

2019

# chna

community health needs assessment



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## acknowledgements



Summit County Public Health was hired to conduct this Community Health Needs Assessment under the direction of the Summit Coalition for Community Health Improvement (SCCHI) that was comprised of representatives from the following:

Akron Area YMCA  
Akron Canton Regional Foodbank  
Akron Children's Hospital  
Akron Metropolitan Area Transportation Study  
Akron Metropolitan Housing Authority  
Akron Region Interprofessional Area Health Education Center  
Akron Summit Community Action, Inc.  
Akron Summit County Public Library  
American Cancer Society  
Asian Services in Action, Inc.  
AcessPointe Community Health Center  
Child Guidance and Family Solutions  
City of Akron  
Cleveland Clinic Akron General  
Community Health Center  
Community Legal Aid  
County of Summit  
County of Summit Alcohol Drug Addiction and Mental Health Services Board  
Hattie Larlham  
Infoline, Inc.  
International Institute of Akron  
Mature Services  
Mustard Seed Market & Café  
Northeast Ohio Medical University  
Ohio Guidestone  
Open M  
OSU Extension  
Project Learn of Summit County  
Summa Health  
Summit County DD Board  
The Blick Center  
The Ohio Affiliate of Prevent Blindness  
U.S. Representative Marcia Fudge  
U.S. Senator Sherrod Brown  
United Way of Summit County

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# Executive Summary

In 2019 Summa Health partnered with Summit County Public Health (SCPH) and the Summit Coalition for Community Health Improvement (SCCHI) to conduct the 2019 Community Health Needs Assessment (CHNA). During this process, over 200 indicators were reviewed, community leaders and residents were consulted, and significant health needs were identified.

As readers move through the report, they will see that Summit County’s collective health has changed over the past three years. Some outcomes have improved, while others have gotten worse. And in some cases, it is still too soon to tell if any progress has been made.

Good health starts with people taking care of themselves; eating good food and exercising, not smoking, getting all recommended immunizations and screenings and seeing a doctor when sick or injured.

However, good health goes beyond maintaining a healthy lifestyle. It depends on several factors that on the surface may

not seem to be linked to health. Many of the factors that impact health come from the outside; things like the kind of social and economic opportunities available; the physical condition of people’s homes, schools and businesses, the safety and vitality of the neighborhoods they live in, the education they receive, and the work they do. People’s health also depends on things like access to clean water, food and air, and effective and affordable health care.

The report that follows contains a great deal of statistics. Collectively, they show the complex web of personal, social, economic and environmental factors that help determine at a community-wide level who is healthy and who is unhealthy. But statistics alone do not tell the whole story. Health outcomes improve by combining individual commitment to healthier living with a commitment to the design and implementation of effective programming by public agencies and their private, non-profit, and faith-based partners.

In addition to statistics, this report highlights several critical areas impacting

health in Summit County. These sections present the background of each issue and discuss the community partners engaged in addressing the issues. These sections also include some of the major challenges and opportunities that will help determine success in the years ahead.

This assessment builds upon the work that was completed in 2013 and the implementation plan that was published in May of 2017. Although Summa Health has made significant strides in addressing the 2017 priorities, it has been decided that to truly affect health outcomes, Summa Health, with the help of community partners, has to commit to a long-term strategy that addresses the following priorities for another three years and beyond. These priority areas are as follows:

- Chronic Disease Management
- Access & Barriers to Health Care
- Health Disparities
- Prevention
- Wellness

## PRIORITY AREAS

### Chronic Diseases

Chronic diseases are diseases that a person has for a long time, sometimes indefinitely. People with chronic diseases usually need to see their doctors on a regular basis to monitor the progression of their disease and get treatment.

### Access and Barriers to Health Care

Access to health care is a broad term used to describe the availability, acceptability, affordability, and accessibility of health care systems and providers. Adults with poor access to health care, or who face barriers to care, have a harder time getting preventive services or medication.

### Health Disparities

A health disparity is a particular type of health difference that is closely linked to social, economic, or environmental disadvantage. Disparities can be based upon racial or ethnic characteristics, religion, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination and exclusion.

### Prevention

Prevention activities focus on improving lifestyle risk factors and “everyday” behaviors that can negatively impact

health. People who have these risk factors and engage in these behaviors are at higher risk for a large number of chronic diseases such as heart disease, diabetes, and cancer, as well as other negative health outcomes.

### Wellness

Wellness can be defined as the quality or state of being healthy in body and mind, especially as the result of deliberate effort and intervention.

*Complete data results in the Summa service area can be found in the Data Appendix.*



## Purpose of the CHNA

Summa Health has a long history of collaboration on a wide range of projects aimed at improving community health. Together with Summit County Public Health and the Summit Coalition for Community Health Improvement, Summa worked to complete the 2019 community health needs assessment (CHNA) and to prioritize the identified community health needs.

The Patient Protection and Affordable Care Act (ACA) was designed to improve access, affordability, and quality in healthcare. It included the expansion of Medicaid and the creation of the health insurance marketplace, greatly increasing access to health insurance coverage and decreasing the amount of charity care needed. However, it also brought with it the responsibility of hospitals to educate the community about the care and programs available and the best ways to access appropriate care, to ensure that newly insured patients weren't underserved. The goal is to improve the health of the entire community.

Since the passage of the ACA, hospitals and public health departments have been encouraged to align priorities and use common timelines and data metrics to measure health outcomes. Additionally, hospitals and health departments are intentionally aligning with The State of Ohio to ensure that state and local initiatives, including funding, are intentionally designed to collectively impact health outcomes.

Population health has become a key strategy for Summa Health. Summa is focused on improving the patient experience by coordinating care between every patient's team of caregivers and improving the quality of care with each episode. Summa is proactively reaching out to patients on an ongoing basis to assess how they are doing and using population health approaches to improve the health of large groups of patients.

The CHNA helps Summa prioritize the community's needs. As defined by the requirements set forth by the Internal Revenue Service (IRS), the federal agency that is charged with enforcing these requirements, the Summa CHNA includes a description of:

- The community served and how it was defined; (see pages 8-9)
- The process and methods used to conduct the assessment, including the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs; (see page 10, data appendix)
- Collaborating hospitals and vendors used while conducting the CHNA; (see page 2)
- How input was received from persons who have expertise in public health and from persons who represent the broad interests of the community, including a description of when and how these persons were consulted; (see pages 12-16)
- The prioritized community health needs, including a description of the process and criteria used in prioritizing the health needs; (see pages 3, 10)
- Existing healthcare facilities and other community resources available to meet the prioritized community health needs. (see pages 6-7)
- The evaluation of impact of actions that were taken to address significant health needs identified in previous CHNA(s); (see pages 4-5)

Thus, the purpose of this CHNA is to improve the health of our community. This report will also act as a resource for other community groups working toward improving the health of the community. In addition, this report will fulfill the CHNA requirements established by the ACA for the hospital facilities listed.

## Evaluation of Impact Since 2016 CHNA

Summa's 2016 Community Health Needs Assessment (CHNA) prioritized prevention, wellness, chronic diseases, access to care, and health disparities in Summit County. Since the completion of the 2016 CHNA, Summa has worked diligently to address these needs in order to improve the overall health of the populations served. At Summa, we take a unique approach in supporting the health of our community. We step outside the walls of the traditional healthcare model and, together with our community partners, address all social determinants of our patients' health.



So while our impact highlights Summa Health's steadfast commitment to being a strong community presence, please take note of the many critical alliances we've formed among numerous community partners and agencies. We've pooled resources. We've established clear and aligned objectives. And we've created valuable programs, relying on our partners' expertise, to create programs that truly address the unmet needs of our community.

It's our success in strategically leveraging these powerful partnerships that has led to increased efficiencies and, most importantly, greater community change.

Summa's culture of servant leadership is deeply rooted in our system's mission, vision and values. We focus on improving the health status of the diverse communities we serve. These collaborative efforts help us to:

- Address the most significant health needs of the community
- Improve access to health services
- Support chronic disease management through education
- Reduce health disparities

Summa has developed numerous strategies around the adult health needs of cancer, cardiovascular disease, diabetes, infant mortality, lifestyle factors, mental health, substance abuse, and quality of care factors.

Summa collaborated with local agencies to assist individuals who had been identified as eligible for health coverage, but who needed assistance obtaining coverage. Summa also worked in partnership with the American Cancer Society, American Diabetes Association, and American Heart Association, at community outreach events to provide education on risk factors, risk behaviors, and genetic considerations that often lead to the development of cancer, cardiovascular disease, or diabetes.

Summa Health Medical Group primary care sites recently implemented the Patient-Centered Medical Home model of care. This method puts patients at the center of care by building better relationships between patients and their care teams, resulting in those who are happier and healthier. Also, incorporating nurse and behavioral health care teams into primary care offices has allowed care teams to further support complex patient needs. These are just two methods that Summa uses to promote early detection, diagnosis, and treatment of depression in primary care settings.

Summa has taken many steps to address the growing issue of substance abuse in the community, specifically targeting prescription and opioid abuse solutions and MAT treatment. Summa has begun initiatives to remove or neutralize these pills with drug take-back days, expanded opioid risk screening, and 24/7 access to MAT treatment. In addition, partnerships with Summit County Public Health and the Summit County Community Partnership have allowed Summa to install D.U.M.P. boxes and distribute Deterra® bags, respectively associated with those partners. Through a partnership with the United Way of Summit County and other community partners, "First Step" an addiction recovery pathway that treats the physical, mental, and behavioral addiction of opiate addiction launched at Summa Barberton Campus and after much success expanded to Akron Campus. First Step provides addiction treatment right in the emergency room, 24 hours a day, seven days a week.

In collaboration with Project Ujima and Minority Behavioral Health Group, the Summa Health Equity Center is working to reduce infant mortality rates. Summa's Centering® Pregnancy program has expanded by adding two pregnancy groups of minority women which use targeted programming, based on life experience, in order to reduce the elevated infant mortality rates found in minority groups. Building on the Centering® Pregnancy program, Summa is now offering peer support, specialized prenatal care, parenting and financial classes, and access to a variety of community resources to targeted area ZIP codes.

These are just some of the actions Summa took to address the most significant health needs in the community. To read more about these efforts, view Summa's community benefit reports at [www.summahealth.org/pressroom/mediacenter/newspublications](http://www.summahealth.org/pressroom/mediacenter/newspublications).

## Description of Hospital Facilities

Summa Health serves more than one million patients each year in comprehensive acute, critical, emergency, outpatient, and long-term/home-care settings and has more than 1,300 licensed inpatient beds, as of 2015. It consists of three hospital campuses and several offsite locations. The hospitals employ more than 5,600 employees; the entire system employs more than 8,000 employees. The buildings and facilities on all campuses total approximately 2.2 million square feet.



As a leader in medical education, Summa Health System supports the education of its physicians and healthcare professionals. The Akron and St. Thomas campuses are teaching affiliates of the Northeast Ohio Medical University (NEOMED) and include a staff of physicians and accredited residency and fellowship programs that foster a dynamic medical environment. Approximately 80 residents and fellows graduate from the Akron Campus's medical education programs each year. The Barberton Campus has a family practice residency program affiliated with NEOMED, and also provides educational rotations for medical students.

### Akron Campus

Summa Health System-Akron Campus was founded in 1892 to provide a place where patients could be treated with compassion, in a manner adhering to best principles of medical practice. Located in the heart of Akron, Ohio, Summa Health System-Akron Campus is the largest hospital in the community. The Akron Campus provides general medical, surgical, obstetrical, trauma, and critical care services on a campus of approximately 60 acres. The campus is home to specialty health centers and offers a wide range of outpatient services.

Summa Health is moving forward with plans to invest up to \$350 million in its facilities to help establish Summa Health as the leading healthcare provider in the region. This investment has funded extensive renovations at the Akron Campus, including construction of a new 300,000-square-foot tower, which includes new facilities for women's health, modern inpatient rooms, and nursing units and expanded surgical capacity; construction of a new 50,000-square-foot medical office building; and increasing the number of private rooms by approximately 80 percent. Recently, Summa Health announced plans to build a \$60 million 60-bed inpatient and outpatient behavioral health facility as part of Phase 2 of the Summa Health Master Facility Plan.

### St. Thomas Campus

Originally operated by the Sisters of Charity of Saint Augustine as a non-denominational, non-profit general hospital, Summa Health System-St. Thomas Campus opened its doors to the Akron community in 1922. St. Thomas merged with Akron City Hospital to become Summa Health System in 1989. The St. Thomas Campus was among the first in the country to recognize the medical aspects of alcoholism as a disease and is the founding location of Alcoholics Anonymous. The St. Thomas campus is the headquarters of the Summa Health Behavioral Institute and operates specialized programming including for traumatic stress and substance abuse.

### Barberton Campus

Summa Health System-Barberton Campus has served residents of Barberton and the surrounding communities since its founding in 1915. In December 2007, it became a full member of Summa Health. The hospital is located approximately 10 miles southwest of Akron. The hospital is a 500,000-square-foot facility located on nearly 16 acres. The Barberton Campus provides the community with easy access to comprehensive, high-quality cancer services at the Commission on Cancer-accredited Parkview Pavilion; the full spectrum of cardiovascular disease care, including diagnostic, interventional, and surgical services; and a variety of outpatient services.

### Summa Rehab Hospital, LLC

Summa Rehab Hospital, LLC is a joint venture between Summa Health System and Vibra Healthcare. It was founded in 2012. A 60-bed acute medical facility, Summa Rehab Hospital, LLC provides inpatient rehabilitation care and services. The freestanding 65,000-square-foot inpatient care facility houses a multidisciplinary team of 265 employees.

## Community Resources

There are a wide variety of resources in the community that are available to respond to the health needs of the community identified in this CHNA. These include:

- Access, Inc.
- Akron Canton Regional Foodbank
- Akron Children's Hospital
- Akron Metropolitan Housing Authority
- Akron Urban League
- American Academy of Pediatrics, Ohio Chapter
- American Cancer Society



- American Diabetes Association
- American Heart Association
- American Lung Association
- AxessPointe Community Health Center
- Child Guidance & Family Solutions
- Children's Hospital Association
- Cleveland Clinic Akron General
- Coleman Professional Services
- County of Summit Alcohol, Drug Addition & Mental Health Services Board
- Faithful Servants Care Center
- Greenleaf Family Services
- Haven of Rest Ministries
- International Institute
- March of Dimes
- Open M
- Portage Path Behavioral Health
- Salvation Army
- Summit County Children's Services
- Summit County Department of Job and Family Services
- Summit County Public Health
- United Way of Summit County

InfoLine also maintains a searchable database of community resources at [www.211summit.org](http://www.211summit.org)

## To Request Copies and for More Information

In addition to being publicly available on the Summa website, a limited number of reports have been printed. If you would like a copy of this report or if you have any questions about it, please contact:

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# DEMOGRAPHICS

## Summit County

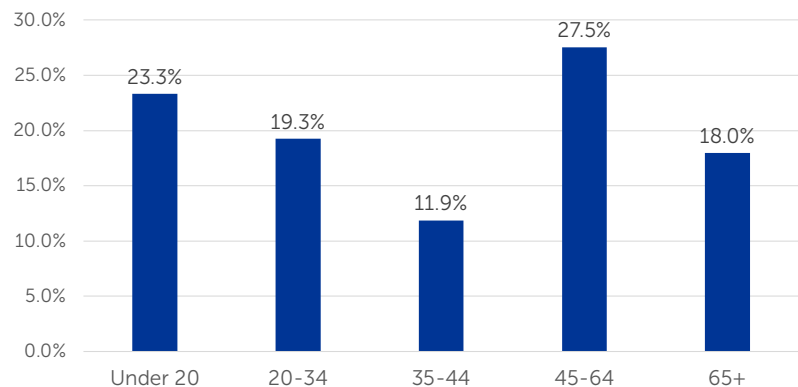
Based on 2017 patient admission data, Summa health care delivery is primarily in Summit County. Summit County represents 75.97% of the 2017 admissions from Summa Health. While Summa also treats patients from Medina, Northern Stark, and Wayne Counties, most patients come from Summit County.

Summit County, Ohio is comprised of nine townships, nine villages and thirteen cities. It is located in the northeastern part of the state and covers 412.7 square miles. As of 2018, it had approximately 541,918 residents, making it the 4th most populous county in Ohio. The county seat is Akron, in which almost 37% of the county's population resides. Summit County has world renowned medical facilities, two universities, and beautiful parks and churches.

## Age and Gender

The largest proportion of Summit County residents are between ages of 45 to 64 followed by those 18-34 and under 18 years of age. The smallest age group in the county is 35-44 making up about 12% of the population. The median age is 41 years which is unchanged since the 2016 CHNA. Gender distribution has also remained steady within the county with 51% females and 49% males.

Summit County age distribution, 2018

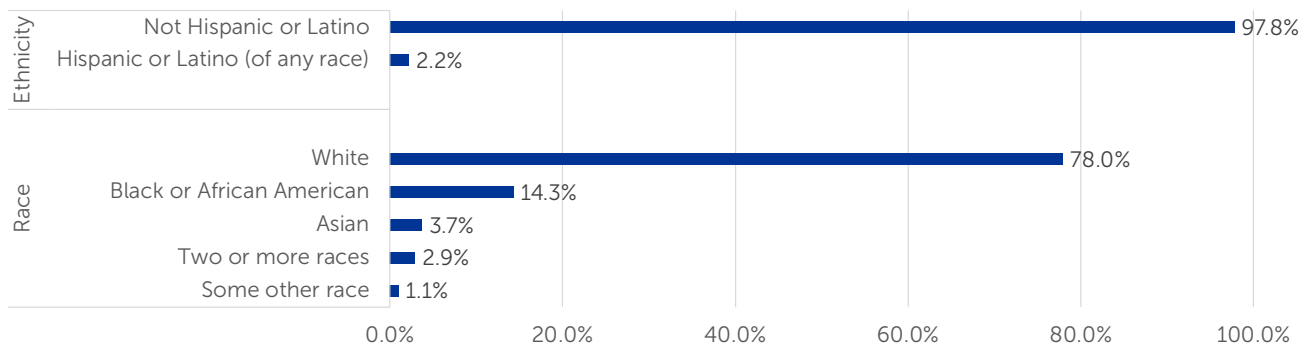


Source: 2018 ACS 1-year estimates

## Race, Ethnicity and Nativity

The majority of Summit County residents identify as white. The next largest racial group consists of those who identify as black accounting for about 14% of the population. Approximately 2% of the population identify as Hispanic or Latino. Additionally, 5.2% of Summit County residents are foreign born. Seven percent of residents 5 years of age and older speak a language other than English at home and 2.8% of residents 5 years of age or older speak English less than "very well".

Summit County race & ethnicity distribution, 2018

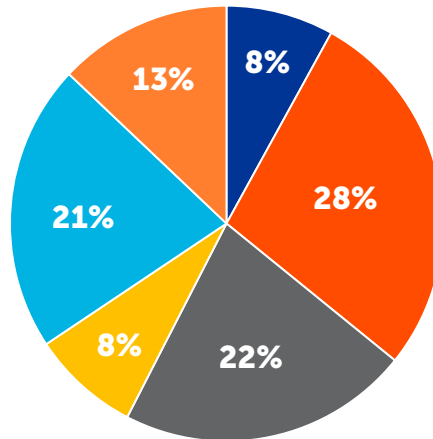






### Education

Ninety-two percent of Summit county residents (25 years and older) have a degree equal to or higher than a high school diploma, and 34.3% of residents have a bachelor's degree or higher. Many residents have a high school degree as their highest level of education accounting for nearly 28% of residents. This is closely followed by those with some college and no degree and those with a bachelor's degree accounting for approximately 22% and 21% of residents respectively.



