Clark County Community Health Assessment 2022

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Record of Change

Clark County Community Health Assessment 2022			
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1.0	Draft document created	06/16/2022	Kalli Luthi
1.1	Community Themes & Strengths added	07/13/2022	Gracie Hemphill
2.0	Narratives for FOCA, LPHSA, and CHSA added	09/14/2022	Daisy Okpa
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Acknowledgements

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Steering Committee

City of Springfield

Clark County Combined Health District

Clark County Educational Service Center

Clark County Family & Children First Council

Clark County, Ohio

Clark County – Springfield Transportation Coordinating Committee

Community Health Foundation

Developmental Disabilities of Clark County

Mental Health Recovery Board of Clark, Greene, and Madison Counties

Mental Health Services for Clark and Madison Counties

Mercy Health – Springfield

New Carlisle Community Health Center

Ohio Valley Surgical Hospital

Rocking Horse Community Health Center

Springfield Foundation

Springfield Metropolitan Housing Authority

United Senior Services

Wittenberg Hagan Center

Executive Summary

A Community Health Assessment (CHA) provides an opportunity for the local public health system to evaluate the health of the population and factors that contribute to high health risks, and subsequently set goals to address these issues through the Community Health Improvement Plan (CHIP).

During the last CHA/CHIP cycle, Clark County and the entire world has been overwhelmed responding to an unprecedented pandemic caused by a novel coronavirus called SARS-CoV-2 (COVID-19). Even in the midst of testing and vaccinating the entire population of Clark County, the local public health system has made progress towards achieving the goals outlined in the last CHIP. Pandemics are typically known as "equalizers" and affect the entire population; however, the COVID-19 pandemic set known health inequities ablaze and created new issues. After careful review of the previous CHA/CHIP documents and consideration of the dampened efforts to achieve the goals previously outlined due to the overwhelming COVID-19 response of the entire community, the CHA Steering Committee decided to 1) collect new primary and secondary data with an eye towards "pandemic skew," and 2) look at previous goals and "reboot" many of them into the next CHA/CHIP cycle. This reboot was dependent on "Continuation Evaluation Criteria" that included: 1) support from newly collected/pooled data, 2) current or renewable momentum towards previous goals, 3) alignment with state priorities, 4) willing leadership in the strategic issue areas, and 5) community capacity to make additional strides in the priority areas.

The overarching goal of this new CHA/CHIP cycle is to:

1. Tell the community story: identify willing partners, explain the status of the community's health, and wrap the story in the context of Clark County conditions.
2. Build interest and infrastructure: marry data with current and future community capacity.
3. Develop a plan with goals: define how we measure success and how we can remain flexible and change gears along the way.
4. Share wins and challenges: turn previously partner-oriented updates into a narrative for the community.

Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment aims to gather community members' perceptions, thoughts, opinions, and concerns regarding the quality of life in Clark County. This input provides valuable insight into the issues of importance to the community. Identified priority characteristics of a healthy community included:

→ Access to and capacity of high-quality, affordable healthcare.
→ Access to and capacity of behavioral and mental health services.
→ Availability of life skills training including personal finance, home economics, literacy, and post-secondary education.
→ Affordable and safe housing options.
→ Access to transportation, quality food, and resources for youth.

Forces of Change Assessment

Forces of Change looks at what is occurring or might occur that affects the health of our community or the health system that we might not be able to quantify right now through data collection, but we know it is happening or coming soon. The CHA Steering Committee focused extra time on forces of change in response to the unique circumstances of the last two years. Priority areas of focus identified included:

→ Economic
→ Social
→ Political

Additional forces of change included:

→ Wages
→ Financial literacy
→ Social isolation and cognitive/relational changes
→ Gun violence
→ Kids in crisis in multiple areas of life
→ Racism
→ Mental health in everything
→ Primary care provider recruitment
→ Senior services funding cuts
→ Economy, inflation, impending recession
→ Life skills not taught in schools
→ Arts education in schools in jeopardy
→ Technical/skills schooling enrollment down
→ Affordable housing – both private and public
→ Senior housing degradation and improvement
→ Social service agencies providing less in-person service, more virtual
→ Residential internet access especially in high-need, low income, and rural settings
→ Governmental and formal social service agency capacity reduction
→ Non-traditional capacity building
→ Community resilience

Local Public Health Systems Assessment

The Local Public Health System is defined as the collective efforts of public, private, and voluntary entities, as well as individuals and informal associations that contribute to the public's health within Clark County. The assessment depicts the overall strengths and weaknesses of the local public health system (*which is broad, not just the Health Department*) based on the 10 Essential Public Health Services. General areas of focus identified included:

→ Essential Service #5: Create, champion, and implement policies, plans, and laws that impact health.
→ Essential Service #8: Build and support a diverse and skilled public health workforce.
→ Essential Service #10: Build and maintain a strong organization infrastructure for public health.

Community Health Status Assessment

The Community Health Status Assessment is a collection of primary and secondary data that is analyzed to identify current community health issues and assess trends over time. Along with the other CHA assessments, this data helps create a health profile for the selection of priority topics for the Community Health Improvement Plan. Areas of focus identified included:

→ Capacity of translation services for non-English speaking residents
→ Black/African American infant mortality rates
→ Prenatal care during the first trimester of pregnancy
→ Drug overdose mortality rates
→ Syphilis and other STI rates
→ Routine childhood immunization rates
→ Capacity of and access to high quality, safe food
→ Capacity of and access to affordable housing
→ Rates of those experiencing homelessness
→ Tobacco and electronic vapor product use
→ Dietary behaviors of high school students
→ Bullying and suicide

Cross-Cutting Factors

The Community Health Assessment highlights powerful underlying drivers of wellbeing. From the CHA data, the Community Health Improvement Plan takes a comprehensive approach to improving health priorities by identifying cross-cutting factors that impact multiple outcomes. While these factors can be involved in setting goals and establishing strategies in each priority area, cross-cutting factors can be elevated to priority areas and vice versus over multiple CHA/CHIP cycles. The Steering Committee suggested the creation of a "watch list" of items that may transition from cross-cutting factors to strategic issues. Identified cross-cutting factors included:

→ Health equity and minority access
→ Capacity/infrastructure building
→ Education

Strategic Issues

The ultimate goal of the CHA process is to identify strategic issues after reviewing all preliminary data collected during the four assessments (Community Themes and Strengths, Forces of Change, Local Public Health System, and Community Health Status). Three priority topics are typically selected. The group identified the following priority areas for consideration during the next three-year CHA/CHIP cycle:

→ Maternal, infant, and sexual health (continuation from last CHA/CHIP cycle)
→ Chronic Disease (continuation from last CHA/CHIP cycle but with a new/increased focus on food access)
→ Mental health (continuation from last CHA/CHIP cycle but with a new/increased focus on crime)
→ Housing that is affordable, safe/healthy, sustainable (personal finance, education/jobs, etc.), accessible (ADA), and paired with support services/case management.

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Introduction

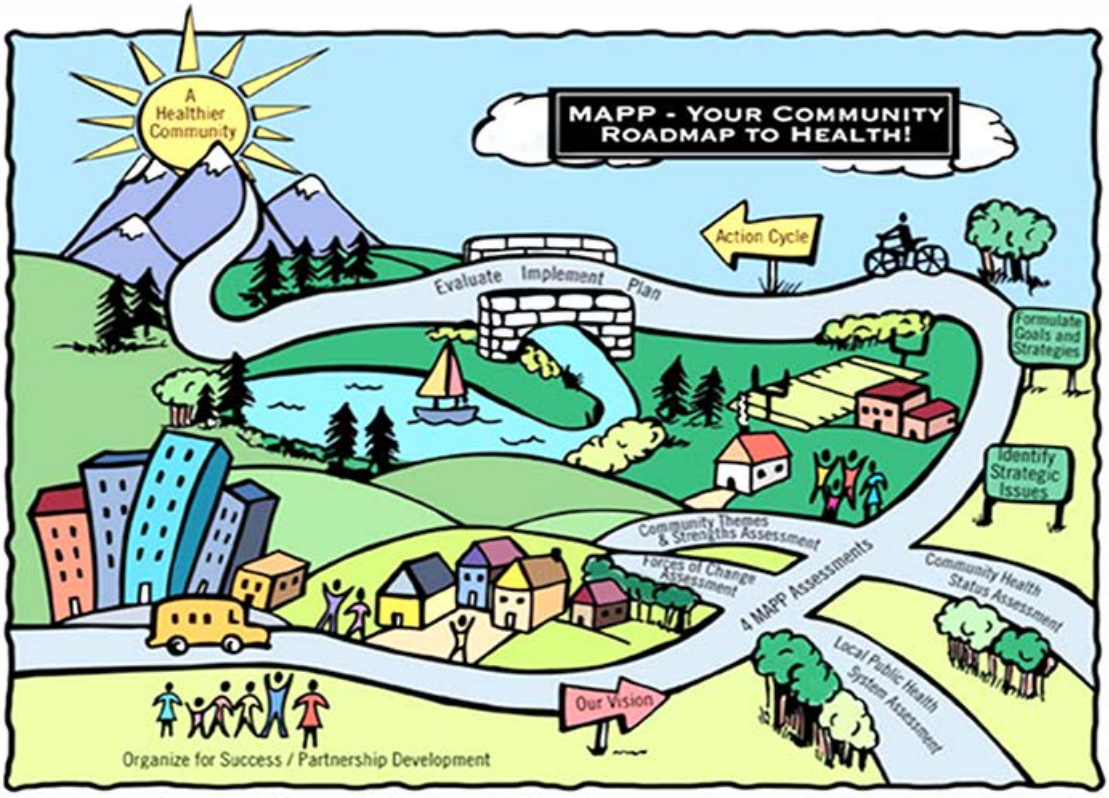
Purpose

The purpose of the Community Health Assessment is to learn about the health of the population, factors that contribute to higher health risks or poorer health outcomes, and resources available to improve the community's health status (Public Health Accreditation Board (PHAB), 2013). In Clark County, a CHA has been completed by the Clark County Combined Health District (CCCHD) and community partners every three years since 2013.

This CHA is continuation of a collaborative process of collecting and analyzing data, developing priorities, and planning actions to improve Clark County's health. The results of this CHA will provide the general public and policy leaders with information on the health of the community and the broad range of factors that impact health on the population level (PHAB, 2013). This CHA provides the basis for the development of the Clark County Community Health Improvement Plan (CHIP).

Methodology

The methodology for this CHA was based on Mobilizing for Action through Planning and Partnerships (MAPP). The National Association of County and City Health Officials (NACCHO) defines the MAPP methodology as a community-driven strategic planning process for improving community health. This framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.



2022 Clark County Community Health Assessment Timeline and Methodology

November 2021

Community Health Status Assessment (CHSA)
- Begun planning and implementation of the Community Health Status Assessment; Used existing data sources to compile reports descriptive of Clark County.

January – March 2022

Community Themes and Strengths Assessment (CTSA)
- Conducted CTSA in five community focus groups and online survey
- Collected data on the health issues that residents feel are important, including perceived quality of life and the assets available to improve community health

February 2022

Mobilizing for Action through Planning and Partnerships (MAPP) Process
- Reviewed MAPP process model with Steering Committee
- Shared projected timeline

March 2022

Forces of Change Assessment (FoCA)
- Performed FoCA with Steering Committee
- Identified forces in the community that may alter how the public health system operates, including legislation, technology, social shifts, and emergencies/crises.
- Identified threats and/or opportunities generated by the current forces that are changing the system

April 2022

Local Public Health Systems Assessment (LPHSA)
- Performed LPHSA with Steering Committee and other community stakeholders
- Collected data on all organizations and entities that contribute to the public's health, including the components, activities, competencies, and capacities of the entire healthcare system

May 2022

CHSA Data Presentation
- Presented preliminary data from CHSA to Steering Committee

July 2022

Issue Identification and Prioritization
- Steering Committee reviewed results of all assessments and identified strategic issues from the presented data

February 2023

Publication of the Clark County Community Health Assessment (CHA)

Ongoing

Steering Committee
- Continuous recruitment
- Monthly meetings
- Reviewed CHA progress

CHA Progress Updates
- Shared with CCCHD Staff and at Clark County Board of Health meetings
- Occurred every three months

Multi-agency Coordination
- Collaborated with neighboring Local Health Department and Mercy Health Community Outreach staff to ensure hospital needs were met
- Weekly meetings

Visioning

Visioning is the second phase of MAPP and guides the community through a collaborative, creative process that leads to a shared community vision and common values. Vision and values statements provide focus, purpose, and direction to the CHA/CHIP so that participants collectively achieve a shared vision for the future. A shared community vision provides an overarching goal for the community - a statement of what the ideal future looks like. Values are the fundamental principles and beliefs that guide a community-driven planning process.

The CHA Steering Committee adopted a vision for an involved, safe, and healthy community:

Our vision for creating a healthy community starts with a county-wide network of partners all working together to provide high-quality, affordable services for all residents that are easy to access.

The CHA Steering Committee adopted a community value system to improve health:

1. **Safe**: support a safe environment for people to live, work, and play.
2. **Fair**: promote and provide services and resources in a straightforward and non-judgmental way that makes all feel welcome and valued.
3. **Flexible**: recognize the different paths people take towards better health and work to provide innovative programs.
4. **Accessible**: reduce barriers to achieving better health caused by differences in income, education, race, ethnicity, and transportation.
5. **Flexible**: recognize the different paths people take towards better health and work to provide innovative programs.
6. **Accessible**: reduce barriers to achieving better health caused by differences in income, education, race, ethnicity, and transportation.
7. **Involved**: encourage residents, community agencies, businesses, and faith-based organizations to be involved in improving community health.
8. **Equitable**: actively address whole system imbalances that perpetuate disparities.

Community Themes and Strengths Assessment

The Clark County Combined Health District (CCCHD) conducted a Community Themes and Strengths Assessment (CTSA) as part of the Community Health Assessment process. The purpose of the CTSA is to understand the issues that residents feel are most important, the barriers to the health of the community, as well as assets and strengths that support improving the health of the community.

To complete the Community Themes and Strengths Assessment, CCCHD conducted five community focus groups and collected data from an online survey throughout the county to reflect on community assets, challenges, and barriers to maintaining a healthy community.

During the focus groups, participants addressed the following topics:

- What do you believe are the 2-3 most important characteristics of a healthy community?
- What makes you most proud of our community?
- What barriers do you believe is keeping our community from doing what needs to be done to improve health and quality of life?
- What do you think are the biggest health priorities of the community?

Community input gathered from the focus groups and online survey revealed the following key findings and emerging themes of health-related assets, challenges, and barriers across the county:

Most Important Characteristics of a Health Community

- **Access to affordable and quality health care** was consistently identified as one of the most important characteristics of a health community.
- **Access to affordable and safe housing**, **financial stability**, as well as respect for **diversity and inclusion** were also commonly discussed throughout all the focus groups.

What makes you most proud of our community?

- Participants described a **sense of community** that promotes strong bonds and unity among community members.
- Participants reported the large network of **community gardens** and **strong collaboration** among community service agencies and organizations as an asset that contributes to the heath of the county.

What barriers do you believe is keeping our community from doing what needs to be done to improve health and quality of life?

- A lack of adequate **access to affordable, quality healthcare** services was commonly reported by participates as one of the biggest barriers to improving the health of Clark County. This includes a lack of mental health resources as well.
- Accessibility **to transportation, quality food, and affordable, safe housing** was also identified as barriers in all the focus groups.
- Additionally, participants noted **youth vaping** and lack of **mental health resources for youth** as major barriers to improving the health of the community.

What do you think are the biggest health priorities of the community?

- **Access** (transportation, health, food, affordable housing, culturally appropriate services) was identified as one of the biggest health priorities in Clark County throughout the focus groups and online survey responses.
- **Behavioral Health**, including mental health, substance abuse, trauma, and suicide, were also noted as health priorities in the community.
- Additionally, participants reported **financial stability** for all residents is one of the biggest health priorities in Clark County.

Forces of Change Assessment

On March 4, 2022, a group of thirteen (13) community leaders representing a diverse perspective completed a Forces of Change Assessment (FOC Assessment, Appendix A). This Assessment was administered virtually using an online survey tool. The group was asked to answer a series of fifteen (15) questions centered around a common theme: *What is occurring or might occur that affects the health of our community or the health system that we might not be able to quantify right now through data collection, but we know it is happening or coming soon.* After identifying forces of change, the group identified potential threats and opportunities that may be generated from these occurrences. The group was also asked to rank previous forces of change theme areas in order of 1) overall potential impact on the community over the next three (3) years and 2) health disparity impact.

FOC Assessment Results

Through the FOC Assessment, participants identified 71 forces falling within 14 theme areas (Table 1). Participants were also asked to rank each theme area by health disparity impact and overall potential impact (Figure 1)(Figure 2). For each force identified, specific threats and opportunities were discussed.

Full results can be found in Appendix A.

Table 1: Forces of change affecting health in Clark County.

Theme Area	Forces
Crime	Neighborhood safety
	Identify theft, burglary, crime
	Domestic violence
Development/Economy	New hotel planned
	New grocery store
	High gas prices
	Inflation
	Supply chain issues
	Technology
Education	Home schooling
	Inequity of funding schools
	Undereducated adult population
Employment	Declining number of people in trades
	Unemployment rate
	Entry level jobs below living wage
	Need for more diverse workforce
	Workforce shortages
	High retirement rates
	Paid maternity leave
	Remote work

Environment/Infrastructure	Access to green spaces
	Air quality and asthma
	Clean water supply
	Climate change
	Public transportation
Family/Youth	Lack of quality/affordable childcare
	Children in poverty
	High number of children eligible for free or reduced school lunch
	Children behind in learning curve
	Child abuse
	Need for summer programs and after school programs
Food Security	Access to healthy food
	Access to affordable food
	Limited availability in grocery stores
Healthcare	Lack of primary care physicians taking new patients
	Telehealth
	Increased health care costs
	Shortage of dentists and primary care physicians
	New hospital opening
	Vaccine mandates
	Healthcare worker burnout
	Shortage of health care works, nurses, and support staff
	Lack of wellness and prevention programs
	High costs of prescriptions
	Overweight/obesity trends
	Covid implications
Housing	Lack of affordable housing
	Homelessness
	Lack of desirable housing (leaky roofs, lead paint, asbestos)
	Landlord accountability
	Sewage regulations
Inclusion	Better acceptance of LGBTQ community
	Cultural diversity
	Racism
	Immigration
	Aging population

Mental health	Lack of mental health care coverage Long waitlists for mental health services Covid impact
Policy/Governance	Un-Fluoridated water Tightening restrictions on women's reproductive rights Gun law challenges Political tensions Governor election Changes in covid benefits Medicaid/Medicare reimbursements and requirement changes War
Premature Life Loss	Drug abuse/addiction Infant mortality
Other	Distrust of news and scientific information

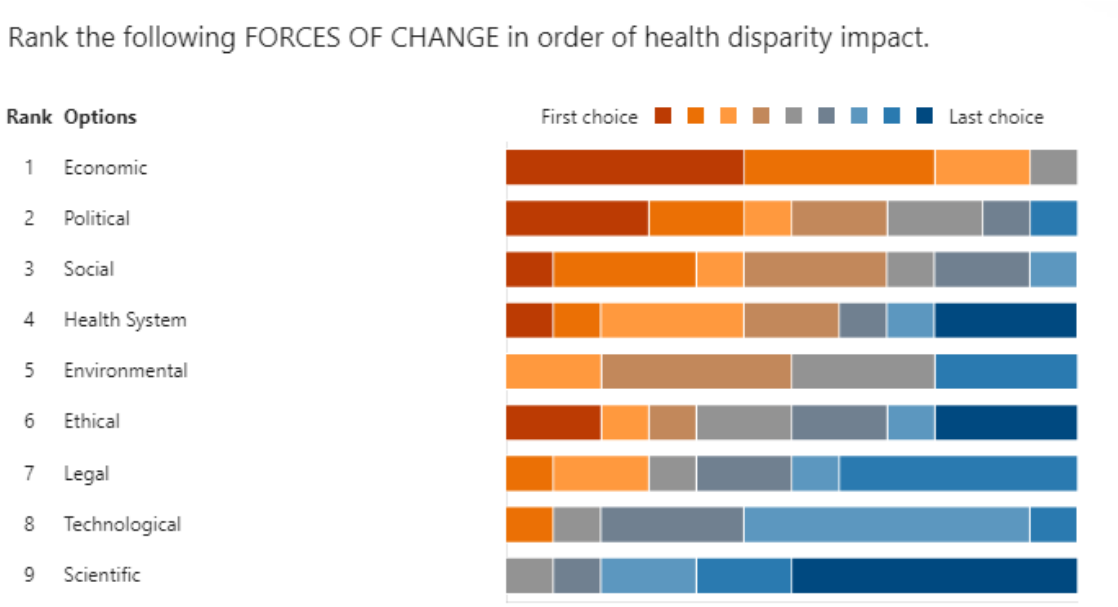


Figure 1: Forces of Change ranked in order of health disparity impact, Forces of Change Assessment, 2022

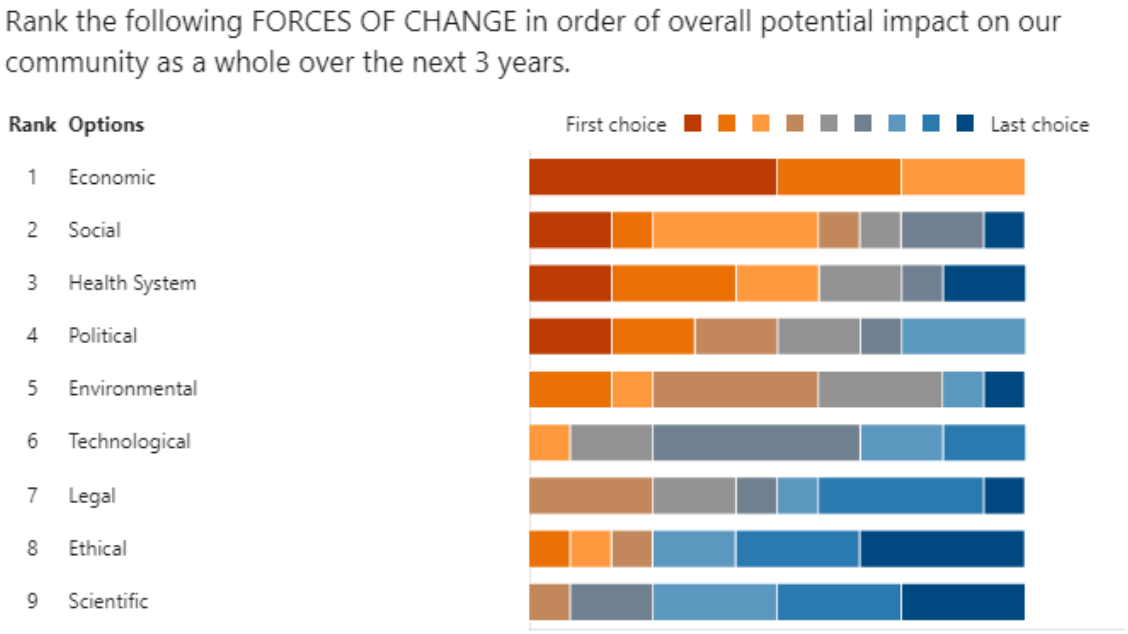


Figure 2: Forces of Change ranked in order of overall potential impact on the community over the next 3 years, Forces of Change Assessment, 2022

Local Public Health System Assessment

On April 12, 2022, a group of eleven (11) community leaders representing a diverse perspective completed a Local Public Health System Assessment (LPHS Assessment, Appendix B). This Assessment was administered virtually using an online survey tool. This assessment focuses on the local public health system; this includes all entities that contribute to the delivery of public health services (which includes traditionally defined "healthcare") within Clark County. The LPHS is a network of entities with differing roles, relationships, and interactions whose activities combined contribute to the health and well-being of the community. The 10 Essential Public Health Services provide the framework for this assessment by describing the public health activities that should be undertaken in all local communities. The LPHS includes more than just the Clark County Combined Health District. To fully understand the entire public health system, assessment participants were encouraged to review the CDC's graphic of the public health system (https://www.cdc.gov/publichealthgateway/publichealthservices/images/phs-figure1.gif?_=48905). For the 2022 LPHS assessment, partners were also asked to rate the status of *previous* opportunities/weaknesses *and* identify current strengths and weaknesses.

