Code (Mercy Hospital, North)

44641	44703	44705	44708	44709	44714	44718	44720	44721
710900	700100	700200	700800	700600	700300	700702	531406	710900
712300	700600	700300	701000	700701	700400	700800	531407	711001
712400	700800	700400	701100	700702	700500	711312	531502	711002
712500	701000	700500	701200	700800	700600	711321	532999	711122
712601	701700	701800	701300	711700	700701	711322	711121	712102
712602		712202	701500	711800	700702	711402	711122	712112
712700		712300	711322	712201	711700	711502	711312	712201
712800		712400	711402		712201	711600	711321	712202
713000			711501		712202	711800	711323	712300
713100			711502		712300		711324	712700
			711600				711800	
			713401				711900	
			713402				712000	
			713501				712112	
							712113	
							712114	
							712201	

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

Figure 13: Census Tract Key (Mercy Hospital, South)

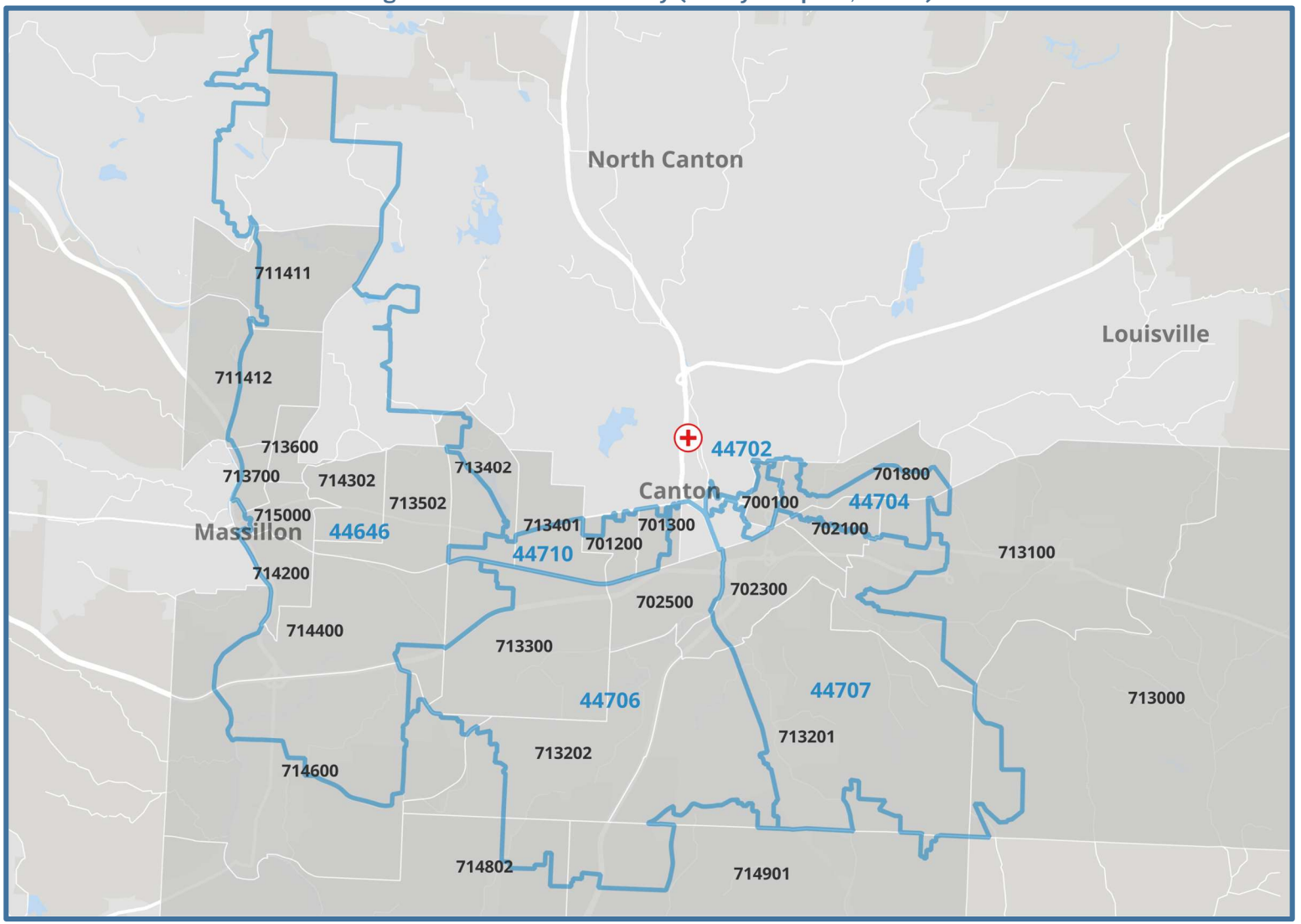


Table 6: Census Tracts by Zip Code (Mercy Hospital, South)

44646	44702	44704	44706	44707	44710
711312	700100	700100	701300	700100	701200
711323	701000	700500	701500	701500	701300
711324	701500	701800	702300	701800	702500
711402	701700	702100	702500	702100	713300
711411	701800	713100	713201	702300	713401
711412			713202	702500	713402
713300			713300	713000	
713402			714400	713100	
713501			714600	713201	
713502			714802	714901	
713600			714901		
713700					
714200					
714302					
714400					
714600					
715000					

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 population data for certain groups 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 7 describes how to interpret the icons used to describe county distributions and trend data.

Table 7: 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 1.25 out of 3. Those indicators scoring at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	STARK COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.00	Adults with Health Insurance: 18+	*percent*	74.2	--	74.7	75.2			
1.94	Dentist Rate	*dentists/ 100,000 population*	63.3	--	65.2	73.5			
1.85	Adults With Group Health Insurance	*percent*	34.8	--	37.4	39.8			--
1.65	Adults who Visited a Dentist	*percent*	44.0	--	44.3	45.3			
1.59	Children with Health Insurance	*percent*	94.9	--	95.1	94.6	--		
1.50	Adults who go to the Doctor Regularly for Checkups	*percent*	65.6	--	65.2	65.1			--
1.50	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	2963	--	3269	2769			--

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 *Mental Health and Mental Disorders* (Score: 1.51), followed by Alcohol and Drug Use (1.32), and the least concerning was *Tobacco Use* (1.28). Indicators from these three topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed below.

SCORE	INDICATOR	UNITS	STARK COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.71	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	51.8	--	35.5	31			
2.56	Depression: Medicare Population	*percent*	20	--	18	17			--
2.06	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	18.2	12.8	14.7	13.9			
1.94	Tobacco Use: Medicare Population	*percent*	8	--	7	6		--	--
1.91	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	33.7	--	32.1	--			
1.59	Adults Ever Diagnosed with Depression	*percent*	23.3	--	--	20.7			--
1.59	Adults who Binge Drink	*percent*	16.8	--	--	16.6			--
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.3	--	2.1	1.9			
1.50	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	30.7	--	40.4	23.5			--
1.50	Mothers who Smoked During Pregnancy	*percent*	10.1	4.3	7.9	3.7		--	
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	85.2	--	85.4	86.0			

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: 1.70), followed by *Older Adults* (1.58), *Nutrition and Healthy Eating* (1.55), *Wellness and Lifestyle* (1.49), *Heart Disease and Stroke* (1.46), *Cancer* (1.40), *and* the least concerning topic was *Diabetes* (1.34). Indicators from these seven topic areas which scored at or above 1.70 were categorized as indicators of concern and are listed below.

SCORE	INDICATOR	UNITS	STARK COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.71	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	51.8	--	35.5	31.0			
2.65	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	12.3	--	10.8	9.8			
2.56	Depression: Medicare Population	*percent*	20	--	18	17			--
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	40	--	39	36			--
2.21	Adults who Frequently Cook Meals at Home	*Percent*	66.8	--	67.6	67.7			--
2.09	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	70.8	--	60.9	--			
2.09	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.3	--	7.8	7.5	--		
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20	--	19	18			--
2.03	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.5	15.3	20.2	19.3			

2.03	Adults Happy with Weight	*Percent*	41.2	--	42.1	42.6			--
1.94	Adults 65+ with Total Tooth Loss	*percent*	19.2	--	--	12.2			--
1.94	People 65+ Living Alone (Count)	*people*	21,308	--	--	--	--	--	
1.94	People 65+ Living Below Poverty Level (Count)	*people*	5,773	--	--	--	--	--	
1.94	High Blood Pressure Prevalence	*percent*	39.0	41.9	--	32.7			--
1.94	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.5	--	--	8.2			--
1.94	Mammogram in Past 2 Years: 50-74	*percent*	72.3	80.3	--	76.5			--
1.85	Heart Failure: Medicare Population	*percent*	13	--	12	11			--
1.85	Hyperlipidemia: Medicare Population	*percent*	69	--	67	66			--
1.82	People 65+ Living Alone	*percent*	28.4	--	30.2	26.5			
1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.7	--	--	6.8			--
1.71	Adults 20+ with Diabetes	*percent*	9.8	--	--	--			
1.71	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	162.3	122.7	161.1	146.0			

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 1.73, followed by *Children's Health*, with a score of 1.40. Indicators from these topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed below.