Summit County education distribution, 2018

- Less than a high school degree
- High school graduate (includes equivalency)
- Some college, no degree
- Associate's degree
- Bachelor's degree
- Graduate or professional degree

### Income & Poverty

The majority of Summit County residents 15 years of age and older have an annual income between \$25,000 and \$49,999. The median income county income has increased since the 2016 CHNA from approximately \$27,615 to \$31,405. Additionally, the percentage of individuals in 2018 living below 100% of the poverty level (\$12,140 in 2018) decreased from the previous CHNA to nearly 12%. Families living below the poverty level also decreased from 10.1% in 2015 to 7.7%.

# OUR METHODOLOGY

## The MAPP Process

The 2019 Community Health Needs Assessment (CHNA) was completed using the National Association of County and City Health Officials (NACCHO) modified- Mobilizing Action through Partnerships and Planning (MAPP) process. MAPP is a community driven planning process for improving community health. This process was facilitated by Summit County Public Health and conducted with the Summit Coalition for Community Health Improvement (SCCHI). SCCHI is a 40+ member collaborative with the mission of identifying key health priorities in Summit County and coordinating action to improve population health and promote health equity for all.

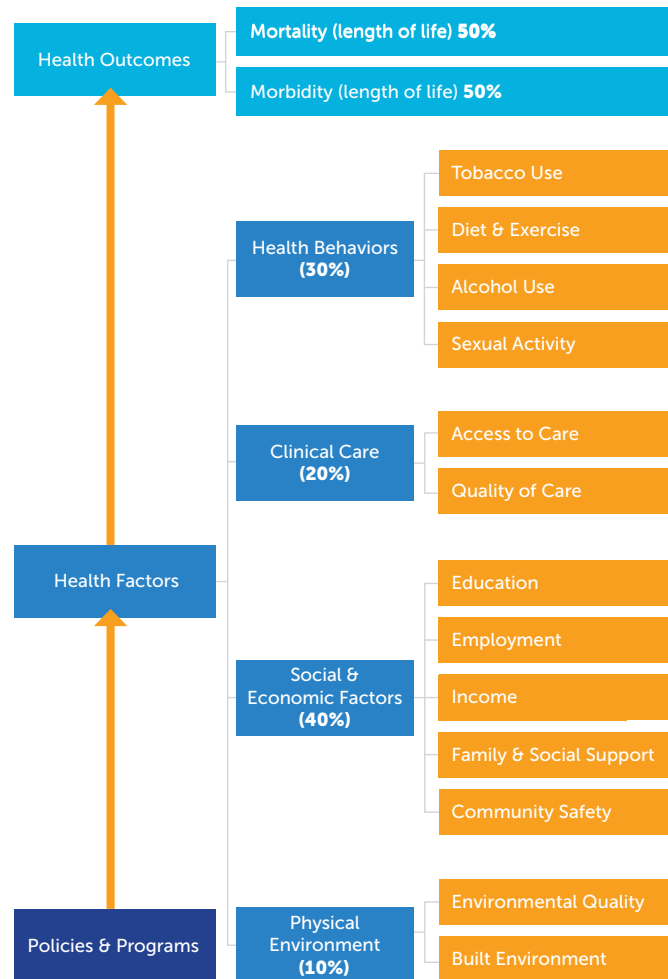
## Indicator Selection

The 2019 CHNA indicators were selected with the assistance and guidance of SCCHI during an intensive year-long planning process in 2016 and refined in 2018 based on availability of data. SCCHI organized into four subcommittees: Clinical, Health Behaviors, Social/Economic and Physical Environment to discuss and propose indicators for this assessment. The entire SCCHI coalition then reconvened to select the final list of indicators.

The CHNA indicators are organized using the County Health Rankings model of population health, developed jointly by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. This model, outlined below in a graphic reproduced from the County Health Rankings website, provides a comprehensive methodology for understanding how a community's collective efforts to improve health and social conditions interacts with prevailing socioeconomic and health conditions to produce desirable (or undesirable) outcomes in a community's health and quality of life.

## Data Sources

SCPH Epidemiology gathered data from a variety of sources including County Health Rankings, American Community Survey, and Community Health Status Indicators. SCPH also utilized the 2018 Youth Risk Behavioral Survey, the Ohio Department of Health Birth and Death Data, and EpiCenter. A full list of data sources can be found in the Data Appendix



COUNTY HEALTH RANKINGS MODEL ©2012 UWPHI

## Qualitative Assessments

SCCHI and SCPH also completed two qualitative MAPP assessments: Community Themes and Strengths and the Forces of Change. These assessments identified key themes regarding Summit County's strengths, weaknesses, opportunities and threats. Focus groups and surveys were conducted and distributed throughout the community in 2019 to identify barriers and opportunities through the lens of the community member. All information obtained through both quantitative and qualitative data sources are presented in this report.



## community perspectives

Qualitative data collected through surveys, focus groups and community meetings are utilized to gather information about how Summit County leaders and residents experience the health outcomes and community conditions that affect quality of life. This information can provide additional context to quantitative data and help to strategically inform improvements.



# Engaging Our Partners & Community

SCPH conducted surveys and focus groups with both community leaders and residents to supplement quantitative data sources and determine strengths, opportunities weaknesses and threats to the health of Summit County residents.

## COMMUNITY THEMES & STRENGTHS

The Community Themes and Strengths survey was completed during focus groups with community leaders and community members in the spring of 2019. The following list represents a compiling of these conversations.

### QUESTION: What makes you most proud of our county?

Summit County residents were most proud of the people, art, music and culture, as well as a rich history of economic opportunities and development. Residents and community leaders acknowledged the progressive built environment changes that are intended to spur development. Summit County is home to many community resources such as the public libraries, community learning centers, universities, healthcare resources, and many parks and green spaces.

Category	Percent
People (diversity, pride, collaboration)	23%
Art, music & culture	20%
Economic opportunities & development	15%
Community resources	14%
Healthcare resources	11%
Parks & green space	11%
Educational opportunities	8%

### QUESTION: What do you believe is keeping our county from doing what needs to be done to improve health and quality of life?

Lack of collaboration and alignment included data sharing challenges, a lack of coordination between partners and service gaps for vulnerable populations. Resource constraints included reductions in funding, needing to do more with less, and struggles among vulnerable populations to secure safe and affordable housing and adequate insurance coverage. Population challenges included a lack of community engagement, loss of family infrastructure, shifts in population demographics and language barriers.

Category	Percent
Lack of collaboration or alignment	40%
Resource constraints	38%
Population challenges	21%



## FORCES OF CHANGE

The Forces of Change Assessment was completed by both community leaders and community members in the spring of 2019. The following list represents the most critical forces of change that were identified through the selection process.

**QUESTION: What broad events, trends, and factors do you believe will most affect health and quality of life in Summit County over the next several years?**

Lack of collaboration and alignment included data sharing challenges, a lack of coordination between partners and service gaps for vulnerable populations.

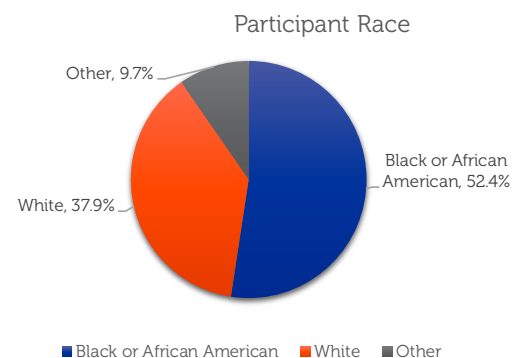
Category	Percent
Political landscape	22%
Substance use (medical marijuana, children born to opiate addicted mothers entering school)	16%
Cultural/Lifestyle changes (social media's effect on health)	14%
Built/physical environment (climate change, infrastructure change)	12%
Demographic changes (aging population, refugee population)	10%
Social issues (homelessness, youth violence, social justice)	10%
Education	8%
Economic landscape	6%

## COMMUNITY SURVEY

SCPH attended the Metro Minority Health Fair event held by the Office of Minority Health. At the event, SCPH passed out detailed surveys in which the participants received incentives for their participation. SCPH collected a total of 127 completed surveys. Data collected from the surveys was analyzed by SCPH epidemiology. The following summarizes data collected during this event.

### Race

Survey results showed the majority of the participants identified as Black or African American representing a percentage of 52.4%. The participants that identified as White and other represented 37.9% and 9.7% respectively.



### Gender

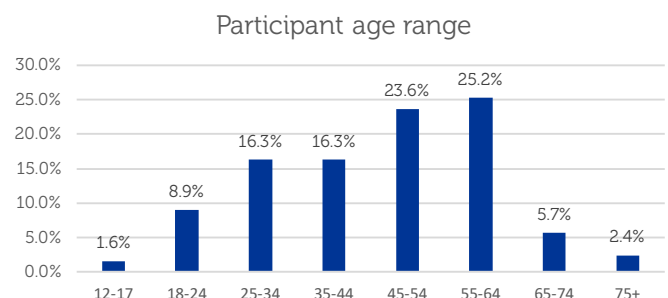
The gender data was divided as follows 56.6% female, 42.5% male, and 0.8% transgender.

### Age

A wide age range of participants were surveyed, with roughly half of participants falling between ages 45 and 64.

### Income

Over 80% of survey participants reported income under \$20,000 annually. Though this is not representative of the overall population, it overrepresents a subset of the population which experience the most significant barriers to care.



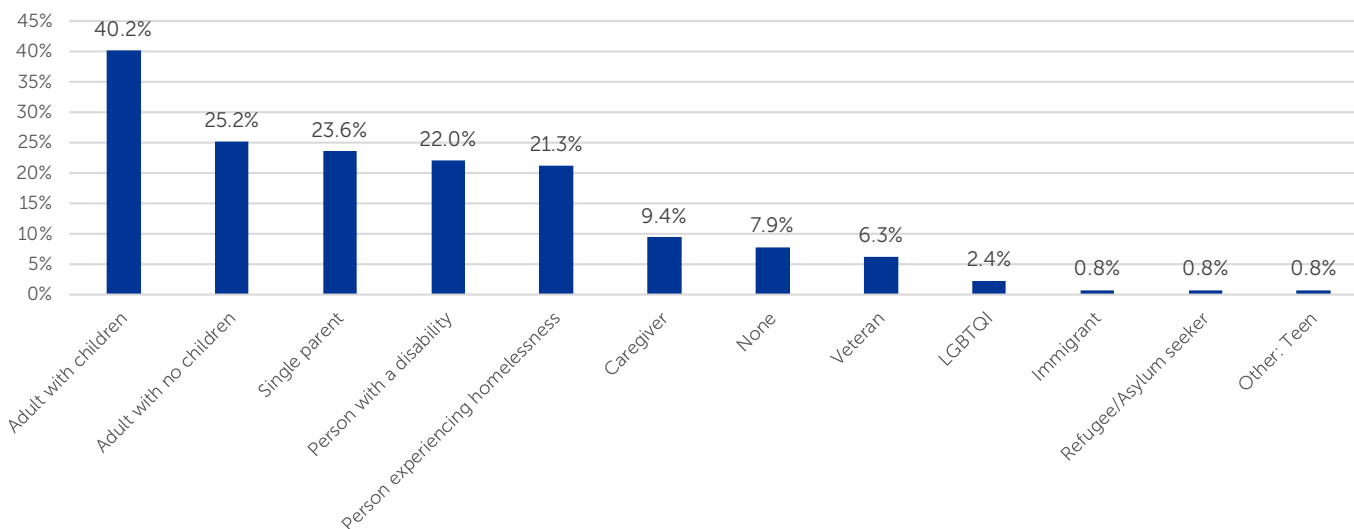


### Education

The education breakdown showed that 47.2% of participants have a diploma or GED, 25.2% of participants have less than a high school education, and 23.6% of participants had either enrolled in college or acquired an associate’s degree/college degree.

### Other Identifying Characteristics

The majority of the participants surveyed identified themselves as an adult with children equaling around 40.2%, adults with no children followed behind with 25.2%, and single parents came in third with 23.6%.



### Mental & Physical Health Ratings

The participants’ mental and physical health ratings showed that the majority of participants feel that their health is good or fair.

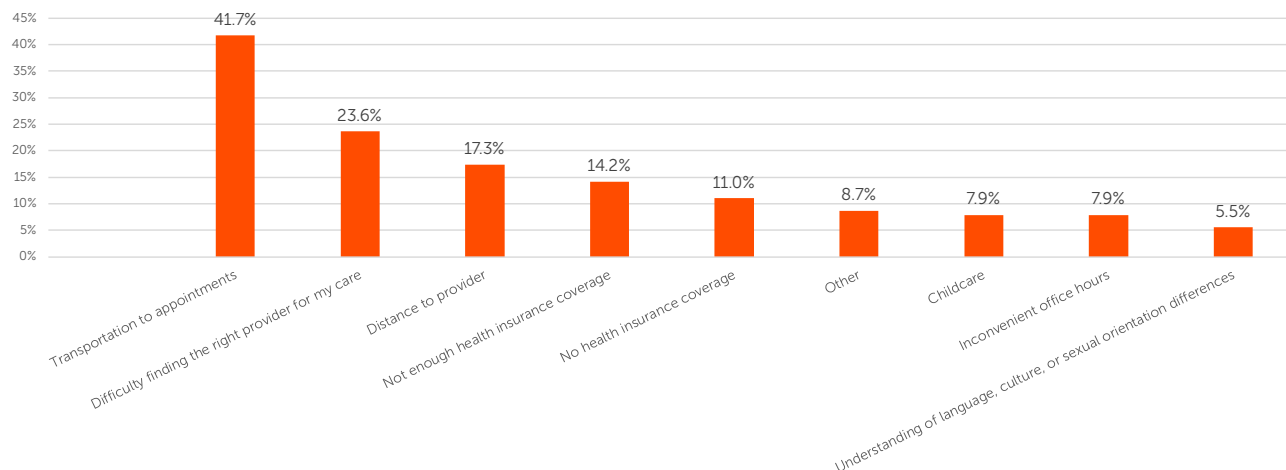
### Frequency of Services, Financial Ability & Trust

The next few questions were rated using a never, sometimes, and always system. Nearly 47% of participants felt that they can sometimes get the mental health services that they need whereas 43.4% felt that they could always acquire needed services. The next question discussed trust or the lack thereof in participants’ communities, 61.3% said that they felt people in their communities sometimes can trust one another, and 20.5% felt that people in their communities can never trust one another.

### Healthcare Access & Availability

As for healthcare, 52.8% of participants have Medicaid, 31.5% have Medicare, and 11.8% have health insurance purchased by a family member or by themselves. Forty-one percent of participants felt that transportation was their biggest barrier in accessing healthcare with a percentage. Approximately 24% stated a difficulty in finding the right provider for care option and 17.3% identified the distance to provider were barriers to access.

What are your biggest barriers to accessing healthcare in your community?





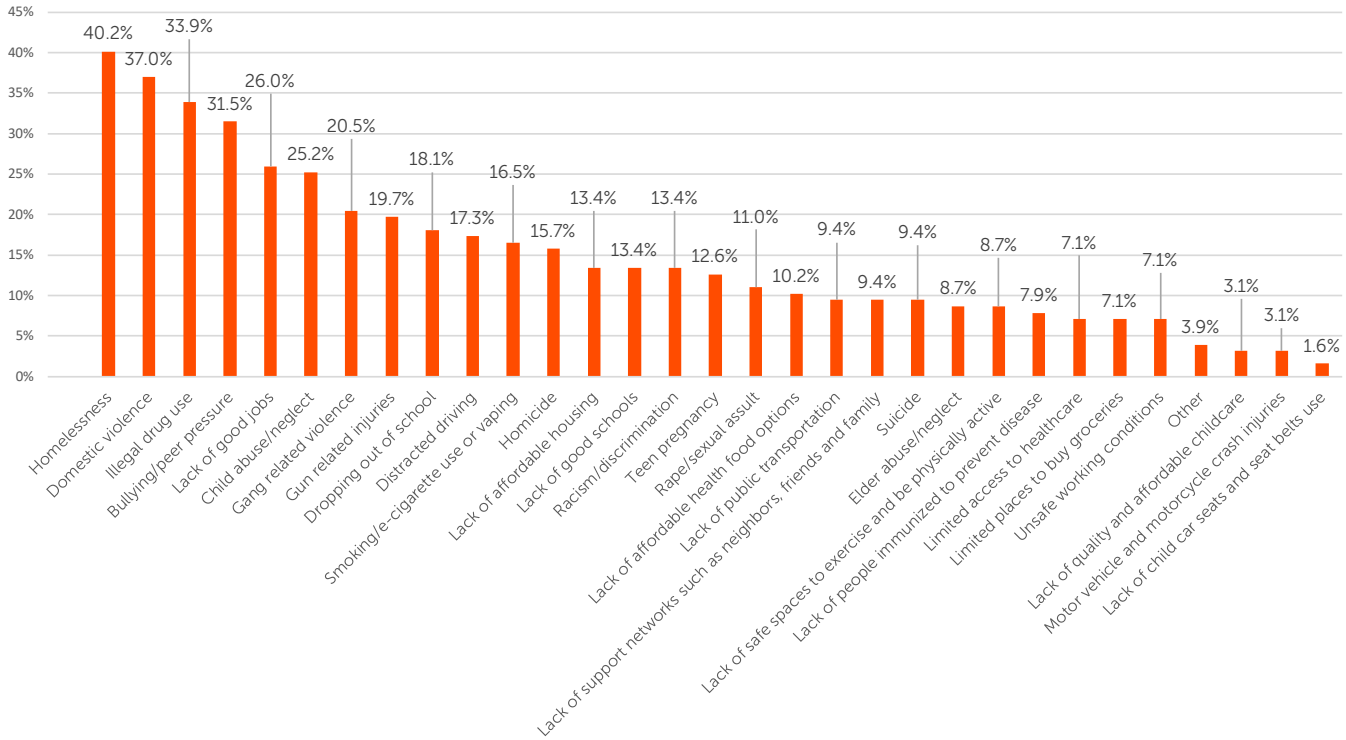
### Strengths & Weaknesses

Interestingly enough, participants also felt that access to public transportation was the greatest strength to their community with a total percentage of 44.1%. Access to parks and recreation sites as well as access to public libraries /community centers followed with 30.7%, respectively. On the other end of the strengths question, SCPH noticed the majority of people felt Summit County is not a good place to raise children; participants identified the high crime activity and lack of senior services as a weaknesses.