As part of the Local Public Health System Assessment, a crosswalk between Essential Public Health Services and Ohio Improvement Standards was designed and shared to all interested parties (Table 2).

The essential service areas that are being actively worked on and need to continue are: ES1, ES2, ES3, ES4, ES6, ES7, and ES9 (Table 3). The essential service areas that still need to be addressed in the Clark County community are ES5 and ES9 (Table 3). ES10 was revised in 2020 and cannot be compared to previous data for assessment.

Full results are available in Appendix B.

Table 2: Crosswalk between Essential Public Health Services and Ohio Improvement Standards

Essential Public Health Service		Ohio Improvement Standards	
1	Assess and monitor population health status, factors that influence health, and community needs and assets	1	Conduct and disseminate assessments focused on population health status and public health issues facing the community
2	Investigate, diagnose, and address health problems and hazards affecting the population	2	Investigate health problems and environmental public health hazards to protect the community
		4	Engage with the community to identify and address health problems
3	Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it	3	Inform and educate the public about public health issues and functions
4	Strengthen, support, and mobilize communities and partnerships to improve health	4	Engage with the community to identify and address health problems
5	Create, champion, and implement policies, plans, and laws that impact health	5	Develop public health policies and plans
6	Utilize legal and regulatory actions designed to improve and protect the public's health	6	Enforce public health laws
7	Assure an effective system that enables equitable access to the individual services and care needed to be healthy	7	Promote strategies to improve access to health care services
8	Build and support a diverse and skilled public health workforce	8	Maintain a competent public health workforce
9	Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement	9	Evaluate and continuously improve health department processes, programs, and interventions
		10	Contribute to and apply the evidence base of public health
10	Build and maintain a strong organizational infrastructure for public health	11	Maintain administrative and management capacity
		12	Maintain capacity to engage the public health governing entity

Table 3: Local Public Health System Assessment Performance Ranking by Essential Service, 2022.

Model Standards by Essential Service	Performance Ranking
ES1: Assess and monitor population health status, factors that influence health, and community needs and assets.	Our system is actively working on this and needs to continue
ES2: Investigate, diagnose, and address health problems and hazards affecting the population.	Our system is actively working on this and needs to continue
ES3: Investigate, diagnose, and address health problems and hazards affecting the population.	Our system is actively working on this and needs to continue
ES4: Strengthen, support, and mobilize communities and partnerships to improve health.	Our system is actively working on this and needs to continue
ES5: Create, champion, and implement policies, plans, and laws that impact health.	I don't think this has been significantly addressed in our community and it's still a need
ES6: Utilize legal and regulatory actions designed to improve and protect the public's health.	Our system is actively working on this and needs to continue
ES7: Assure an effective system that enables equitable access to the individual services and care needed to be healthy.	Our system is actively working on this and needs to continue
ES8: Build and support a diverse and skilled public health workforce.	I don't think this has been significantly addressed in our community and it's still a need
ES9: Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.	Our system is actively working on this and needs to continue
ES10: Build and maintain a strong organization infrastructure for public health.	This essential service was revised in 2020. No previous data to assess progress.

Community Health Status Assessment

The Community Health Status Assessment (CHSA) consists of primary and secondary data that was analyzed to identify community health issues and determine where the community stands in relation to state and national data. Data collection for the CHSA began in the winter of 2021 and continued through the summer of 2022. The topics in this chapter are ordered based on the Robert Wood Johnson Foundation's County Health Rankings organization.

Demographic Characteristics

The majority of the Clark County population is white, non-Hispanic (84.1%), followed by Black non-Hispanic (8.0%) (Figure 3).

Age and Birthrate

57.3% of the Clark County population is at least 35 years of age, and 25.5% are under the age of 19 years of age (Figure 4). Between 2008 and 2020, there has been a decline in the overall birth rate within Clark County (Figure 5). The Hispanic birth rate has been consistently higher than the non-Hispanic black and non-Hispanic white birthrates between 2014-2020 (Figure 6).

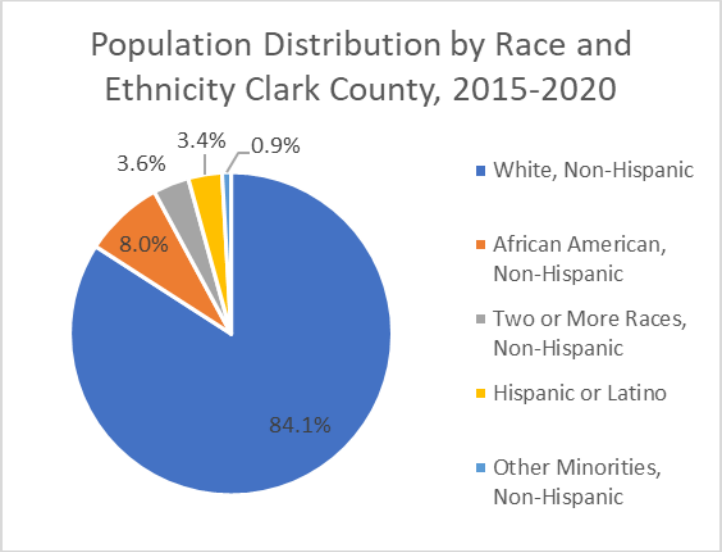


Figure 3: Population distribution by Race and Ethnicity, Clark County, Ohio, American Community Survey 2015-2020

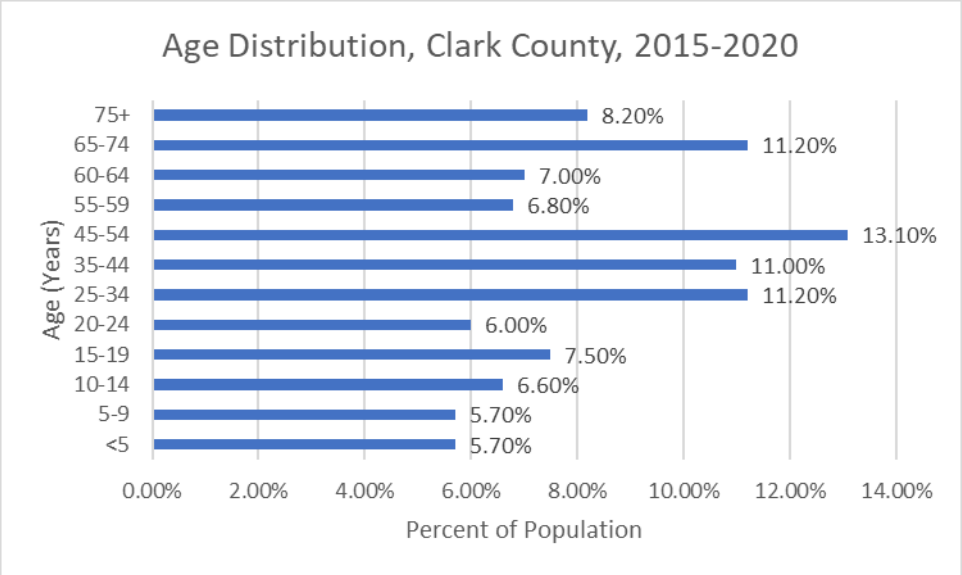


Figure 4: Age Distribution, Clark County, 2015-2020. American Community Survey, 2015-2020

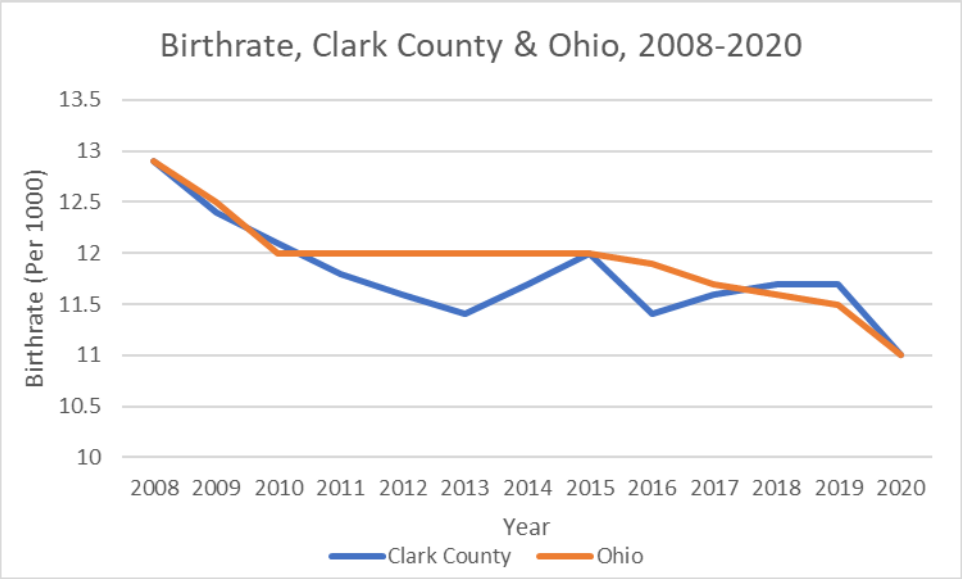


Figure 5: Birthrate, Clark County, Ohio, 2008-2020. Data queried from the Ohio Department of Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

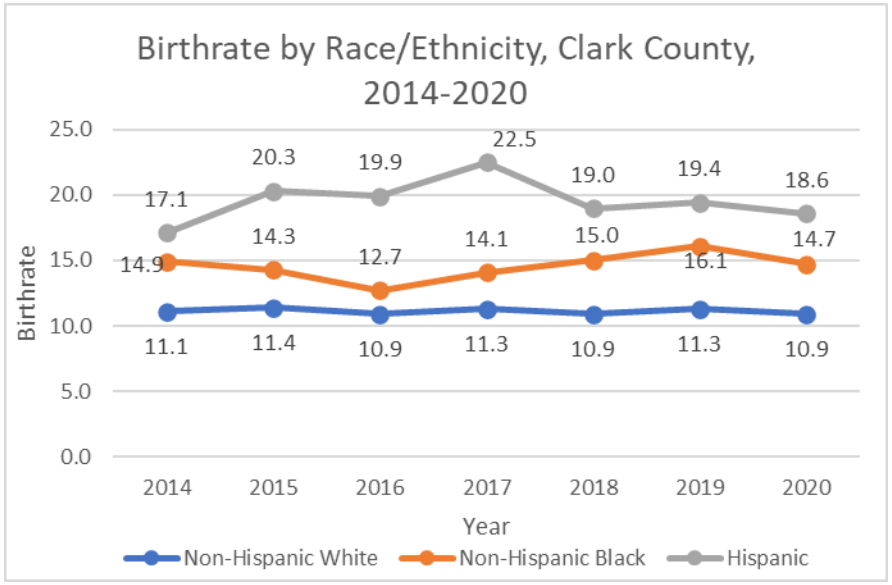


Figure 6: Birthrate by race, Clark County, 2014-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Population Projections

From 2010 to 2050, there is an expected decrease of 7.4% in the Clark County population, projected from the Ohio Development Services Agency (Figure 7). This contrasts with the state of Ohio and the United States populations, both expected to increase over time (0.95% and 29.7%, respectively) (Figure 8, Figure 9). Between 2015 and 2050, the 20-64 years old population is expected to decline by 8.8% and the 65-85+ year old population is expected to decline by 7.7%, while the 0-19 years old population is expected to grow by 3.9% (Figure 10).

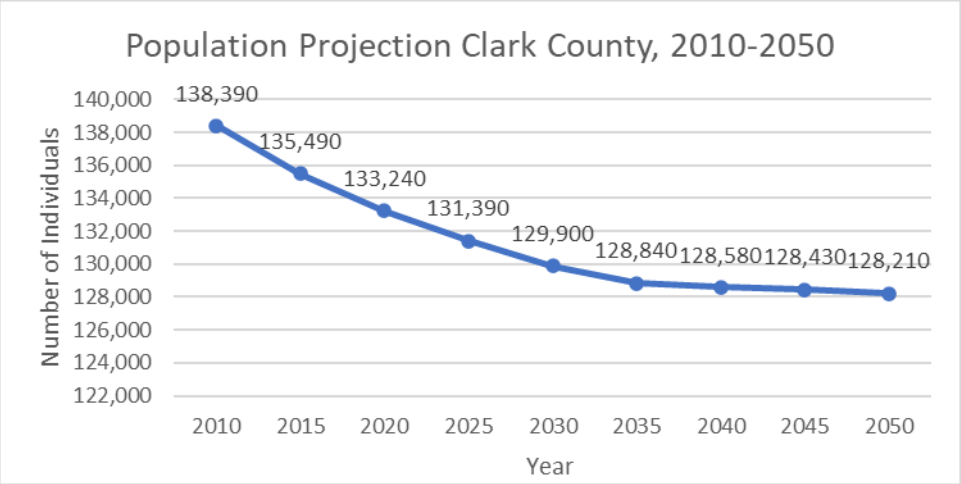


Figure 7: Population projection for Clark County, 2010-2050, Ohio Development Services Agency, 2018

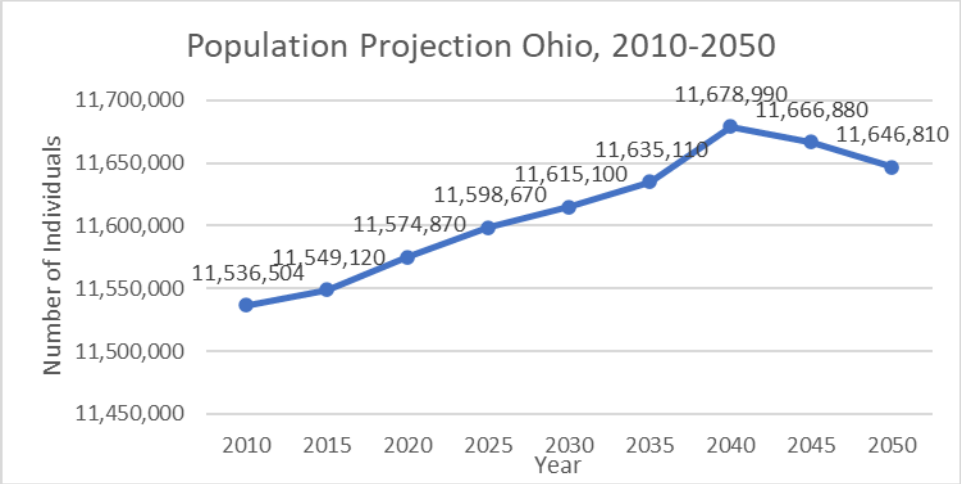


Figure 8: Population projection for Ohio, 2010-2050, Ohio Development Services Agency, 2018

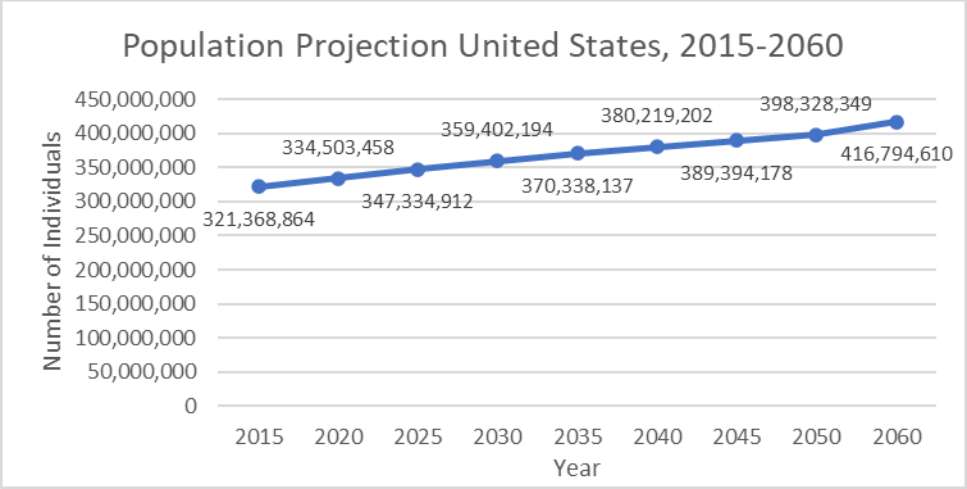


Figure 9: Population projection for the United States, 2015-2060, CDC Wonder

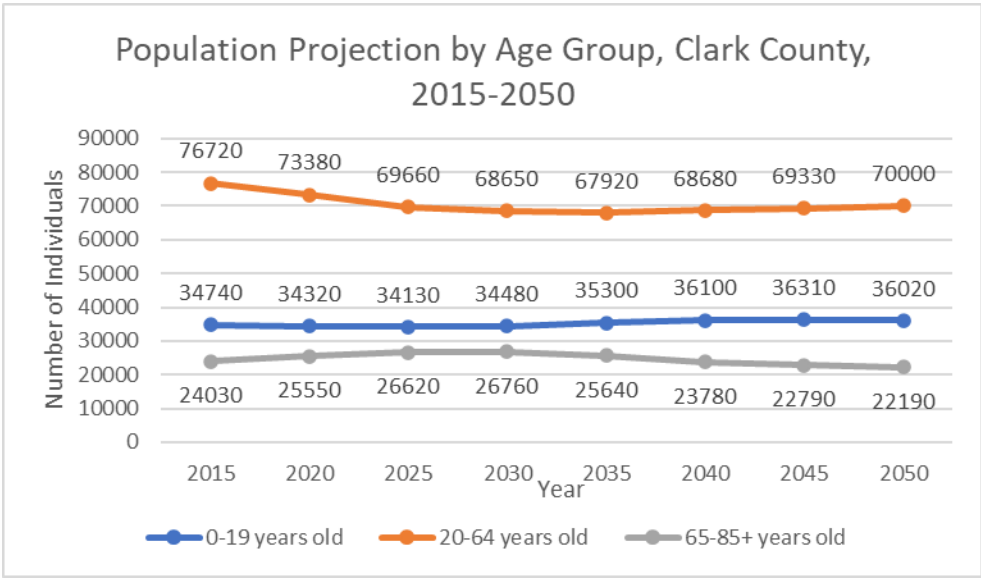


Figure 10: Population projection by age group, Clark County, 2015-2050, Ohio Development Services Agency 2018

Health Outcomes

Length of Life

The average life expectancy for Clark County is 73.9 years, which is lower than both the state of Ohio (76.5 years) and the United States (80.6 years) (Table 4). The central portion of Clark County has the lowest life expectancy concentration ranging from 65.7 to 75.0 years of age. The northern, northwestern, and southern parts of Clark County have the highest life expectancy ranging from 77.5 to 83.6 years of age (Figure 11).

Table 4: Average life expectancy for Clark County, Ohio & US, 2018-2020, U.S. Small-area Life Expectancy Estimates Project (USALEEP)

Location	Average Life Expectancy (Years)
Clark County	73.9
Ohio	76.5
US	80.6

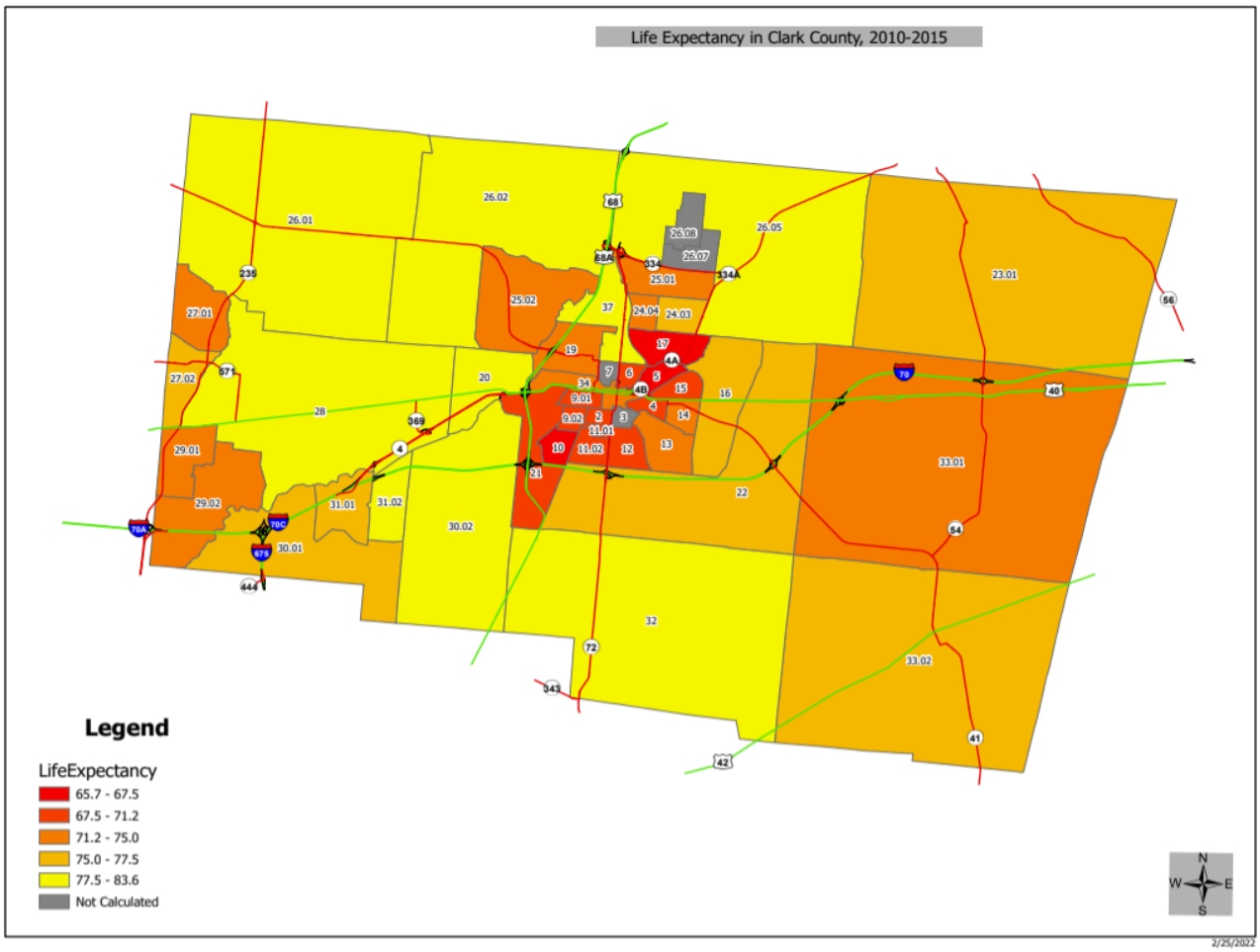


Figure 11: Life expectancy in Clark County, 2010-2015, U.S. Small-area Life Expectancy Estimates Project (USALEEP)

Heart disease, cancer, and drug poisonings are the top three causes of premature death in Clark County overall (Table 5). The highest cause of premature death for white residents is heart disease, compared to drug poisonings for Black residents (Table 6). For every 1,000 people under the age of 75 years, Black residents lose 23.9 years of potential life compared to white residents who lose 10.9 years of potential life due to accidents (Table 6). Black Residents have a higher rate for a majority of causes of premature death (Table 6). The greatest disparities can be seen from diabetes mellitus, septicemia, COVID-19, accidents, and stroke.