SCORE	INDICATOR	UNITS	STARK COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.18	Child Food Insecurity Rate	*percent*	20.4	--	20.1	18.4			
2.18	Babies with Very Low Birthweight	*percent*	1.8	--	1.5	--			--
1.97	Infant Mortality Rate	*deaths/ 1,000 live births*	7.9	5.0	6.7	5.4	--	--	
1.82	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.6	--	0.5	--		--	
1.82	Preterm Births	*percent*	10.9	9.4	10.8	--		--	
1.79	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	6.3	--	6.1	5.6		--	
1.59	Children with Health Insurance	*percent*	94.9	--	95.1	94.6	--		
1.50	Mothers who Smoked During Pregnancy	*percent*	10.1	4.3	7.9	3.7		--	
1.50	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.9	--	1.9	--		--	

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 twelfth highest scoring health topic with a score of 1.51. The most concerning quality of life topic was *Community* (Score: 1.41), followed by *Economy* (1.38), and the least concerning topic was *Education* (1.35). 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 below.

SCORE	INDICATOR	UNITS	STARK COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.65	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	12.3	--	10.8	9.8			
2.35	Workers who Walk to Work	*percent*	1.4	--	2.0	2.4			
2.24	Youth not in School or Working	*percent*	2.5	--	1.7	1.7			
2.21	Total Employment Change	*percent*	2.5	--	2.9	5.8			
2.18	Adults with Internet Access	*percent*	79.7	--	80.9	81.3			
2.18	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.4	--	2.7	2.6	--	--	
2.18	Child Food Insecurity Rate	*percent*	20.4	--	20.1	18.4			
2.12	Households with Cash Public Assistance Income	*percent*	4.1	--	2.5	2.7			
2.06	Homeowner Spending-to-Income Ratio	*percent*	14.7	--	14.3	13.5			
2.06	Unemployed Workers in Civilian Labor Force	*percent*	5.7	--	5.4	4.5			
2.03	Grandparents Who Are Responsible for Their Grandchildren	*percent*	38.9	--	41.3	32		--	
1.91	People Living Below 200% of Poverty Level	*percent*	30.5	--	29.6	28.2	--		

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 8 below as a reference key for indicator data sources.

Table 8: 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 9: All Stark County Secondary Data Indicators

SCORE	ALCOHOL & DRUG USE	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.91	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	33.7		32.1		*2018-2022*	10
1.59	Adults who Binge Drink	*percent*	16.8			16.6	*2022*	5
1.50	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	30.7		40.4	23.5	*2018-2020*	6
1.50	Mothers who Smoked During Pregnancy	*percent*	10.1	4.3	7.9	3.7	*2022*	17
1.24	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	37.6	20.7	44.7		*2020-2022*	10
1.21	Adults who Drink Excessively	*percent*	19.6		21.2		*2022*	10
0.29	Liquor Store Density	*stores/ 100,000 population*	4.8		5.6	10.9	*2022*	23

SCORE	CANCER	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.09	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.3		7.8	7.5	*2017-2021*	12
2.03	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.5	15.3	20.2	19.3	*2018-2022*	12
1.94	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.5			8.2	*2022*	5

1.94	Mammogram in Past 2 Years: 50-74	*percent*	72.3	80.3		76.5	*2022*	5
1.71	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	162.3	122.7	161.1	146	*2018-2022*	12
1.65	Breast Cancer Incidence Rate	*cases/ 100,000 females*	127.5		132.3	129.8	*2017-2021*	12
1.50	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	19.1	16.9	19.3	19	*2018-2022*	12
1.50	Cancer: Medicare Population	*percent*	12		12	12	*2023*	7
1.41	Cervical Cancer Screening: 21-65	*Percent*	82.1			82.8	*2020*	5
1.41	Colon Cancer Screening: USPSTF Recommendation	*percent*	64.8			66.3	*2022*	5
1.35	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	60.7		64.3	53.1	*2017-2021*	12
1.32	Mammography Screening: Medicare Population	*percent*	49		51	39	*2023*	7
1.29	All Cancer Incidence Rate	*cases/ 100,000 population*	454.5		470	444.4	*2017-2021*	12
1.18	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.4		12.8	12	*2017-2021*	12
1.06	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	39.4	25.1	39.8	32.4	*2018-2022*	12
0.82	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	105.3		118.1	113.2	*2017-2021*	12
0.47	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	12	8.9	13.9	12.9	*2018-2022*	12
0.47	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	34.5		38.9	36.4	*2017-2021*	12

SCORE	CHILDREN'S HEALTH	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.18	Child Food Insecurity Rate	*percent*	20.4		20.1	18.4	*2023*	11
1.82	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.6		0.5		*2022*	19
1.59	Children with Health Insurance	*percent*	94.9		95.1	94.6	*2023*	1
1.50	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.9		1.9		*2022*	19
1.24	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	55.7		59.2		*2019-2022*	10
1.06	Child Care Centers	*per 1,000 population under age 5*	8		8	7	*2022*	10
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9

SCORE	COMMUNITY	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Workers who Walk to Work	*percent*	1.4		2	2.4	*2019-2023*	2
2.24	Youth not in School or Working	*percent*	2.5		1.7	1.7	*2019-2023*	2
2.21	Total Employment Change	*percent*	2.5		2.9	5.8	*2021-2022*	23
2.18	Adults with Internet Access	*percent*	79.7		80.9	81.3	*2024*	8
2.18	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.4		2.7	2.6	*2016-2020*	6

2.03	Grandparents Who Are Responsible for Their Grandchildren	*percent*	38.9		41.3	32	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	21308				*2019-2023*	2
1.91	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	33.7		32.1		*2018-2022*	10
1.88	Children in Single-Parent Households	*percent*	26.5		26.1	24.8	*2019-2023*	2
1.88	Children Living Below Poverty Level	*percent*	18.4		18	16.3	*2019-2023*	2
1.88	Violent Crime Rate	*crimes/ 100,000 population*	439		331		*2024*	18
1.85	Adults With Group Health Insurance	*percent*	34.8		37.4	39.8	*2024*	8
1.82	People 65+ Living Alone	*percent*	28.4		30.2	26.5	*2019-2023*	2
1.65	Workers Commuting by Public Transportation	*percent*	0.9	5.3	1.1	3.5	*2019-2023*	2
1.59	Median Household Gross Rent	*dollars*	877		988	1348	*2019-2023*	2
1.59	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	507		570	612	*2019-2023*	2
1.59	Young Children Living Below Poverty Level	*percent*	20.7		20	17.6	*2019-2023*	2
1.53	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7		7.4	7.1	*2025*	9
1.50	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	85.2		84.9	85.1	*2024*	8
1.44	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	13.4	10.7	13.5	12	*2018-2020*	6
1.41	Households with an Internet Subscription	*percent*	86.1		89	89.9	*2019-2023*	2

1.41	Mortgaged Owners Median Monthly Household Costs	*dollars*	1311		1472	1902	*2019-2023*	2
1.41	People 25+ with a Bachelor's Degree or Higher	*percent*	25		30.9	35	*2019-2023*	2
1.41	Workers who Drive Alone to Work	*percent*	79.4		76.6	70.2	*2019-2023*	2
1.38	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	6.9	5.5	9		*2020-2022*	19
1.35	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3		3.3	3.1	*2025*	9
1.35	Households with a Computer	*percent*	84.8		85.2	86	*2024*	8
1.35	Population 16+ in Civilian Labor Force	*percent*	59.3		60.1	59.8	*2019-2023*	2
1.35	Voter Turnout: Presidential Election	*percent*	73.5	58.4	71.7		*2024*	20
1.32	Social Vulnerability Index	*Score*	0.3				*2022*	6
1.24	Households with a Smartphone	*percent*	86.2		87.5	88.2	*2024*	8
1.24	Median Household Income	*dollars*	65740		69680	78538	*2019-2023*	2
1.24	Per Capita Income	*dollars*	35802		39455	43289	*2019-2023*	2
1.24	Persons with an Internet Subscription	*percent*	89.2		91.3	92	*2019-2023*	2
1.21	Social Associations	*membership associations/ 10,000 population*	11.9		10.8		*2022*	10
1.21	Solo Drivers with a Long Commute	*percent*	26.2		30.5		*2019-2023*	10

1.18	People Living Below Poverty Level	*percent*	12.7	8	13.2	12.4	*2019-2023*	2
1.09	Residential Segregation - Black/White	*Score*	58.7		69.6		*2025*	10
1.06	Adult Day Care Spending-to-Income Ratio	*percent*	10.8		11.1	11.9	*2025*	9
1.06	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	10.5		11.1		*2016-2022*	10
1.06	Female Population 16+ in Civilian Labor Force	*percent*	57.2		59.2	58.7	*2019-2023*	2
1.06	Households with One or More Types of Computing Devices	*percent*	93.4		93.6	94.8	*2019-2023*	2
0.97	Broadband Quality Score	*BQS Score*	55.7		53.4	50	*2022*	21
0.97	Digital Distress		1				*2022*	21
0.91	Persons with Health Insurance	*percent*	93.5	92.4	92.9		*2022*	24
0.82	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.6	8.7	6.9		*2021*	4
0.79	Adults With Individual Health Insurance	*percent*	21.1		20.5	20.2	*2024*	8
0.79	Digital Divide Index	*DDI Score*	18.7		40.1	50	*2022*	21
0.65	Linguistic Isolation	*percent*	0.4		1.5	4.2	*2019-2023*	2
0.65	Mean Travel Time to Work	*minutes*	21.8		23.6	26.6	*2019-2023*	2
0.53	People 25+ with a High School Diploma or Higher	*percent*	92.8		91.6	89.4	*2019-2023*	2