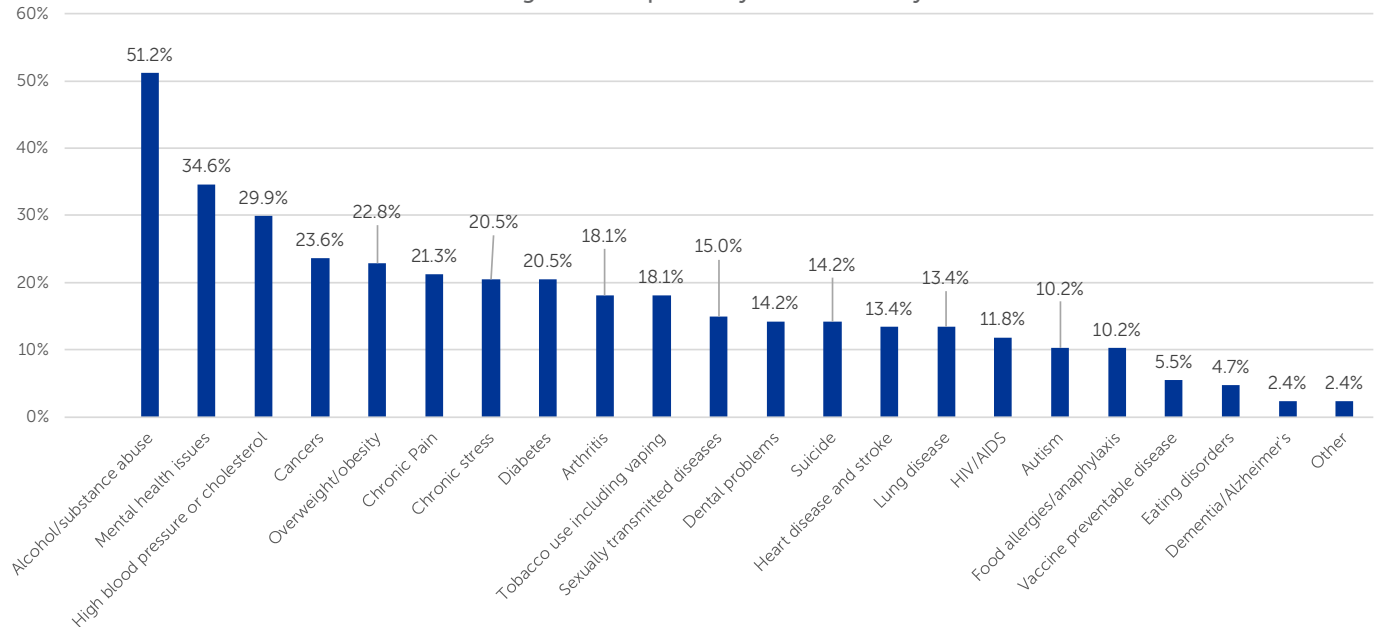
### Perceived Community Health Issues

The issues having the greatest impact on the communities' health question received interesting results. Homelessness was ranked as the greatest impact on health and wellness at 40.2%, domestic violence was next at 37.0%, and illegal drug use came in third at 33.9%.

Which issues have the greatest impact on your community's health and wellness



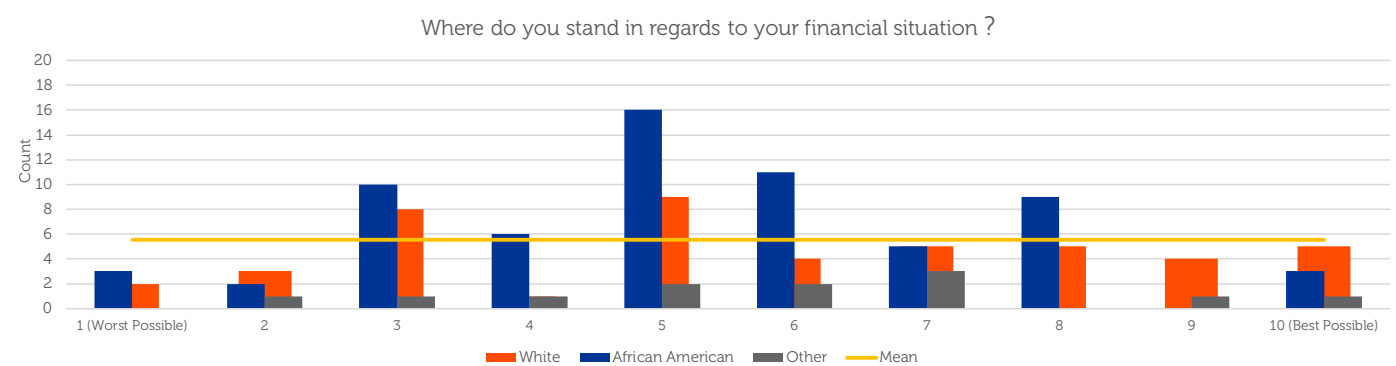
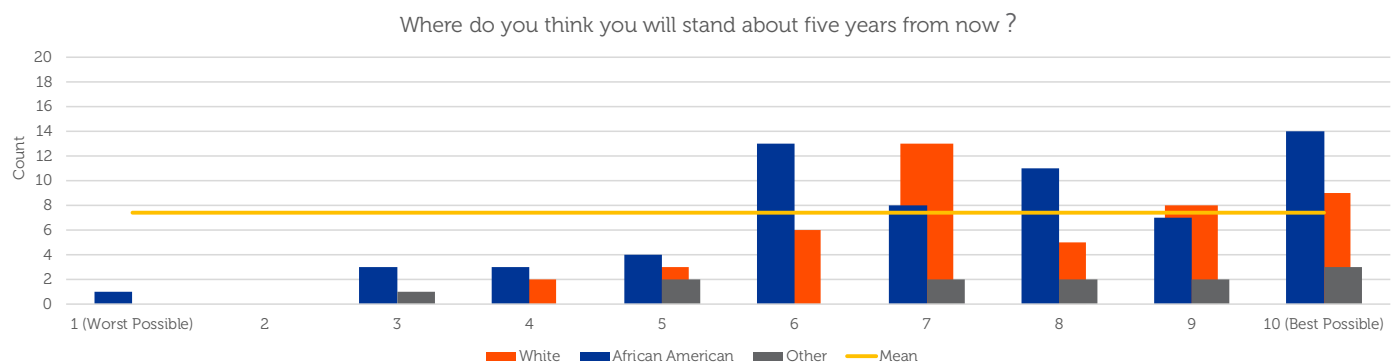
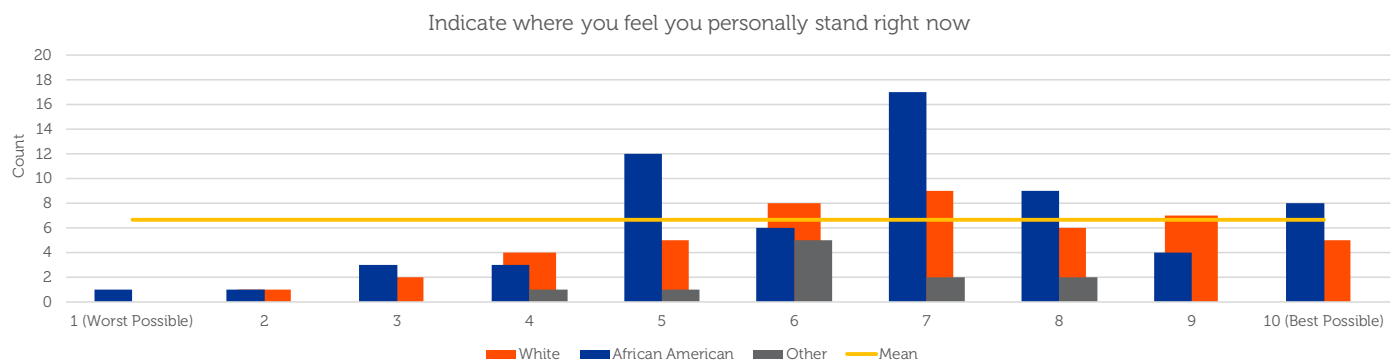
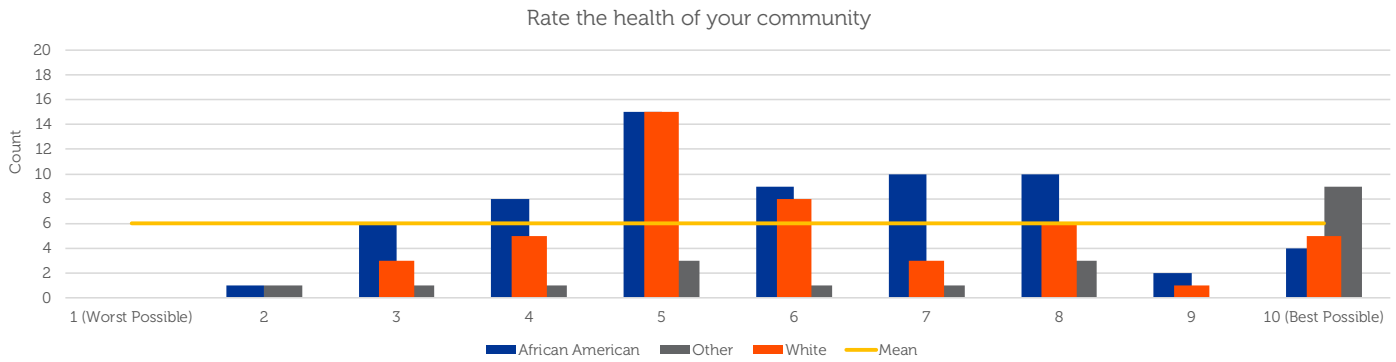
Which health conditions have the greatest impact on your community's overall health and wellness?





### Ratings of Community Health, Personal Health, Future Health, & Personal Financial Wellness

The last question asked individuals to rate their communities' health in general, their own personal standing, their future standing, and their current financial standing, each on a scale of 1 to 10 with 1 being the worst possible and 10 being the best possible. The following show the results of those questions.







## key findings

The data presented in this report paints a clear picture of the health outcomes of our community. This section outlines those key findings, as well as the factors that influence them.



# Summary Of Key Findings

Good health comes from a combination of people taking care of themselves and of many factors that are beyond an individual person's control. The data presented in this report describe many of these factors. That leads to the question, what do all of these factors have to say about the collective health of our citizens?

## HEALTH OUTCOMES OF CONCERN

Trends in several key health outcomes have emerged that are either unsatisfactory and / or moving in the wrong direction. These include:

### SUICIDE

Thanks in part to increased efforts at targeting at-risk children and teens over the past three years, the percent of middle and high school students who attempted suicide dropped from 10% in 2013 to 8% according to the 2018 Youth Risk Behavior Survey (YRBS). However, additional data from the YRBS shows that the danger to our children is far from over. In the 2018 survey, the percent of high school students saying they felt sad and hopeless for at least two weeks during the past year (i.e., depressive sadness) rose from 29% in 2013 to 34% in 2018. Efforts to help at-risk teens will need to expand if we hope to keep the rising levels of depressive sadness among our youth from progressing into future suicide attempts.

Suicide remains an adult problem as well. Nearly one-in-five adults say they have been told they had a depressive disorder at some point in their lives. Meanwhile, adult age-adjusted suicide rates in Summit County have been trending upward since 2010.

### COMMUNICABLE DISEASE

At the time of the writing of the 2016 CHNA, rates of HIV/AIDS, vaccine-preventable diseases, and the total number of communicable disease cases that must be reported to the state all rose between the base year and 2016. Chlamydia and gonorrhea infection rates both increased, as did the incidence of HIV/AIDS. Unfortunately, each of those categories have continued to increase between 2016 and 2018. Rates of Hepatitis A infections related to IV drug use have also grown significantly during the past year.

### LIFE EXPECTANCY

Finally, life expectancy has been declining. Overall life expectancy at birth in Summit County dropped from 78.3 years between 2007 and 2013 to 77.6 years from 2014 to 2018; a decrease of 1.7 years. The increase in drug overdose deaths over the past several years is the main driver of this decrease. The number of drug overdose deaths between 2007 and 2013 averaged about 64 per year, but rose to an average of 189 per year between 2014 and 2018. If the number of drug overdose deaths had remained the same between 2014 and 2018 as the average between 2007 and 2013, life expectancy at birth would have been 3.5 months higher. To put that figure into perspective, in order for heart disease (the county's #1 cause of death) to produce the same 3.5 month decline in life expectancy by itself in just five years, heart disease deaths would have to rise by 26%.

A related measure, years of potential life lost (YPLL) increased by 5% from 2008 to 2015. This indicator measures premature death; that is, the collective years of life lost by people who die before their normal life expectancy (considered to be age 75 by this indicator). By either measure, Summit County residents are not living as long as they used to, nor as long as they should be.



## CONTRIBUTING FACTORS

What factors are behind the health outcomes in our community?

### HEALTH BEHAVIORS

In the County Health Rankings model, the health habits and behaviors of individual people account for 30% of the impact on a person's health. Unfortunately, several important health behavior indicators show that health behaviors are contributing to poor health outcomes.

#### Use of tobacco and tobacco products

Though smoking is declining, and the dangers of smoking have been common knowledge for a long time, nearly one-in-five Summit County residents still smoke. Comparing youth and adult smoking rates, the rates tend to increase as age increases, from 1.9% of middle school students reporting they are current smokers, to 5.8% of high school students reporting the same, up to the 20% of adults who say they are also current smokers. Cigarette smoking among high school students has dropped significantly in the past five years, from 13.5% in 2013 to 5.8% in 2018. Despite the decline in traditional tobacco use, there has been an increase in the use of e-cigarettes and other vaping products. The number of people using e-cigarettes such as Juul, which only entered the mass market within the past decade, has been growing rapidly. According to the National Youth Tobacco Survey, "current e-cigarette use increased from 1.5% (220,000 students) in 2011 to 20.8% (3.05 million students) in 2018."<sup>1</sup> The growth in e-cigarette use has been no less explosive in Summit County.

Nearly one-quarter of Summit County adults have tried an e-cigarette at least once (22.8%) according to the 2017 Behavioral Risk Factor Surveillance Survey. The Summit County Youth Risk Behavior Survey found that nearly half of the county's high school students have tried e-cigarettes at least once (42%), while 25% have used them in the past 30 days. E-cigarette use has already penetrated far down the age scale, with 16% of the county's middle school students saying they have tried an e-cigarette at least once and 9% saying they've used e-cigarettes in the past 30 days. Nearly 3% of middle school students say they tried their first e-cigarette before age 11, while 4% of high school students say they tried their first e-cigarette before age 13.

The rapid growth in e-cigarette use may be helping to drive down rates of cigarette smoking among teens in the short-term. However, teens appear to be replacing cigarettes with a product that delivers a far higher dose of nicotine far more efficiently.<sup>1</sup> In addition, evidence is mounting that teens who use e-cigarettes in the short-term are more likely than those who don't to become cigarette smokers in the long-term.

As of this writing, little evidence exists to determine what the long-term impact of e-cigarette use will be. At the same time, there is a growing body of evidence that in the short-term e-cigarette use can cause severe lung damage as well as seizures and other neurological problems.<sup>2</sup> Other than an outbreak of a highly-contagious disease or the overdose epidemic, few public health threats have the potential to harm as many people as quickly as e-cigarettes.

#### Physical activity

One-in-four Summit County residents still report being physically inactive, despite the fact that nearly everyone has access to at least some exercise opportunities (96%). At the same time, the percent of adults who are obese rose from one-in-four in 2016 to nearly one-in-three in 2018 (30.9%). High school and middle school obesity also increased from 2013 to 2018.

#### Alcohol use

About one-in-five Summit County residents say they drink excessively. Alcohol use also happens among a significant minority of teens (more than 6% of middle school students and 24% of high school students). On a positive note, both of these figures are down significantly from 2016. Another item of good news is that the share of motor vehicle accidents caused by alcohol-impaired driving dropped from 52% of all deaths at the time of the 2016 CHNA to 44% currently.

#### Sexual behaviors

A small but meaningful minority of teens engage in risky sexual behavior, with nearly 4% having their first sexual intercourse before



age 13. More than 4% say they have either been pregnant or gotten someone else pregnant, though that figure is down from 7% just three years ago. Only about half of sexually active teens report using a condom. One positive finding is that teen pregnancies have decreased significantly. This is consistent with national trends that also show reduced teen pregnancy rates.

### Drug use

Drug use among Summit County's population has been rising, as it has throughout the U.S. Abuse of both legal and illegal drugs, especially opiates, sharply increased overdose death rates. Overdose deaths skyrocketed from 76 in 2013 to a high of 310 in 2016. While overdose deaths declined in both 2017 and 2018, deaths appear to be heading up again in 2019. Even though opiates are still at the center of the overdose epidemic, the county is currently experiencing sharp increases in overdoses related to cocaine and methamphetamine as well.

There is hope for the future, however. Self-reported drug use among both middle and high school students is down for all types of drugs surveyed according to the Summit County Youth Risk Behavior Survey. The largest drop in drug use among high school students is in the use of prescription opioids, which dropped from 16% to 6% between 2013 and 2018. This decline is possibly the most important, since many people who wind up in opiate addiction begin with prescription opioids. Marijuana use among high school students is also down, dropping from 37% to 32% in the past five years. Marijuana use dropped for middle school students as well. These improvements happened despite the fact that far fewer teens report that their parents believe marijuana use is very wrong than in 2013.

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## ACCESS TO CLINICAL HEALTH SERVICES

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Access to clinical care accounts for 20% of a person's health status according to the Wisconsin County Health Rankings model. Both access to care and the quality of that care have impacted the health of our community.

### Access to health care services

Even after the implementation of the Affordable Care Act (ACA), 9% of adults and 4% of children still do not have health insurance.

Having health insurance is only one part of the health access picture. Having access to a provider when they're needed is also important. While ratios of primary care physicians to population worsened since the 2016 CHNA, the ratio of mental health providers and dental providers to population showed meaningful improvement.

Language barriers also impact health care access. In this area, the recent influx of immigrant and particularly refugee populations from around the world has created challenges to health care access. The cost of translation services has risen quickly for many public and private service providers, creating resource problems for these agencies who have many competing needs to address.

### Preventive health screenings

At the time of the 2016 CHNA, only 59% of female Medicare patients receive mammographies. That percentage dropped further in the current assessment, and is now down to just 40%. Low rates of eligible women receiving routine mamograms means that many women with cancer will not receive a diagnosis of breast cancer until that cancer is in its later stages. With regard to other screenings, about two-thirds of adults have visited a dentist in the past 12 months (68%). Similar percentages of middle and high school students say the same.

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## SOCIAL AND ECONOMIC FACTORS

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Factors such as education, employment, and income make up the largest single share of individual health, 40% in the County Health Rankings model. Unfortunately, the recession of 2007-2009 has continued to have a huge impact on the socioeconomic landscape in Summit County a decade later, with economic hardship continuing to make itself felt in a number of key areas.

### Employment

The 2007-2009 recession was difficult for many Summit County residents, many of whom were still recovering from the 2001 recession. Unemployment rose sharply and many discouraged workers dropped out of the workforce. Signs of recovery that began late in the period before the 2016 CHNA was released have continued to improve, though slowly. The unemployment rate continued



to improve, and like many places in the nation is now at or below the “natural” unemployment rate, currently 4.6%. This time, however, low unemployment is happening side by side with a growing labor force. In other words, the local economy appears to be growing strong enough to both reduce unemployment and attract workers who have fallen out of the labor force.

Despite the improvement, labor force participation and unemployment continue to be problems for those at the lowest educational levels. Less than two thirds of working age adults with less than a high school diploma are in the labor force, while the unemployment rate for those who are in the labor force is far higher than the rate for those with a 4-year degree or more.

### Income and poverty

Estimated poverty rates are lower than reported at the time of the 2016 CHNA, though the decline is not statistically significant. Pockets of the community continue to experience poverty rates that have either not improved or have not improved enough. Although the recession ended in 2009, median household incomes didn’t begin to show any meaningful improvement until 2012. Summit County’s median household income grew by 6.4% since then. However, median household income for the nation grew by 10% during those same years, and the gap between the county’s median household income and national median household income is increasing.