Table 5: Years of Potential Life Lost (YPLL), Clark County, 2020. Ohio Department of Health Vital Statistics, Mortality Files 2010-2020

Cause of Death	YPLL	Rate
Heart Disease	2571	20.9
Cancer	2035	16.5
Drug Poisonings	1899	15.4
Accidents	1500	12.2
COVID-19	1261	9.9
Suicide	982	8.0
Diabetes Mellitus	516	4.2
Stroke	431	3.5
Chronic Lower Respiratory Disease	385	3.1
Septicemia	276	2.2
Influenza & Pneumonia	151	1.2
Alzheimer's	25	0.2

Table 6: Years of Potential Life Lost by Race (YPLL), Clark County, 2020, Ohio Department of Health Vital Statistics, Mortality Files 2010-2020.

	White		Black	
	YPLL	Rate	YPLL	Rate
Heart Disease	2346	22.2	223	21.4
Cancer	1793	17.0	231	22.2
Drug Poisonings	1644	15.6	255	24.5
Accidents	1148	10.9	249	23.9
COVID-19	953	8.8	218	20.3
Suicide	809	7.7	124	11.9
Diabetes Mellitus	417	3.9	99	9.5
Chronic Lower Respiratory Disease	364	3.4	21	2.0
Stroke	356	3.4	75	7.2
Septicemia	223	2.1	53	5.1
Influenza & Pneumonia	146	1.4	5	0.5

The highest cause of premature death for female residents is cancer, compared to heart disease for male residents (Table 7). For every 1,000 people under the age of 75 years, male residents lose 30.7 years of potential life compared to female residents who lose 11.4 years of potential life due to heart disease (Table 7). Male residents have a higher rate for a majority of causes of premature death (Table 7). The greatest disparities can be seen from suicide, heart disease, drug poisonings, and accidents (Table 7).

Between 2010-2020, drug poisonings have increased 258%, suicides have increased 33.3%, and heart disease deaths have increased 20.8% (Figure 12).

Table 7: Years of Potential Life Lost by Sex (YPLL), Clark County, 2020, Ohio Department of Health Vital Statistics, Mortality Files 2010-2020.

	Female		Male	
	YPLL	**Rate**	**YPLL**	**Rate**
Heart Disease	714	11.4	1857	30.7
Drug Poisonings	570	9.1	1329	22.0
Cancer	874	13.9	1161	19.2
Accidents	490	7.8	1010	16.7
Suicide	165	2.6	817	13.5
COVID-19	429	6.6	832	13.3
Diabetes Mellitus	249	4.0	267	4.4
Stroke	202	3.2	229	3.8
Chronic Lower Respiratory Disease	164	2.6	221	3.7
Septicemia	173	2.8	103	1.7
Influenza & Pneumonia	111	1.8	40	0.7

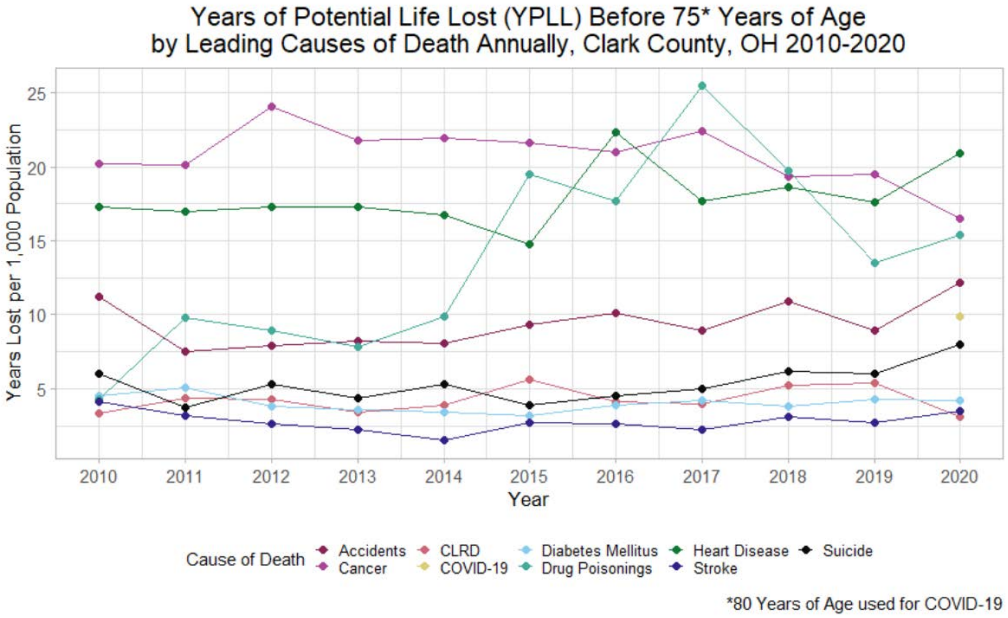


Figure 12: Years of potential life lost (YPLL) before 75 years of age by leading causes of death annually, Clark County, OH 2010-2020. Ohio Department of Health Vital Statistics, Mortality Files 2010-2020.*

From 2016-2020, Cancer was the greatest contributor to YPLL in most of Clark County, except in the cities of Springfield and New Carlisle, where drug poisonings were the greatest contributor to YPLL (Figure 13).

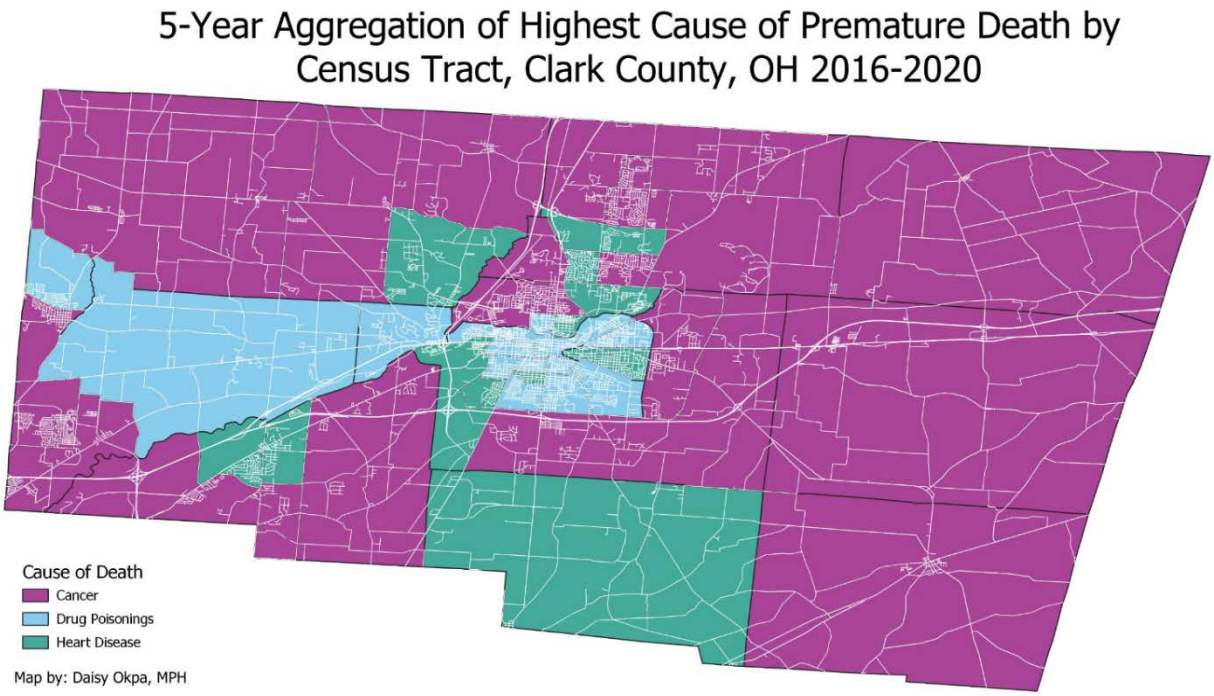


Figure 13: 5-year aggregation of highest cause of premature death by census tract, Clark County, OH 2016-2020. Ohio Department of Health Vital Statistics, Mortality Files 2010-2020.

Infant Mortality

Between 2013 and 2020, the state of Ohio infant mortality has remained relatively constant ranging between 6.8 and 7.2. Clark County has experienced some fluctuations in their infant mortality rates, ranging from 3.7 to 13.0. There was a 251% increase from 2015-2016, followed by a 52.3% decrease from 2016-2017 (Figure 14). The leading cause of infant death between 2016-2020 is prematurity related, followed by congenital anomalies (Figure 15). Black infants have the highest rates of mortality for all categories of infant death (Table 8).

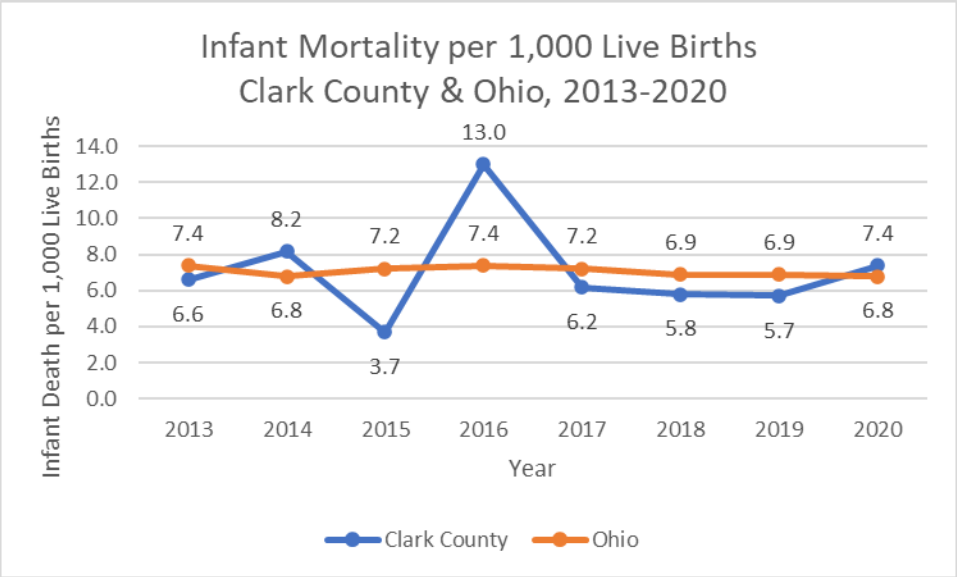


Figure 14: Infant Mortality per 1,000 live births, Clark County and Ohio, 2013-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

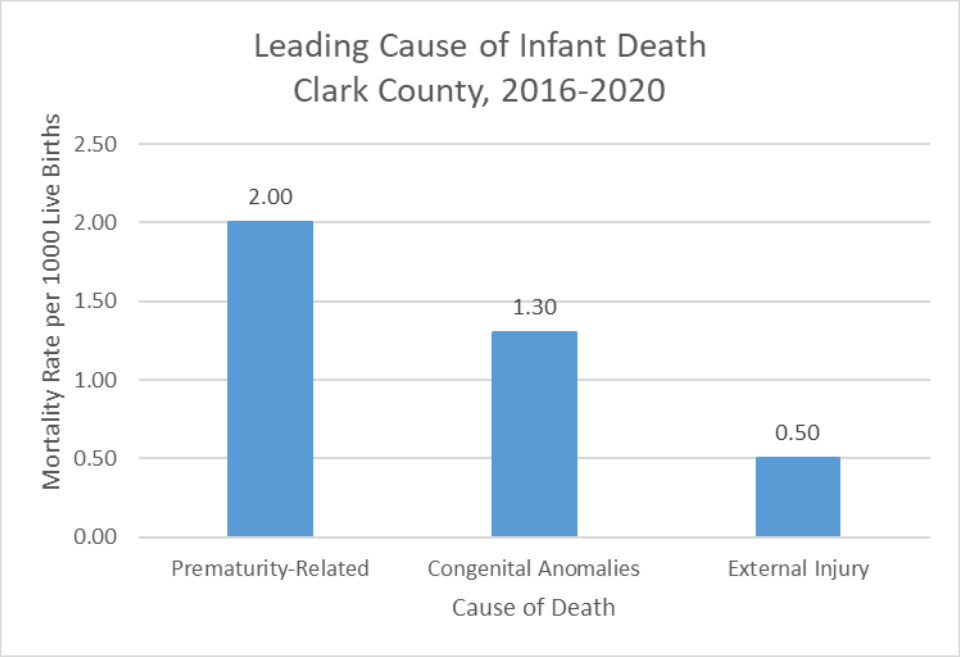


Figure 15: Leading causes of infant death, Clark County, 2016-2020. Data queried from the Ohio Department of health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 8: Leading causes of infant death by race, Clark County, 2016-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Cause of Infant Death	All Races	Black	White	Hispanic
Prematurity-Related	2.00	4	1.4	1.8
Congenital Anomalies	1.30	1.5	1.3	1.5
Obstetric Conditions	0.80	1.4	0.7	0.3
External Injury	0.50	1	0.3	0.7
Sudden Infant Death Syndrome (SIDS)	0.40	1.2	0.2	0.8
Perinatal Infections	0.40	0.9	0.3	0.4
Other infections	0.30	0.6*	0.2	**
Birth Asphyxia	0.10	**	**	**
Undetermined	0.10	**	**	**

*Based on less than 20 deaths, interpret with caution

**Suppressed due to less than 10 deaths

Leading Causes of Death

Between 2015-2020, heart disease and cancer have remained the top two causes of death within Clark County annually. There has been an overall 1.7% decline in heart disease mortality rate, and an overall 10.2% decline in the cancer mortality rate (Table 9).

Between 2016-2020, the suicide rate per 100,000 within Clark County has consistently been greater than the suicide rate for the state of Ohio and the United States populations (Table 10). The suicide rate for men within Clark County has increased 69.2% between 2010-2020, with 2020 having the highest rate. The suicide rate for women has fluctuated between 1.4 and 10.1, the overall increase is 4.8%. (Figure 18). When comparing suicide rates by age group between 2011-2015 and 2016-2020, all age groups except for the 40-49 group has seen an increase in suicide rate (Figure 19).

Table 9: Top 10 leading causes of death, Clark County, 2015-2020, age-adjusted mortality rate. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Cause of Death	2015	2016	2017	2018	2019	2020
Heart Disease	201.5	207.3	210.7	204.9	187.9	198
Cancer	191.4	183.5	187.9	183.7	177	171.8
Stroke	61.2	70.2	74.3	52	52.8	75.1
Unintentional Injuries	94.0	95.6	116.6	106.3	61.2	67.9
Chronic Lower Respiratory Diseases	64.8	61.8	51.0	59.4	59.7	56.3
Diabetes Mellitus	30.7	32.6	33.2	34.4	36.2	39.7
Alzheimer's Disease	46.6	32.5	36.6	35.3	36.6	36
Suicide	15.4	15.2	18.4	21	18	20.4
Septicemia	21.0	13.7	15.3	19	9.8	15.9
Influenza & Pneumonia	30.2	18.7	24.0	14.9	10.9	11.1

*Drug Overdose Deaths are included in the Unintentional Injuries Category

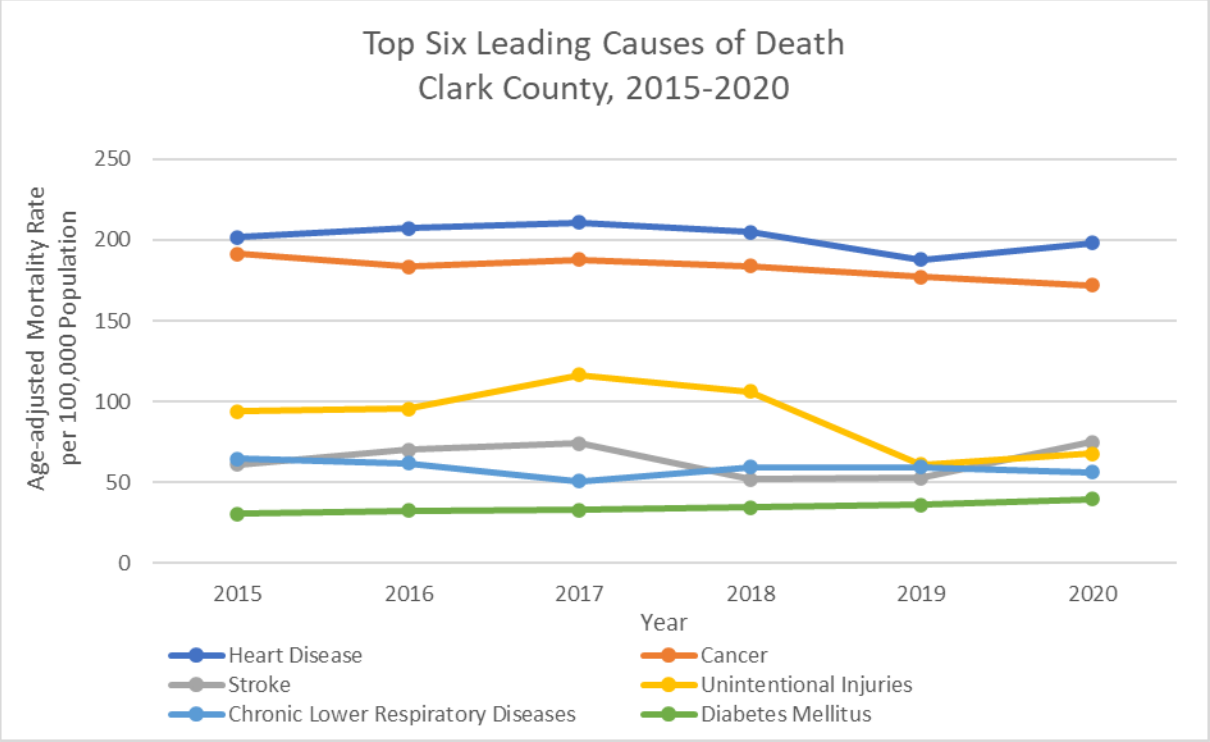


Figure 16: Top six leading causes of death, Clark County, 2015-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 10: Suicide rates per 100,000 population, Clark County, Ohio & US, 2016-2020, CDC Wonder.

Year	Clark County	Ohio	US
2016	15.2	14.2	13.5
2017	18.4	14.8	14.0
2018	16.3	15.7	14.8
2019	14.9	15.5	14.5
2020	16.3	14.1	14.0

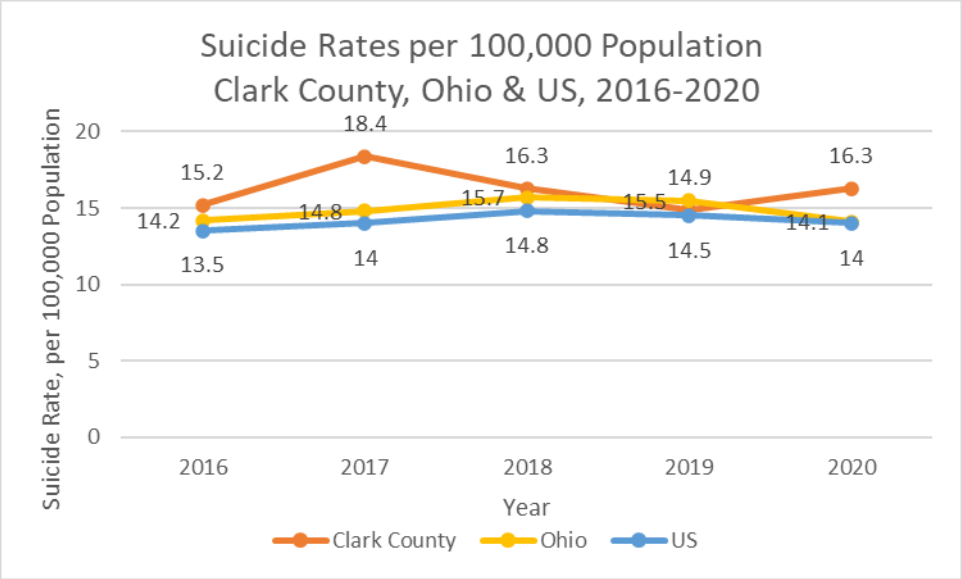


Figure 17: Suicide rates per 100,000 population, Clark County, Ohio, and US, 2016-2020, CDC Wonder

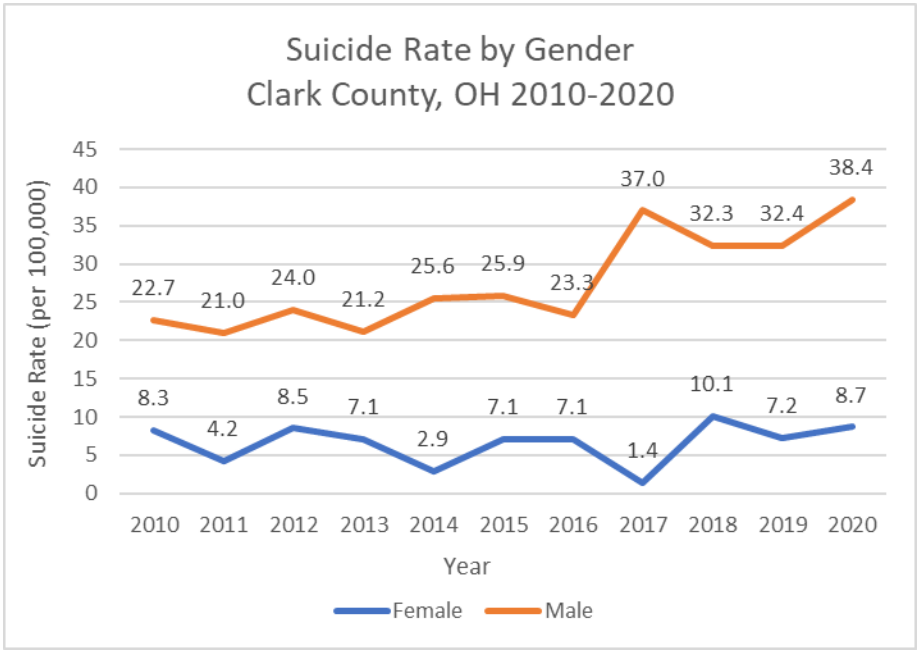


Figure 18: Suicide rate by gender, Clark County, Ohio 2010-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

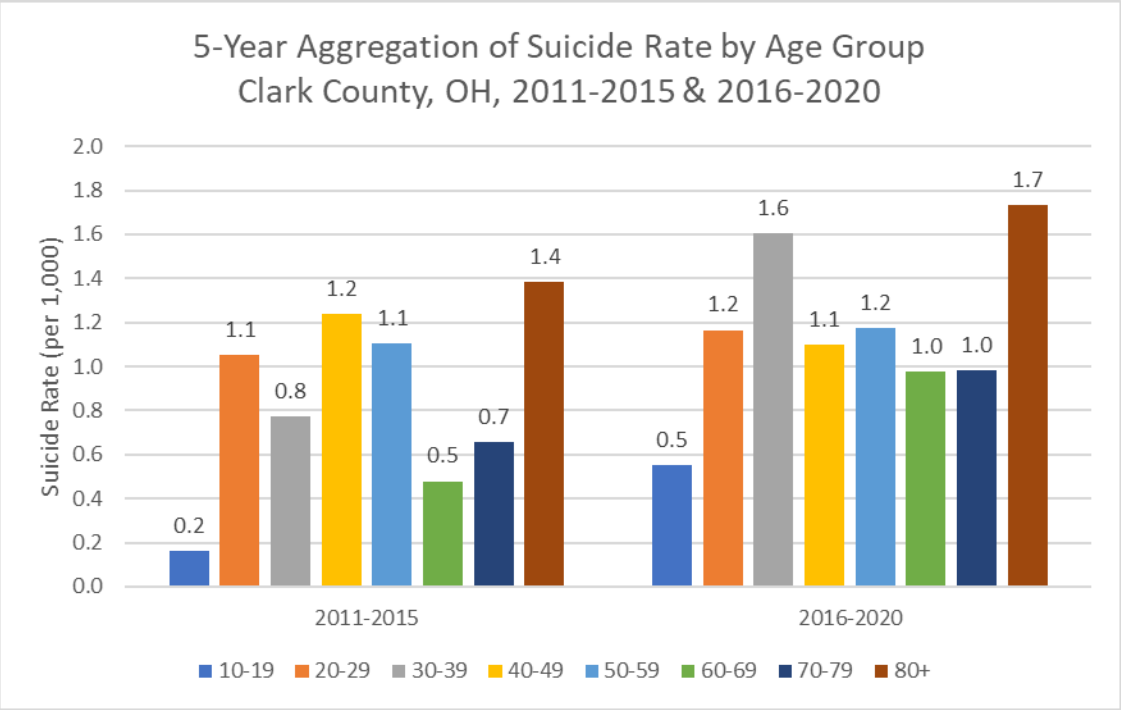


Figure 19: Age-specific suicide rates, Clark County, 2011-2015 and 2016-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions

Quality of Life

Overall Health

Based upon the Behavioral Risk Factor Surveillance System conducted in 2018, 22.0% of Clark County residents have a fair or poor health status, which is higher than both the state of Ohio and the United States (Table 11). Clark County has a higher average of poor physical health days and poor mental health days compared to Ohio and the United States (Table 12).