SCORE	**DIABETES**	**UNITS**	**STARK COUNTY**	**HP2030**	**OH**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.71	Adults 20+ with Diabetes	*percent*	9.8				*2021*	6
1.35	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	25.1		26.4	22.6	*2018-2020*	6

0.97	Diabetes: Medicare Population	*percent*	24		25	24	*2023*	7

SCORE	ECONOMY	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.71	Adults with Disability Living in Poverty	*percent*	32.9		28.2	24.6	*2019-2023*	2
2.24	Youth not in School or Working	*percent*	2.5		1.7	1.7	*2019-2023*	2
2.21	Total Employment Change	*percent*	2.5		2.9	5.8	*2021-2022*	23
2.18	Child Food Insecurity Rate	*percent*	20.4		20.1	18.4	*2023*	11
2.12	Households with Cash Public Assistance Income	*percent*	4.1		2.5	2.7	*2019-2023*	2
2.06	Homeowner Spending-to-Income Ratio	*percent*	14.7		14.3	13.5	*2025*	9
2.06	Unemployed Workers in Civilian Labor Force	*percent*	5.7		5.4	4.5	*Apr-25*	22
1.94	Children Living Below 200% of Poverty Level	*percent*	41		38.3	36.1	*2023*	1
1.94	People 65+ Living Below Poverty Level (Count)	*people*	5773				*2019-2023*	2
1.91	People 65+ Living Below 200% of Poverty Level	*percent*	28.5		28.4	28.1	*2023*	1
1.91	People Living Below 200% of Poverty Level	*percent*	30.5		29.6	28.2	*2023*	1
1.88	Children Living Below Poverty Level	*percent*	18.4		18	16.3	*2019-2023*	2
1.76	Gender Pay Gap	*cents on the dollar*	0.7		0.7	0.8	*2023*	1
1.71	College Tuition Spending-to-Income Ratio	*percent*	12.4		12.6	11.9	*2025*	9
1.71	Households with a 401k Plan	*percent*	35.8		38.4	40.8	*2024*	8

1.71	Utilities Spending-to-Income Ratio	*percent*	6.3	6.1	5.6	*2025*	9
1.62	Families Living Below 200% of Poverty Level	*Percent*	23.2	22.8	22.3	*2023*	1
1.59	Median Household Gross Rent	*dollars*	877	988	1348	*2019-2023*	2
1.59	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	507	570	612	*2019-2023*	2
1.59	Young Children Living Below Poverty Level	*percent*	20.7	20	17.6	*2019-2023*	2
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.3	2.1	1.9	*2025*	9
1.53	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7	7.4	7.1	*2025*	9
1.53	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.7	1.6	1.5	*2025*	9
1.47	Food Insecurity Rate	*percent*	15.1	15.3	14.5	*2023*	11
1.41	Health Insurance Spending-to-Income Ratio	*percent*	7	6.6	5.9	*2025*	9
1.41	Households Living Below Poverty Level	*percent*	12.8	13.5	12.7	*2023*	26
1.41	Mortgaged Owners Median Monthly Household Costs	*dollars*	1311	1472	1902	*2019-2023*	2
1.38	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	61.9	61.5	58	*2023*	26
1.38	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	25.3	25	29.4	*2023*	26
1.35	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3	3.3	3.1	*2025*	9

1.35	Households with a Savings Account	*percent*	70.3		70.9	72	*2024*	8
1.35	Population 16+ in Civilian Labor Force	*percent*	59.3		60.1	59.8	*2019-2023*	2
1.35	Size of Labor Force	*persons*	182870				*45748*	22
1.32	Income Inequality		0.4		0.5	0.5	*2019-2023*	2
1.24	Median Household Income	*dollars*	65740		69680	78538	*2019-2023*	2
1.24	Per Capita Income	*dollars*	35802		39455	43289	*2019-2023*	2
1.18	Families Living Below Poverty Level	*percent*	8.9		9.2	8.7	*2019-2023*	2
1.18	People Living Below Poverty Level	*percent*	12.7	8	13.2	12.4	*2019-2023*	2
1.18	Student Loan Spending-to-Income Ratio	*percent*	4.5		4.6	4.5	*2025*	9
1.09	Residential Segregation - Black/White	*Score*	58.7		69.6		*2025*	10
1.06	Adult Day Care Spending-to-Income Ratio	*percent*	10.8		11.1	11.9	*2025*	9
1.06	Female Population 16+ in Civilian Labor Force	*percent*	57.2		59.2	58.7	*2019-2023*	2
1.06	Home Renter Spending-to-Income Ratio	*percent*	16.3		16.3	17	*2025*	9
1.06	People 65+ Living Below Poverty Level	*percent*	8		9.5	10.4	*2019-2023*	2
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
1.00	Renters Spending 30% or More of Household Income on Rent	*percent*	42.4	25.5	45.1	50.4	*2019-2023*	2

0.97	Adults who Feel Overwhelmed by Financial Burdens	*percent*	33.2		34	33.6	*2024*	8
0.97	Households Spending 50% or More of Household Income on Housing	*percent*	9.8		11.5	14.3	*2019-2023*	2
0.88	Median Household Income: Householders 65+	*dollars*	53007		51608	57108	*2019-2023*	2
0.88	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.1	25.5	21.2	28.5	*2023*	1
0.71	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	1.8		2	2	*2024*	8
0.71	Households with Student Loan Debt	*percent*	7.9		9.1	9.8	*2024*	8
0.65	Unemployed Veterans	*percent*	1		2.8	3.2	*2019-2023*	2
0.65	Veterans Living Below Poverty Level	*percent*	6.1		7.4	7.2	*2019-2023*	2
0.62	Severe Housing Problems	*percent*	10.7		12.7		*2017-2021*	10
0.59	Overcrowded Households	*percent*	0.9		1.4	3.4	*2019-2023*	2
0.59	Students Eligible for the Free Lunch Program	*percent*	20		23.6	43.6	*2023-2024*	13
0.18	Homeowner Vacancy Rate	*percent*	0.5		0.9	1	*2019-2023*	2

SCORE	EDUCATION	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.71	Student-to-Teacher Ratio	*students/ teacher*	18.4		16.6	15.2	*2023-2024*	13
1.71	College Tuition Spending-to-Income Ratio	*percent*	12.4		12.6	11.9	*2025*	9
1.53	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7		7.4	7.1	*2025*	9

1.53	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.7		1.6	1.5	*2025*	9
1.50	High School Graduation	*percent*	92.7	90.7	92.5		*2022-2023*	15
1.47	8th Grade Students Proficient in English/Language Arts	*percent*	53.4		49.4		*2023-2024*	15
1.41	People 25+ with a Bachelor's Degree or Higher	*percent*	25		30.9	35	*2019-2023*	2
1.35	4th Grade Students Proficient in English/Language Arts	*percent*	67.1		64.1		*2023-2024*	15
1.18	Student Loan Spending-to-Income Ratio	*percent*	4.5		4.6	4.5	*2025*	9
1.18	Veterans with a High School Diploma or Higher	*percent*	95		94.4	95.2	*2019-2023*	2
1.06	4th Grade Students Proficient in Math	*percent*	73		67.2		*2023-2024*	15
1.06	Child Care Centers	*per 1,000 population under age 5*	8		8	7	*2022*	10
1.00	8th Grade Students Proficient in Math	*percent*	54.4		46.3		*2023-2024*	15
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
0.53	People 25+ with a High School Diploma or Higher	*percent*	92.8		91.6	89.4	*2019-2023*	2

SCORE	ENVIRONMENTAL HEALTH	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	9.1		7.9		*2020*	10
2.24	Houses Built Prior to 1950	*percent*	28.2		24.9	16.4	*2019-2023*	2

1.82	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.6	0.5		*2022*	19
1.82	Daily Dose of UV Irradiance	*Joule per square meter*	3468	3384		*2020*	14
1.74	Annual Ozone Air Quality	*grade*	D			*2021-2023*	3
1.74	Annual Particle Pollution	*grade*	F			*2021-2023*	3
1.71	Utilities Spending-to-Income Ratio	*percent*	6.3	6.1	5.6	*2025*	9
1.65	Weeks of Moderate Drought or Worse	*weeks per year*	0			*2021*	14
1.59	Access to Exercise Opportunities	*percent*	73.9	84.2		*2025*	10
1.50	Asthma: Medicare Population	*percent*	7	7	7	*2023*	7
1.50	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.9	1.9		*2022*	19
1.44	Food Environment Index		7.4	7		*2025*	10
1.41	Proximity to Highways	*percent*	4.6	7.2		*2020*	14
1.35	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3	3.3	3.1	*2025*	9
1.35	Number of Extreme Heat Days	*days*	21			*2023*	14
1.35	Number of Extreme Heat Events	*events*	16			*2023*	14
1.35	Recognized Carcinogens Released into Air	*pounds*	17299.3			*2023*	25
1.32	Social Vulnerability Index	*Score*	0.3			*2022*	6
1.24	Adults with Current Asthma	*percent*	10.7		9.9	*2022*	5
1.06	Number of Extreme Precipitation Days	*days*	4			*2023*	14
1.06	PBT Released	*pounds*	16360.8			*2023*	25