### Housing

During the 2007-2009 recession, housing affordability got much worse, especially for renters. Nearly half of renters paid at least 30% of their income for housing alone, putting severe pressure on other vital household expenditures such as food, clothing, and medical care. Little has changed for renters since then, with an estimated 43% of renters still paying 30% or more in 2017; no different statistically than it was in 2014.

### Social Connectivity

The decline in the percentage of Summit County households that do not have broadband access has continued, indicating rapidly improving potential for social connectivity. The percent of households without any form of internet access has been cut almost in half between 2015 and 2018, and now stands at 13%.

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## PHYSICAL ENVIRONMENT

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Physical environmental conditions related to air and water quality, as well as housing quality and public transit usage makes up 10% of individual health in the County Health Rankings model.

### Housing condition

The improvement in the percent of housing in Summit County that is in below average or worse condition cited in the 2016 CHNA continues in this report. The two-decade difference in the average age of housing between those in older, lower income census tracts and newer, higher income census tracts reported in 2016 remains a problem.

Lead in housing is still a big potential problem as well, with nearly three-quarters of homes in Summit County being built before 1978, the last year that lead-based paint could be sold for residential purposes. Fortunately, the number of children testing positive for lead exposure per 1,000 has improved over the past seven years; an indication that mitigation, testing, and treatment programs are having an effect.

### Transportation

Like many places, Summit County is very automobile-dependent, with a vast majority of residents relying on their own vehicles to travel to and from work. Public transit usage is low, with only 2% of commuters relying on public transit. Vehicle miles travelled have continued to increase over the past several years.

### Land use

Summit County’s network of stores that sell alcohol and/or tobacco is able to reach a high percentage of the county’s population. Over 1,200 establishments (bars, restaurants and stores) are currently licensed to sell alcohol. The number of tobacco sales licenses dropped from 474 to 460 since the time of the 2016 CHNA. Together, about one-third of Summit County residents live within a quarter mile of a store that sells alcohol, tobacco, or both. The growth of e-cigarettes is also an issue, with the number of retail outlets licensed



to sell e-cigarettes rising from 11 at the time of the 2016 CHNA to 19 currently.

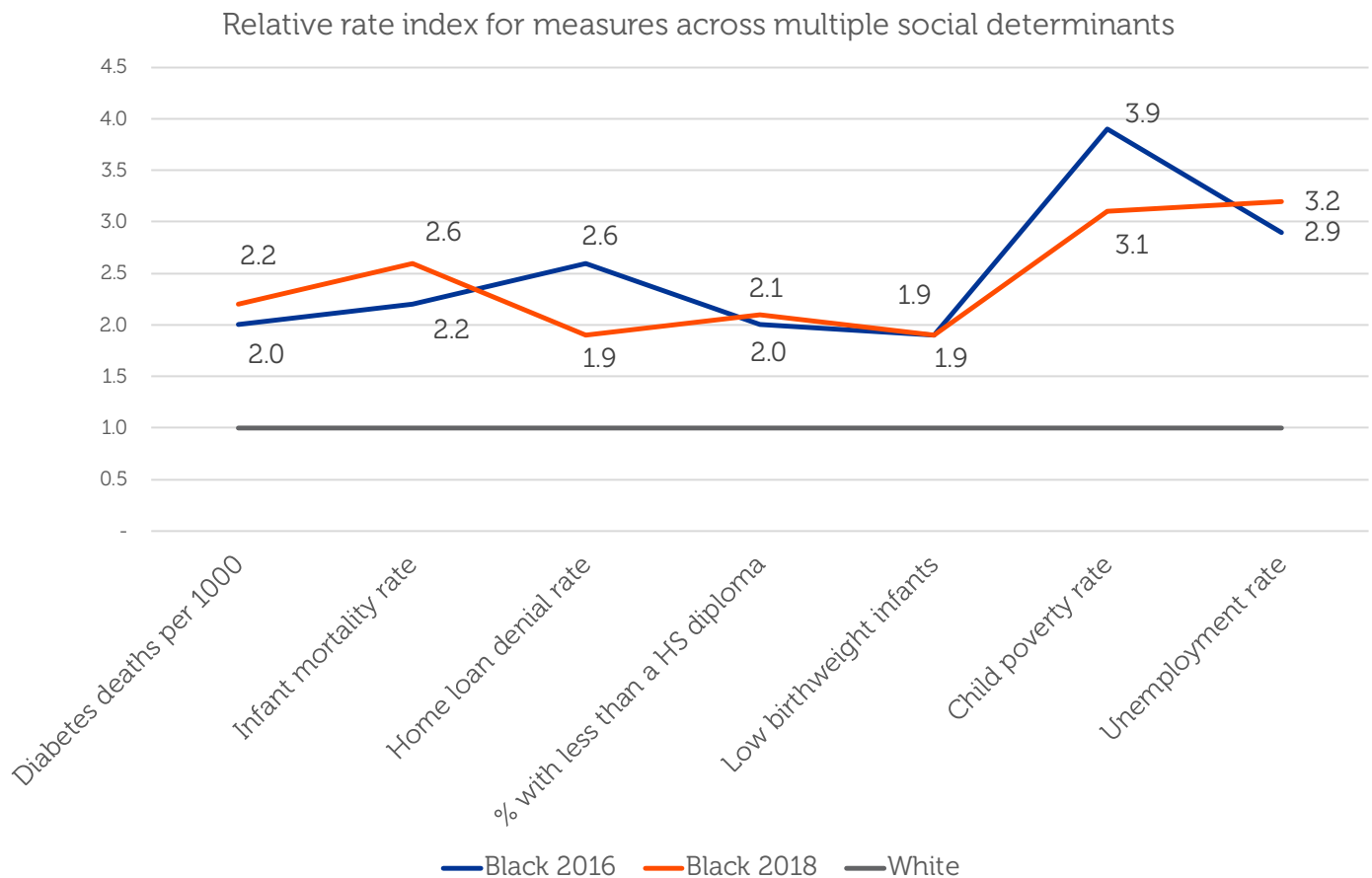
Toxic chemicals released from sources located in Summit County also have an impact on the health of county residents. Collectively, at least 600,000 pounds of toxic waste were released into Summit County’s environment in 2014. That amounted to about 1.1 pounds of toxic waste for every Summit County resident. Those figures have been dropping since then, and as of 2017 amounted to 173,000 pounds of toxic releases, or about one-third of a pound for every Summit County resident. Finally, Summit County is home to 27 officially designated Brownfield sites, down from the 40 sites reported at the time of the 2016 CHNA.

## HEALTH DISPARITIES

There is one final impact on the health of Summit County’s population to note; the impact of disparities in health between different types of people. According to Healthy People 2020, a health disparity is “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”<sup>4</sup>

When looking at the many indicators chosen to be part of this assessment, the one type of disparity that stands out above the others is racial disparity. While different types of disparity can be found in one or more subject areas, meaningful racial disparities can be found in a majority of subject areas where data is available.

For example, the following chart (adapted from the Race Equity Institute presents data from a variety of social determinants of health. The chart presents the data as a ratio of black-to-white figures for each indicator. The white figure is set to a benchmark of one, while the black figure is compared to that number. In all seven areas shown, the ratio of black-to-white is always 1.9 or higher; that is, the black rate is at least twice as bad as the white rate for all seven indicators.





The causes of racial disparities are hard to nail down precisely. A great deal of research has shown that racial differences in morbidity rates (how often people suffer from medical problems) and mortality rates (how often people die and from what causes) are caused by socioeconomic conditions. More recently, a growing body of research is beginning to show the opposite as well, that such differences cannot be explained by socioeconomic conditions alone, but that race itself is often the primary cause.

These two findings aren't necessarily as contradictory as they seem. They highlight the complex nature of how health is determined; partly by people's own behavior, partly by the environment they live in, and partly by the way they are treated by others.

Addressing racial disparities is one of the ongoing strategies of Summit County's Community Health Improvement Plan. For purposes of the Community Health Needs Assessment, it is enough to say that important health disparities by race continue to exist in Summit County, and that addressing them will require a continued focus on whether race is a cause of these disparities or a result of other factors.

1 (n.d.). How much nicotine is in JUUL? Retrieved from <https://truthinitiative.org/research-resources/emerging-tobacco-products/how-much-nicotine-juul>.

1 Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students – United States, 2011–2018, Retrieved from [https://www.cdc.gov/mmwr/volumes/67/wr/mm6745a5.htm?s\\_cid=mm6745a5\\_w](https://www.cdc.gov/mmwr/volumes/67/wr/mm6745a5.htm?s_cid=mm6745a5_w).

2 (2019, August 19). CDC, state health officials investigating link between vaping and severe lung disease. Retrieved from <https://www.cnn.com/2019/08/17/health/vaping-lung-disease-states/index.html>

3 Toxic release data in the 2019 CHA include only "core" chemicals which were released every year from 2011 to 2017. United States Environmental Protection Agency. (2019). TRI Explorer (2017 Updated Dataset (released April 2019) ) [Internet database]. Retrieved from <https://enviro.epa.gov/triexplorer/>, (September 20, 2019).

4 Healthy People 2020 (2016). Retrieved from <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>.

5 <https://www.racialequityinstitute.org/>

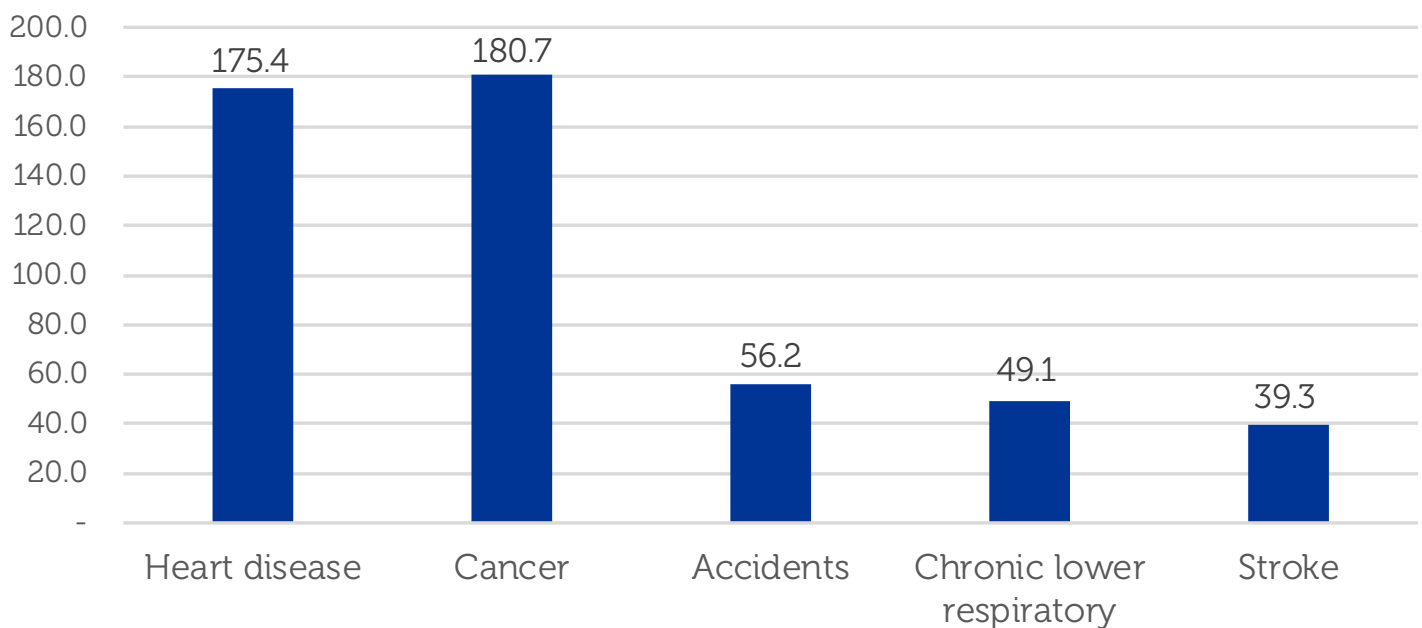


# A Closer Look

## LEADING CAUSES OF DEATH

The top five causes of death in Summit County are heart disease, cancer, chronic lower respiratory disease, accidental deaths and stroke. While heart disease is currently the most frequent cause of death, deaths by cancer are not far behind.

Age-Adjusted Death Rates (per 100,000) for Top 5 Causes of Death in Summit County, 2013 - 2017

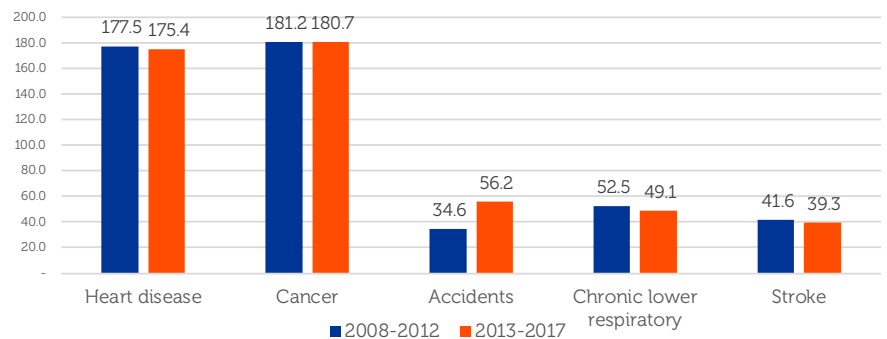






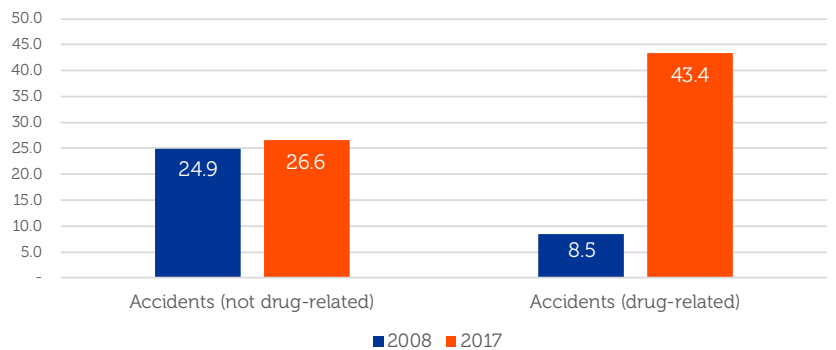
The age-adjusted heart disease death rate dropped from 177.5 per 100,000 people from 2008-2012 to 175.4 from 2013-2017. Cancer deaths improved slightly during those same years, falling from 181.2 per 100,000 people to 180.7 per 100,000 people. Summit County's age-adjusted death rates for chronic lower respiratory disease and stroke both dropped slightly between the 2008-2012 and 2013-2017 periods.

Age-Adjusted Death Rates (per 100,000) for Top 5 Causes of Death in Summit County, 2008-2012 vs. 2013-2017



The accidents category is split into two sub-categories, those accidental deaths caused by drug poisonings, and those from other causes. Accidental deaths from other causes such as motor vehicle accidents or falls have stayed fairly stable, increasing slightly from 2008 to 2017. However, accidental deaths caused by drug poisonings have risen sharply over that same period, rising by 410%.

Age-Adjusted Death Rate, Drug-related and Non Drug-related Causes, 2008 vs. 2017

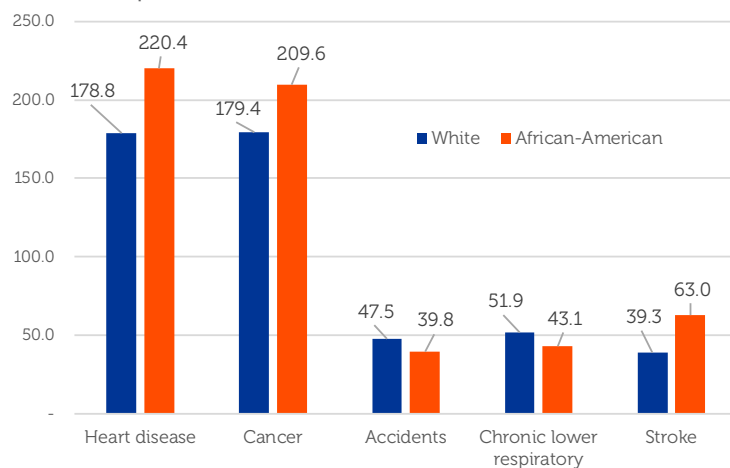


Looked at another way, between 2009 and 2013, accidental drug overdoses were the 11th ranked cause of death, while non-drug related accidents (mostly fall-related) were the 7th ranked cause. Between 2014 and 2018, non-drug related accidents dropped from 7th to 8th place, while drug-related causes of death rose from 11th place to 6th place.

### Differences in leading causes of death

While the county's two largest racial groups, Whites and African-Americans, share the same top-five causes of death, the death rates for each racial group are different for each cause; sometimes very different. Age-adjusted death rates for African-Americans are higher than for whites on three of the five most common causes of death. More importantly, age-adjusted death rates for African-Americans are higher than for Whites on the two most common causes of death, heart disease and cancer. As shown in the figure below, the rate of heart disease deaths for African-Americans over the 2013-2017 period was 220.4 per 100,000 people, while the rate for Whites was 178.8 per 100,000. For cancer deaths, the rates were 209.6 for African-Americans and 179.4 for Whites. Rates are also very different for stroke, where the death rate for Whites is 39.3 per 100,000 and 63.0 per 100,000 for African-Americans. Only accidental deaths and deaths due to chronic lower respiratory disease were higher for Whites than African-Americans.

Age-Adjusted Death Rates per 100,000 by Race, Top 5 Causes of Death White vs. African-American



The table on the following page is based on a format originally designed by the CDC. It shows the top 10 leading causes of death for each of 10 age groups for people in Summit County. Some of the more common causes of death are color-coded so that readers can follow the progression of that disease throughout the age spectrum. For example, unintentional injuries are the third leading cause of death for children and infants under five years of age. However, unintentional injuries rise to become the most common cause of death for those age five to 44 years of age. In age groups older than 44, unintentional injuries begin dropping to lower relative rankings as diseases that frequently occur later in life such as cancer and heart disease begin to impact the health of the population.

# 10 LEADING CAUSES OF DEATH BY AGE GROUP, SUMMIT COUNTY 2000-2017

RANK	Under 5 years	5 - 14 years	15 - 24 years	25 - 34 years	35 - 44 years	45 - 54 years	55 - 64 years	65 - 74 years	75 - 84 years	85 yrs & over
1	Condition originating in the perinatal period	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Cancer	Cancer	Cancer	Heart disease	Heart disease
2	Congenital Anomalies	Homicide	Suicide	Suicide	Heart disease	Heart disease	Heart disease	Heart disease	Cancer	Cancer
3	Unintentional Injury	Cancer	Homicide	Homicide	Cancer	Unintentional Injury	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Cerebrovascular diseases
4	Homicide	Heart disease	Cancer	Cancer	Suicide	Suicide	Unintentional Injury	Cerebrovascular diseases	Cerebrovascular diseases	Alzheimer's Disease
5	Influenza or Pneumonia	Suicide	Heart disease	Heart disease	Homicide	Chronic liver disease / cirrhosis	Diabetes	Diabetes	Alzheimer's Disease	Chronic Lower Respiratory Disease
6	Heart disease	Condition originating in the perinatal period	Congenital Anomalies	Diabetes	Chronic liver disease / cirrhosis	Diabetes	Cerebrovascular diseases	Kidney Diseases	Diabetes	Influenza or Pneumonia
7	Kidney diseases	Congenital Anomalies	In situ neoplasms	Cerebrovascular diseases	Diabetes	Cerebrovascular diseases	Chronic liver disease / cirrhosis	Unintentional Injury	Influenza or Pneumonia	Diabetes
8	Septicemia	Cerebrovascular diseases	Pregnancy complications	HIV	Cerebrovascular diseases	Chronic Lower Respiratory Disease	Kidney Diseases	Influenza or Pneumonia	Kidney Diseases	Unintentional Injury
9	Cerebrovascular diseases	Septicemia	Congenital Anomalies	Congenital Anomalies	HIV	Septicemia	Suicide	Septicemia	Unintentional Injury	Kidney Diseases
10	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Cerebrovascular diseases	Influenza or Pneumonia	Influenza or Pneumonia	Influenza or Pneumonia	Influenza or Pneumonia	Chronic liver disease / cirrhosis	Septicemia	Lung Inflammation

Note: Top 5 causes of death for all age groups are color-coded, as are suicide and homicide, so their impact can be followed through the life span.