Table 11: Fair or poor health status among adults, Clark County, Ohio & US, Behavioral Risk Factor Surveillance System (BRFSS), Ohio State Health Assessment 2018.

Location	Percent of Respondents
Clark County	22.0%
Ohio	18.0%
US	15.0%

Table 12: Poor health days in the last 30 days among adults, Clark County, Ohio & US, 2018, Behavioral Risk Factor Surveillance System (BRFSS), Ohio State Health Assessment 2018.

Type of Poor Health Day	Location	Number of Days
Poor Physical Health Days	Clark County	4.7
	Ohio	4.2
	US	3.4
Poor Mental Health days	Clark County	5.5
	Ohio	5.2
	US	4

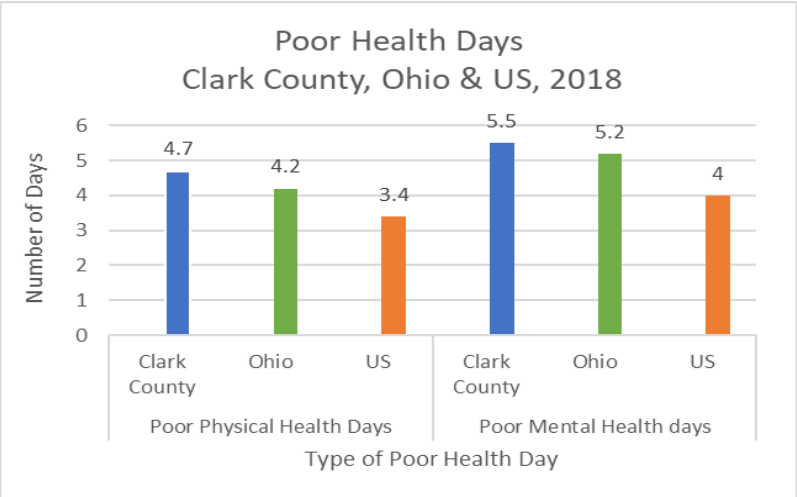


Figure 20: Poor Health Days in the Past 30 Days Among Adults, 2018, Behavioral Risk Factor Surveillance System (BRFSS), Ohio State Health Assessment 2018

Asthma

In 2021, there were 591 asthma-related emergency department visits with CMHP Mercy Hospital Springfield seeing 480 of those visits (Figure 21). The average age of asthma-related emergency department visitors is 32.1 at CMHP Mercy Hospital Springfield, and 30.4 at CMHP Mercy Hospital Memorial.

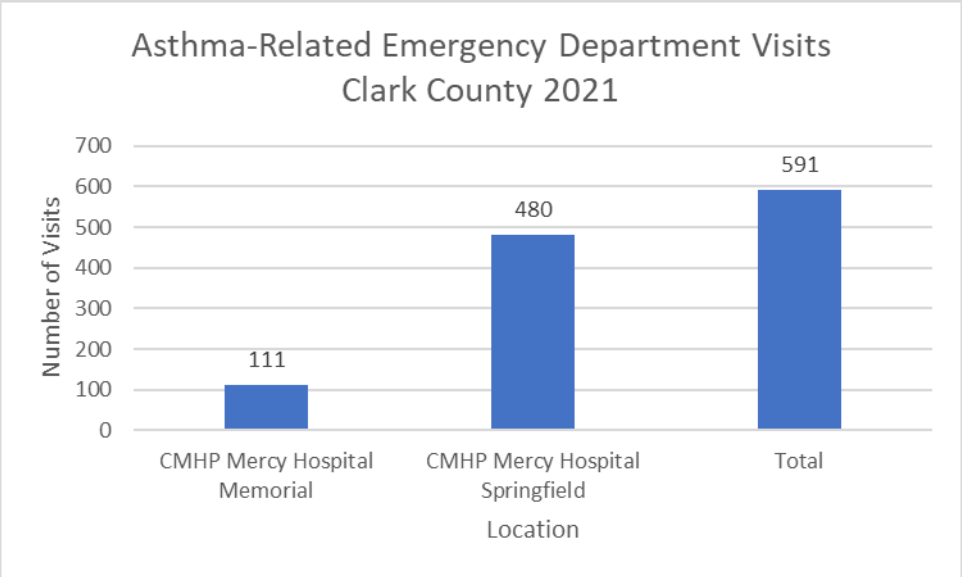


Figure 21: Asthma-related emergency department visits, Clark County, 2021, Springfield Regional Medical Center.

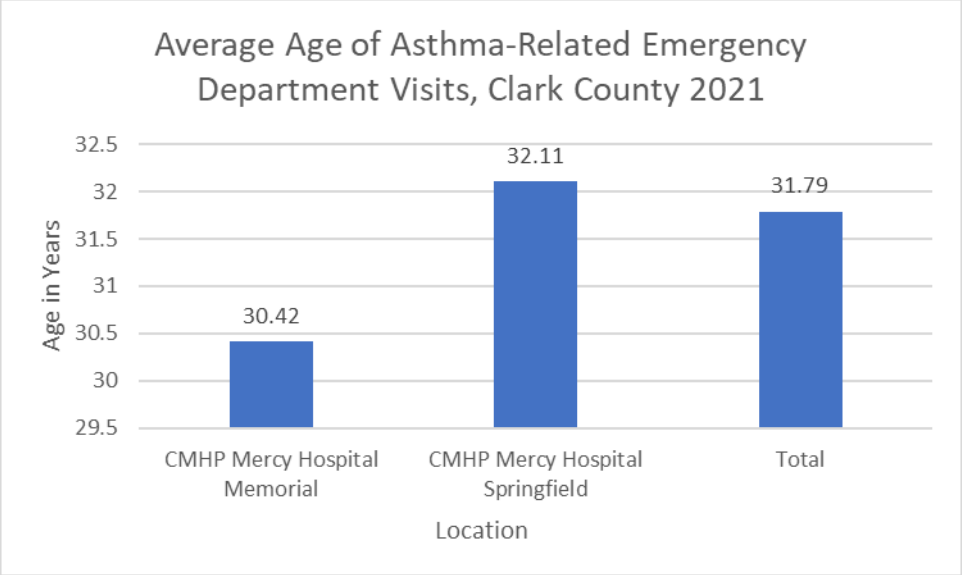


Figure 22: Average age of asthma-related emergency department visits, Clark County, 2021, Springfield Regional Medical Center.

Birth Outcomes

Between 2012-2020, non-Hispanic white residents of Clark County and Ohio have maintained relatively consistent percentages of live births with low birthweight. Non-Hispanic Black residents have seen some fluctuation with values ranging from 10.6% to 18.1% (Table 13). Non-Hispanic white residents of Clark County and Ohio have maintained consistent percentages of preterm births (Figure 243). Non-Hispanic Black residents of Clark County and Ohio have seen a decline of 32.2% and 0.7%, respectively (Table 14).

Table 13: Percent of live births with low birthweight by race and ethnicity, Clark County & Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Year	Clark County			Ohio		
	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2012	8.58%	12.97%	6.06%	7.41%	13.83%	7.55%
2013	7.24%	12.09%	7.95%	7.41%	13.37%	8.00%
2014	8.10%	15.84%	6.85%	7.30%	13.58%	7.82%
2015	7.03%	18.13%	10.11%	7.27%	13.93%	7.68%
2016	7.83%	13.45%	3.30%	7.39%	14.15%	8.68%
2017	9.70%	12.57%	6.73%	7.27%	14.28%	8.60%
2018	7.89%	17.24%	3.33%	7.24%	13.70%	7.54%
2019	9.48%	13.92%	11.70%	7.26%	13.66%	7.84%
2020	9.02%	10.61%	8.89%	7.14%	14.00%	7.70%

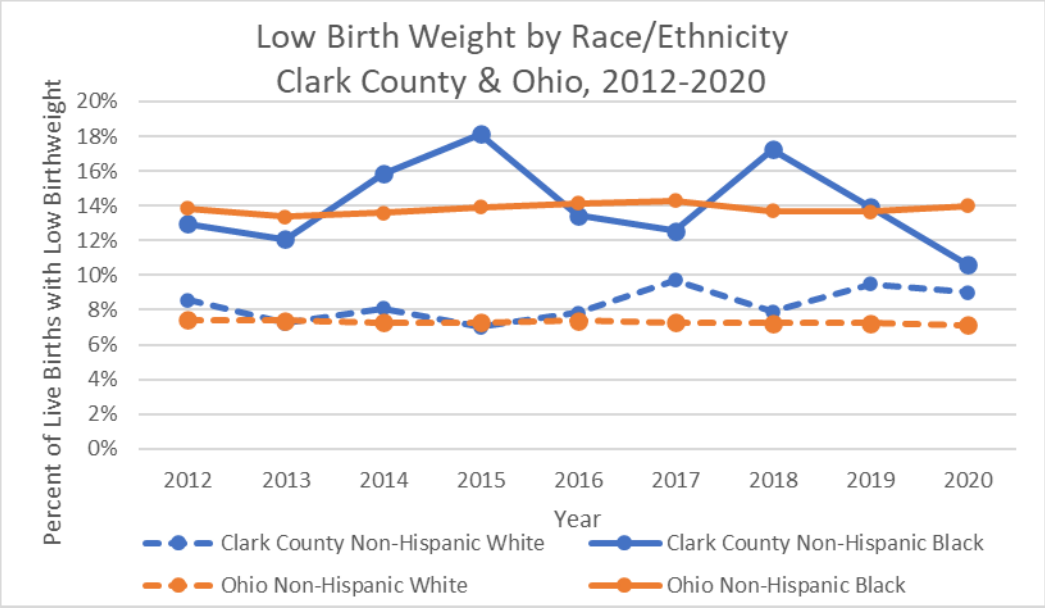


Figure 23: Percent of live births with low birthweight by race and ethnicity, Clark County and Ohio, 2012-2020. Data queried from the Ohio Department of Health Public health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 14: Percent of preterm live births by race and ethnicity, Clark County & Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Year	Clark County			Ohio		
	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2012	13.18%	16.67%	7.07%	9.62%	14.35%	10.09%
2013	12.52%	17.58%	11.36%	9.57%	13.85%	10.54%
2014	10.57%	14.36%	8.22%	9.51%	13.78%	10.09%
2015	11.80%	15.54%	13.48%	9.44%	14.13%	10.36%
2016	11.50%	18.13%	6.59%	9.57%	14.25%	10.13%
2017	10.55%	15.71%	8.65%	9.40%	14.47%	10.51%
2018	10.61%	18.23%	14.44%	9.48%	13.83%	11.08%
2019	11.61%	15.54%	11.70%	9.65%	13.95%	10.54%
2020	12.51%	11.30%	12.22%	9.38%	14.25%	10.18%

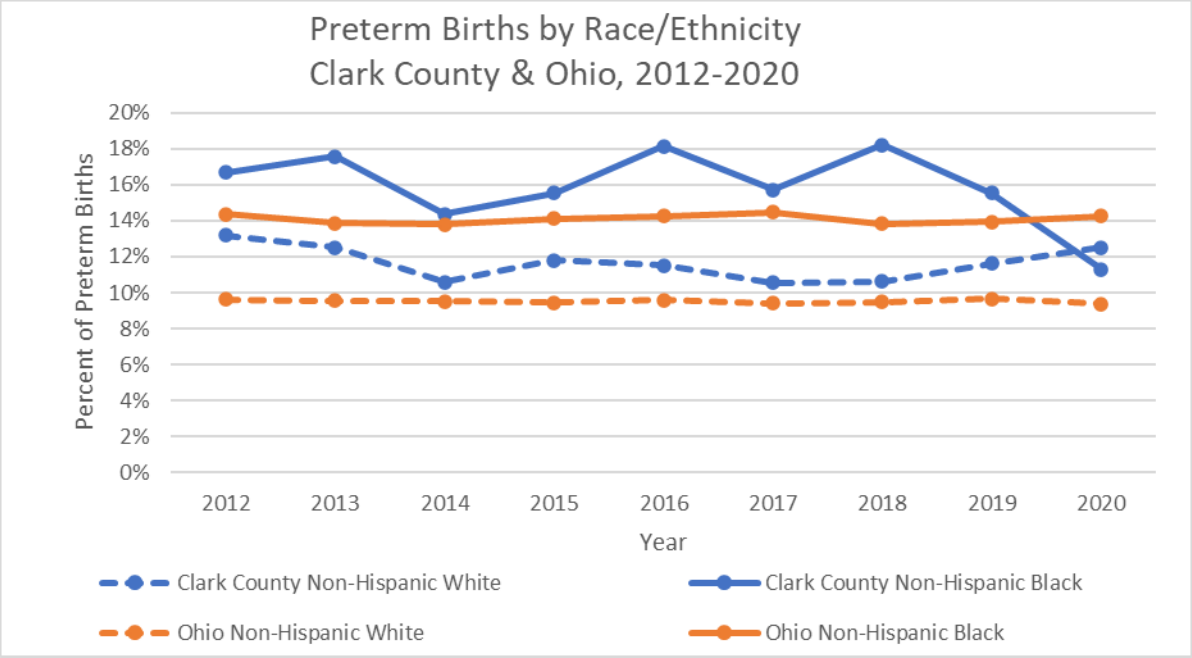


Figure 24: Percent of preterm births by race and ethnicity, Clark County and Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Cancer Incidence

The top five cancer types in Clark County as breast, colon and rectum, lung and bronchus, melanoma of the skin, and prostate cancer. All these types have seen a decline in incidence between 2012 and 2020 (Table 15). Clark County has higher cancer incidence rates and higher cancer mortality rates in males, females, white residents, and Black residents compared to Ohio and the US (Figure 26, Figure 27).

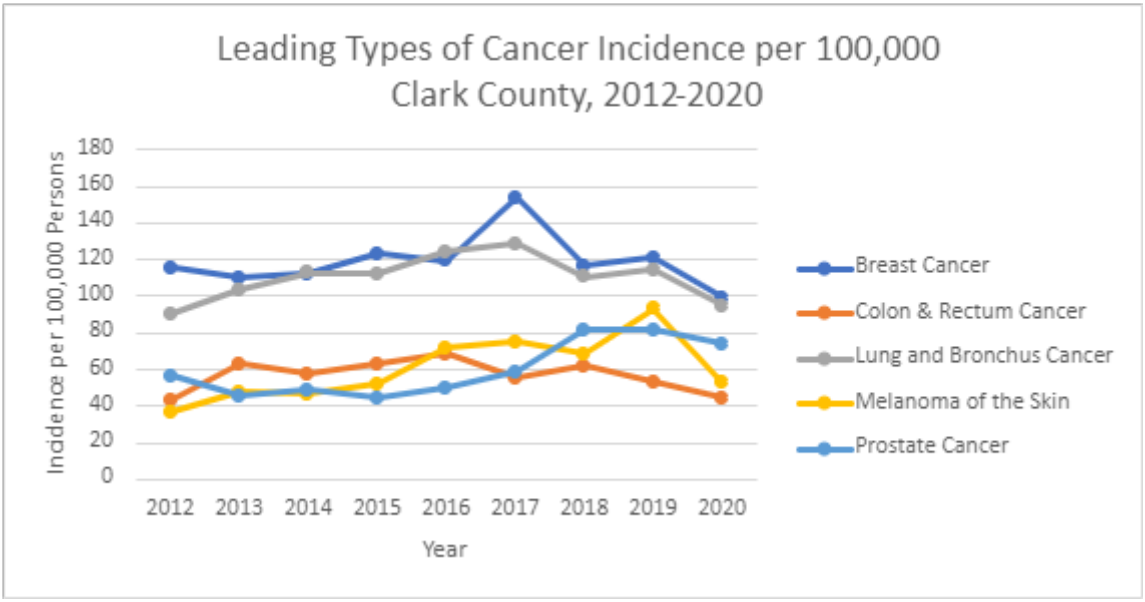


Figure 25: Leading cancer incidence per 100,000, Clark County, 2012-2020. Data queried from the Ohio Cancer Incidence Surveillance System (OCISS). The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 15: Leading cancer incidence per 100,000, all stages, Clark County, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Cancer Type	2012	2013	2014	2015	2016	2017	2018	2019	2020
Breast Cancer	115.92	110.51	112.24	123.02	119.50	153.85	116.7	121.57	99.0
Colon & Rectum Cancer	43.01	63.67	57.22	63.35	69.03	55.74	61.7	53.7	44.6
Lung and Bronchus Cancer	90.40	103.19	112.97	112.71	124.70	129.32	110.76	114.11	94.5
Melanoma of the Skin	36.45	48.30	46.95	52.30	72.00	75.07	69.13	93.23	52.8
Prostate Cancer	56.14	45.38	49.15	44.94	50.47	58.71	81.77	82.04	74.4

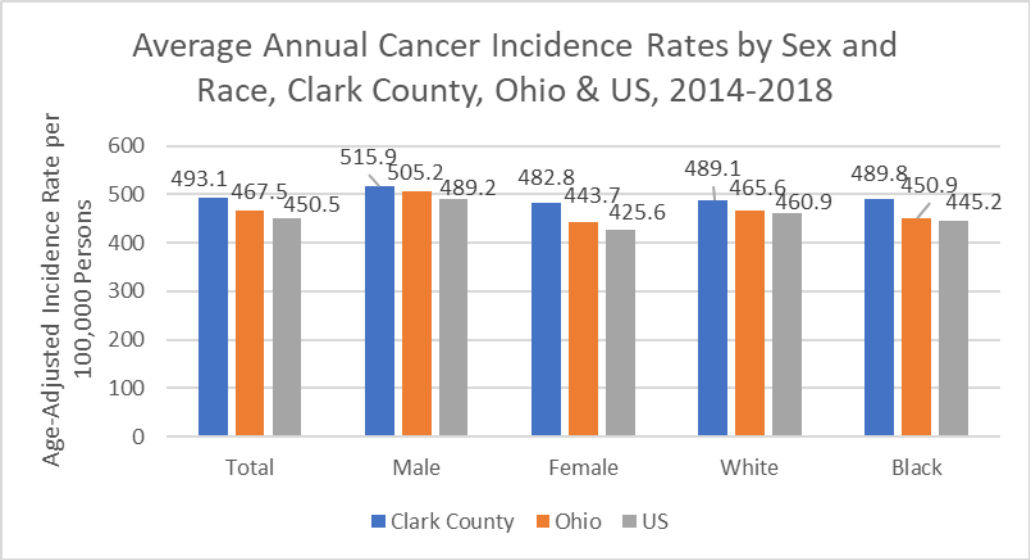


Figure 26: Average annual cancer incidence rates by sex and race, Clark County, Ohio, and US, 2014-2018. Data queried from the Ohio Cancer Incidence Surveillance System (OCISS). The Ohio Department of Health specifically disclaims any analysis, interpretations, or conclusions

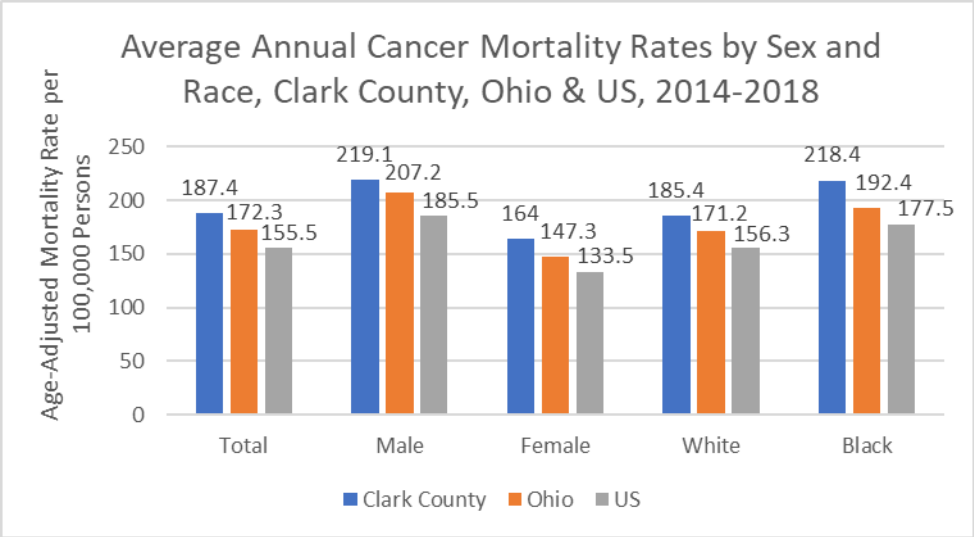


Figure 27: Average annual cancer mortality rates by sex and race, Clark County, Ohio, and US, 2014-2018. Data queried from the Ohio Department of Health Bureau of Vital Statistics. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Disability

Between 2015-2019, Clark County had higher disability status for all age groups compared to Ohio and the US (Figure 28). Table 12 shows the prevalence of six disability types within Clark County, Ohio, and the US for the total population, under 18 years old, 18-64 years old, and 65+ years old.