0.97	Broadband Quality Score	*BQS Score*	55.7		53.4	50	*2022*	21
0.88	Access to Parks	*percent*	63.4		59.6		*2020*	14
0.79	Digital Divide Index	*DDI Score*	18.7		40.1	50	*2022*	21
0.62	Severe Housing Problems	*percent*	10.7		12.7		*2017-2021*	10
0.59	Overcrowded Households	*percent*	0.9		1.4	3.4	*2019-2023*	2
0.29	Liquor Store Density	*stores/ 100,000 population*	4.8		5.6	10.9	*2022*	23

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.00	Adults with Health Insurance: 18+	*percent*	74.2		74.7	75.2	*2024*	8
1.94	Dentist Rate	*dentists/ 100,000 population*	63.3		65.2	73.5	*2022*	10
1.85	Adults With Group Health Insurance	*percent*	34.8		37.4	39.8	*2024*	8
1.65	Adults who Visited a Dentist	*percent*	44		44.3	45.3	*2024*	8
1.59	Children with Health Insurance	*percent*	94.9		95.1	94.6	*2023*	1
1.50	Adults who go to the Doctor Regularly for Checkups	*percent*	65.6		65.2	65.1	*2024*	8
1.50	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	2963		3269	2769	*2023*	7
1.41	Adults who have had a Routine Checkup	*percent*	78.1			76.1	*2022*	5
1.41	Health Insurance Spending-to-Income Ratio	*percent*	7		6.6	5.9	*2025*	9
1.09	Adults with Health Insurance	*percent*	93.1		91.6	89	*2023*	1

0.91	Persons with Health Insurance	*percent*	93.5	92.4	92.9		*2022*	24
0.88	Persons without Health Insurance	*percent*	5.7		6.4	8.6	*2019-2023*	2
0.79	Adults With Individual Health Insurance	*percent*	21.1		20.5	20.2	*2024*	8
0.79	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	140.1		148.7		*2024*	10
0.79	Primary Care Provider Rate	*providers/ 100,000 population*	77.3		75.3	74.9	*2021*	10
0.71	Adults without Health Insurance	*percent*	4.5			10.8	*2022*	5
0.44	Mental Health Provider Rate	*providers/ 100,000 population*	374.8		349.4		*2024*	10

SCORE	HEART DISEASE & STROKE	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.09	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	70.8		60.9		*2021*	14
1.94	High Blood Pressure Prevalence	*percent*	39	41.9		32.7	*2021*	5
1.85	Heart Failure: Medicare Population	*percent*	13		12	11	*2023*	7
1.85	Hyperlipidemia: Medicare Population	*percent*	69		67	66	*2023*	7
1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.7			6.8	*2022*	5
1.65	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.1	33.4	43.4	37.6	*2018-2020*	6
1.50	Ischemic Heart Disease: Medicare Population	*percent*	22		22	21	*2023*	7

1.41	Adults who Experienced a Stroke	*percent*	3.9			3.6	*2022*	5
1.41	Cholesterol Test History	*percent*	84.2			86.4	*2021*	5
1.41	High Cholesterol Prevalence	*percent*	35.6			35.5	*2021*	5
1.32	Atrial Fibrillation: Medicare Population	*percent*	15		15	14	*2023*	7
1.06	Adults who Have Taken Medications for High Blood Pressure	*percent*	81.4			78.2	*2021*	5
0.97	Hypertension: Medicare Population	*percent*	65		67	65	*2023*	7
0.82	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	91.4	71.1	101.9	90.2	*2018-2020*	6
0.79	Stroke: Medicare Population	*percent*	5		5	6	*2023*	7

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.09	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.3		7.8	7.5	*2017-2021*	12
2.03	Syphilis Incidence Rate	*cases/ 100,000 population*	15.8		16.4	15.8	*2023*	16
1.94	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	14.2	11.5	13.8		*2023*	16
1.44	Gonorrhea Incidence Rate	*cases/ 100,000 population*	164		168.8	179.5	*2023*	16
1.26	Chlamydia Incidence Rate	*cases/ 100,000 population*	436.6		464.2	492.2	*2023*	16
1.21	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.5	1.4	1.6	2.9	*2023*	16
1.18	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.6		13.9	13.4	*2018-2020*	6

1.15	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	59.8		59.8	60.4	*2024*	8
0.79	Flu Vaccinations: Medicare Population	*percent*	50		50	3	*2023*	7
0.59	Overcrowded Households	*percent*	0.9		1.4	3.4	*2019-2023*	2
0.44	Pneumonia Vaccinations: Medicare Population	*percent*	10		9	9	*2023*	7

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.18	Babies with Very Low Birthweight	*percent*	1.8		1.5		*2022*	17
1.97	Infant Mortality Rate	*deaths/ 1,000 live births*	7.9	5	6.7	5.4	*2020*	17
1.82	Preterm Births	*percent*	10.9	9.4	10.8		*2022*	17
1.79	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	6.3		6.1	5.6	*2022*	17
1.50	Mothers who Smoked During Pregnancy	*percent*	10.1	4.3	7.9	3.7	*2022*	17
1.44	Mothers who Received Early Prenatal Care	*percent*	68.5		68.6	75.3	*2022*	17
1.41	Babies with Low Birthweight	*percent*	8.6		8.7	8.6	*2022*	17

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.71	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	51.8		35.5	31	*2018-2020*	6
2.56	Depression: Medicare Population	*percent*	20		18	17	*2023*	7

2.06	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	18.2	12.8	14.7	13.9	*2018-2020*	6
1.59	Adults Ever Diagnosed with Depression	*percent*	23.3			20.7	*2022*	5
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	85.2		85.4	86	*2024*	8
1.38	Poor Mental Health: Average Number of Days	*days*	5.8		6.1		*2022*	10
1.24	Poor Mental Health: 14+ Days	*percent*	17.2			15.8	*2022*	5
0.97	Adults who Feel Life is Slipping Out of Control	*Percent*	23.5		24.1	23.9	*2024*	8
0.62	Alzheimer's Disease or Dementia: Medicare Population	*percent*	5		6	6	*2023*	7
0.44	Mental Health Provider Rate	*providers/ 100,000 population*	374.8		349.4		*2024*	10

SCORE	NUTRITION & HEALTHY EATING	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	Adults who Frequently Cook Meals at Home	*Percent*	66.8		67.6	67.7	*2024*	8
1.44	Food Environment Index		7.4		7		*2025*	10
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.8		38.1	38.2	*2024*	8
1.15	Adults who Drank Soft Drinks: Past 7 Days	*percent*	48.7		48.6	47.5	*2024*	8

SCORE	OLDER ADULTS	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source

2.71	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	51.8	35.5	31	*2018-2020*	6
2.65	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	12.3	10.8	9.8	*2018-2020*	6
2.56	Depression: Medicare Population	*percent*	20	18	17	*2023*	7
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	40	39	36	*2023*	7
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20	19	18	*2023*	7
1.94	Adults 65+ with Total Tooth Loss	*percent*	19.2		12.2	*2022*	5
1.94	People 65+ Living Alone (Count)	*people*	21308			*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	5773			*2019-2023*	2
1.85	Heart Failure: Medicare Population	*percent*	13	12	11	*2023*	7
1.85	Hyperlipidemia: Medicare Population	*percent*	69	67	66	*2023*	7
1.82	People 65+ Living Alone	*percent*	28.4	30.2	26.5	*2019-2023*	2
1.68	COPD: Medicare Population	*percent*	13	13	11	*2023*	7
1.50	Asthma: Medicare Population	*percent*	7	7	7	*2023*	7
1.50	Cancer: Medicare Population	*percent*	12	12	12	*2023*	7
1.50	Ischemic Heart Disease: Medicare Population	*percent*	22	22	21	*2023*	7
1.50	Osteoporosis: Medicare Population	*percent*	11	11	12	*2023*	7
1.32	Atrial Fibrillation: Medicare Population	*percent*	15	15	14	*2023*	7

1.32	Mammography Screening: Medicare Population	*percent*	49	51	39	*2023*	7
1.06	Adult Day Care Spending-to-Income Ratio	*percent*	10.8	11.1	11.9	*2025*	9
1.06	People 65+ Living Below Poverty Level	*percent*	8	9.5	10.4	*2019-2023*	2
0.97	Diabetes: Medicare Population	*percent*	24	25	24	*2023*	7
0.97	Hypertension: Medicare Population	*percent*	65	67	65	*2023*	7
0.88	Median Household Income: Householders 65+	*dollars*	53007	51608	57108	*2019-2023*	2
0.82	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	105.3	118.1	113.2	*2017-2021*	12
0.79	Stroke: Medicare Population	*percent*	5	5	6	*2023*	7
0.62	Alzheimer's Disease or Dementia: Medicare Population	*percent*	5	6	6	*2023*	7

SCORE	ORAL HEALTH	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.94	Adults 65+ with Total Tooth Loss	*percent*	19.2			12.2	*2022*	5
1.94	Dentist Rate	*dentists/ 100,000 population*	63.3		65.2	73.5	*2022*	10
1.65	Adults who Visited a Dentist	*percent*	44		44.3	45.3	*2024*	8
1.18	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.4		12.8	12	*2017-2021*	12