<sup>1</sup> One death each in this age group was caused by Diabetes, Influenza or Pneumonia, Meningococcal Infection, and Kidney Disease

<sup>2</sup> Three deaths each in this age group were caused by Diabetes, Influenza or Pneumonia, or Kidney Disease



## ADOLESCENT HEALTH

In the years 2018/2019 the Youth Risk Behavior Survey (YRBS) was given to students in Summit County in grades ranging from 7th to 12th grade. A total of 19 middle schools and 20 high schools were surveyed equaling a total of almost 19,000 surveys completed. Approximately 65% of survey participation was from Akron and 35% from the suburbs. Participant ages ranged from 10 to 18 years of age. The majority of respondents were White (~59%) this was followed by African American (~18%), Hispanic (~6%) and Asian (~5%).

### SIGNIFICANT IMPROVEMENTS

Since 2013 Summit County adolescents have seen statistically significant improvement in a multitude of indicators. To help further discuss these indicators they will be placed into 5 categories: unintentional injuries and violence, tobacco, alcohol and drugs, gambling and sexual behaviors, and physical activity and other health issues.

#### Unintentional Injuries and Violence

Middle school students reported wearing seatbelts more often. They claimed to be electronically bullied or bullied on and off of school property less often. Additionally, middle school students had less suicide attempts in the last month. High school students reported that they carried a weapon, attempted suicide and drove after consuming alcohol less often than those students surveyed in 2013.

#### Tobacco, Alcohol and Drugs

Less middle and high school students reported having ever used alcohol. There was a decrease in the number of middle school students reporting use of marijuana and cigarettes in the last 30 days. Furthermore, middle school students saw a decrease in the initiation of the use of drugs such as heroin and prescription pain medications.

### Comparison of significant change in tobacco, alcohol and drug questions, YRBS 2013 vs. 2019

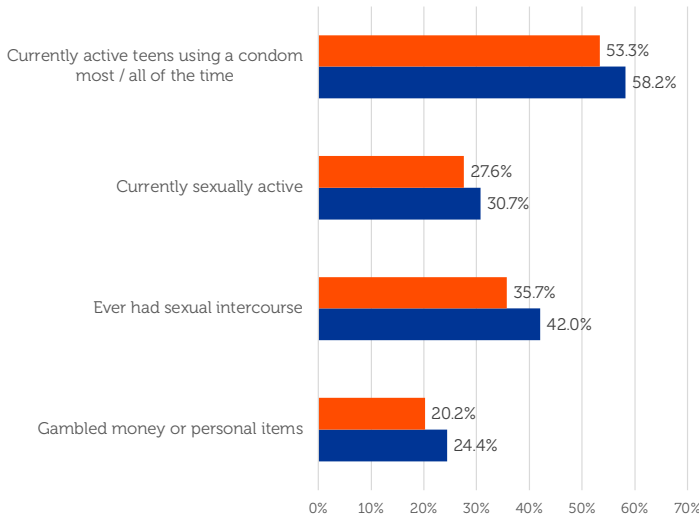
QUESTION		2013	2019
MIDDLE SCHOOL	Ever used alcohol	23.4%	15.6%
	Alcohol use before age 11	10.0%	6.3%
	Feel parents think it's very wrong to use alcohol	75.2%	68.3%
	Used cigarettes in the last 30 days	4.2%	1.9%
	Ever used e-cigarettes**	--	16.3%
	Offered, sold, given illegal drug on school property in the last 12 months	13.8%	6.4%
	Used marijuana in the last 30 days	5.2%	3.8%
	Feel parents think it's very wrong to use marijuana	89.0%	62.2%
	Ever used unprescribed prescription pain medications	6.9%	5.2%
	Ever used heroin	1.4%	0.5%
HIGH SCHOOL	Ever used alcohol	57.0%	45.7%
	Used alcohol in the past 30 days	30.3%	23.8%
	Alcohol use before age 13	16.2%	10.5%
	Ever used tobacco	24.9%	25.8%
	Ever used e-cigarettes**	--	45.3%
	Ever used marijuana	36.6%	32.2%
Parents think it's very wrong from them to use marijuana	74.3%	53.0%	



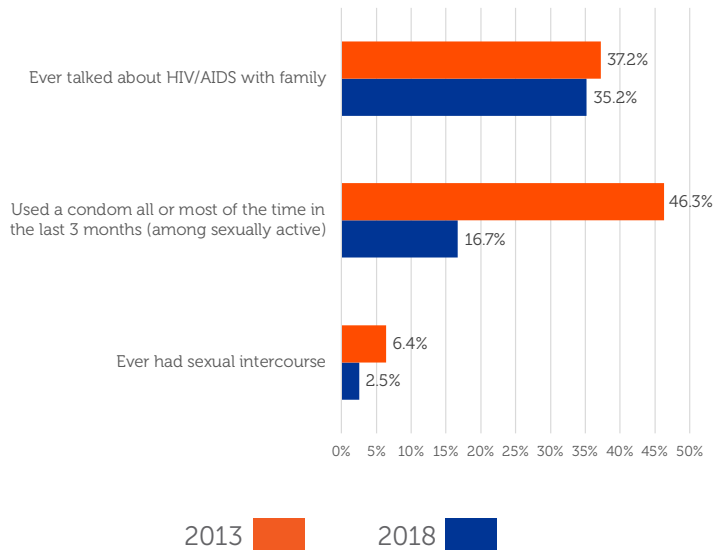
### Gambling and sexual behaviors

Among those middle school students reporting being currently sexually active there was improvement in reported condom use. Middle school students were also more likely to have ever had a discussion with their family regarding HIV/AIDS. Less high school students had ever had sex or were currently sexually active.

SIGNIFICANT CHANGES IN GAMBLING AND SEXUAL BEHAVIOR QUESTIONS FOR MIDDLE SCHOOL STUDENTS, YRBS 2013 VS. 2019



SIGNIFICANT CHANGES IN SEXUAL BEHAVIOR QUESTIONS FOR MIDDLE SCHOOL STUDENTS, YRBS 2013 VS. 2019



### SIGNIFICANT DECLINES & OTHER ISSUES

Since 2013 Summit County adolescents have seen statistically significant declines in several key indicators as well.

#### E-cigarettes (vaping)

The explosive growth of e-cigarettes may be the most serious public health threat the nation has faced since the beginning of the overdose crisis. According to the U.S. Surgeon General, e-cigarette use nationwide grew by 900% between 2011 and 2015. In Summit County, the question of e-cigarette use wasn't even included in the 2013 Youth Risk Behavior Survey, though it was added to the 2018 survey. In 2018, 16% of middle school students and 42% of high school students had tried e-cigarettes at least once. Nearly 9% of middle school and 25% of high school students say they used an e-cigarette in the past 30 days. More troubling is how early in life some students begin vaping. Nearly 3% of middle school students say they began before age 11, while 4% of high school students say they began before age 13. To put the use of e-cigarettes in perspective, in the 2018 YRBS just 2% of middle school students and 26% of high school students say they have ever smoked a traditional cigarette; far below the percentages of teens who have ever vaped.

#### Obesity, diet, and physical activity

Obesity rates for both middle and high school students rose from 2013 to 2018. For middle school students, obesity rose from 12% to 15%, while high school students saw obesity rise from 13% to 16%. High school students were more likely to describe themselves as overweight in 2018 than in 2013 (31% and 33%, respectively). Middle school students saw a more modest increase (from 29% to 30%), but that change was not statistically significant.

Just over one-third of middle school and about one-fourth of high school students eat breakfast every day. Since eating breakfast daily is thought to reduce the risk for obesity and insulin resistance syndrome, low rates of youth eating breakfast daily are cause for concern. In Summit County at least, few middle and high school students eat breakfast daily, and the figures for both groups grew worse between 2013 and 2018. At the same time, both middle and high school students saw increases in the percentage of students who ate fast food at least once in the week before the survey. Among middle school students, the percentage who ate fast food at least once rose from 67% in 2013 to 71% in 2018. Among high school students, the percentage who ate fast food at least once rose from 70% in 2013 to 75% in 2018.



The percent of middle school students who met the recommended level of physical activity dropped from 48% in 2013 to 44% in 2018. The rate for high school students remained about the same at 42%. A related issue is the percentage of teens who either watch television or use computers or video games at least three hours daily. As mentioned in the improvement section above, the percent watching 3 hours or more of television per day went down for both middle and high school students. Unfortunately, it appears that the use of computers and video games is taking the place of television watching for teens. Both middle and high school students saw big increases in the percent using computers or playing games at least 3 hours per day. In 2013, 41% of middle school and 40% of high school students spent at least 3 hours per day on such devices. By 2018, those figures rose to just under 50% for each group.

### The LGBTQ experience

One troubling set of findings from the 2018 YRBS was the self-reported experiences of LGBTQ high school students (sexual orientation was not asked of middle school youth). In the 2018 YRBS, LGBTQ youth were significantly more likely than heterosexual youth to say they:

- ***Felt unsafe at, going to, or coming home from school in the past 30 days***
- ***Were physically hurt (on purpose) by someone they were dating***
- ***Were forced to do sexual things that they didn't want to do***
- ***Were bullied in school, away from school, and electronically***
- ***Purposely hurt themselves***
- ***Felt so sad that they stopped normal activities***
- ***Seriously considered suicide***
- ***Attempted suicide***

All told, LGBTQ youth were at least 2-3 times more likely than heterosexual youth to have experienced violence, self-harm, depressive sadness, or suicide-related behavior. LGBTQ youth were also more likely than heterosexual youth to say they have used cigarettes, e-cigarettes, alcohol, marijuana, or a hard drug such as heroin, methamphetamine, or cocaine at least once.

An even more troubling finding is that those who have been forced to do something sexual are more likely to have experienced violence, self-harm, depressive sadness, or suicide-related behavior, whatever their sexual orientation. Overall, just under 14% of all high school students say they have been forced to do something sexual. However, LGBTQ high school students were 3 times more likely than heterosexual students to say they were ever forced to do something sexual (30.3% and 10.9%, respectively).

Heterosexual youth who have ever been forced to have sex are three times as likely as heterosexual youth who haven't to say they feel unsafe, suffer from violence, suffer bullying, and have poorer outcomes on self-harm, depressive sadness, and suicide-related questions. LGBTQ youth who have ever been forced to have sex are two times as likely as other LGBTQ youth to suffer from violence, suffer bullying, and have poorer outcomes on self-harm, depressive sadness, and suicide-related questions. However, LGBTQ youth who have been forced to have sex have the most worrying outcomes on these questions of any demographic group in the survey. For example, 10% of heterosexual youth without a forced sexual experience say they seriously considered suicide in the past 12 months. That figure rises to 36% for heterosexual youth with a forced sexual experience. Just over 33% of LGBTQ youth without a forced sexual experience say they seriously considered suicide in the past 12 months; a figure that rises to 62% for LGBTQ youth who have ever had a forced sexual experience.

The same situation exists with substance use and sexual activity. Any youth who ever had a forced sexual experience is significantly more likely to use marijuana and other drugs, and also more likely to have ever had sexual intercourse and to be currently sexually active than those who didn't. As with the violence-related questions, rates of substance use and sexual activity are higher among LGBTQ youth with a forced sexual experience than heterosexual youth with a forced sexual experience.

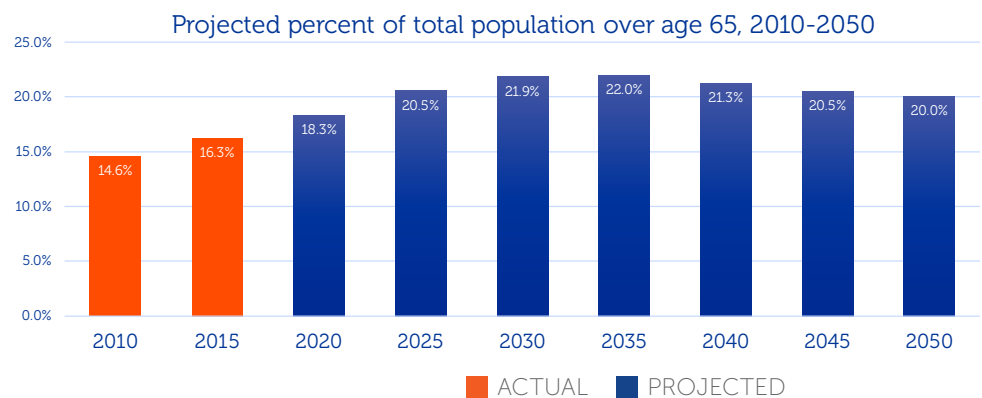
One last finding related to forced sexual experiences is the gender of the victims. Nearly 80% of heterosexual teens and 85% of LGBTQ teens who have ever been forced to do something sexual were female. Only one-in-five heterosexual and one-in-seven LGBTQ victims of a forced sexual experience were male. Just under 44% of heterosexuals who were never forced to do something sexual were female, while 65% of LGBTQ teens who were never forced to do something sexual were female.

<sup>1</sup> Surgeon General's Advisory on E-cigarette Use Among Youth; Centers for Disease Control and Prevention; [https://www.cdc.gov/tobacco/basic\\_information/e-cigarettes/surgeon-general-advisory/index.html](https://www.cdc.gov/tobacco/basic_information/e-cigarettes/surgeon-general-advisory/index.html)



## AGING POPULATION

Summit County is home to about 97,000 people age 65 or older (as of 2018), or nearly 18% of Summit County’s population. The percentage of seniors is expected to rise sharply in the coming years because of the aging of the Baby Boom generation. In fact, according to the Ohio Development Services Agency, Summit County’s senior population will peak in 2035. By that year, more than one out of every five people will be age 65 or older; nearly 116,000 people in all.



### WHO ARE THE SENIORS IN SUMMIT COUNTY?

The 2013-2017 American Community Survey (ACS) offers many statistics on seniors in Summit County. Below is a brief overview of some of those facts and figures:

#### Age, sex and race

The median age of seniors in Summit County is 73.4 years. Most seniors are female (57%), which is higher than the total population figure of 51%. A higher percentage of seniors are white (88%); above the total population figure of 79%. Only 10% of seniors are African-American; a lower figure than African-Americans in the total population (15%). Asians make up about 1.4% of the 65 and older population, which is about half the proportion of Asians in the total population (3%).

#### Disability

Nearly one-third of seniors (32%) have at least one disability. Of those with a disability, 38% have an ambulatory disability (difficulty walking), while 29% have a cognitive disability, and 26% have a disability that makes independent living difficult or impossible. Other disabilities include self-care (13% of all seniors), hearing (12%), and vision (11%).

#### Housing and households

About half of seniors (51%) live in a household with at least one spouse or family member, while nearly half (47%) live in a one-person household. A higher percentage of seniors live in owner-occupied housing than the general population (78% and 66%, respectively). Nearly 22% of seniors rent their home.

#### Income and poverty

The median household income for all seniors is just under \$58,000 per year; higher than the figure for all households (\$53,000). Nearly all seniors in Summit County receive Social Security income (89%), while 58% receive other forms of retirement income. Social Security benefits averaged \$19,700 per year, while other retirement sources averaged \$24,000. One-third of seniors receive earned income (36%), while nearly 9% receive benefits from the SNAP program. Nearly 7% of seniors live below the poverty line; half as high as the county-wide poverty rate (14%).

#### Employment

Nearly 8% of Summit County seniors worked full-time in the past 12 months, while nearly 13% worked part-time. Almost 80% did not work at all. Younger seniors (ages 65-69) worked the most, with 17% working full-time and another 21%, working part-time. Only 3% of those age 70 and older worked full-time while 9% worked part-time.

#### Mortgage burden

Half of the homes occupied by seniors age 65 to 74, and a quarter of homes occupied by those age 75 or older carry a mortgage. According to the ACS, the median monthly cost for senior homeowners with a mortgage is \$1,061. Median monthly owner costs for



seniors without a mortgage is \$458. One-fifth of seniors who own their homes (19%) pay at least 30% of their income for mortgages and other housing costs, leaving these seniors with an excessive housing burden.

### Renter burden

Seniors who rent face a more serious housing cost burden. A total of 58% of seniors who rent spend at least 30% of their income on rent. According to the National Low Income Housing Coalition, Ohio’s fair market rent is \$793 per month. ACS data show that the median gross rent for retired seniors, many of whom have much lower incomes than when they were working, is only slightly lower (\$755).

### Grandparents raising grandchildren

Here in Summit County, an estimated 8,759 grandparents live in the same household as their grandchildren. Just over 4,000 of those grandparents were responsible for raising their grandchildren.

## WHAT PROBLEMS DO SENIORS IN OUR COMMUNITY FACE?

Seniors in Summit County face some unique challenges, which we discuss below:

### Fall-related injuries

Between 2014 and 2018, Summit County seniors had just over 30,000 emergency room (ER) visits for a fall-related injury; an average of 5,900 per year. Fall-related ER visits rose from just under 48 per 1,000 seniors in 2014 to 82.4 per 1,000 in 2018, or from 4,200 visits to 7,900.

Of those 30,000 visits, records for 1,900 visits included specific mentions of a head injury associated with the ER visit. Forty of the records included specific mentions of traumatic brain injury. A total of 3,610 records, about 13% of the total, visited an ER more than once for a fall-related injury.

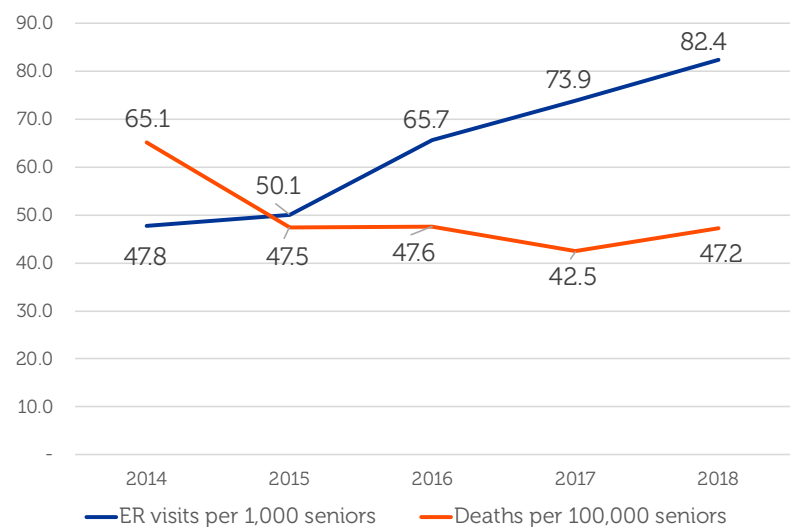
### Fall-related deaths

Between 2014 and 2018, 229 Summit County seniors suffered a fall-related death. While fall-related injuries have been steadily rising over the past 5 years, fall-related deaths have moved in the opposite direction. Fall-related deaths dropped from nearly 71 per 100,000 in 2014 (62 deaths) to 51.4 in 2018 (49 deaths); a 28% decline.