Within Clark County, 9.6% of the population has an ambulatory disability and 7.6% have a disability but are independently living (Table 16). Within the under 18 population, 80.0% have a vision disability (Table 16). Within the 18-64 population, 7.7% have an ambulatory disability (Table 16). Within the 65+ population, 23.3% have an ambulatory disability followed by 15.7% with a hearing disability (Table 16). More information about disabilities can be found in Appendix C.

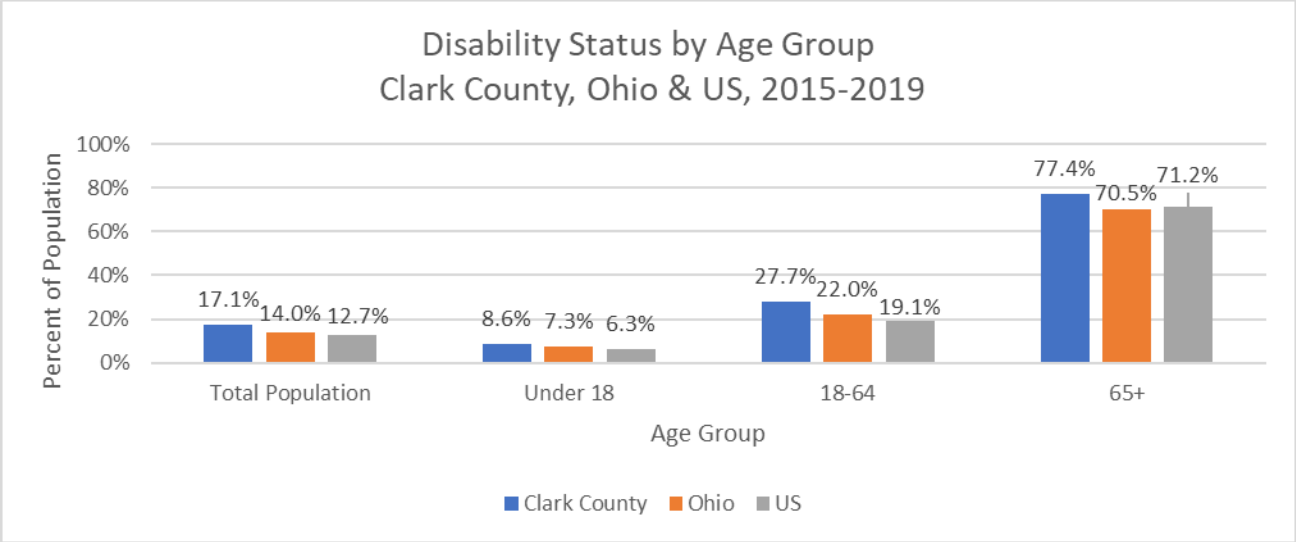


Figure 28: Disability status by age group, Clark County, Ohio and US, American Community Survey 5-year Estimates, 2015-2019

Table 16: Prevalence of disability type within the total population, Clark County, Ohio & US, 2015-2019, American Community Survey 5-year Estimates.

Disability Type	Age Group	Clark County	Ohio	US
Ambulatory	Total Population	9.6%	7.5%	6.9%
	Under 18	1.2%	0.6%	0.6%
	18-64	7.7%	5.7%	4.9%
	65+	23.3%	21.5%	21.9%
Cognitive	Total Population	7.1%	5.8%	5.1%
	Under 18	7.3%	5.3%	4.2%
	18-64	6.8%	5.4%	4.4%
	65+	8.0%	7.9%	8.6%
Hearing	Total Population	4.9%	3.8%	3.6%
	Under 18	0.4%	0.6%	0.6%
	18-64	3.2%	2.2%	2.0%
	65+	15.7%	14.1%	14.3%
Independent Living	Total Population	7.6%	6.3%	5.8%
	18-64	5.8%	4.3%	3.7%
	65+	13.3%	13.8%	14.2%
Self-Care	Total Population	3.2%	2.8%	2.6%
	Under 18	1.6%	1.1%	1.0%
	18-64	2.6%	2.0%	1.8%
	65+	6.8%	7.4%	7.9%
Vision	Total Population	2.8%	2.4%	2.3%
	Under 18	80.0%	0.7%	0.8%
	18-64	2.7%	2.0%	1.9%
	65+	5.7%	5.9%	6.3%

Communicable Diseases

Between 2020 and 2021, the annual disease totals will be greatly increased due to COVID-19 cases. There is a separate figure for totals including COVID-19 cases (Figure 29) and a figure for totals not including COVID-19 cases (Figure 30). There has been a 15% decline in annual communicable diseases cases from 2017 to 2021, not including COVID-19 cases (Figure 30). During the same time period, there has been a decline in Camplyobacteriosis cases (Figure 31) and an increase in Carbapenemase-Producing Carbapenem-Resistant Enterobacteriaceae (CP-CRE) cases (Figure 32). A detailed table of communicable diseases reported in Clark County over a 10-year period can be found in Appendix C.

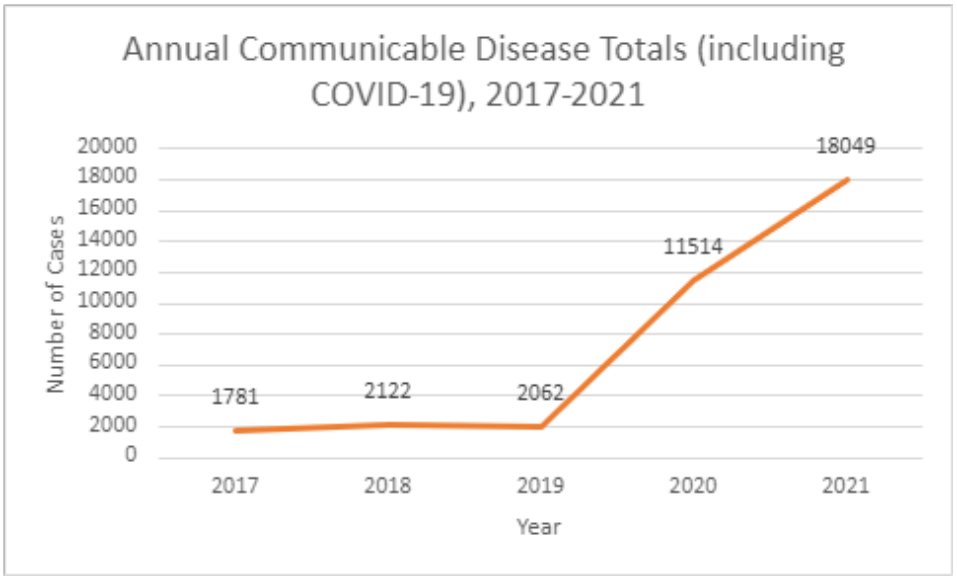


Figure 29: Annual communicable disease totals including COVID-19, Clark County, 2017-2021. Data queried from Ohio Disease Reporting System (ODRS).

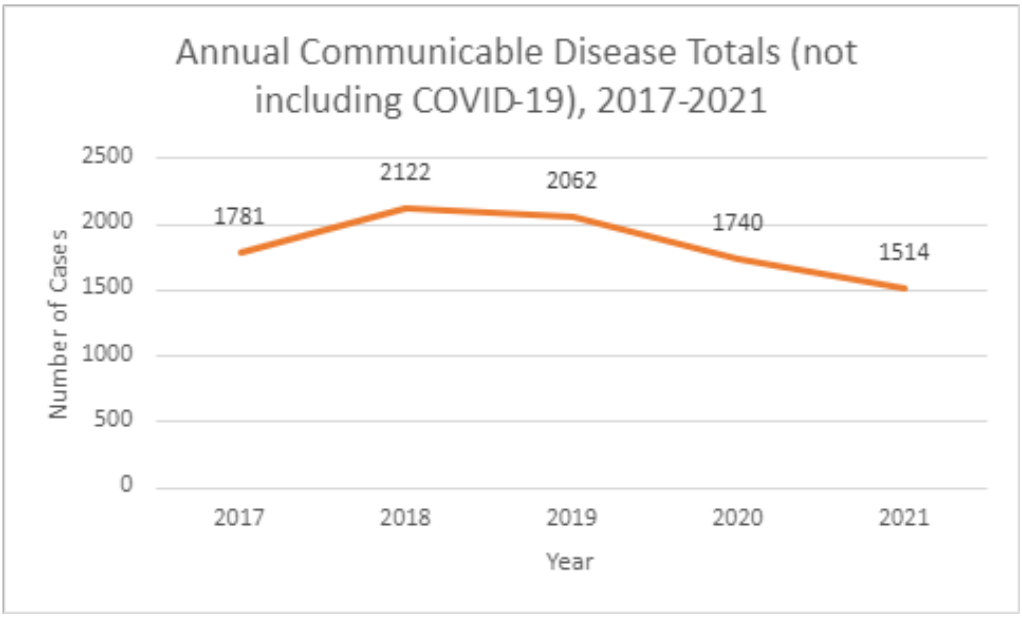


Figure 30: Annual communicable disease totals not including COVID-19, Clark County, 2017-2021. Data queried from Ohio Disease Reporting System (ODRS).

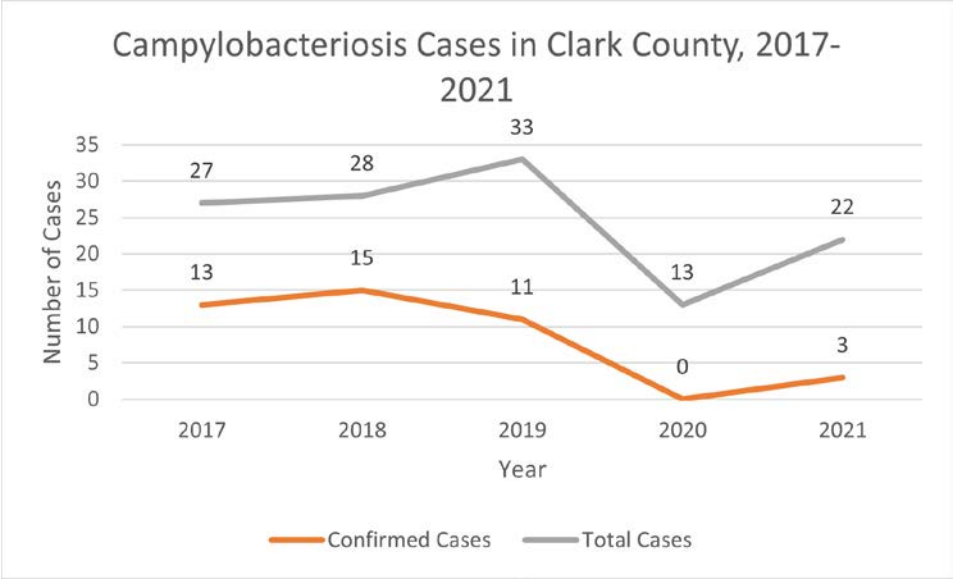


Figure 31: Campylobacteriosis cases, Clark County, 2017-2021. Data queried from Ohio Disease Reporting System (ODRS).

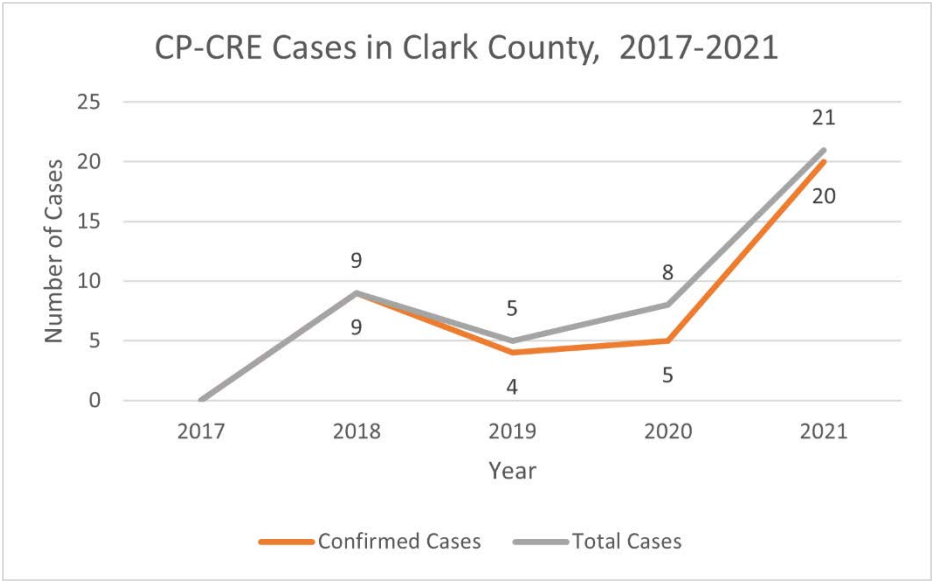


Figure 32: Carbapenemase-Producing Carbapenem-Resistant Enterobacteriaceae (CP-CRE) cases, Clark County, 2017-2021. Data queried from Ohio Disease Reporting System (ODRS).

Key Events in Communicable Disease – COVID-19

During 2020-2021, there were more than 26,300 COVID-19 cases within Clark County. 54.5% of COVID-19 cases were female (Figure 33), 68.2% were white (Figure 34), and 19.1% were in the 0-19 age group (Figure 35).

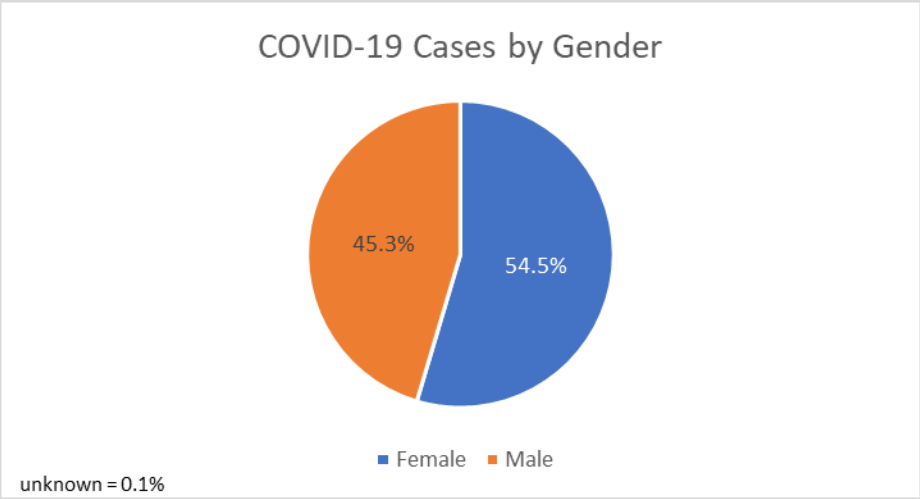


Figure 33: COVID-19 cases by gender, Clark County, 2020-2021, Clark County COVID-19 Report.

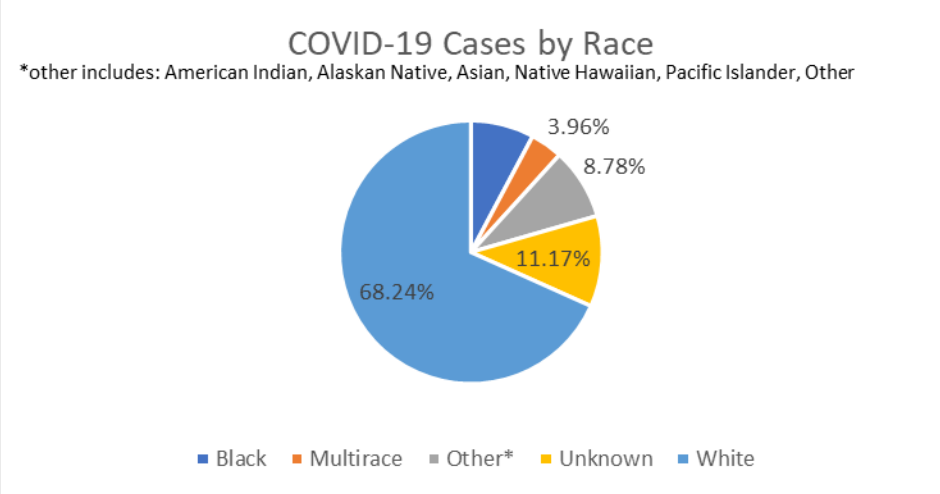


Figure 34: COVID-19 cases by race, Clark County, 2020-2021, Clark County COVID-19 Report.

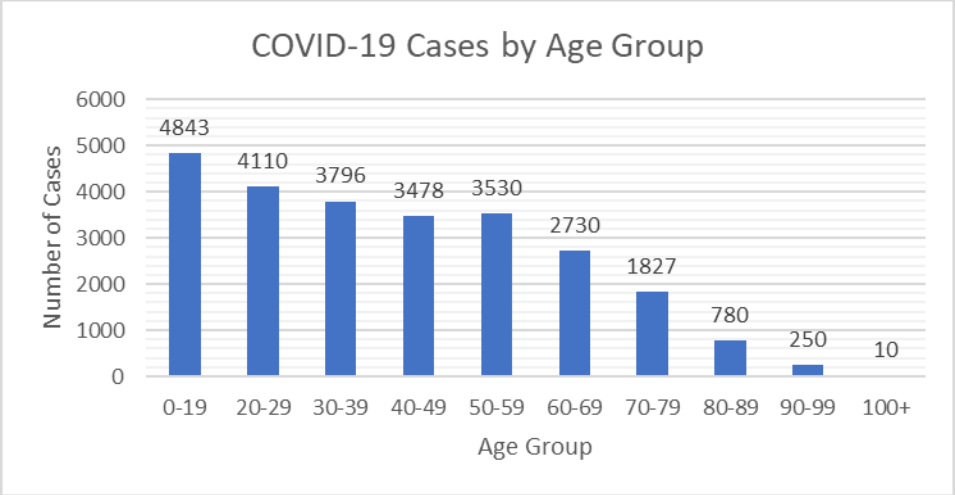


Figure 35: COVID-19 cases by age group, Clark County, 2020-2021, Clark County COVID-19 Report.

Health Behaviors

Sexual Activity

Sexually Transmitted Infections

Sexually transmitted disease rates in Clark County have been increasing for gonorrhea and syphilis, while remaining relatively constant for chlamydia. Both gonorrhea and syphilis rates are higher than the state. There has been an 8.8% increase in the chlamydia rate between 2015-2020 (Figure 36). There has been a 225.8% increase in the gonorrhea rate between 2015-2020 (Figure 37). There has been an 88.9% increase in the syphilis rate between 2015-2020 (Figure 38).

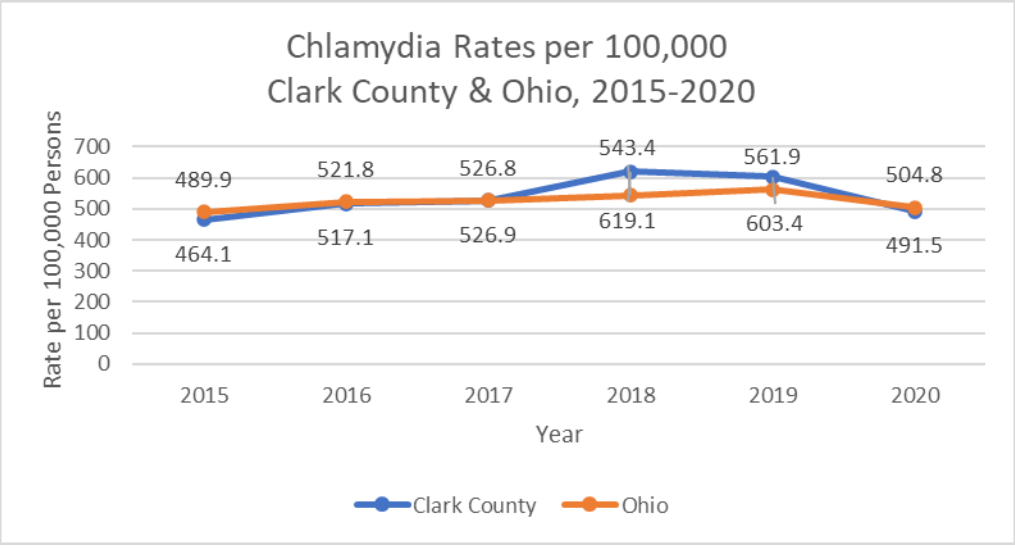


Figure 36: Chlamydia rates per 100,000, Clark County and Ohio, 2015-2020, Ohio Department of Health STD Surveillance Program

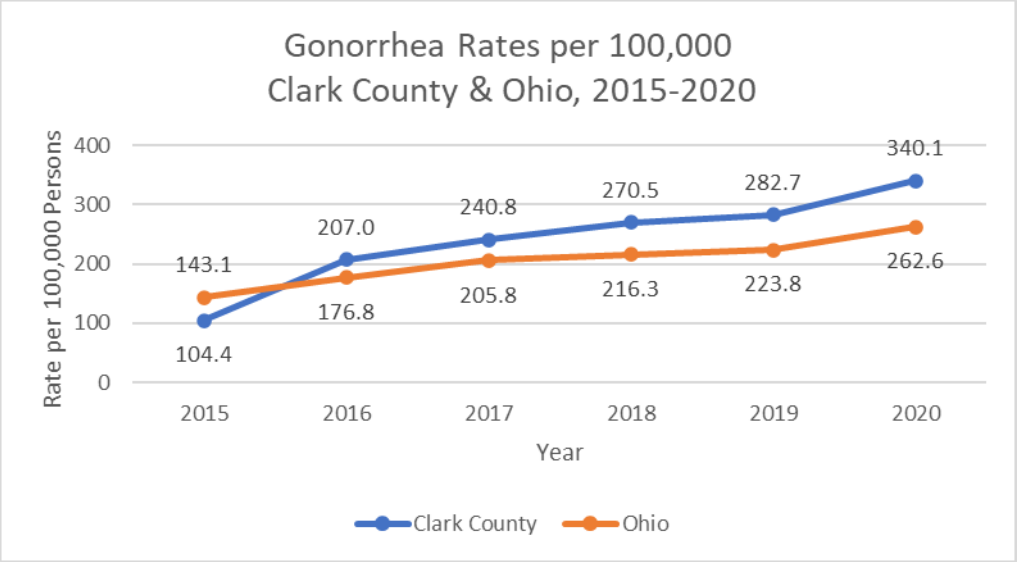


Figure 37: Gonorrhea rates per 100,000, Clark County and Ohio, 2015-2020, Ohio Department of Health STD Surveillance Program

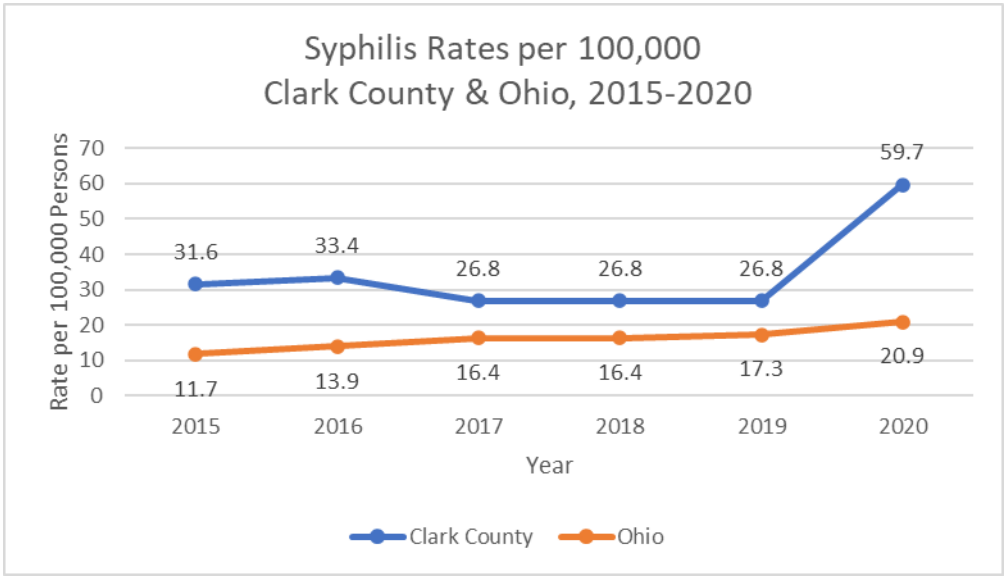


Figure 38: Syphilis rates per 100,000, Clark County and Ohio, 2015-2020, Ohio Department of Health STD Surveillance Program

Teen Births

There has been a decline in teen birth rates for both Clark County and Ohio between 2012 and 2020 (Figure 39). Clark County has seen a 34% decline, and Ohio has seen a 46% decline. Clark's teen birth rate has been consistently higher than the states during this time period.