SCORE	OTHER CHRONIC CONDITIONS	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	40		39	36	*2023*	7

2.03	Chronic Kidney Disease: Medicare Population	*percent*	20		19	18	*2023*	7
1.50	Osteoporosis: Medicare Population	*percent*	11		11	12	*2023*	7
1.41	Adults with Arthritis	*percent*	29.3			26.6	*2022*	5
1.18	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	13.3		14.2	12.8	*2018-2020*	6

SCORE	PHYSICAL ACTIVITY	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Workers who Walk to Work	*percent*	1.4		2	2.4	*2019-2023*	2
2.18	Adults 20+ Who Are Obese	*percent*	39.1	36			*2021*	6
1.59	Access to Exercise Opportunities	*percent*	73.9		84.2		*2025*	10
1.06	Adults 20+ who are Sedentary	*percent*	21.4				*2021*	6
0.88	Access to Parks	*percent*	63.4		59.6		*2020*	14

SCORE	PREVENTION & SAFETY	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.65	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	12.3		10.8	9.8	*2018-2020*	6
2.18	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.4		2.7	2.6	*2016-2020*	6
1.65	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	30.8		40.5	23.5	*2018-2020*	6
1.47	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	59.5	43.2	69.9	51.6	*2018-2020*	6
1.44	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	13.4	10.7	13.5	12	*2018-2020*	6

1.24	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	37.6	20.7	44.7		*2020-2022*	10
1.24	Death Rate due to Injuries	*deaths/ 100,000 population*	95.3		100.7		*2018-2022*	10

SCORE	RESPIRATORY DISEASES	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.68	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	49.2		46.5	38.1	*2018-2020*	6
1.68	COPD: Medicare Population	*percent*	13		13	11	*2023*	7
1.59	Adults with COPD	*Percent of adults*	9.1			6.8	*2022*	5
1.50	Asthma: Medicare Population	*percent*	7		7	7	*2023*	7
1.41	Adults who Smoke	*percent*	16.5	6.1		12.9	*2022*	5
1.41	Proximity to Highways	*percent*	4.6		7.2		*2020*	14
1.35	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	60.7		64.3	53.1	*2017-2021*	12
1.24	Adults with Current Asthma	*percent*	10.7			9.9	*2022*	5
1.21	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.5	1.4	1.6	2.9	*2023*	16
1.18	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.6		13.9	13.4	*2018-2020*	6
1.06	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	39.4	25.1	39.8	32.4	*2018-2022*	12
0.79	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.5		6.9	6.8	*2024*	8

0.65	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.5		1.7	1.6	*2024*	8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.03	Syphilis Incidence Rate	*cases/ 100,000 population*	15.8		16.4	15.8	*2023*	16
1.44	Gonorrhea Incidence Rate	*cases/ 100,000 population*	164		168.8	179.5	*2023*	16
1.26	Chlamydia Incidence Rate	*cases/ 100,000 population*	436.6		464.2	492.2	*2023*	16

SCORE	TOBACCO USE	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.94	Tobacco Use: Medicare Population	*percent*	8		7	6	*2023*	7
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.3		2.1	1.9	*2025*	9
1.41	Adults who Smoke	*percent*	16.5	6.1		12.9	*2022*	5
1.35	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	60.7		64.3	53.1	*2017-2021*	12
0.79	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.5		6.9	6.8	*2024*	8
0.65	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.5		1.7	1.6	*2024*	8

SCORE	WEIGHT STATUS	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Obesity: Medicare Population	*percent*	30		25	20	*2023*	7
2.18	Adults 20+ Who Are Obese	*percent*	39.1	36			*2021*	6

2.03	Adults Happy with Weight	*Percent*	41.2		42.1	42.6	*2024*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	Adults who Frequently Cook Meals at Home	*Percent*	66.8		67.6	67.7	*2024*	8
2.03	Adults Happy with Weight	*Percent*	41.2		42.1	42.6	*2024*	8
1.94	High Blood Pressure Prevalence	*percent*	39	41.9		32.7	*2021*	5
1.59	Life Expectancy	*years*	75.1		75.2		*2020-2022*	10
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	85.2		85.4	86	*2024*	8
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.8		38.1	38.2	*2024*	8
1.24	Poor Physical Health: 14+ Days	*percent*	13.4			12.7	*2022*	5
1.24	Self-Reported General Health Assessment: Poor or Fair	*percent*	18			17.9	*2022*	5
1.15	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	59.8		59.8	60.4	*2024*	8
1.06	Poor Physical Health: Average Number of Days	*days*	4.1		4.3		*2022*	10
0.97	Adults who Feel Life is Slipping Out of Control	*Percent*	23.5		24.1	23.9	*2024*	8

SCORE	WOMEN'S HEALTH	UNITS	STARK COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.09	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.3		7.8	7.5	*2017-2021*	12

2.03	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.5	15.3	20.2	19.3	*2018-2022*	12
1.94	Mammogram in Past 2 Years: 50-74	*percent*	72.3	80.3		76.5	*2022*	5
1.65	Breast Cancer Incidence Rate	*cases/ 100,000 females*	127.5		132.3	129.8	*2017-2021*	12
1.41	Cervical Cancer Screening: 21-65	*Percent*	82.1			82.8	*2020*	5
1.32	Mammography Screening: Medicare Population	*percent*	49		51	39	*2023*	7

Additional Demographic Data

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

Table 10: Population Size of Hospital Community by Zip Code

Zip Code	Population
44641	20,714
44646	47,767
44702	1,085
44703	8,076
44704	3,603
44705	17,301
44706	16,643
44707	9,337
44708	24,939
44709	18,143
44710	9,152
44714	9,000
44718	12,485
44720	40,225
44721	14,383
Mercy Hospital Community (Total)	252,853

Table 11: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Mercy Hospital Community	Ohio
0-4	5.4%	5.6%
5-9	5.6%	5.7%
10-14	5.9%	6.1%
15-17	3.8%	3.8%
18-20	4.0%	4.4%
21-24	4.9%	5.3%
25-34	11.8%	12.4%
35-44	12.0%	12.2%
45-54	11.3%	11.7%
55-64	13.2%	13.0%
65-74	12.5%	11.6%
75-84	6.9%	6.1%
85+	2.7%	2.2%
Median Age	42.2 years	40.5 years

Table 12: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	Mercy Hospital Community	Ohio	U.S.
White	78.9%	75.7%	63.4%
Black/African American	10.5%	12.8%	12.4%
American Indian/Alaskan Native	0.4%	0.3%	0.9%
Asian	1.1%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.1%	0.2%
Another Race	1.5%	2.1%	6.6%
Two or More Races	7.7%	6.4%	10.7%
Hispanic or Latino (any race)	4.1%	5.0%	19.0%

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

Table 13: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	Mercy Hospital Community	Ohio	U.S.
Only English	96.5%	92.8%	78.0%
Spanish	1.4%	2.3%	13.4%
Asian/Pacific Islander Language	0.4%	1.0%	3.5%
Indo-European Language	1.5%	2.8%	3.8%
Other Language	0.1%	1.1%	1.2%

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

Table 14: Household Income of Hospital Community and Surrounding Geographies

Income Category	Mercy Hospital Community	Ohio
Under $15,000	9.0%	9.5%
$15,000 - $24,999	8.9%	7.8%
$25,000 - $34,999	9.5%	8.0%
$35,000 - $49,999	14.5%	12.2%
$50,000 - $74,999	17.0%	17.0%
$75,000 - $99,999	12.9%	13.0%
$100,000 - $124,999	9.5%	9.9%
$125,000 - $149,999	6.0%	7.0%
$150,000 - $199,999	6.0%	7.2%
$200,000 - $249,999	3.1%	3.5%
$250,000 - $499,999	2.6%	3.4%
$500,000+	1.1%	1.6%
Median Household Income	$63,168	$68,488

Table 15: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Mercy Hospital Community	10.9%
Ohio	9.4%
U.S.	8.8%
Mercy Hospital Zip Codes	-
44641	6.1%
44646	7.2%
44702	42.2%
44703	26.0%
44704	35.0%
44705	25.2%
44706	17.7%
44707	31.1%
44708	7.3%
44709	14.2%
44710	14.3%
44714	9.6%
44718	7.1%
44720	4.8%
44721	2.7%

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

Table 16: Educational Attainment of Hospital Community and Surrounding Geographies

	Mercy Hospital Community	Ohio	U.S.
Less than High School Graduate	5.3%	8.6%	10.6%
High School Graduate	36.5%	32.8%	26.2%
Some College, No Degree	21.7%	19.6%	19.4%
Associate Degree	9.2%	8.9%	8.8%
Bachelor's Degree	16.1%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	9.3%	11.6%	13.7%

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

Table 17: High Rent Burden in Hospital Community and Surrounding Geographies

	Renters Spending 30% or More of Income on Rent
Stark County	42.4%
Ohio	45.1%
U.S.	50.4%
Mercy Hospital Zip Codes	-
44641	38.4%
44646	43.1%
44702	45.2%
44703	58.5%
44704	53.3%
44705	40.5%
44706	49.9%
44707	37.4%
44708	53.8%
44709	49.6%
44710	46.4%
44714	31.9%
44718	32.2%
44720	34.8%
44721	26.3%

All values: American Community Survey (2019-2023)

Table 18: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Stark County	86.1%
Ohio	89.0%
U.S.	89.9%
Mercy Hospital Zip Codes	-
44641	87.0%
44646	91.0%
44702	40.8%
44703	73.0%
44704	79.0%
44705	74.2%
44706	85.2%
44707	71.6%
44708	87.5%
44709	85.8%
44710	86.0%
44714	84.1%
44718	87.2%
44720	92.9%
44721	87.3%

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 Stark 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 Stark County Community Health Assessment (CHA) corroborated the relevance of the five prioritized needs in this 2025 CHNA process for Mercy Hospital.