### Alzheimer’s disease and dementia

Between 2014 and 2018, there were 2,631 Summit County residents who died of either Alzheimer’s Disease or dementia. The causes of death were evenly split between Alzheimer’s Disease and dementia (50% of cases each). The vast majority of cases, nearly 70%, occurred in the 85 and older population. The youngest victim of either disease was just over age 50, while the oldest was just over 106.

Rates of fall-related ER visit and deaths, 2014-2018



## WHAT IS THE LIFE EXPECTANCY OF SENIORS?

The answer to this question depends on how old that person is to begin with. For example, people born in Summit County between 2008 and 2017 can expect to live to age 80 if they are female and age 74 if they are male. Summit County residents who were 65 years old during those years could expect an estimated 19.3 additional years of life; nearly identical to the overall figure for the nation of

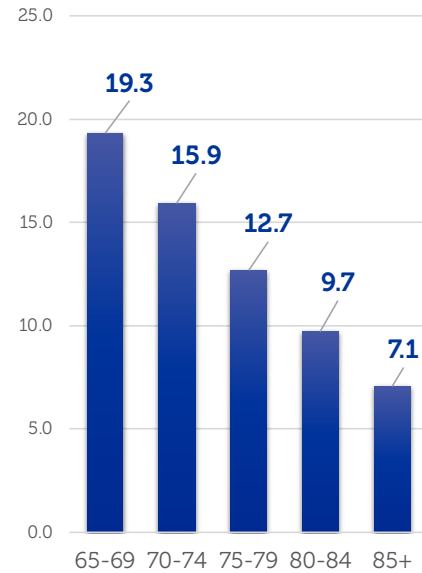


19.4 years. As expected, overall estimated life expectancy declines with age, from an additional 19.3 years of life between ages 65-69 to an additional 7.1 years of life at age 85.

Unfortunately, not everyone can expect to do as well as these overall life expectancy figures because people's health varies greatly based on their race, ethnicity, or income level. In other words, how long you live depends a great deal on who you are and where you live. For example, we took a look at life expectancy for different areas of Summit County (called clusters). The Richfield / Boston cluster has the highest estimated life expectancy at age 65 at 22.5 years, closely followed by Akron Northwest, Copley / Bath / Fairlawn, Hudson, and Twinsburg, all of which have estimated life expectancies at age 65 at of 21 years or above. On the opposite end, the Akron Central cluster has the lowest estimated life expectancy at 15.6 years. Most other Akron clusters (Southwest, North, Southeast, and West), as well as the Barberton cluster, have life expectancies at age 65 of less than 18 years.

When looking at race and gender, 65-year-old white females can expect to live another 20 years, while black females can expect to live an additional 18.8 years. White males can expect an additional 17.2 years age age 65, while black males can expect an additional 15.2 years.

Additional expected years by age







## CHRONIC DISEASE

Chronic diseases such as diabetes, high blood pressure, high cholesterol, or chronic obstructive pulmonary disease (COPD) pose serious risks to the health of Summit County’s population. These diseases directly contribute to our most common causes of death such as heart disease, stroke, and cancer. These diseases are, in turn, heavily influenced by our lifestyle choices, the widespread availability of unhealthy food, and the difficulty lower income people face in accessing and affording healthy food options.

While all of these factors need to be addressed, issues with the availability and affordability of food take a long time to change and a long time to show positive impact. The sections below focus on those health behaviors that can directly improve or harm individual health in the short-term:

### Tobacco use

Tobacco use leads to a number of chronic diseases including asthma, chronic lower respiratory disease, heart disease, cancer, and diabetes. Stopping tobacco use is one of the most effective ways to improve individual health for those who use it. Smoking rates among adults in Summit County have remained unchanged in recent years, remaining at about one-in-five smokers. Smoking among teens has dropped sharply since the time of the 2016 CHNA, which is an improvement on one level. However, as will be discussed in more detail later, teens are replacing traditional cigarette smoking with e-cigarette use, which carries with it a stronger dose of nicotine as well as potentially fatal short-term risks. The long-term risks of e-cigarettes are currently unknown.

### Physical inactivity

Regular, moderate-intensity exercise is another activity that improve health immediately; according to CDC recommendations, all it takes is 22 minutes of exercise per day. Staying active helps reduce the risk of all the chronic diseases mentioned earlier. Unfortunately, only about one-quarter of Summit County adults exercise regularly; a figure that hasn’t changed since the release of the 2016 CHNA.

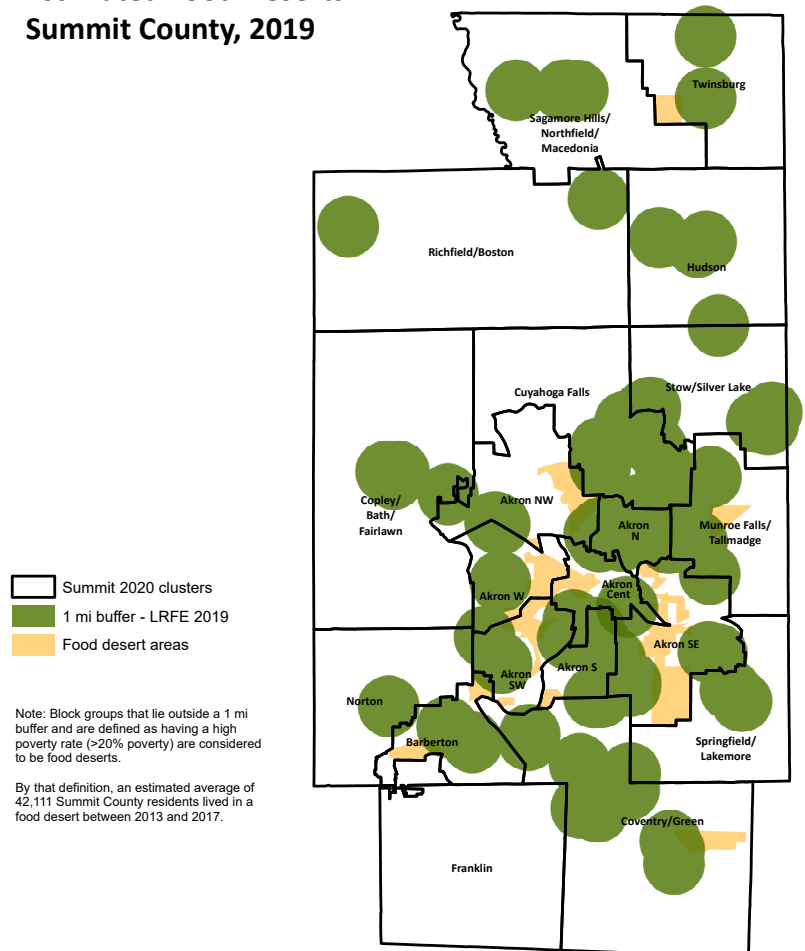
### Access to adequate food

Poor nutrition is a major risk factor not only for diabetes but also for many other chronic diseases. Food deserts consists of areas were fresh vegetables, fruits and other healthy foods are sparse due to lack of farmer’s markets, grocery stores and other establishments that sell healthy foods near the places people live. The percent of Summit County residents living in a food desert fell from about 12% at the time of the 20116 CHNA to just under 9% in 2018.

### Obesity

Obesity is defined as having a body mass index or BMI of greater than or equal to 30.0 kg/m2. It is a risk factor leads to many other chronic diseases such as type II diabetes, cardiovascular disease, asthma and many other diseases. When the 2016 CHNA was released, one-fourth of Summit County adults were obese according to the 2015 Behavioral Risk Factor Surveillance Survey. In 2018, that number rose to nearly one-third (30%). Teen obesity also rose significantly, with middle school obesity rising from 12% to 15% and high school obesity rising from 13% to 16% between 2013 and 2018.

**Estimated Food Deserts in Summit County, 2019**





## COMMUNICABLE DISEASE

The number of reportable infectious diseases has increased steadily since the beginning of the decade. From 2015 to 2018, the rate of reported disease increased by nearly 35%: from 965 cases per 100,000 to 1,302 cases per 100,000 residents. This increase is the result of multiple factors, including but not limited to: changes in health behaviors, improved disease screening practices, innovations in medical testing, local and statewide disease outbreaks, and yearly fluctuations in influenza season severity.

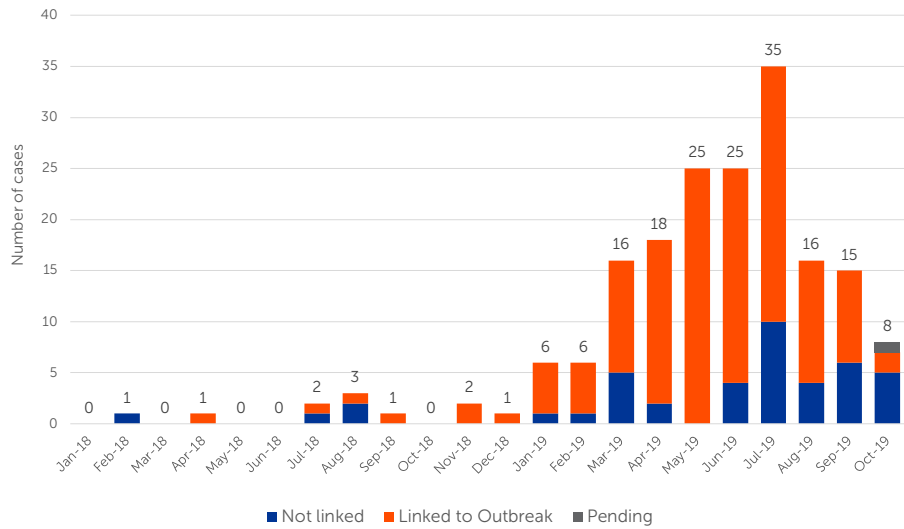
### Hepatitis

Hepatitis is a viral infection that primarily attacks the liver. Hepatitis A, B and C are the types that are the most common in Summit County.

#### Hepatitis A Outbreak

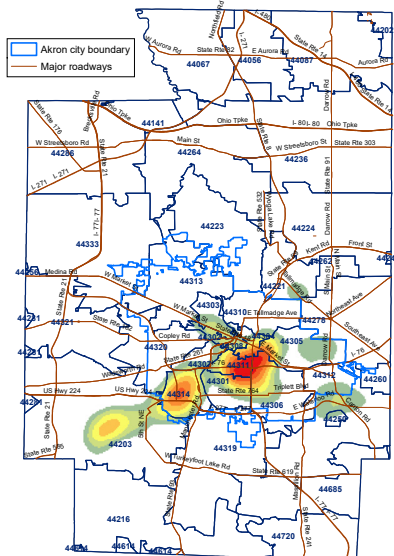
Hepatitis A is transmitted via the fecal-oral route and is therefore considered to be an enteric illness. People with hepatitis A will experience an acute infection, but will then clear the virus and have immunity. The hepatitis A virus is highly contagious and can survive on surface outside the body for weeks. Since 2016, at least 30 states have experienced community hepatitis A outbreaks, and Ohio declared an outbreak in January, 2018. Those most at risk are people with direct contact with others infected with hepatitis A, people who use street drugs, people who are incarcerated, the homeless population, men who have sex with other men, and people who traveled to other areas with ongoing hepatitis A outbreaks. A significant portion of the hepatitis A cases are also co-infected with hepatitis B, hepatitis C, or both (46% in Summit County).

Hepatitis A cases in Summit County 2018 to 2019 YTD (as of 10/31/2019)



DATA SOURCE: OHIO DISEASE REPORTING SYSTEM

Heat map of hepatitis A cases in Summit County, 1/1/2018 - 10/31/2019



DATA SOURCE: OHIO DISEASE REPORTING SYSTEM

Northeast Ohio was not impacted by this outbreak until early 2019. In an average year, Summit County will have 5-7 hepatitis A cases reported; as of October 31, 2019, 171 hepatitis A cases have been reported. Although cases have been reported throughout Summit County, density heat mapping indicates that the areas most impacted in Summit County are the Akron neighborhoods of Middlebury, South Akron, University of Akron, Kenmore, Ellet, and the city of Barberton. An effective vaccine is available to prevent hepatitis A infection, and the Communicable Disease Unit at SCPH has organized vaccination clinics for at-risk individuals throughout the outbreak.

#### Hepatitis B and C

The hepatitis B and C viruses are considered to be blood-borne pathogens, and are transmitted spread through direct contact with infected body fluids. Sexual contact is the most common mode of transmission, but the disease is also spread through childbirth, sharing living quarters, and/or sharing of drug paraphernalia. Most adults infected with hepatitis B will clear the virus, but 5-10% will become chronically infected. The risk for chronic infection is much higher in exposed infants and children aged 1 to 5. As with hepatitis A, an effective vaccine is available for hepatitis B. Antiviral medication is available to reduce the viral load of chronic hepatitis B cases, but a cure is not available.

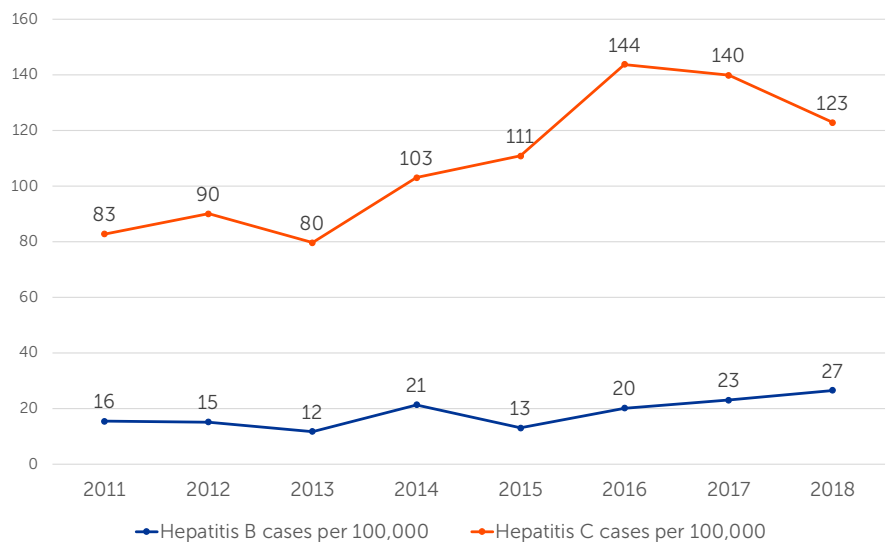


Hepatitis C is commonly transmitted through contact with infected blood or blood products, especially through medical exposures or sharing of needles during intravenous drug use. An estimated 70-85% of hepatitis C infections will become chronic. A vaccine for hepatitis C is not yet available, but there are medications that can provide a cure for the infection. Many individuals with chronic hepatitis B or C infections are asymptomatic and may be unaware that they have the disease, but the infections can still attack the liver. Chronic hepatitis infections can cause liver cancer, cirrhosis, liver failure, and death.

In Summit County, hepatitis B infection rates remained relatively stable from 2011 to 2016, but an increasing trend has been observed in 2017 and 2018. Hepatitis C rates increased from 2013 to 2016, but the rates have moderately decreased in 2017 and 2018.

This downward trend coincides with the introduction of the needle exchange program at SCPH, which began in May of 2016. The needle exchange program has also provided SCPH with an opportunity to reach out to the population for other health intervention, such as offering hepatitis A and B vaccine during the hepatitis A outbreak.

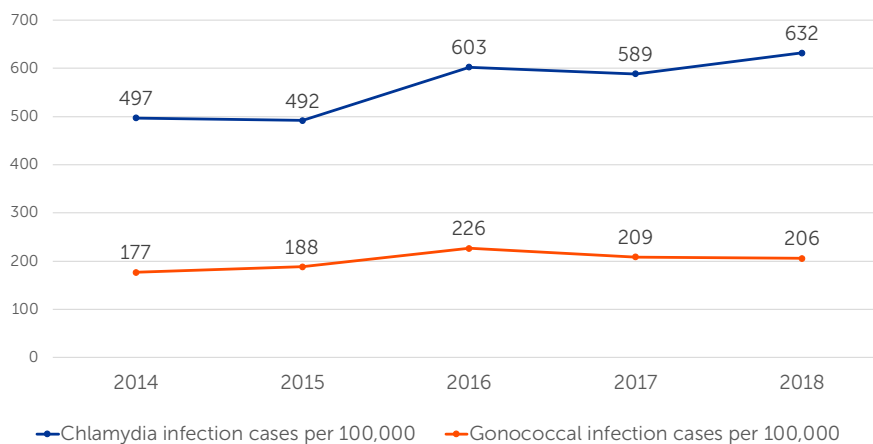
Incidence rates of hepatitis B and hepatitis C in Summit County, 2011-2018



### Sexually Transmitted Infections (STI's)

Chlamydia and gonococcal infection are the most common STI's in Summit County. Untreated chlamydia and gonococcal infections can lead to pelvic inflammatory disease (PID) and infertility. In pregnant women, chlamydia can also cause premature birth and complications in the newborn. In addition, an untreated gonococcal infection can spread to the bloodstream and develop into disseminated gonococcal infection (DGI), which has systemic impacts and can be life threatening.

Incidence rates of chlamydia and gonococcal infections in Summit County, 2011-2018



DATA SOURCE: OHIO DISEASE REPORTING SYSTEM

Rates of sexually transmitted infections have increased throughout the United States, including Summit County. As seen in Figure 4, the rate of chlamydia infections increased by 27.2% from 2014 to 2018, which is higher than the increases observed in Ohio (16.0%) and nationally (22.0%) during the same time period. Gonococcal infection rates also increased by 16.3% from 2014 to 2018 in Summit County, but the rate increases in Ohio and the United State were approximately four times higher during the same time span (56.4% and 66.7%, respectively). The CDC attributes these rate increases to "multiple factors, including drug use, socioeconomic status, decreased condom use, reduced access to health care service, and cuts to STD programs on the state and local level."



## HOUSING

Few things impact the public’s health as powerfully as the condition of a community’s housing stock. According to Healthy People 2020, a lack of housing maintenance can “...harm health by increasing exposure to hazards such as carbon monoxide, allergens, and lead in paint, pipes, and faucets. Carbon monoxide has been shown to cause heart damage, neurological impairment, and death. Likewise, even low levels of lead exposure can have serious effects on children’s health and behavior.”<sup>1</sup>

Like most long-established communities around the nation, Summit County has its share of housing-related issues. Below, we take a brief look at both the condition of the county’s housing and some of the housing-related issues faced by those living in them.

### Age

The median age of Summit County’s housing stock is 63 years, with an average year of construction of 1956, Akron’s housing stock is much older than housing in the suburbs (with a median of 87 years of age in Akron vs. 55 years in the suburbs). Nearly a third of the county’s housing stock was built before 1940; more than three quarters were built before 1978. This last figure is important because the sale of lead-based paint was still legal until 1978.

Many homes built before that date still contain this dangerous substance.