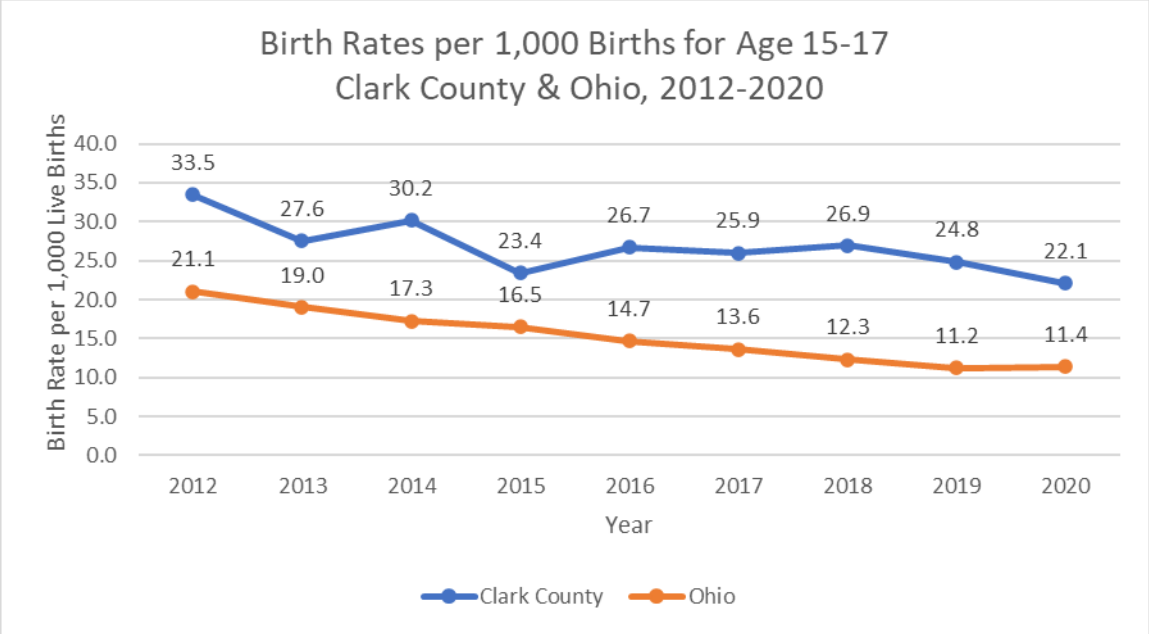


Figure 39: Birthrates per 1,000 births for ages 15-17, Clark County and Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions

Smoking

All smoking status in Ohio between 2013-2020 has remained relatively constant (Figure 40), according to the BRFSS conducted by the CDC.

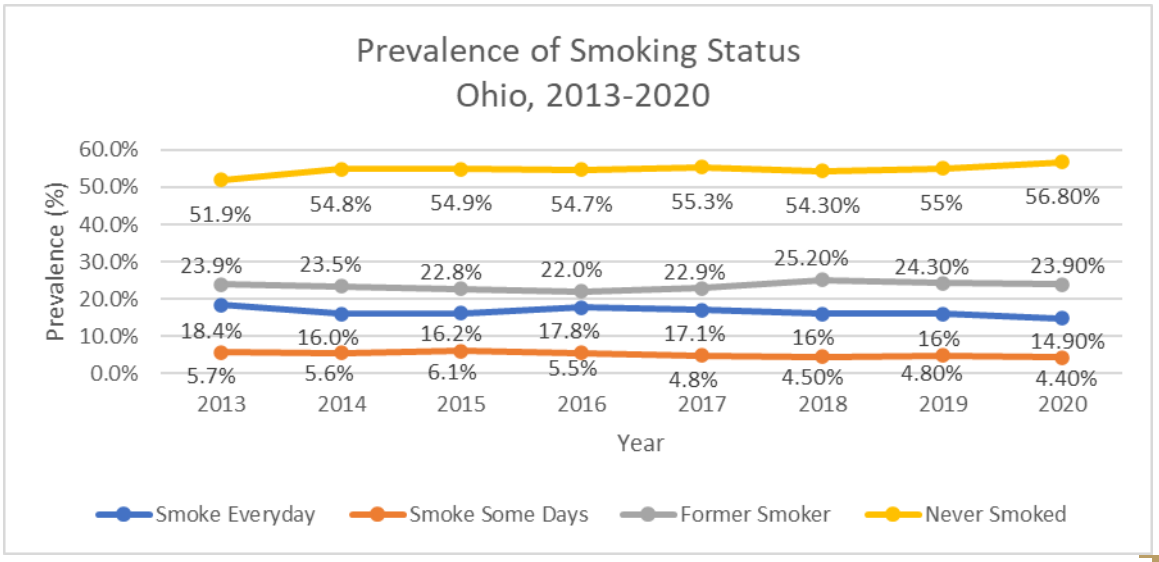


Figure 40: Prevalence of smoking status, Ohio, 2013-2020, CDC BRFSS

Smoking During Pregnancy

While Clark County has a higher percentage of pregnant mothers who have smoked during pregnancy compared to Ohio, there has been an overall decline in percentages for both Clark County and Ohio (Figure 41). More data regarding smoking during pregnancy can be found in Appendix C.

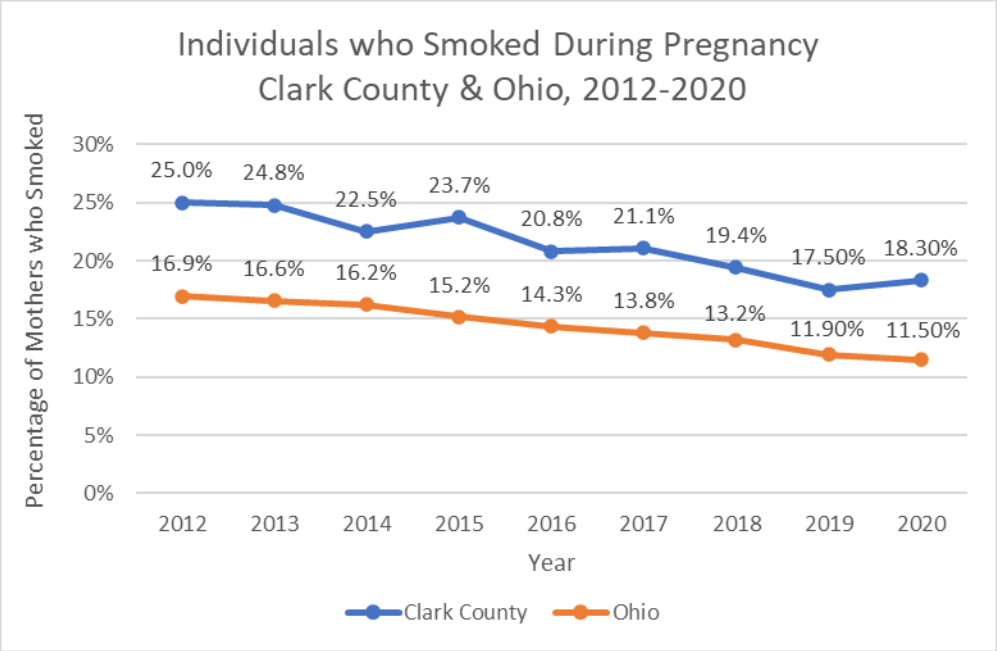


Figure 41: Individuals who smoked during pregnancy, Clark County and Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Diet and Exercise

Clark County has a higher percentage of physical inactivity (31%) and adult obesity (41%) compared to Ohio (Table 17).

Table 17: Behavioral risk factors for diet and exercise, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021. Data from 2019.

	Clark County	Ohio
Physical Inactivity	31%	28%
Adult Obesity	41%	35%

Other Health Behaviors

Between 2014 and 2020, there has been a 43.8% increase in total number of traffic deaths in Clark County (Figure 42). OVI-related traffic fatalities have experienced a downward trend from 2014-2020 (Figure 42). While there has been a 18.7% decline the percent of traffic fatalities involving no seatbelt use, there has been a 92.3% increase in traffic injuries involving no seatbelt use (Figure 43).

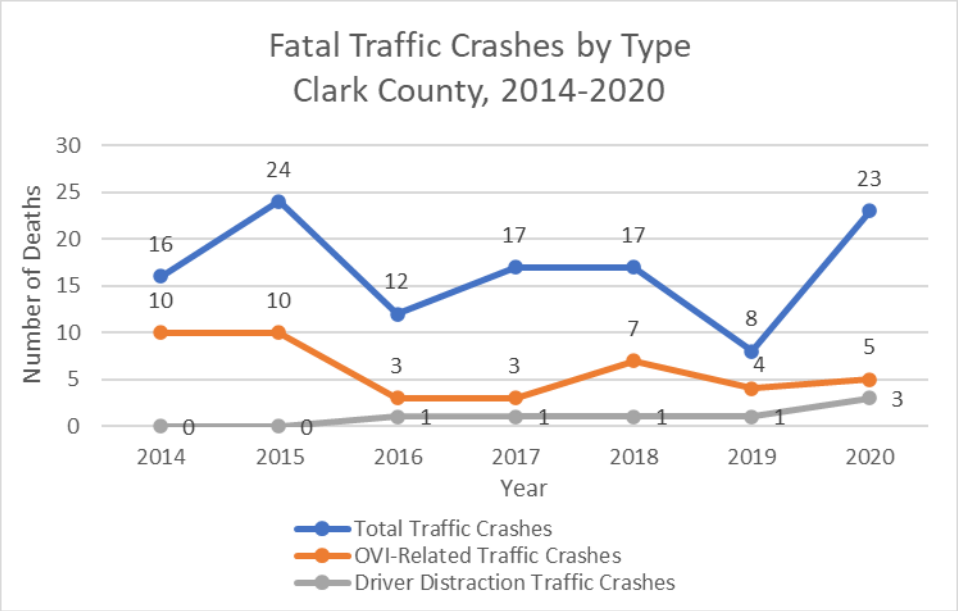
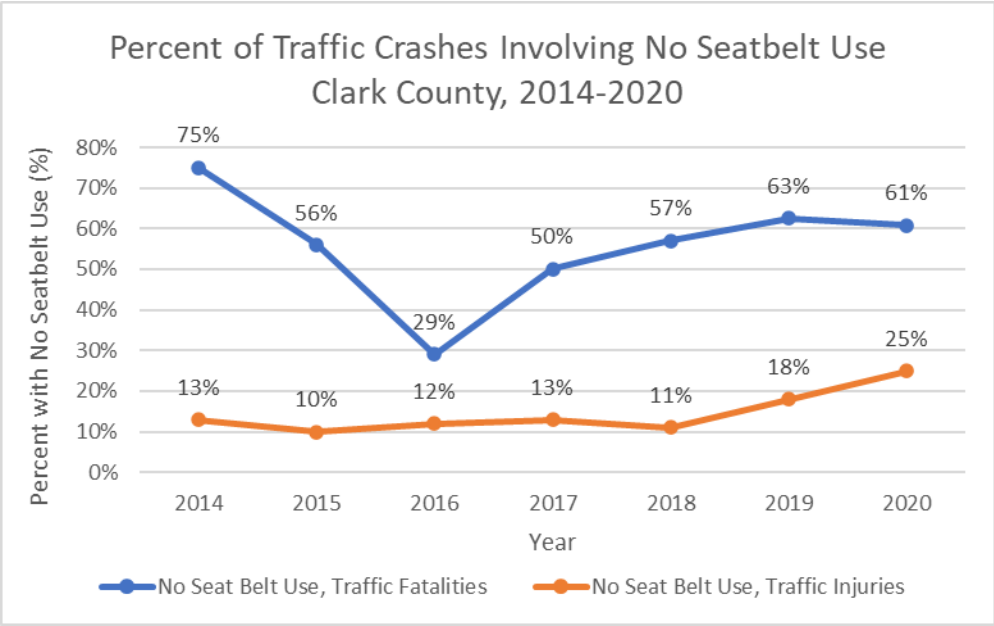


Figure 42: Fatal traffic crashes by type, Clark County, 2014-2020. Ohio State Highway Patrol Statistical Analysis Unit. Note: OVI-related includes alcohol &/or drug related traffic crashes. Driver distraction includes any crash in which one or more drivers were distracted by: manually operating an electronic communication device, talking on hands-free communication device, talking on hand-held communication device, other activity with communication device, passenger, or other distraction inside the vehicle.

Figure 43: Percent of traffic crashes involving no seatbelt use, Clark County, 2014-2020. Ohio State Highway Patrol Statistical Analysis Unit. Note: seatbelt usage includes only passengers in unit types 1-5, 14-15, & 17-18 (excludes motorcycles, ATVs, buses, Amish buggies, other non-specified units, and non-motorists such as pedestrians. Unbelted includes none, unknown, and other non-applicable categories.



Alcohol and Drug Use

Overdose Deaths

There has been an overall decline in the unintentional drug overdose death rate in Clark County, while the state of Ohio has been experiencing an increase in the rate between 2015 and 2020. In 2020, there is a 6.8% difference between the Clark County rate and the Ohio rate (Figure 44). Drug overdose deaths involving heroin (Figure 45) and prescription opioids (Figure 47) have been declining for both Clark County and Ohio. Drug overdose deaths involving fentanyl (Figure 46) has increased 28.8% for Clark County and 121.9% for Ohio.

Within Clark County, males make up the majority of drug overdose deaths every year except for 2018 and 2019 (Figure 48). The 35-44 age group contributes the highest percentage of total drug overdose deaths, followed by the 45-54 age group (Figure 49).

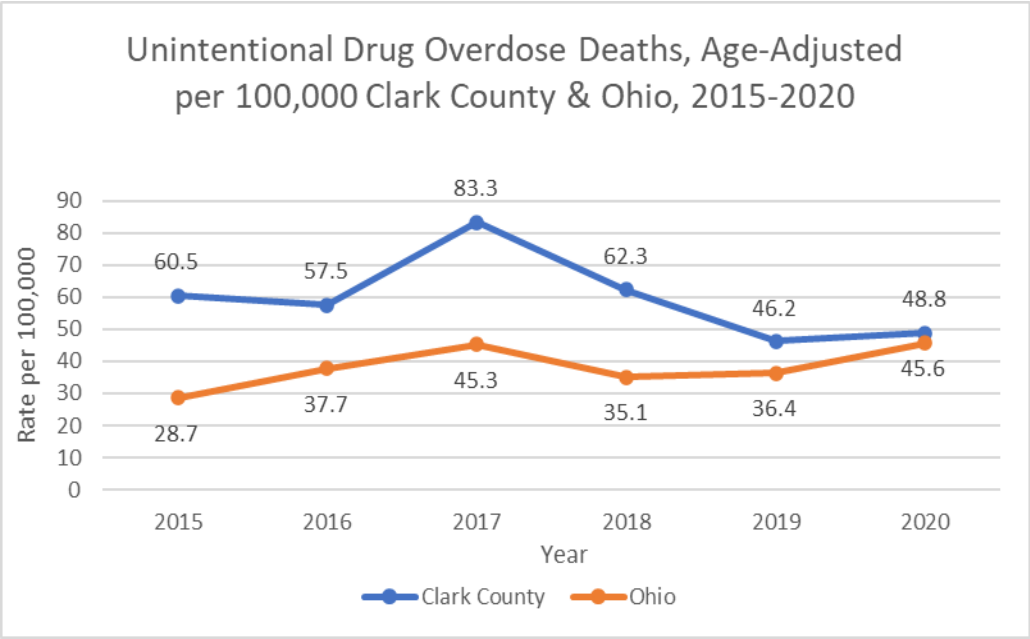


Figure 44: Unintentional drug overdose deaths, age-adjusted per 100,000, Clark County and Ohio, 2015-2020. Clark County data collected during County Drug Death Review. Ohio Department of Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

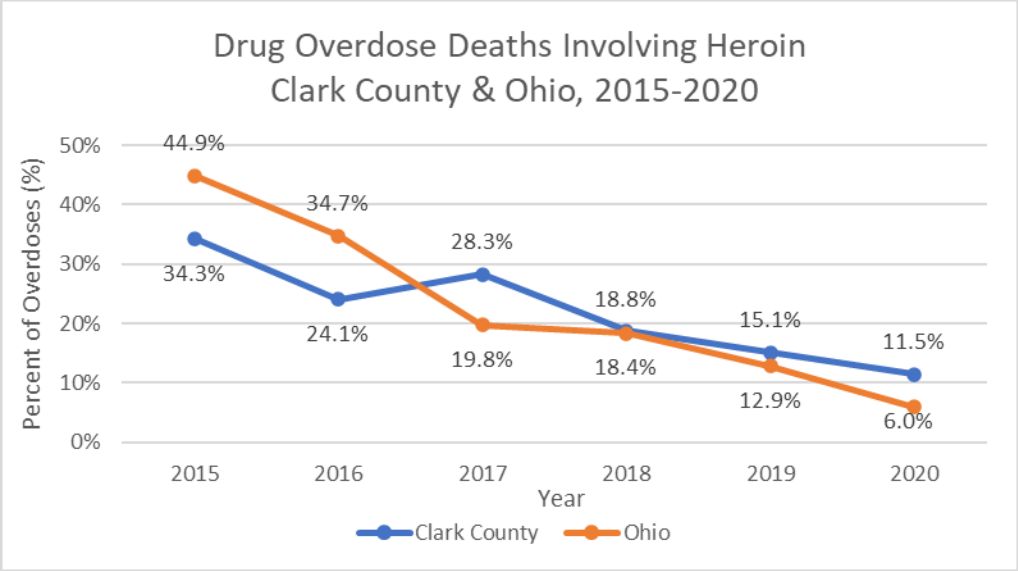


Figure 45: Drug overdose deaths involving heroin, Clark County and Ohio, 2015-2020. Clark County data collected during County Drug Death Review. Ohio Department of Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

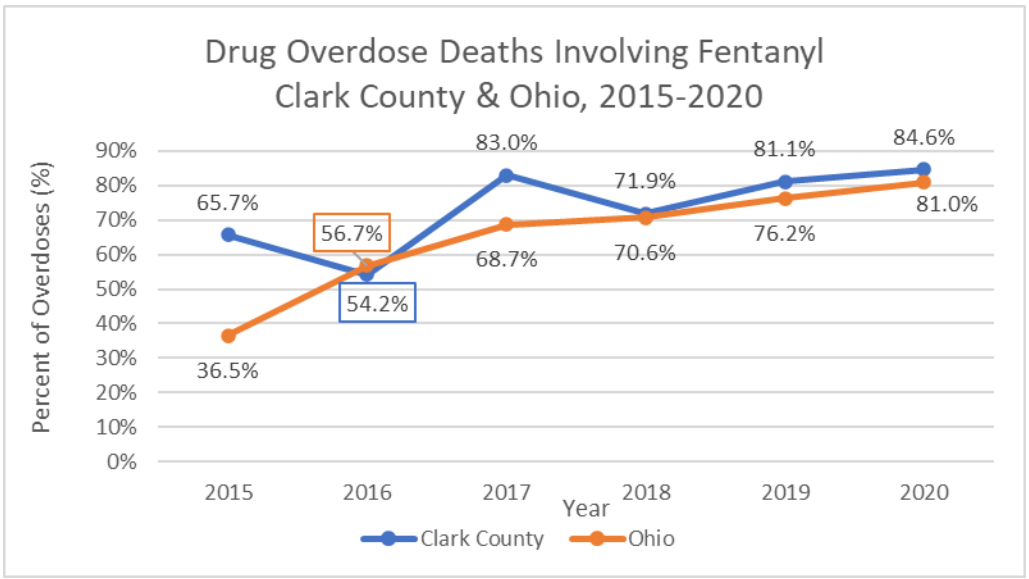


Figure 46: Drug overdose deaths involving fentanyl, Clark County and Ohio, 2015-2020. Clark County data collected during County Drug Death Review. Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

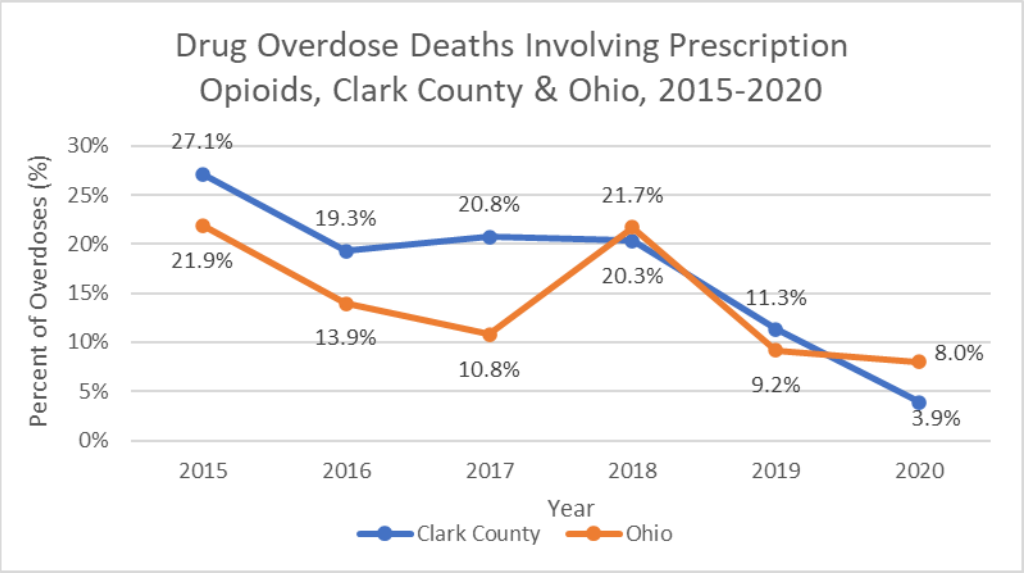


Figure 47: Drug overdose deaths involving prescription opioids, Clark County and Ohio, 2015-2020. Clark County data collected during County Drug Death Review. Ohio Department of Health Public Health Information Warehouse. The Ohio Department of health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 18: Drug overdose deaths by race, Clark County, 2015-2020. Data collected during Clark County Drug Death Review.