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 different 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[12]
- 2025 Stark County Community Health Assessment[13]
- 2022 Akron Children's Hospital CHNA[14]
- 2022 Greater Akron LGBTQ+ Community Needs Assessment[15]

[12] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[13] Stark County Health Department. (2025). *2025 Stark County Community Health Assessment*. Center for Marketing & Opinion Research, LLC. Retrieved from https://starkhealth.org/government/offices/public_health/community_health_assessment.php
[14] Akron Children's Hospital. (2022). *Community Health Needs Assessment.* Retrieved from https://www.akronchildrens.org/pages/Community_Health_Needs_Assessment.html?tab=sctabtwo
[15] 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

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 equal access to care and reduction of barriers? (Equal Access 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 Mercy Hospital 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 Mercy Hospital community:

- Akron Canton Regional Foodbank
- Beacon Charitable Pharmacy
- Canton City Schools- Patrick Elementary School
- Cleveland Clinic Children's
- Cleveland Clinic Mercy Hospital
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Stark County Community Action Agency Pathways HUB
- Stark County Health Department
- Stark County Mental Health & Addiction Recovery
- Stark Metropolitan Housing Authority
- United Way of Greater Stark County

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 interviews highlighted persistent challenges with access to healthcare in the Mercy Hospital community. Affordability, transportation, and shortages of providers were consistently cited as barriers to both preventive and ongoing care. Many residents struggle with the cost of insurance, copays, and prescriptions, while transportation issues limit access to timely services. Stakeholders also noted that specialty and primary care services are not always available when and where needed, contributing to delayed treatment and worsening outcomes. Despite these barriers, participants emphasized opportunities to expand mobile clinics, telehealth, and coordinated care models that could improve reach, particularly for low-income and under resourced populations.

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

- Cost barriers: Insurance gaps, copays, and prescription affordability.
- Transportation challenges: Difficulty accessing care without reliable transport.
- Provider shortages: Limited primary and specialty care availability.
- Long wait times: Delays in accessing appointments and treatment.
- Resource awareness: Many residents are unaware of available services.
- Older adult needs: Seniors struggle with transportation, multiple conditions, and costs.

- Telehealth potential: Seen as a promising strategy to expand access.

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

> *"Transportation is a big barrier in this community. Even when services are available, people cannot get to them."*
>
> *"People are delaying care because they cannot afford their deductibles or prescriptions."*
>
> *"We have long wait times for specialists, especially for behavioral health, and that discourages people from following up."*
>
> *"Older adults are juggling multiple appointments and cannot always afford or manage the travel."*
>
> *"Telehealth could help, but not everyone has reliable internet or knows how to use it."*

Access to healthcare remains a pressing concern for the Mercy Hospital community. Stakeholders described cost, transportation, and limited provider availability as persistent challenges that contribute to gaps in preventive and ongoing care. Older adults, low-income families, and those living in more rural parts of the county were identified as particularly at risk. Expanding telehealth, mobile health services, and community-based supports were viewed as essential strategies to improve access, reduce delays in care, and strengthen health outcomes.

Behavioral Health: Mental Health and Substance Use Disorder

Stakeholder conversations for Mercy Hospital identified behavioral health, including mental health and substance use disorder, as one of the most pressing needs in the community. Participants emphasized widespread challenges such as provider shortages, long wait times, and limited crisis intervention services. These barriers make it difficult for residents to access timely and appropriate care, particularly for youth and low-income populations. Stigma and lack of culturally responsive services were also noted as significant barriers that discourage individuals from seeking help. Substance use, especially related to opioids and other drugs, was described as a persistent issue requiring more robust treatment and recovery resources.

The following are highlights of participant feedback regarding behavioral health:

- Shortage of providers and long wait times.
- Limited access to crisis intervention and recovery services.
- Stigma continues to prevent treatment-seeking.
- Youth mental health concerns are growing.
- Substance use disorders, including opioids, remain widespread.

- Lack of culturally responsive and community-based behavioral health resources.

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

"There are simply not enough behavioral health providers in Stark County to meet the need, especially for children."

"Substance use continues to be a huge issue here, but treatment options are too limited and waiting lists are long."

"Stigma keeps people from reaching out, and for some families, behavioral health is still not talked about."

"We see more and more young people struggling with depression and anxiety, but services are not keeping up with the demand."

Overall, stakeholders stressed that behavioral health remains the top health priority for the Mercy Hospital community. The need spans both mental health and substance use disorder services, with youth and under resourced populations facing particularly significant barriers. Expanding the behavioral health workforce, investing in crisis care and recovery resources, and building culturally responsive community supports were identified as essential next steps. Addressing stigma and increasing awareness about available resources were also highlighted as critical strategies to improve access and outcomes.

Chronic Disease Prevention & Management

Stakeholders in the Mercy Hospital community emphasized that chronic disease prevention and management remains a critical area of concern. Conditions such as diabetes, heart disease, obesity, hypertension, and stroke were described as highly prevalent, with participants consistently linking them to poor nutrition, physical inactivity, stress, and health-related social needs. Stakeholders noted that barriers such as the excessive cost of care, limited access to specialists, and gaps in preventive screenings lead to delayed detection and poorer outcomes. Older adults were described as especially at risk, as many juggle multiple chronic illnesses while also facing transportation, financial, and social barriers that complicate management. Participants stressed the need for stronger preventive education, community-based wellness supports, and integrated care approaches to reduce the burden of chronic disease.

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.
- Food insecurity is linked to obesity and chronic conditions.

- Stress and inactivity worsen health outcomes.
- Community education on nutrition and wellness is needed.
- Stronger support for physical activity and lifestyle change.

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

"Healthy food is not affordable for many families, and that drives a lot of the health conditions we are seeing."

"People want to make better choices, but stress and lack of resources often keep them from living healthier lifestyles."

"Wellness and prevention programs are limited, yet they are key to reducing the burden of chronic diseases in this community."

Cancer

The following are highlights of participant feedback regarding cancer:

- Low screening rates for key cancers.
- Late-stage diagnosis due to delayed detection.
- Barriers include cost, awareness, and access.
- Need for expanded outreach and education programs.

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

"Access to affordable testing options would make a real difference in catching cancer earlier."

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

"We need more outreach and education, so residents understand the importance of preventive screenings."

Diabetes, Heart Disease, & Stroke

The following are highlights of participant feedback regarding diabetes, heart disease, stroke, and other chronic conditions:

- High prevalence of diabetes, hypertension, and cardiovascular disease.
- Stroke and heart disease remain leading causes of illness and death.
- Preventive screenings and consistent follow-up care are underutilized.
- Cost of medications and services limit long-term disease management.
- Lack of patient education contributes to poor disease control.

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

"People are not getting regular screenings, and when they do, it is often too late to prevent complications."

"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 across Stark 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 manage multiple chronic conditions simultaneously.
- Transportation and mobility challenges limit healthcare access.
- Fixed incomes make medication and care unaffordable for some.
- Social isolation worsens both physical and mental health outcomes.
- Fragmented services make care coordination difficult for seniors.

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

"Transportation is one of the biggest challenges for our senior population."

"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 one of the most pressing needs in the Mercy Hospital community. Stakeholders emphasized that poor nutrition, physical inactivity, limited access to screenings, and cost barriers continue to fuel high rates of diabetes, heart disease, stroke, and other chronic conditions. Older adults were highlighted as a particularly at risk group facing compounding challenges in access, coordination of care, and social support. Community members stressed the importance of preventive education, affordable nutrition, expanded screening opportunities, and integrated supports that empower residents to better manage chronic conditions and improve long-term health outcomes.

Maternal and Child Health

Stakeholder feedback highlighted that maternal and child health is an important and growing concern within the Mercy Hospital community. Participants described limited access to prenatal and postpartum services, particularly for low-income and rural women, as a significant gap. Rising maternal mental health needs, including postpartum depression and anxiety, were also emphasized, with stakeholders noting that supports for mothers often end too quickly after delivery. Pediatric care challenges were also noted, especially for behavioral and mental health services, where provider shortages and long wait times leave families without timely support. Stakeholders consistently stressed the importance of coordinated family-centered care and supportive community networks to ensure mothers and children receive comprehensive, ongoing care across all stages of development.

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

- Prenatal and postpartum care gaps for low-income and rural women.
- Maternal mental health concerns including postpartum depression and anxiety.
- Pediatric care challenges are especially for behavioral and mental health services.
- Provider shortages and wait times limiting access to timely care.
- Need for family-centered support networks and coordinated services.