### Condition / Desirability / Utility

Most of Summit County’s housing stock is rated as average by the Summit County Fiscal Office (71%). One in five units (22%) are rated as good, very good, or excellent. A final 6% of housing units are rated as fair, poor, or very poor. Just under 9,900 of the county’s 160,000 residential housing parcels fall into this category. According to the American Community Survey (ACS), a small but meaningful number of occupied housing units also lacks one or more basic facilities that the vast majority of people take for granted. These homes lack either complete kitchen facilities, plumbing facilities, or telephone service; sometimes all three.

BASIC FACILITIES	OCCUPIED HOMES
<i>Lacking complete kitchen facilities</i>	<b>2,278</b>
<i>Lack complete plumbing facilities</i>	<b>589</b>
<i>Lack telephone service</i>	<b>22,738</b>
<i>Lack heating equipment or use no fuel</i>	<b>628</b>

### Appraised value

According to the Summit County Fiscal Office, the median appraised value of the county’s housing units is \$107,850. One-third of housing units are valued at \$75,000 or less, while 12% are valued at \$250,000 or more.

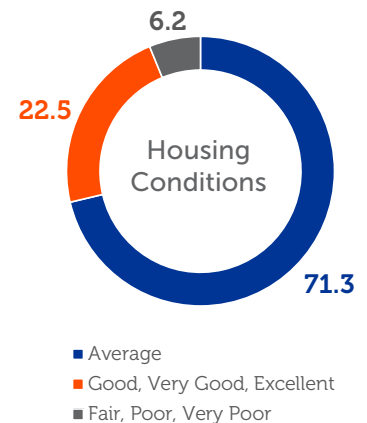
### Occupancy and Tenure

Just over 90% of housing units in Summit County are occupied, while 9% are vacant (about 21,000 units). Of the county’s 223,000 occupied housing units, two-thirds are owner-occupied, while the rest are renter-occupied.

### Housing burden (owners and renters)

The median cost of a home for homeowners with a mortgage is \$1,235 per month; more than 2.5 times the monthly cost for homeowners without a mortgage. According to the 2017 ACS, nearly a quarter of Summit County homeowners with a mortgage are paying 30% or more of their income for their home; a figure which falls to just 12% for those without a mortgage. The 30% figure is generally recognized as the highest amount people should pay for their homes before being considered overburdened. Paying more than 30% for housing often results in people having to shift resources away from other important areas of life like food, health care, or transportation costs, creating hardships for everyone involved. Renters face an even greater challenge than homeowners. Close to half of renters in Summit County (45%) were paying at least 30% of their income for rent as of 2017.

Data from the National Low Income Housing Coalition (NLIHC) highlights the challenges renters face. In Summit County, those making the minimum wage can only afford to pay \$432 per month for rent while still keeping housing costs below 30% of income. However, the cheapest zero-bedroom unit at fair market rent is over \$100 beyond that level. For low-income renters, simply finding a place to





live means making unacceptable trade-offs between other necessities, working more than one job, relying on food stamps or other public assistance, or all of these. As an example, according to NLIHC, a renter making the minimum wage would have to work 58 hours per week just to afford a one-bedroom unit in Summit County, while a two-bedroom unit would require 77 hours per week; the equivalent of two full-time minimum wage jobs.<sup>3</sup>

### Loan denials

Another important part of affordable housing is the ability to get home purchase and/ or improvement loans. Both here and in many places around the nation, low income and minority loan applicants are far less likely to be approved for either type of loan. For home purchase loans, both low income and minority applicants are twice as likely to be turned down as middle or upper income applicants. For home improvement loans, which are essential to maintain home value and neighborhood viability, low income and racial minority applicants are also twice as likely to be denied.

### Housing disparities

While most areas in Summit County enjoy stable, good quality housing, the fact is that many individuals and families in our community face housing-related problems that create economic and health burdens that many others do not have to bear. This is especially true of racial and ethnic minorities and low-income residents of all races and ethnicities, who are more likely to live in housing that is:

- Rated as being in fair, poor, or very poor condition
- Old
- Low value
- More expensive to purchase or rent for those living in them despite the lower quality and value
- More difficult to maintain and improve when they are able to buy
- Overcrowded
- More likely to cause lead poisoning, mold-related health problems, and safety issues for their occupants (especially for seniors and children)

1 Healthy People 2020, Quality of Housing. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing>. Accessed 6/25/2019.

2 The Fiscal Office utilizes "Condition/Desirability/Utility" codes in its assessment of a property. As the name implies, these codes represent a composite of physical condition, functional utility, and desirability of the property being rated rather than just physical condition alone.

3 National Low Income Housing Coalition; Out of Reach, 2018. Downloaded from: <https://reports.nlihc.org/oor/ohio>



## FAMILY INSTABILITY

HealthyPeople 2020 cites family instability as an important social determinant of health. While economic issues impacting the nation have received a lot of attention over the past couple of decades, changes in family structure and stability have been no less important. Both of these factors have had a negative impact on people in families and especially on children.

### TRENDS AFFECTING FAMILY STRUCTURE

The structure of families across the nation and here in Summit County have been changing over the past several decades. Some of the most important changes include:

#### Marital status

The number of people over age 15 who are married has been dropping for decades. According to the 1970 census, about 64% of Summit County residents over age 15 were married. That figure dropped to just 55% by 1990. The decline has continued in more recent years, with marriage rates dropping to 51% by 2005, and to 46% by 2017, the most recent year available.

Both divorce rates and the percentage of people who were never married have risen at the same time marriage rates have dropped. In 1970, only 4% of Summit County residents over age 15 said they were divorced. By 2017, that figure had tripled (12%). The percent who say they were never married has also risen, from just 23% in 1970 to 34% by 2017.<sup>1</sup>

#### Family type

The composition of families has also seen dramatic changes over the past several decades. In 1980, married-couple families made up 82% of all families with children in Summit County. Just 25 years later (2005), married couples with children only made up 66% of the total. By 2017, that figure dropped to just below 60%. Female-headed households with children rose from just under 18% in 1980 to just over 27% in 2017 during those same decades. Male-headed households have also been growing, rising from 7% of all families with children in 2005 to just under 10% in 2017.<sup>1</sup>

#### Fertility rates

There has been an 11% drop (15,000) in the number of women of childbearing ages of 15- 50 since 2005. However, more women in that age group have had children in the past 12 months. That increase in births came in the 20-34 age group; births to women younger than 20 and older than 34 both declined.<sup>1</sup> These changes raised the birth rate from 53 per 1,000 women in 2005 to 64 per 1,000 women in 2017.

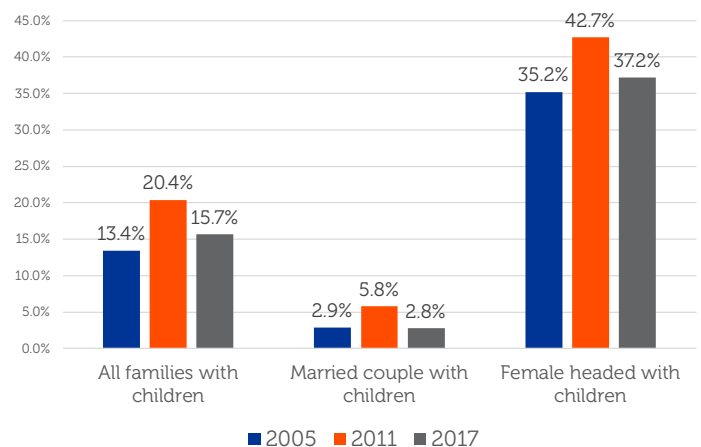
Another major change in births is the increasing rate of so-called “out-of-wedlock” births. This change isn’t all that surprising given the fact that marriage rates have been dropping for a long time. In 2005, 25% of all Summit County births were to unmarried mothers. That figure had risen to 42% by 2017.

### RELATED EFFECTS

These changes in family structure have had significant impact on our communities. Perhaps the most important of these is that the poverty rate for female-headed households with children is far higher than the poverty rate for other family types (see figure). The poverty rate for married couple families with children was just 2.8% in 2017; for female-headed families, the poverty rate was nearly 13 times higher (37%). According to a research brief by Child Trends, “Economic hardship is the most common adverse childhood experience (ACE) reported nationally and in almost all states, followed by divorce or separation of a parent or guardian.” The high poverty rates found among female-headed families

Family Poverty Rates by Family Type, 2005-2017

Source: American Community Survey





force many children to live in poverty. A related issue is that divorce is the second most common ACE across the nation. With divorce rates climbing for decades, many children in Summit County and around the nation are being traumatized by the breakup of their parents.

Children in cohabiting families face an even greater risk of trauma caused by the breakup of their home. A 2017 analysis of North American and European families published by the Social Trends Institute and the Institute for Family Studies shows that across many nations, cohabiting couples are more likely than married couples to experience at least one breakup, and are also more likely to experience more than one breakup. These effects are even greater for parents with lower educational attainment.<sup>2</sup> And, unfortunately, the educational attainment level for cohabiting couples is well below the level for married couples.<sup>3</sup> Adding to the stress such families face is research that suggests that the rate of unintended pregnancies is more than twice as high for cohabiting couples as for married ones.<sup>4</sup>

Adding an unintended pregnancy to families already under stress can make a difficult situation even more challenging. In a 2016 report called *The High Cost of Unintended Pregnancy*, the Brookings Institution notes that almost half of all pregnancies in the U.S. are unintended; a rate that hits 60% for those mothers who are teenaged, unmarried, or low-income.<sup>5</sup> The report goes on to summarize the negative consequences of unintended pregnancies this way: "...women who experience unintended pregnancies have a higher incidence of mental-health problems, have less stable romantic relationships, experience higher rates of physical abuse, and are more likely to have abortions or to delay the initiation of prenatal care. Children whose conception was unintentional are also at greater risk than children who were conceived intentionally of experiencing negative physical- and mental-health outcomes and are more likely to drop out of high school and to engage in delinquent behavior during their teenage years."<sup>5</sup> All of the factors mentioned here are either a cause or a consequence of adverse childhood experiences; factors which will negatively impact the health of children throughout their lifetimes.

<sup>1</sup> U.S. Census Bureau, 1970 Census, 1980 Census, 1990 Census and American Community Survey, 2005–2017.

<sup>2</sup> Mapping Family Change and Child Well-Being Outcomes. (2017). Retrieved July 31, 2019, from <https://worldfamilymap.ifstudies.org/2017/files/WFM-2017-FullReport.pdf>

<sup>3</sup> Reeves, R. V., Krause, E., Reeves, R. V., & Krause, E. (2017, April 05). Cohabiting parents differ from married ones in three big ways. Retrieved from <https://www.brookings.edu/research/cohabiting-parents-differ-from-married-ones-in-three-big-ways/>

<sup>4</sup> Mosher, W. D., Jones, J., & Abma, J. C. (n.d.). Intended and unintended births in the United States: 1982–2010 [Abstract]. National Health Statistics Report. Retrieved July 31, 2019, from <https://www.ncbi.nlm.nih.gov/pubmed/23115878>

<sup>5</sup> Monea, E., & Thomas, A. (2016, July 28). *The High Cost of Unintended Pregnancy*. Retrieved from <https://www.brookings.edu/research/the-high-cost-of-unintended-pregnancy/>



## MENTAL HEALTH & ADDICTION

Drug abuse has a major impact on our society. The financial impact alone is staggering. According to the National Institute on Drug Abuse, the estimated nationwide combined cost of crime, lost work productivity and health care related to alcohol and drug abuse could be as high as \$740 billion per year.<sup>1</sup>

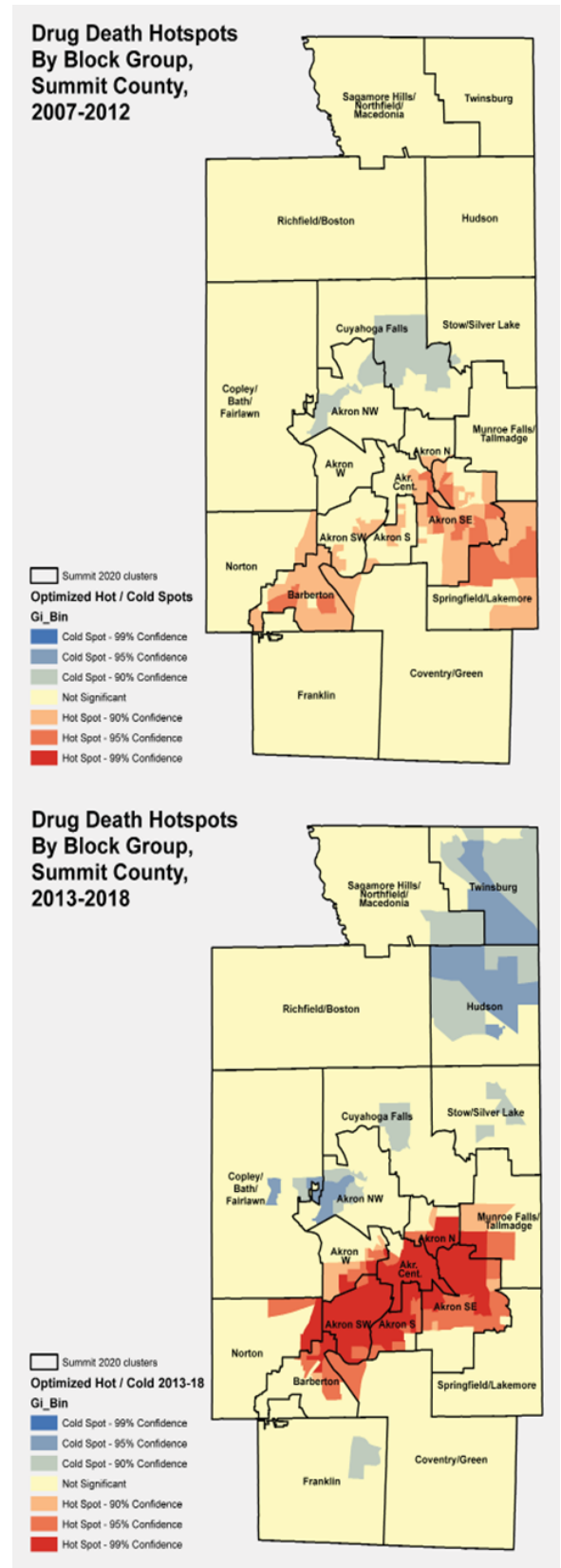
Ohio has been one of the hardest-hit states in the country when it comes to drug overdoses and overdose-related deaths. Here in Summit County, overdose-related deaths began rising in 2013, with 75 deaths due to overdoses in that year. That total rose to 118 in 2014, and 131 in 2015 as fentanyl was introduced into illegal drugs sold here. The addition of carfentanil along with fentanyl in 2016 drove overdose fatalities to never-before-seen levels, topping 300 by the end of that year. While deaths declined in both 2017 and 2018, they appear to be rising again in 2019 as drugs such as fentanyl and carfentanil are beginning to show up in methamphetamine and cocaine as well as heroin.

The maps at right show how drug overdose fatalities have spread over time in Summit County. So-called “hot spots” on these maps show areas of the county where the number of drug overdose fatalities are more heavily clustered than other parts of the county. In the same way, cold spots are those areas where fatalities are less clustered than other parts of the county. Each area of the maps are shaded to show how much confidence there is that each area is either a hot spot (shades of red), a cold spot (shades of blue), or neither (yellow).

What do people who die of drug overdoses look like? Two-thirds of overdose victims are male and are overwhelmingly white (88%). Overdose victims come from all age groups, with 52% between the ages of 15 and 44 and the remaining 48% age 45 or older. Nearly all of that group (45% of the 48%) were between 45 and 64 years old.

Deaths are not the only issue in drug abuse. Overdoses that don't kill but do severely harm victims' health are also a big problem. Nearly 6% of opiate overdose victims who survive the initial overdose die within one year according to article in the Annals of Emergency Medicine. As the article concludes, “The short-term and 1-year mortality of patients treated in the ED for nonfatal opioid overdose is high. The first month, and particularly the first 2 days after overdose, is the highest-risk period. Patients who survive opioid overdose should be considered high risk and receive interventions such as being offered buprenorphine, counseling, and referral to treatment before ED discharge.”<sup>2</sup>

It isn't just hardcore drugs like heroin, cocaine, and methamphetamine that are impacting substance abuse. Marijuana is having a major impact as well. Depending on a person's point of view, marijuana is either a gateway drug (for opponents), or a harmless recreational activity that can also have important medical benefits (for supporters). Without question, support for







legalization has risen nationally. A 2018 Pew Research Center report notes that support for legalization rose from just 31% in 2000 to 62% by 2018. Support for marijuana legalization appears strong among all demographic groups analyzed in the Pew study, with support running between half and two-thirds of survey respondents. Even among groups most likely to oppose marijuana (such as Republicans or white evangelical protestants), large minorities say they support legalization (43% of white evangelicals and 45% of Republicans).<sup>3</sup>

Support locally has also appeared to increase. Middle and high school students responding to the Youth Risk Behavior Survey (YRBS) were asked whether or not their parents think marijuana use is very wrong. In the 2013 YRBS, 89% of middle schoolers and 74% of high schoolers said their parents thought marijuana use was very wrong. In the 2018 survey, those numbers fell to 62% for middle schoolers and 53% for high schoolers.

The negative impact of marijuana use on health is hard to ignore, whatever public attitudes and potential benefits are when it comes to marijuana use. Statistics published by the CDC show that one in ten marijuana users will become addicted; a figure which rises to one in six for those who begin before age 18.<sup>4</sup> Problems such as difficulty with attention, memory, and learning may begin as short-term issues for marijuana users, but can eventually become permanent with long-term use. This is especially true for younger users, whose brains are still developing. In addition, even though evidence suggests that marijuana can help cancer patients with chemotherapy-induced nausea, smoking it introduces many of the same substances into the lungs introduced by cigarette smoke, causing some of the same lung and cardiovascular problems that cigarettes do.<sup>4</sup>

Another major problem is that marijuana is far more potent today than in the past. With the large number of dabs, waxes, oils, and edibles now available in states where marijuana is legal, it's hard to know how much THC (the psychoactive substance in marijuana that causes the high) users are taking in when they use it. While users can't "overdose" on marijuana in the same way users of drugs like heroin can, taking in high amounts of THC can cause hallucinations and even psychosis.

The source of a user's marijuana is a related problem. While legal dispensaries can guarantee that their product doesn't contain other dangerous substances, the same cannot be said for marijuana bought on the street. Most marijuana consumed in the U.S. today is still obtained illegally, because so few states have legalized it. Marijuana is still smuggled and sold in huge quantities by the same drug cartels that have flooded our streets with heroin and other dangerous and lethal substances. Law enforcement agencies, emergency medical personnel, and other medical and social service providers around the nation have reported numerous instances where fentanyl and/or carfentanil have been introduced into other drugs, including marijuana. Marijuana users who ingest these hybrid drugs run the same risks of fatal overdose and opiate addiction as opiate abusers themselves, even though they don't usually know they're running those risks. Finally, while marijuana isn't a gateway drug for most people according to the CDC, it is a gateway drug for some.<sup>4</sup> The risk of addiction and of moving on to harder drugs depends on a number of factors identified in the CDC report, such as family history, having a mental illness (such as anxiety or depression), peer pressure, loneliness or social isolation, lack of family involvement, drug availability, and lower socioeconomic status.<sup>4</sup> How many people might move on to addiction and/or harder drugs due to marijuana use is difficult or impossible to predict.

<sup>1</sup>National Institute on Drug Abuse, Trends and Statistics. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics>.

<sup>2</sup> One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose. (2019). *Annals of Emergency Medicine*, 1-5. Retrieved July 29.