Race	2015	2016	2017	2018	2019	2020	2015-2020
White	90.0%	90.4%	87.7%	89.1%	98.1%	80.8%	89.0%
Black	7.1%	9.6%	11.3%	10.9%	1.9%	19.2%	10.1%
Hispanic	1.4%	0.0%	0.0%	0.0%	1.9%	0.0%	0.5%
Other (specify) Native American	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	0.2%
Other (specify) - Multiple	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%

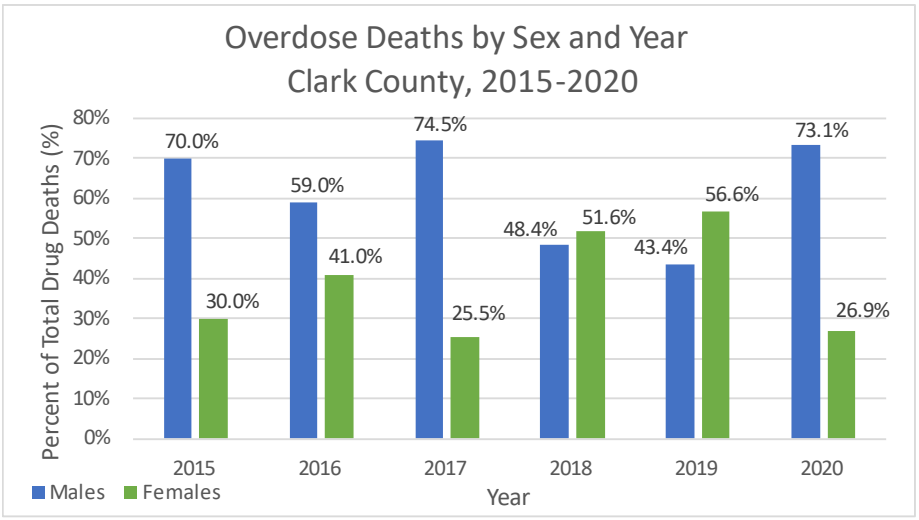


Figure 48: Overdose deaths by sex and year, Clark County, 2015-2020, County Drug Death Review.

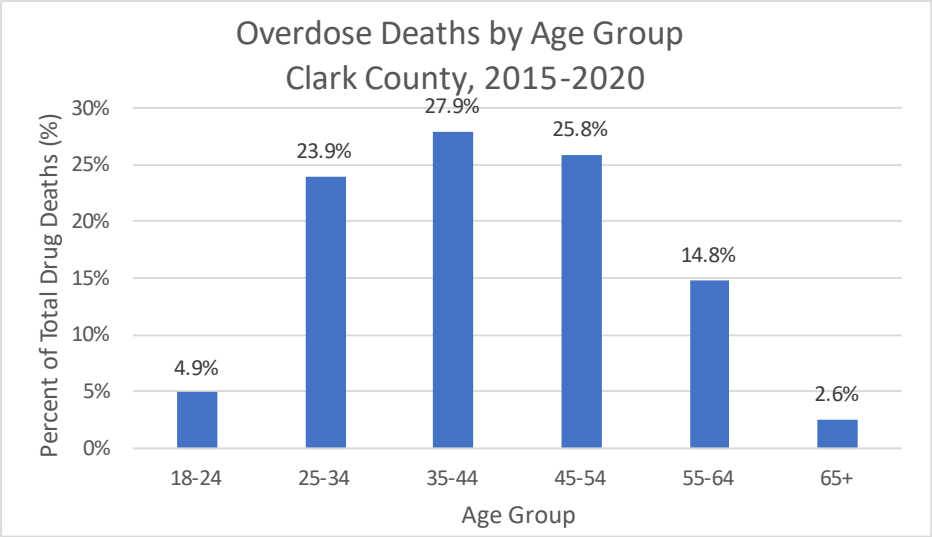


Figure 49: Overdose deaths by age group, Clark County, 2015-2020, County Drug Death Review

Neonatal Abstinence Syndrome

The rate at which babies are being discharged from the hospital for Neonatal Abstinence Syndrome (NAS) in Clark County (10.53) is lower than the rate for Ohio (13.97) (Table 19).

Table 19: Neonatal Abstinence Syndrome (NAS) Discharges, Clark County & Ohio, 2016-2020, ODH NAS County Hospital Discharge Report.

	Clark County	Ohio
2016-2020	82	9417
Birth Rate per 1000 live births	10.53	13.97

Alcohol Use

Compared to the state of Ohio, Clark County has a lower percentage of alcohol-impaired driving deaths and excessive drinking for 2021, based on 2016-2019 data (Table 20).

Table 20: Behavioral risk factors for alcohol use, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021, data from 2016-2019.

	Clark County	Ohio
Alcohol-Impaired Driving Deaths	27%	33%
Excessive Drinking	19%	21%

Clinical Care

Access to Care

Dentists, primary care physicians, and mental health providers within Clark County have a higher number of residents per 1 provider compared to Ohio (Table 21).

Within Clark County, parts of Springfield are designated as Health Professional Shortage Areas (HPSA) for primary care and dental health (Figure 50) (Figure 51). These areas cover more of the southern and southwestern parts of Springfield. A similar area of Springfield is also designated as a Medically Underserved Area/Populations (MUA/P) (Figure 52).

Table 21: Health resource availability, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021. Population per dentist data from 2020, population per primary care physical data from 2019, population per mental health provider data from 2021.

	Clark County	Ohio
Population per Dentist	1,710:1	1,570:1
Population per Primary Care Physician	2,270:1	1,290:1
Population per Mental Health Provider	570:1	350:1

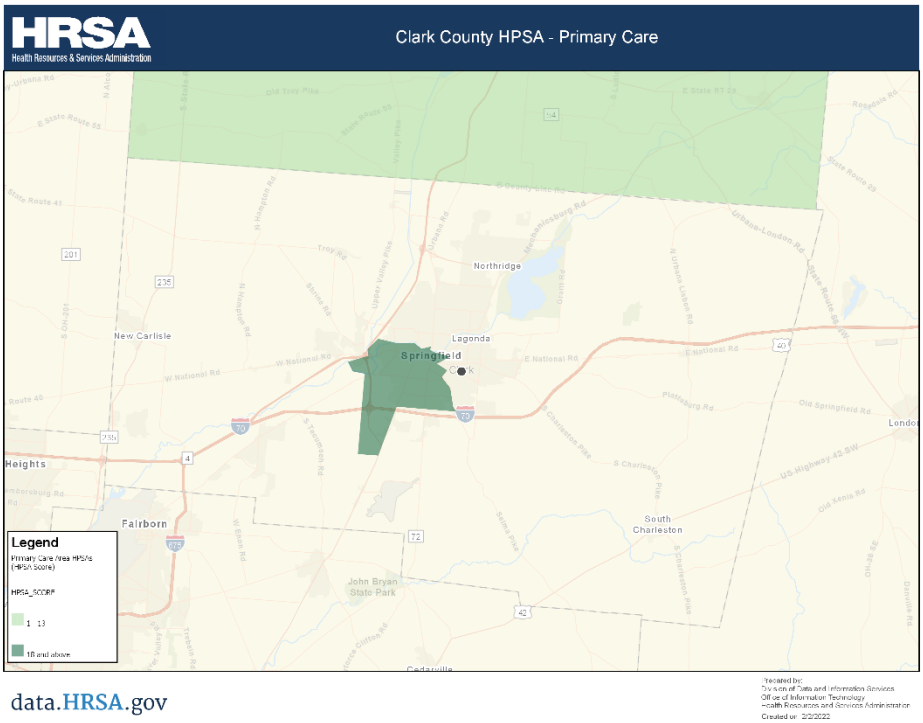


Figure 50: Clark County HPSA Primary Care, Health Resources and Services Administration Map Tool

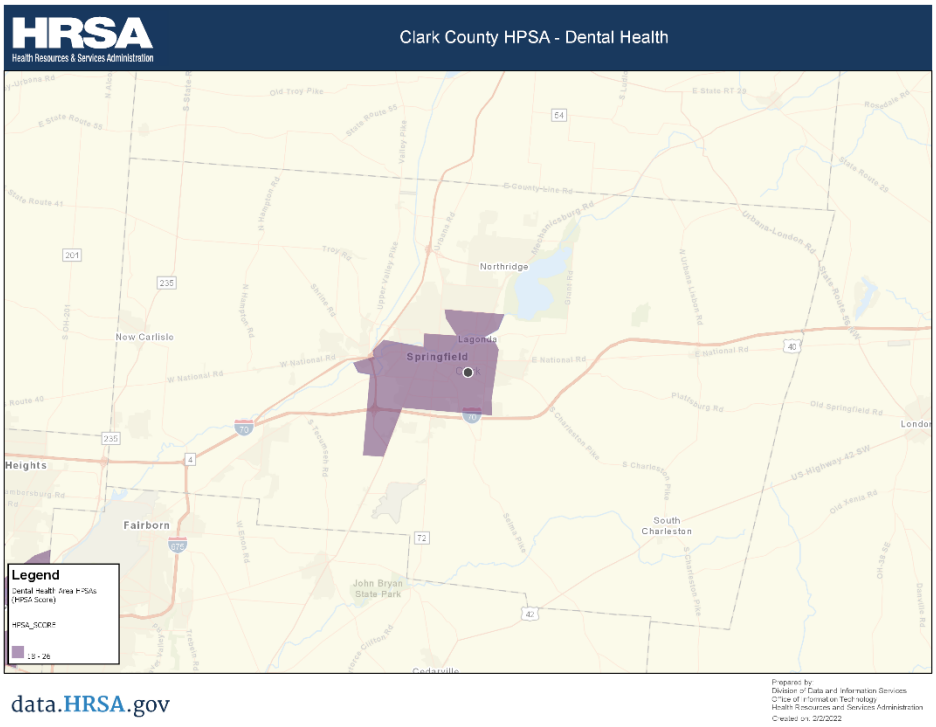


Figure 51: Clark County HPSA Dental Health, Health Resources, and Services Administration Map Tool

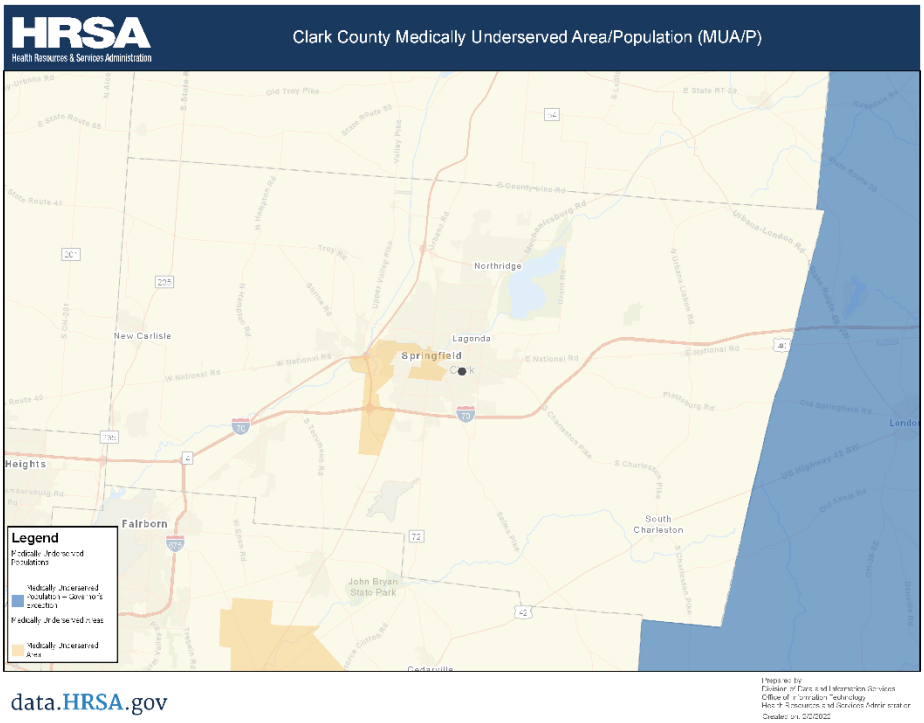


Figure 52: Clark County Medically Underserved Area/Population, Health Resources and Services Administration Map Tool

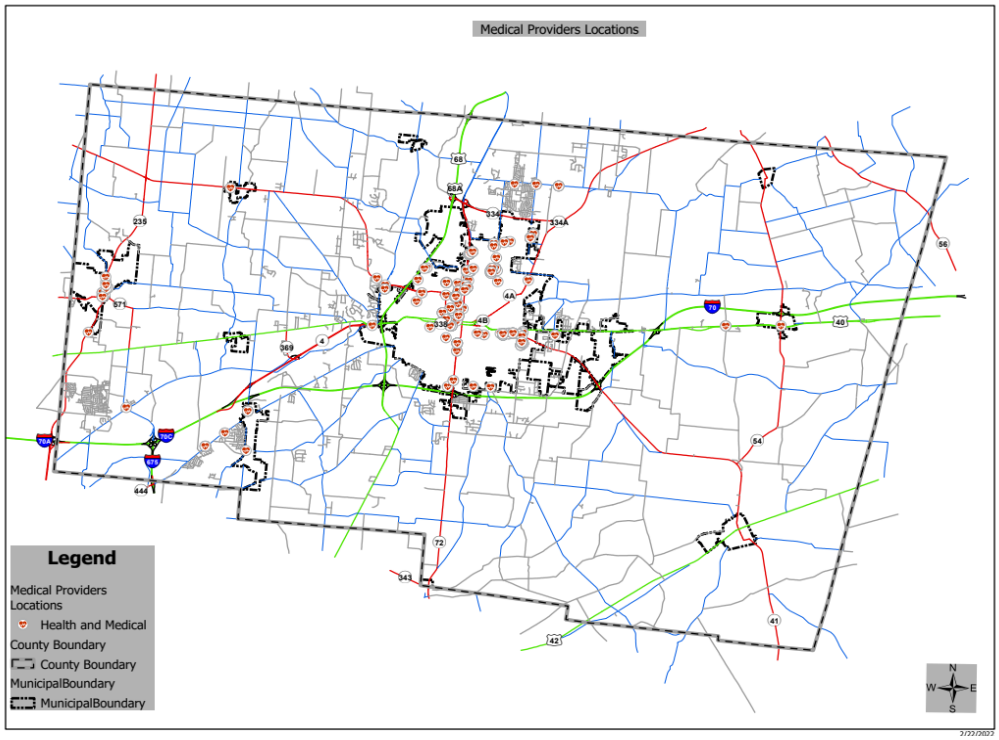


Figure 53: Medical providers in Clark County

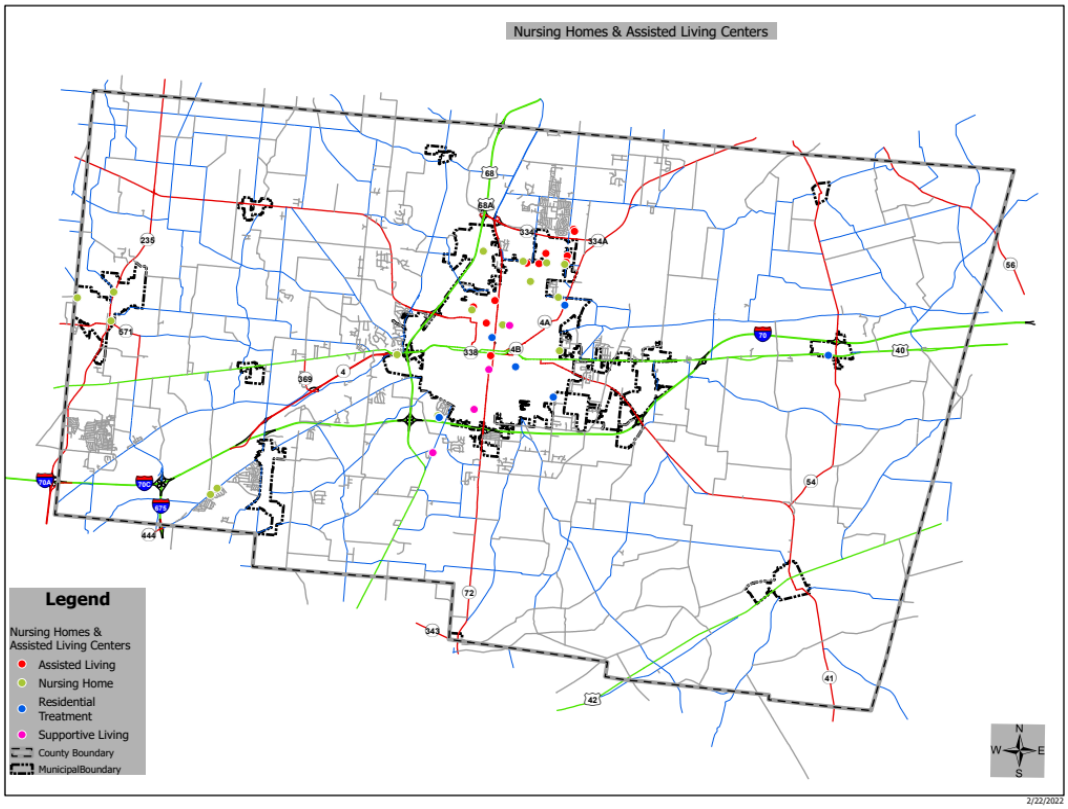


Figure 54: Nursing homes and assisted living facilities in Clark County.

Health Insurance

A majority of residents in Clark County, Ohio, and the US are covered by health insurance (Table 22). The 19-25 and 26-34 age groups fall below 90% insured for Clark County, Ohio, and the US (Table 22). In Clark County, 26.8% of residents have public health insurance, compared to 22.0% of Ohio residents and 20.5% of the US (Table 23).

Table 22: Health insurance coverage, Clark County, Ohio & US, American Community Survey 5-year Estimates, 2015-2019.

Health Insurance Coverage						
	Clark County		Ohio		US	
By Age	**Insured**	**Uninsured**	**Insured**	**Uninsured**	**Insured**	**Uninsured**
<6	96.7%	2.4%	95.6%	4.4%	95.9%	4.1%
6-18	95.3%	3.8%	95.1%	4.9%	94.5%	5.5%
19-25	84.4%	14.2%	89.6%	10.4%	85.3%	14.7%
26-34	86.4%	14.5%	87.7%	12.3%	84.0%	16.0%
35-44	90.4%	12.9%	90.1%	9.9%	86.4%	13.6%
45-54	93.3%	9.7%	92.7%	7.3%	89.2%	10.8%
55-64	93.7%	6.7%	93.7%	6.3%	92.1%	7.9%
65-74	100.0%	0.0%	99.4%	0.6%	99.0%	1.0%
75+	100.0%	0.0%	99.7%	0.3%	99.5%	0.5%
By Household Type						
Married Couple	95.5%	4.5%	95.3%	4.7%	93.1%	6.9%
Single Male Family	90.6%	9.4%	89.0%	11.0%	84.0%	16.0%
Single Female Family	91.5%	8.5%	92.4%	7.6%	88.0%	12.0%
Non-Family Household	92.0%	8.0%	92.4%	7.6%	90.3%	9.7%
By Household Income						
<$25,000	91.9%	8.1%	91.2%	8.8%	86.3%	13.7%
$25,000-$49,999	92.0%	8.0%	90.9%	9.1%	86.7%	13.3%
$50,000-$74,999	92.9%	7.1%	93.1%	6.9%	89.4%	10.6%
$75,000-$99,999	95.4%	4.6%	95.0%	5.0%	92.3%	7.7%
$100,000+	96.5%	3.5%	97.0%	3.0%	95.7%	4.3%

Table 23: Health insurance coverage by type, Clark County, Ohio & US, American Community Survey 5-year Estimates, 2015-2019.

Health Insurance Coverage Alone			
	Clark County	**Ohio**	**US**
Public Health Insurance Alone	26.8%	22.0%	20.5%
Medicare coverage	5.7%	5.8%	5.2%
Medicaid/means tested coverage	20.8%	15.9%	15.0%
VA Health care coverage	0.3%	0.3%	0.3%
Private Health Insurance Alone	46.5%	55.2%	54.3%
Employer-based health insurance	42.7%	50.0%	46.7%
Direct-purchase health insurance	2.9%	4.7%	6.6%
Tricare/military health coverage	0.9%	0.5%	1.0%

Quality of Care

The percent of women Medicare enrollees that received an annual mammography screening in Clark County (41%) than that of Ohio (45%) (Table 24). The rate of hospital stays for ambulatory-care sensitive conditions in Clark (5,100 stays per 100,000 Medicare enrollees) is higher than that of Ohio (4,388 stays for 100,000 Medicare enrollees) (Table 24).

*Table 24: Mammography screening and preventable hospital stays, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021, data from 2019. *Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.*

	Clark County	Ohio
Mammography Screening	41%	45%
Preventable Hospital Stays*	5,100	4,338

Immunizations

The percent of school age children with the require immunizations has been decreasing each academic year since 2016-2017 (Figure 55). Kindergarten students have the highest percentage of immunizations (~90%), followed by 7th grade students (~84%). The percent of school age children with a reason of conscience or religious objection to immunizations has increased slightly and all grades listed are around 4% of pupils (Figure 56).

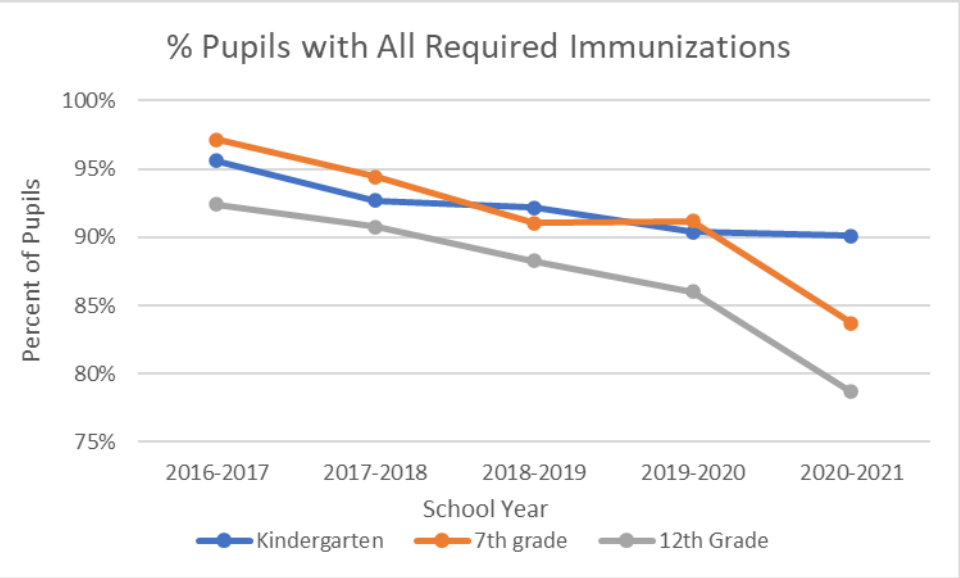


Figure 55: Percent of pupils with all required immunizations for kindergarten, 7th grade, and 12th grade, Clark County, Ohio, 2016-2021, ODH School Immunization Level Assessment.