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

"Women in rural areas or with low incomes have very limited options for prenatal and postpartum care."

"Maternal mental health is not getting the attention it needs, and many moms are struggling with depression and anxiety."

"Families are waiting too long for pediatric behavioral health services, and kids are not getting the help they need."

"We need to make sure services are coordinated so parents don't fall through the cracks once they leave the hospital."

Maternal and child health emerged as a critical area of concern in the Mercy Hospital community, with participants emphasizing both access gaps and quality challenges across the continuum of care. Stakeholders pointed to the lack of affordable prenatal and postpartum care, rising maternal mental health needs, and persistent shortages in pediatric behavioral health services as urgent issues. A family-centered approach that integrates medical, mental health, and social supports was seen as essential to improving outcomes for mothers and children. Strengthening care coordination, reducing wait times, and expanding culturally responsive supports were identified as key strategies for addressing these gaps and fostering healthier families across the community.

Health-Related Social Needs

Stakeholders serving the Mercy Hospital community consistently identified health-related social needs as an underlying driver for the differences in health outcomes. Persistent poverty, unstable housing, and food insecurity were described as barriers that make it difficult for residents to maintain stable health and well-being. Employment challenges, transportation gaps, and differences in access to resources further compound these struggles, particularly for low-income families and at risk populations. Participants emphasized that addressing these social and economic conditions is essential to improving access to care and reducing preventable health burdens across the community.

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

- Food insecurity: Many families lack consistent access to affordable, nutritious foods.
- Housing instability: Safe and affordable housing is limited, contributing to stress and instability.
- Employment challenges: Limited job opportunities and low wages reduce financial stability.
- Transportation challenges: Lack of reliable, affordable transit prevents residents from accessing healthcare and resources.
- Financial stress: High living costs and medical expenses increase household strain.

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

"Food insecurity is rampant. Families are making tough choices between paying bills and buying groceries."

"Housing is one of the biggest issues we hear about, with many residents living in unstable or unsafe conditions."

"People want to work, but the jobs that are available often do not provide enough income or benefits to support a family."

"Transportation is a huge barrier. If you do not have a car, it is very difficult to get to healthcare appointments or even to the grocery store."

Health-related social needs shape nearly every aspect of health for residents in the Mercy Hospital community. Stakeholders emphasized that poverty, housing, food insecurity, and transportation are deeply interconnected and directly impact access to healthcare and health outcomes. Addressing these issues will require coordinated, cross-sector approaches that go beyond clinical care to include housing, workforce development, nutrition assistance, and policy change. Sustainable, community-driven strategies were seen as critical to improving long-term health and well-being.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

Mercy Hospital's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2022 CHNA: Access to Healthcare, Addiction and Mental Health, Infant Mortality and Maternal Health, and Obesity and Health Lifestyle Choices.

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 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, Mercy Hospital connected patients with Cleveland Clinic providers for telehealth and virtual visits. In 2024, Cleveland Clinic provided 1.1 million virtual visits.

C. Mercy Hospital's Transport Program and Mission Outreach continued transportation services for patients with access needs. Services included transport for Cancer patients, vans and car service for out-patients, as well as provision of gas cards and bus vouchers.

Addiction and Mental Health

Actions and Highlighted Impacts:

A. 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.

B. In collaboration with Stark County community-based organizations, Mercy Hospital supported opioid community health education programs regarding education on drug use and addiction.

C. Mercy collaborated with Stark County Health Department in support of their Mobile Harm Reduction Program. The program provided a variety of health screenings and resources at multiple events in the community.

D. The hospital continued the HAVEN (Healing After Violent Encounters Network) Program, providing immediate specialized care and options to victims of assault.

Infant Mortality and Maternal Health

Actions and Highlighted Impacts:

A. Mercy Hospital continued to provide safe sleep education and a sleep sack to every baby born at the hospital. The hospital also provided cribs to families without safe space for their infants to sleep.

B. Mercy Hospital provided *Mommy Empowerment* Mission Outreach programs educating women and their support teams of parenting skills and resources. The hospital provided Baby *Basics* class for infant care, safe sleep.

C. All birthing families received information pertaining to available community resources, including Women Infants and Children (WIC), the Stark County Health Department, Alliance Health Department, Massillon Health Department, Job and Family Services, and services related to food stamps, Medicaid, and cash assistance. Additional resources include Catholic Charities, *Help Me Grow*, the Diaper Bank, and the Crisis Center.

D. Mercy Hospital provided a community health fair for birthing families, the *Annual Community Baby Shower*, a community collaborative providing education, supplies, and program resources to promote healthy, full-term pregnancies.

Obesity and Healthy Lifestyle Choices

Actions and Highlighted Impacts:

A. Mercy Hospital explored a collaborative community referral data platform (Unite Us) with Stark Public Health Department to coordinate health services and ensure optimal communication among social service providers and community members. Rollout is scheduled for Fall 2025.

B. Mercy Hospital continued to support community partnerships to enlist Community Health Workers (CHWs) to assist in service delivery for all populations.

C. Mercy Hospital's Mission Outreach launched the *Pop-Up Grilling Program*, a grassroots initiative that brought food and health education directly to

the community. By distributing meals to those experiencing food insecurity, the hospital provided a warm meal and shared support services information. The *Food Insecurity Project,* a mobile extension of the *Pop-Up Grilling Program,* was initiated to deliver pre-made meals to individuals experiencing homelessness.

D. The hospital provided *Lunch and Learn* sessions designed to promote healthy living and eating habits among community members. The monthly events offered nutrition and wellness education.

E. Mercy Hospital collaborated with the Stark County Metropolitan Housing Authority to distribute heat-and-eat meals to children living on Canton's southeast side.

F. Mercy Hospital continued planning with community-based organizations to address health-related social needs, including food insecurity, transportation, and safe affordable housing. These organizations included: STEAMM Academy, Refuge of Hope, TSL Foundation, Stark County Metropolitan Housing Authority, Access Health, Stark County Community Action Agency, Domestic Violence Project Inc., Beacon Charitable Pharmacy, Arts in Stark/Canton Museum of Art, Canton for All People, Stark Community Foundation, Mercy Service League, Canton Urban League, NAACP, Be a Better Me Foundation, Bethany and Briar Creek Nursing Homes, Stark County Health Department, Canton Health Department, Elevate Life Network, and Canton City Schools.

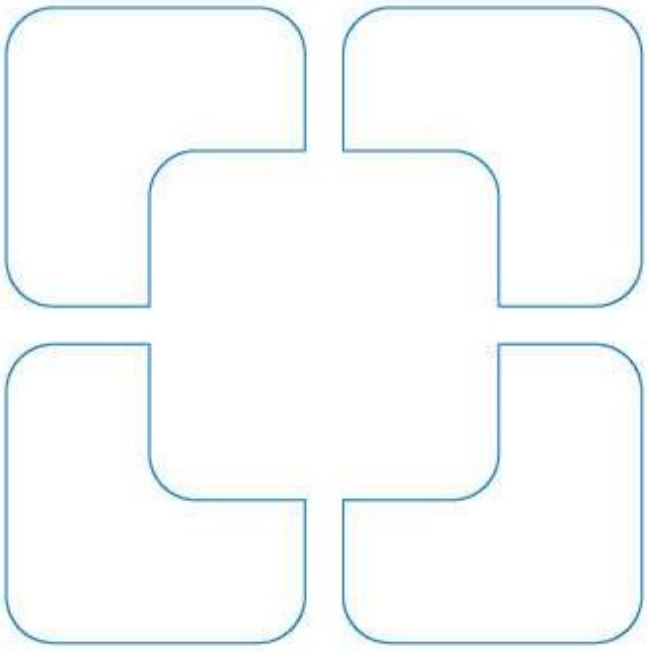
G. Mercy Hospital hosted a Poverty Simulation education session for community partners to promote awareness, collective communication, and service. Community organizations included: faith-based organizations, Walsh University Nursing Program, Canton Regional Area Health Education Center, Stark Community Foundation, Jackson Fire Department, Stark County Health Department, and Canton City Health Department

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
Mercy Hospital

Implementation Strategy Report

2025

MERCY HOSPITAL
2025 Community Health Needs Assessment
Implementation Strategy Report for Years 2026 – 2028

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Mercy Hospital 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 Mercy Hospital 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 Mercy Hospital. 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 Mercy Hospital (Mercy Hospital or "the hospital"), was founded in 1908 in Canton, Ohio, by the Sisters of Charity of St. Augustine. It is a 323-bed[16] hospital with outpatient locations in Alliance, Carroll County, Jackson Township, Lake Township, Louisville, Massillon, North Canton, Plain Township and Tuscarawas County. Mercy Hospital became a full member of the Cleveland Clinic health system on February 1, 2021 and is sponsored by the Sisters of Charity of St. Augustine.

As part of the broader Cleveland Clinic health system, Mercy Hospital upholds the tripartite mission of caring for life, researching for health, 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

[16] 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.

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 Mercy Hospital, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Mercy Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Mercy Hospital 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 equal access to care and reduction of barriers. 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, Mercy Hospital 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.

Mercy Hospital is a trusted part of the community and continues to grow and improve to meet the needs of its patients. To learn more, visit: https://my.clevelandclinic.org/locations/mercy-hospital.