<sup>3</sup> Hartig, H., Geiger, A., Hartig, H., & Geiger, A. (2018, October 08). 62% of Americans favor legalizing marijuana. Retrieved from <https://www.pewresearch.org/fact-tank/2018/10/08/americans-support-marijuana-legalization/>.

<sup>4</sup> Health Effects | Marijuana | CDC. (n.d.). Retrieved from <https://www.cdc.gov/marijuana/health-effects.html>



## POVERTY

Changes in the poverty rate have had a major impact on Summit County's quality of life over the past 25 years. After a brief recession in 1991, the national economy began the longest expansion in U.S. history to date, with low unemployment, rising incomes and stock prices. Falling poverty rates brought prosperous times to Northeast Ohio and the nation for much of the decade, with poverty in Summit County falling from 12% in 1990 to just under 10% in 2000.

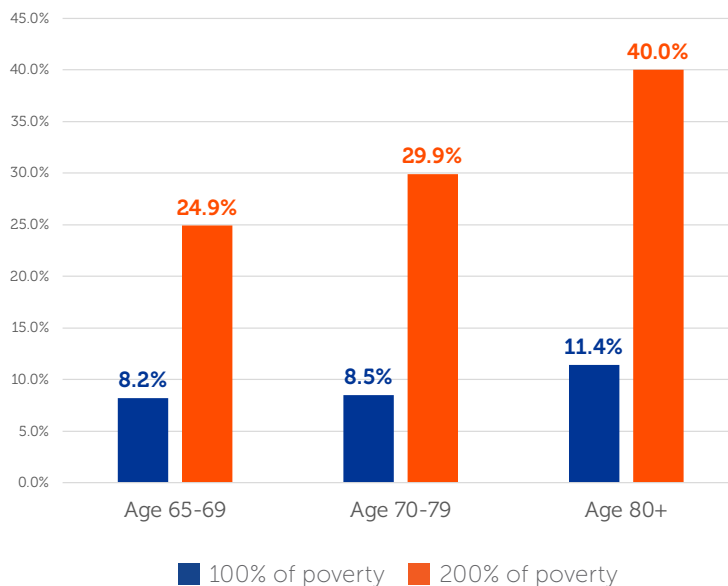
Unfortunately, the economy fell into recession again in 2001, which increased unemployment and drove poverty rates back up to 1990 levels by 2006. Just as the local economy was beginning to recover, the Great Recession hit in 2008. Despite the passage of the American Recovery and Reinvestment Act of 2009 and other federal, state, and local government efforts, the recession hit the entire nation very hard. The next several years brought Summit County and the nation high unemployment, thousands of home foreclosures and growing poverty rates, which hit a high of 17% locally in 2011. Summit County's poverty rate has been declining slowly since then, as the number of jobs finally began to show signs of growth again in 2014. In 2017, the county's poverty rate stood at 12.7%; roughly what it was in 1990.

Like unemployment, poverty isn't just one story. As American Community Survey data show, a person's race makes a big difference in whether he or she lives in poverty. The African-American poverty rate in Summit County has been more than double the countywide rate in every year since 1990. As of 2017, the poverty rate for African-Americans stands at 31%; three times higher than the white rate of 10%.

Poverty rates for other important groups are also much higher. As of 2017, 41% of female-headed households with children were living in poverty, as were 19% of foreign-born people, and 18% of children. All of these rates are above the overall poverty rate for the county (12.7%). However, only about 7% of seniors were currently living in poverty, thanks in part to programs such as Social Security and Medicare, which helps keep many seniors out of poverty.

That said, while the senior poverty rate is low, the number of seniors living near poverty is not. According to the Kaiser Family Foundation, while the national poverty rate for seniors is 9%, 30% of seniors live at or below 200% of poverty. The rate of seniors living at or below 200% of the poverty line grows along with age. From ages 65-69, 25% of seniors live at or below 200% of the poverty line. Those rates rise to 30% between ages 70 and 79, and finally to 40% by age 80.<sup>1</sup> Racial disparities also impact senior poverty. According to Kaiser, the poverty rate for white seniors is 6.9%. For black and Hispanic seniors, the rates are 19% and 17%, respectively.<sup>1</sup>

Percent of Seniors Living Below Poverty & Near Poverty



<sup>1</sup> Cubanski, J., Koma, W., Damico, A., & Newman, T. (n.d.). How Many Seniors Live In Poverty? (Issue brief). <https://www.kff.org/medicare/issue-brief/how-many-seniors-live-in-poverty/>



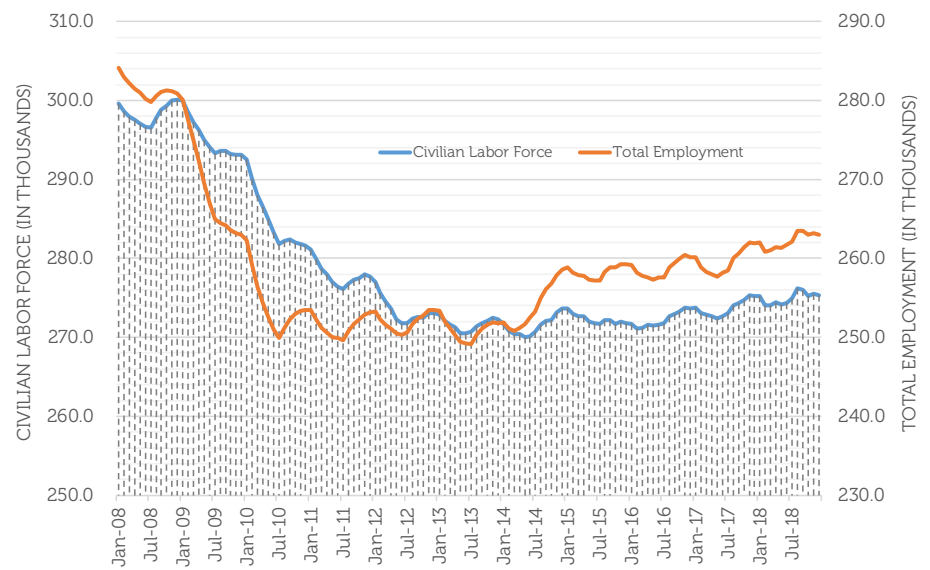
## UNEMPLOYMENT

The Great Recession ran from December 2007 to June 2009. Unfortunately, even though the recession ended, Summit County’s employment problems didn’t. Starting in early 2008 with the beginning of the recession, employment (the orange line on the chart below) began to drop sharply, hitting bottom by spring of 2010. Unfortunately, the total civilian labor force (the blue line) dropped right along with it. A drop in the size of the labor force means that the number of people looking for work is dropping. Because of the way unemployment is calculated, people who leave the labor force aren’t counted in the unemployment rate, which meant the unemployment rate was going down at the same time as fewer people were working or looking for work. Because this recession was so severe, the number of employed people kept dropping for a year after the recession was over. However, the number of people looking for work dropped for an additional five years, taking until 2014 to bottom out.

So why were people still leaving the labor force five years after the recession ended? One answer is that the recession didn’t necessarily end for everybody. Labor force participation for workers with less than a high school diploma dropped for seven straight years, from 59% in 2009 to just 48% in 2016. The unemployment rate for this group peaked in 2011 at nearly 29%, then began to drop as those who remained in the labor force began to find work. As of 2017 (the most recent year available), the unemployment rate for those with less than a high school diploma is 9.4%; still more than double the rate for all workers age 25 and older.

According to a 2014 study by the Economic Policy Institute, “...the reason we are not seeing robust job growth is because businesses have not seen demand for their goods and services pick up in a way that would require them to significantly ramp up hiring.” Supporting that conclusion is research that shows that labor force participation drops when wages and demand for lower-skilled workers both decline, a factor that is especially important for working-age men. Since that 2014 study, the number of jobs has begun to grow again and the size of the labor force has finally stabilized and is beginning to trend upward. Now that Summit County is finally seeing growth once again, there is hope that the recovery that began in 2009 might finally reach everyone by 2020.

Total Employment in Summit County Compared to the Civilian Labor Force





## MATERNAL & CHILD HEALTH

Infant mortality (IM) is defined as any death before a child’s first birthday. Infant mortality rate (IMR) measures this occurrence per 1,000 live births. The majority of child deaths on average occur during the first year of life. Infant mortality rate has been found to be the most sensitive indicator of societal health as well as being a key marker of maternal and child health. It can serve as a crude indicator of the overall health of a community, health disparities existing in a community, and availability and access to health care.

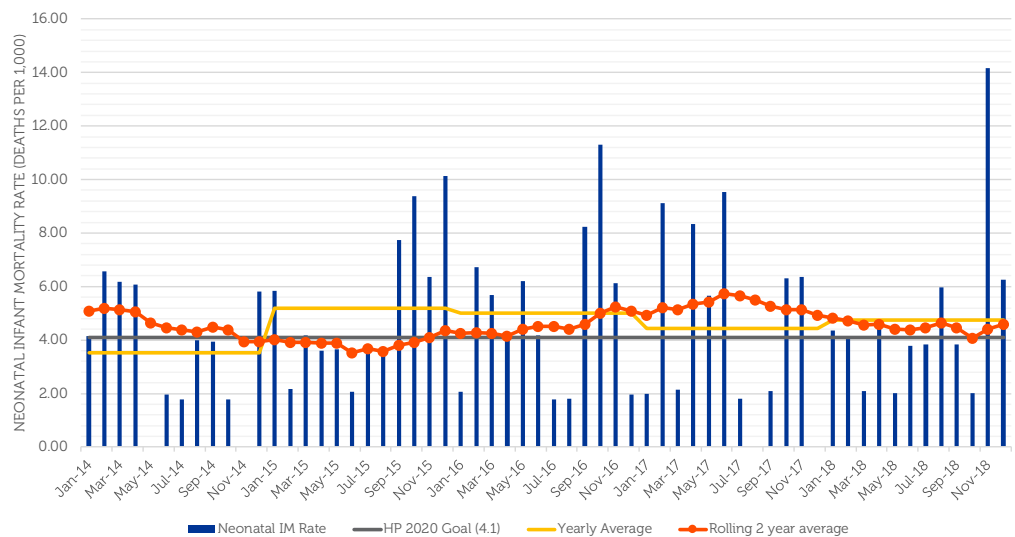
Infant mortality rates are used to detect trends in infant mortality over time, and to compare the rate of infant deaths between different population subgroups. The year to date (YTD) IM rate is calculated by dividing the total number of infant deaths in a specific year by the number of live births in that same year, then multiplying by 1000.

There were 42 infant deaths in Summit County in 2018. This is less than the previous year. Based on the 2018 data, the infant mortality rate in Summit County is trending even closer the Healthy People 2020 goal of 6.0 infant deaths per 1,000 live births.

### Neonatal deaths

Neonatal infant deaths occur in newborn infants that are less than 28 days old, and nearly 60% of infant deaths occur during the first month of life. The neonatal infant mortality rates (NIMR) from 2014 to 2018 exhibit similar trends as were seen in all Summit County infant deaths. The Healthy People 2020 goal for NIMR is 4.1 deaths per 1,000 live births. Summit County met this goal in 2013, however the NIMR for 2018 is 4.8 per 1,000, which is lower than the previous year.

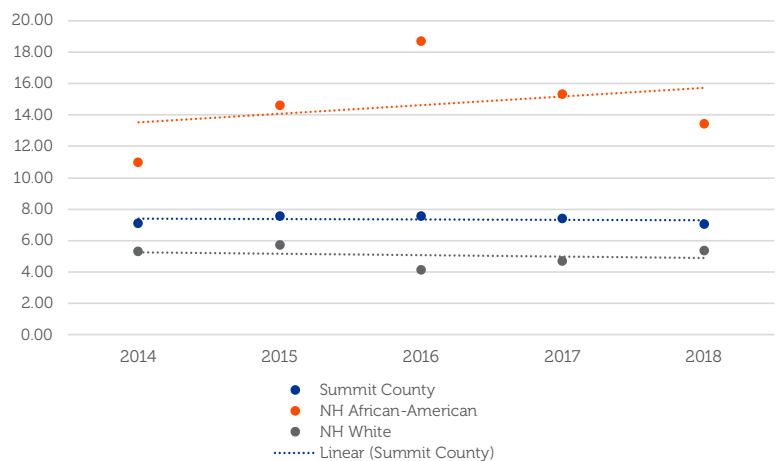
Neonatal infant mortality rate (per 1,000) by month, 2014 - 2018



### Racial disparities in infant mortality

Racial disparities in infant mortality rates continue to persist in Summit County, as indicated in the graph to the right. The average IMR for the past five years (2014-2018) in Summit County was 7.31 deaths per 1,000 live births. IMR’s below the county average were seen in the Non-Hispanic (NH) white, NH Asian, and Hispanic populations, but the NH African American rate was twice the county average, and was 2.8 times higher than the NH white rate. In 2018, the IMR disparity between white and African American infants decreased from previous years, with the NH black IMR being 2.8 times higher than the NH white rate compared to 3.2 times higher than the NH white rate in 2017. The trend line graph below indicates that the IMR in the NH African American community has a larger increasing trend than what was seen in the NH white community or the county IMR.

Trends in annual infant mortality in Summit County by race

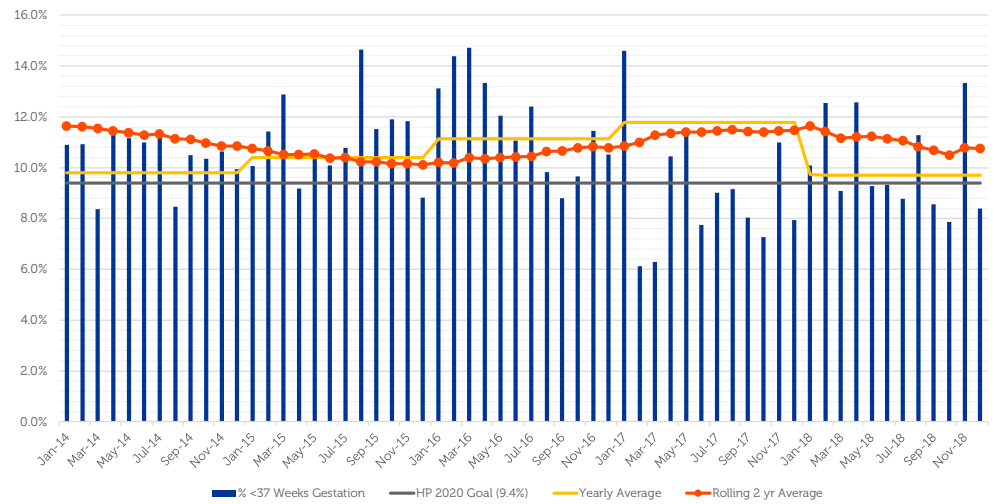




### Preterm birth rates

A birth is considered to be premature when it occurs before 37 weeks of gestation. Prematurity is a leading cause of infant death (especially during the first month). It increases the odds of having a chronic health condition and/or developmental delay. Therefore it's essential to ensure that as many pregnancies as possible deliver at 37 weeks gestation or later. Summit County's preterm birth rate went up from 9.2% in 2017 to 10% in 2018.

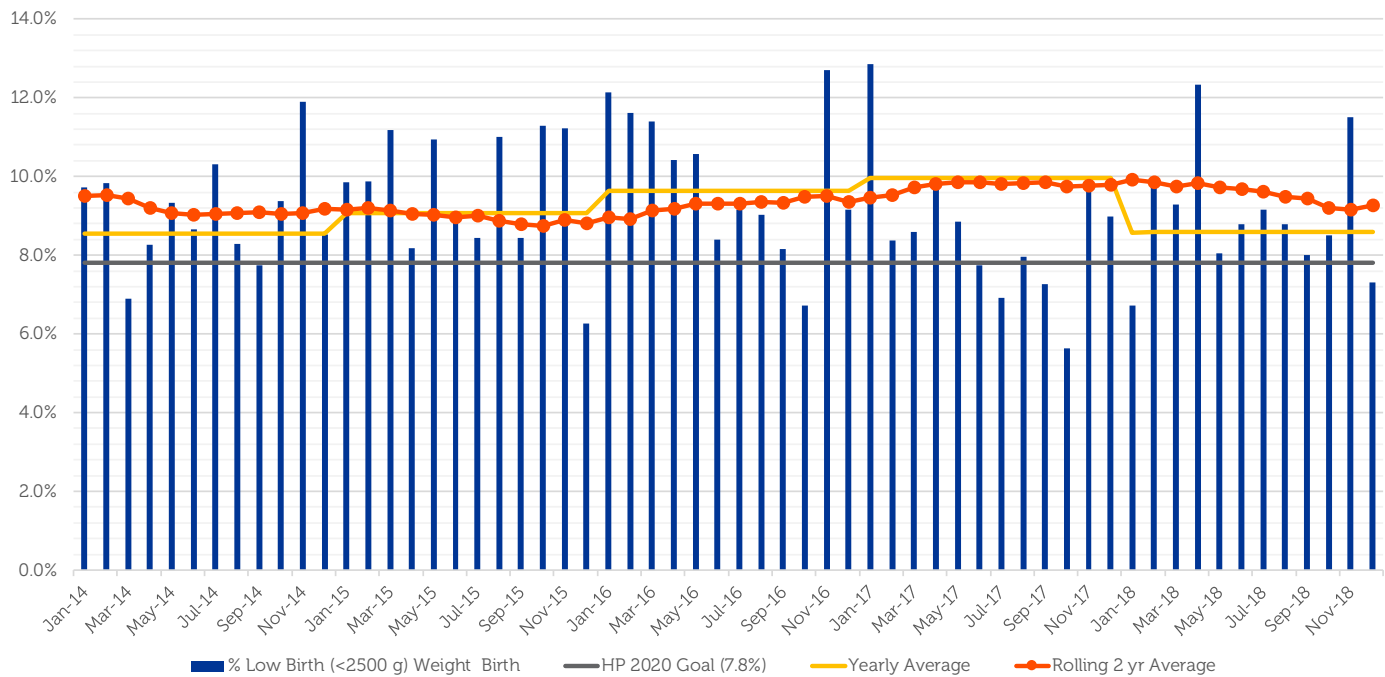
#### Premature birth rate (<37 weeks gestation) by month, 2014 - 2018



### Low birthweight rates

Infants that weigh less than 2500 grams (about 5.5 pounds) at birth are considered to be low birth weight. Although low birth weight is usually associated with premature birth, other factors may negatively affect fetal growth and development. Factors that impact development, include congenital defects, maternal complications, and unhealthy maternal behaviors (such as poor nutrition, smoking and/or substance misuse). An infant having low birthweight, especially those with very low weight, is a major factor of the magnitude of infant mortality. Differences in low birthweight rates account for the higher neonatal mortality rates observed in groups characterized by socioeconomic disadvantages. Low birthweight rates are correlated with preterm birth rates, and the preterm birthweight for Summit County increased from 2017 to 2018. Summit County saw an increase in low birthweight rates from 8.5% in 2017 to 9.0% in 2018.

#### Low birth weight (<2500 grams) birth rate by month, 2014-2018





## Conclusion & Next Steps

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After careful analysis of both the epidemiological and qualitative data, Summa Health has decided to maintain the following five primary categories of health needs that impact the community served by the hospital: chronic disease, access and barriers to healthcare, health disparities, prevention and wellness. These priorities and the hospitals' strategies to address them will be published in the implementation plan that will be available on the hospital website by May 15, 2020.

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