II. Mercy Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Mercy Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Mercy Hospital 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: Mercy Hospital Community Definition

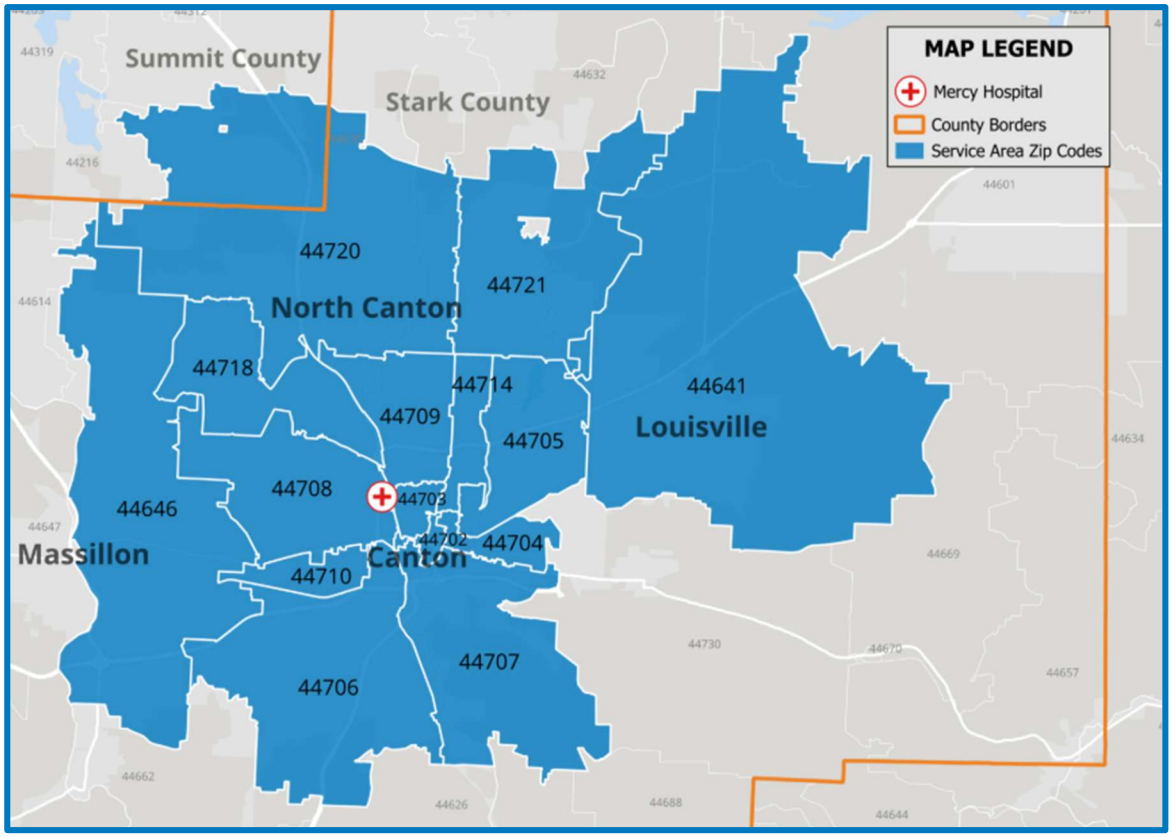


Table 1: Mercy Hospital Community Definition

Zip Code	Postal Name	Zip Code	Postal Name
44641	Louisville	44708	Canton
44646	Massillon	44709	North Canton
44702	Canton	44710	Canton
44703	Canton	44714	Canton
44704	Canton	44718	Canton
44705	Canton	44720	North Canton
44706	Canton	44721	North Canton
44707	Canton		

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of leadership at Mercy Hospital 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 Mercy

Hospital 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

Mercy Hospital'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 Mercy Hospital.

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 Mercy Hospital 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

The 2025 CHNA for Cleveland Clinic Mercy Hospital highlights significant barriers to accessing timely, affordable care, particularly for uninsured and underinsured residents who face high deductibles, copays, and prescription costs. Transportation challenges, especially in rural areas, further delay care, while system complexity and limited awareness of available services hinder preventive and follow-up care. Stakeholders also noted shortages of primary and specialty providers and a need for more culturally and linguistically accessible services. These barriers disproportionately affect low-income families and older adults, contributing to preventable hospital use. Secondary data show low insurance coverage in key Canton zip codes and higher financial and health burdens for Black/African American residents. Several local zip codes score above 90 on the Community Health Index, indicating especially high 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.

B. Behavioral Health

The 2025 CHNA for Mercy Hospital identifies Behavioral Health as a critical priority, with stakeholders reporting significant challenges related to mental health and substance use across all age groups. Provider shortages, long wait times, and limited crisis intervention options leave many residents without timely support, increasing reliance on emergency departments. Stigma, cost, insurance barriers, and transportation difficulties further prevent early treatment, especially for youth experiencing rising depression, anxiety, and trauma. Substance use, including opioid misuse, remains a major concern amid limited, hard-to-navigate services. Secondary data show high depression and suicide rates in Stark County, and more than half of Mercy community zip codes score above 85 on the Mental Health Index, indicating severe unmet 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.

C. Chronic Disease Prevention and Management

The 2025 CHNA for Mercy Hospital identifies chronic disease prevention and management as a major community priority, with high rates of diabetes, hypertension, obesity, heart disease, and cancer driven by poor nutrition, food insecurity, limited screenings, and gaps in education. There are added barriers such as cost, limited insurance, and difficulty accessing specialty care. Older adults are especially susceptible as they manage multiple conditions alongside transportation challenges, fixed incomes, and social isolation. Stakeholders emphasized the need for preventive care, coordinated chronic disease management, and improved access to healthy foods, screenings, and community-based supports. Secondary data confirm elevated risks across nutrition, cancer, cardiovascular health, diabetes, and aging.

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.

D. Maternal and Child Health

The 2025 CHNA for Mercy Hospital identifies Maternal and Child Health as a significant concern, driven by gaps in prenatal, postpartum, and pediatric care. Stakeholders noted limited access to affordable maternal services, shortages of specialized providers, and rising maternal mental health needs compounded by stigma and insufficient behavioral health supports. Children face similar challenges, including provider shortages, long wait times, and inadequate pediatric behavioral health resources, leading to delayed developmental and mental health care. Financial barriers further limit consistent access

for low-income families. Secondary data show elevated risks in Stark County, including higher rates of preterm and teen births, infant mortality, maternal smoking, and disproportionately high child mortality among Black/African American children.

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

The 2025 CHNA for Mercy Hospital identifies health-related social needs as major, interconnected barriers shaping health outcomes across the community. Stakeholders described how poverty, unemployment, high housing costs, and food insecurity limit residents' ability to prioritize healthcare, afford medications, or access transportation and follow-up care. Housing instability and inadequate transit were emphasized as key drivers of chronic disease, stress, and limited access to jobs and services. Participants also pointed to uneven neighborhood investment as a source of persistent differences. They stressed that improving health requires addressing these upstream social and economic factors through stronger community partnerships, expanded support services, and investments in housing, transit, and workforce development. Secondary data further reflect lower income, education, and employment levels, and higher social isolation, across the Mercy Hospital community.

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

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

A. **Initiative:** Explore Cleveland Clinic referral data platform, ConnectWell/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. 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:** Introduce the hospital's new Community Advisory Council with focus on integration of community voice and aligned strategic planning.

   Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives.

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.

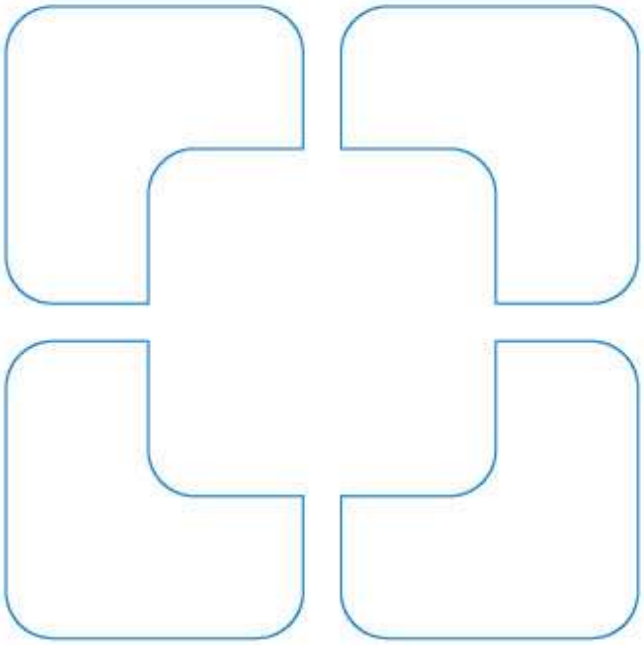
   Anticipated Impacts: Improve local employment opportunities, improve poverty rates.

E. **Initiative:** Continue strategic development regarding transportation and safe affordable housing issues with Stark County Health Department, community-based organizations and area hospitals.

   Anticipated Impacts: Overcome geographical and transportation barriers, increase access to community safety.

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 Mercy Hospital to improve community health. Through this iterative process, opportunities are identified to grow and expand existing work in prioritized areas as well as implement additional programming in new areas. These ongoing strategic conversations will allow Mercy Hospital to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

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



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