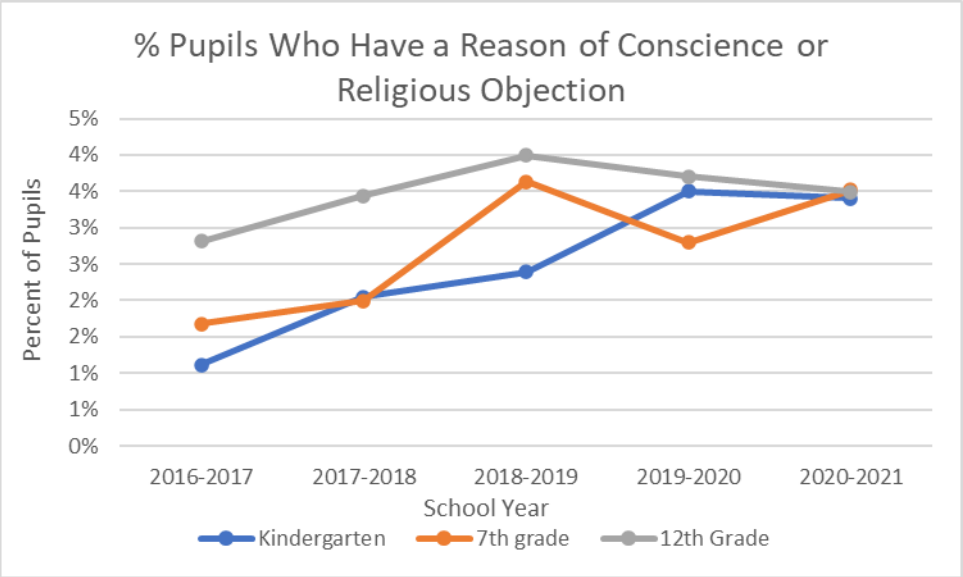


Figure 56: Percent of pupils who have a reason of conscience or religious objection for kindergarten, 7th grade, and 12th grade, Clark County, Ohio, 2016-2021, ODH School Immunization Level Assessment.

Prenatal Care

There has been a steady increase in the percentage of live births receiving 1st trimester prenatal care in Ohio from 2012 to 2020, while it has remained relatively constant within Clark County (Figure 57). White pregnant mothers consistently have a higher percentage of live births that received prenatal care during the 1st trimester compared to Black mothers in Clark County. These values are slightly lower when compared to the state of Ohio (Table 25).

The Kotelchuck Index uses when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services) to measure adequacy of prenatal care. A ratio of observed to expected visits is calculated and grouped into four categories: 1) Inadequate (less than 50% of expected visits), 2) Intermediate (50-75%), 3) Adequate (80-109%), and 4) Adequate Plus (110% or more). A majority of live births in Clark County were classified as Adequate or greater (Figure 60). Clark County has a higher percentage of live births receiving Adequate care compared to Ohio; however, Ohio has a higher percentage receiving Adequate Plus care (Figure 59).

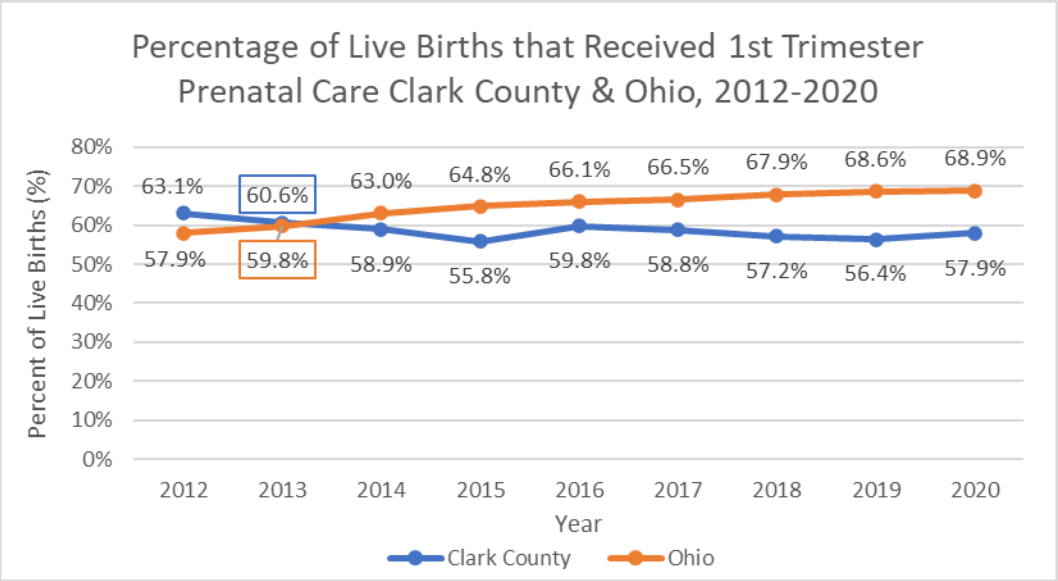


Figure 57: Percent of live births that received prenatal care during the 1st trimester, Clark County and Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 25: Percent of live births that received prenatal care during the 1st trimester, by race, Clark County & Ohio, 2014-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

	Clark County		Ohio	
	Black	**White**	**Black**	**White**
2014	49.8%	60.6%	51.4%	66.3%
2015	47.5%	57.3%	53.6%	68.1%
2016	54.6%	55.7%	55.7%	69.0%
2017	47.5%	60.6%	57.0%	69.2%
2018	47.8%	59.1%	59.5%	70.3%
2019	51.5%	58.0%	60.7%	70.9%
2020	47.9%	60.4%	61.3%	71.4%

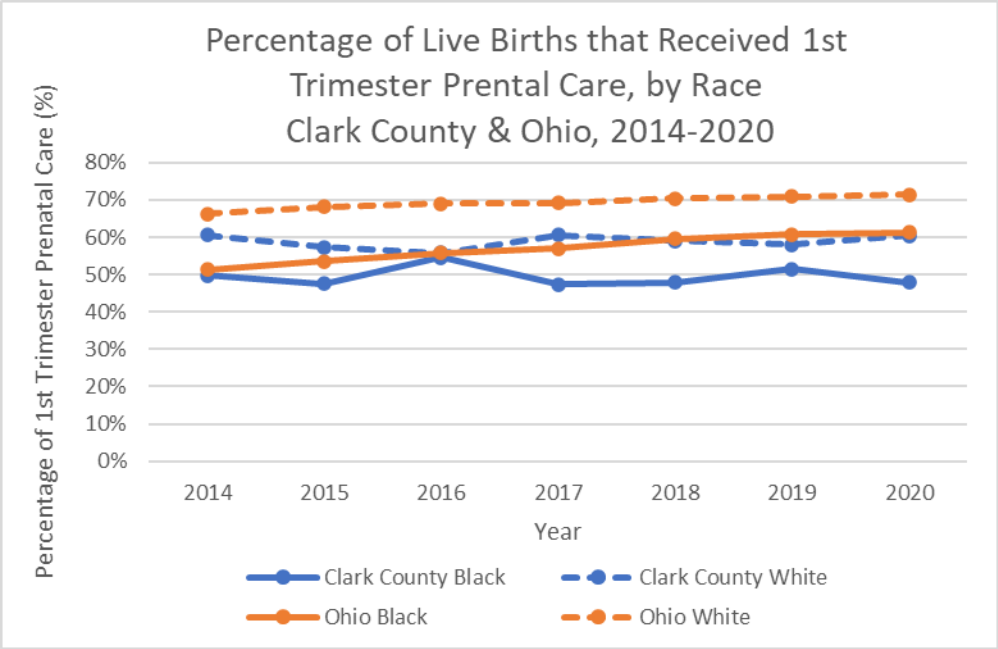


Figure 58: Percent of live births that received prenatal care during the 1st trimester by race, Clark County and Ohio, 2014-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

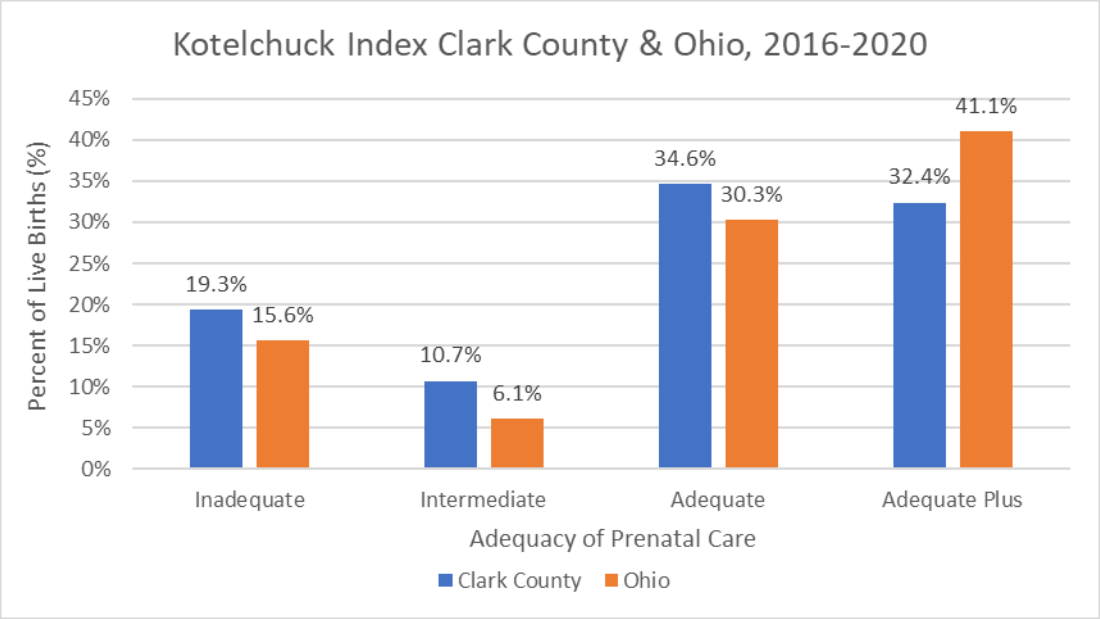


Figure 59: Average Kotelchuck Index for Clark County and Ohio, 2016-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 26: Kotelchuck Index, Clark County & Ohio, 2014-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Location	Year	Inadequate	Intermediate	Adequate	Adequate Plus
Clark County	2014	17.3%	10.5%	34.4%	30.7%
	2015	18.0%	9.5%	36.0%	31.8%
	2016	18.0%	10.3%	34.5%	34.0%
	2017	18.6%	11.4%	35.8%	31.7%
	2018	20.2%	11.5%	33.5%	32.8%
	2019	19.7%	10.4%	33.7%	32.3%
	2020	19.9%	9.6%	35.5%	31.2%
Ohio	2014	16.4%	7.3%	29.4%	35.5%
	2015	15.6%	6.8%	29.8%	37.6%
	2016	16.0%	6.3%	29.8%	39.7%
	2017	16.1%	6.0%	29.2%	40.9%
	2018	15.6%	6.1%	29.9%	41.8%
	2019	15.2%	5.7%	29.9%	43.1%
	2020	14.9%	6.4%	32.7%	40.0%

Socioeconomic Characteristics

Education

In Clark County, 89% of students graduate from high school, which is lower than 91% of students within all of Ohio. The Springfield City School District has the lowest high school graduation rate for all academic years starting from 2015-2016 going to 2019-2020 (Table 27). Between 2015-2019, Springfield City School District has increased their kindergarten readiness to almost 30% (Figure 60). The other school districts range between 35-55% in 2019 with fluctuations every year (Figure 60).

Between 2015-2019, 43.4% of 18–24-year-olds in Clark County have graduated with a high school diploma and 38.8% have some college or an associate's degree. Clark County has more high school graduates in this age group compared to the state of Ohio and the United States, but less people who have some college or an associate degree compared to Ohio and the US. Of those 25 years or older, 37.9% have a high school diploma and 22.8% have attended some college but did not receive a degree. The 25+ year old age group has a higher percentage of high school graduates and some college attendees than Ohio and the United States (Table 29).

Table 27: High school graduation rate, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021, data from 2016-2020.

	High School Graduation Rate
Clark County	89%
Ohio	91%

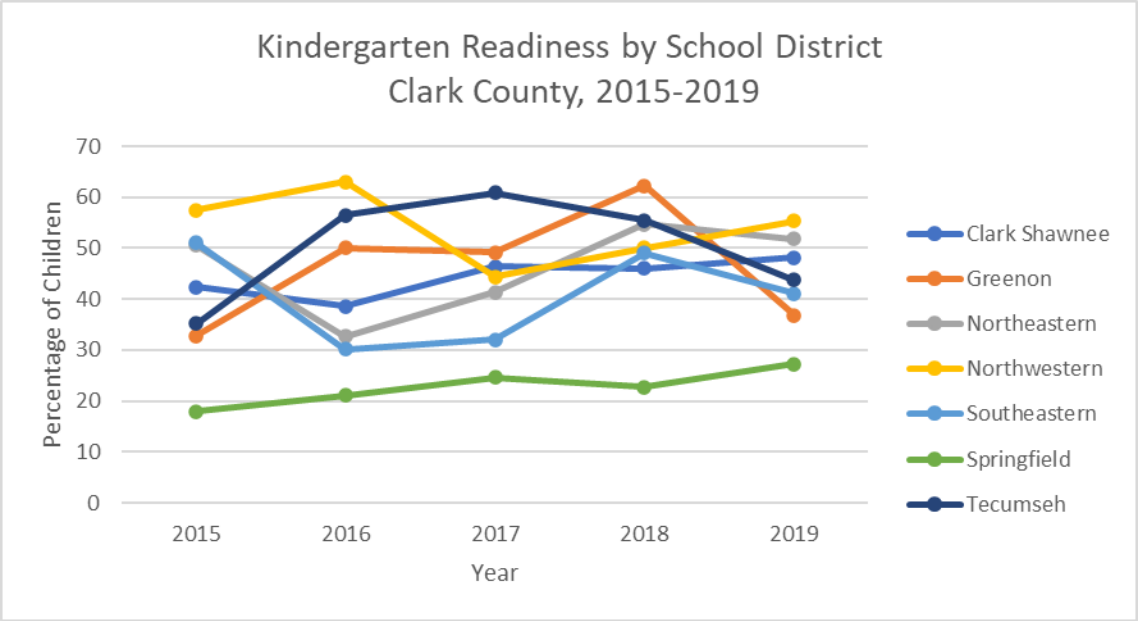


Figure 60: Percentage of children participating in the Kindergarten Readiness Assessment (KRA) who demonstrated readiness for kindergarten by school district, Clark County, 2015-2019. Engage Springfield, 2021.

Table 28: High school graduation rates (four-year graduation) by school district, Clark County, Ohio Department of Education (ODE) School Report Cards, 2020.

School District	2015-16	2016-17	2017-18	2018-19	2019-20
Springfield City School District	75.4%	76.3%	76.7%	77.7%	84.0%
Greenon Local	93.4%	95.0%	89.9%	91.0%	95.1%
Tecumseh Local	88.6%	90.3%	87.7%	89.3%	90.7%
Northeastern Local	95.5%	91.4%	96.8%	93.6%	96.1%
Northwestern Local	95.3%	94.3%	97.4%	98.1%	94.5%
Southeastern Local	92.6%	100.0%	88.9%	93.8%	98.2%
Clark-Shawnee Local	97.4%	93.9%	94.6%	94.8%	95.4%

Table 29: Educational attainment by age group, Clark County, Ohio & US, American Community Survey 5-year Estimates, 2015-2019.

Educational Attainment			
	Clark County	**Ohio**	**US**
18-24 years old			
< High School Graduate	13.2%	13.1%	12.6%
High School Graduate (or equivalent)	43.3%	34.0%	31.4%
Some college or Associates Degree	38.8%	42.6%	44.8%
Bachelor's Degree or higher	4.7%	10.4%	11.2%
25+ years old			
Less than 9th grade	2.6%	2.8%	5.1%
9th grade - 12th grade, no diploma	8.6%	6.8%	6.9%
High School Graduate (or equivalent)	37.9%	33.0%	27.0%
Some College, No degree	22.8%	20.4%	20.4%
Associates Degree	9.3%	8.7%	8.5%
Bachelor's Degree	11.4%	17.6%	19.8%
Graduate or Professional Degree	7.3%	10.7%	12.4%

Employment

The unemployment rate for both males and females within Clark County is higher than Ohio and the US (Table 30).

Table 30: Unemployment rate, Clark County, Ohio & US, American Community Survey 5-year Estimates, 2015-2019.

	Unemployment Rate	
Clark County	Male	5.60%
	Female	6.40%
Ohio	Male	5.1%
	Female	4.6%
US	Male	5.0%
	Female	4.9%

Income

The median household income in Clark County ($50,873) is lower than Ohio ($56,602) and the US ($62,843) (Table 31). The mean income for Clark County residents ($65,280) is also lower than Ohio ($76,958) and the US ($88,607) (Table 31).

Table 31: Median and mean household income, Clark County, Ohio & US, American Community Survey 5-year Estimates 2015-2019.

	Clark County	Ohio	US
Median Household income	$50,873	$56,602	$62,843
Mean Household income	$65,280	$76,958	$88,607

In Clark County, 11.5% of all families are living below the poverty level. This is higher than Ohio (9.2%) and the US (8.6%) (Table 32). There is a higher concentration of families below the poverty level in central Clark County (Figure 61). 48.4% of single mother households with children under 5 years of age in Clark County are living below the poverty level, slightly higher than Ohio (46.6%) and the US (37.6%) (Table 32).

Between 2015 and 2021, the monthly average of SNAP benefits received decreased 13.7% (Figure 62) and the monthly average of cash benefits received decreased 9.8% (Figure 63). There is a greater concentration of SNAP households within Springfield (Figure 64).

During the 2018-2019 academic year, almost 47% of students in Clark County were eligible for free or reduced priced meals, compared to 39% at the state level (Figure 65).

Table 32: Percent of families with income below poverty level, Clark County, Ohio & US, American Community Survey 5-year Estimates, 2015-2019.

	Clark County	Ohio	US
All Families	11.5%	9.2%	8.6%
With related children of the householder under 18 years	16.6%	15.7%	13.8%
With related children of the householder under 5 years	23.9%	16.5%	13.0%
Married Couple Families	5.3%	3.5%	4.2%
With related children of the householder under 18 years	7.3%	4.9%	5.7%
With related children of the householder under 5 years	7.2%	3.9%	4.5%
Single Mother Household	29.0%	28.4%	24.1%
With related children of the householder under 18 years	34.1%	38.4%	33.5%
With related children of the householder under 5 years	48.4%	46.6%	37.6%

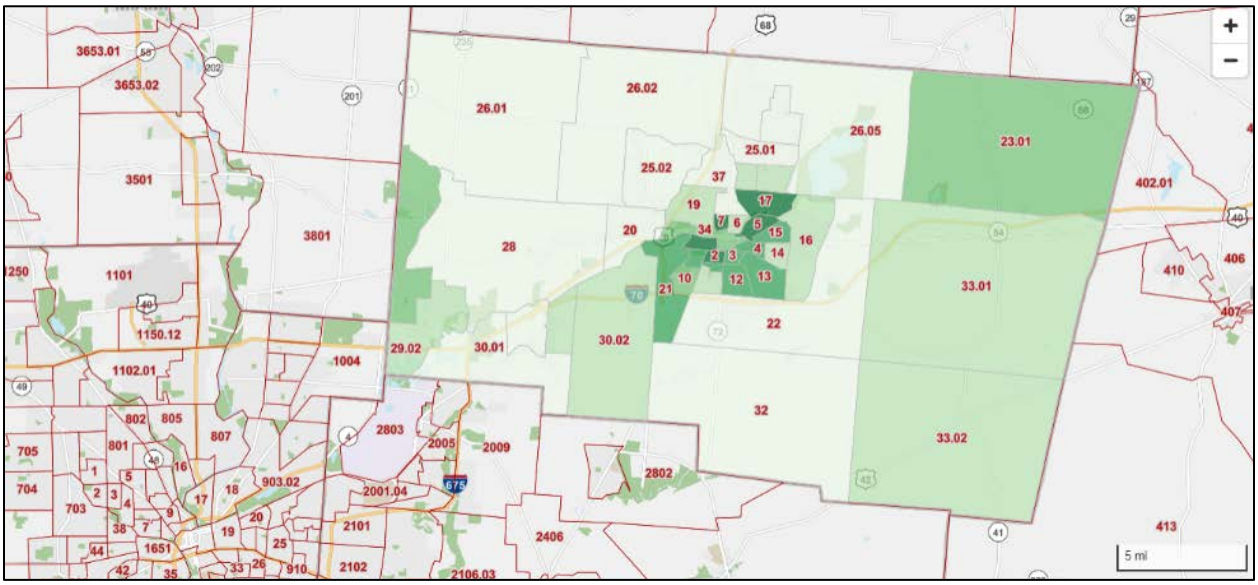


Figure 61: Percent of families below poverty level, Clark County, American Community Survey, 2019.

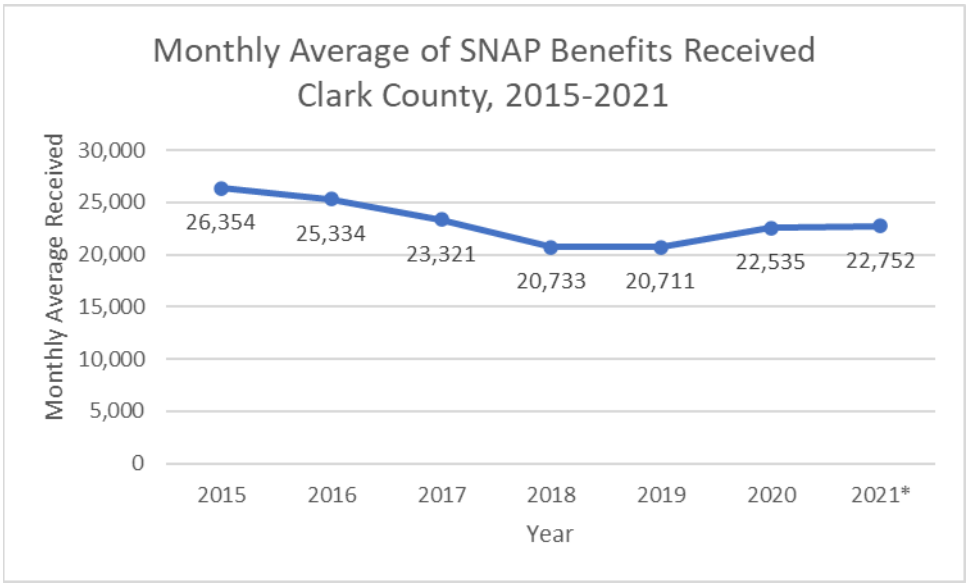


*Figure 62: Monthly average of SNAP benefits received, Clark County, 2015-2021. Clark County Job and Family Services. *2021 data does not include December*

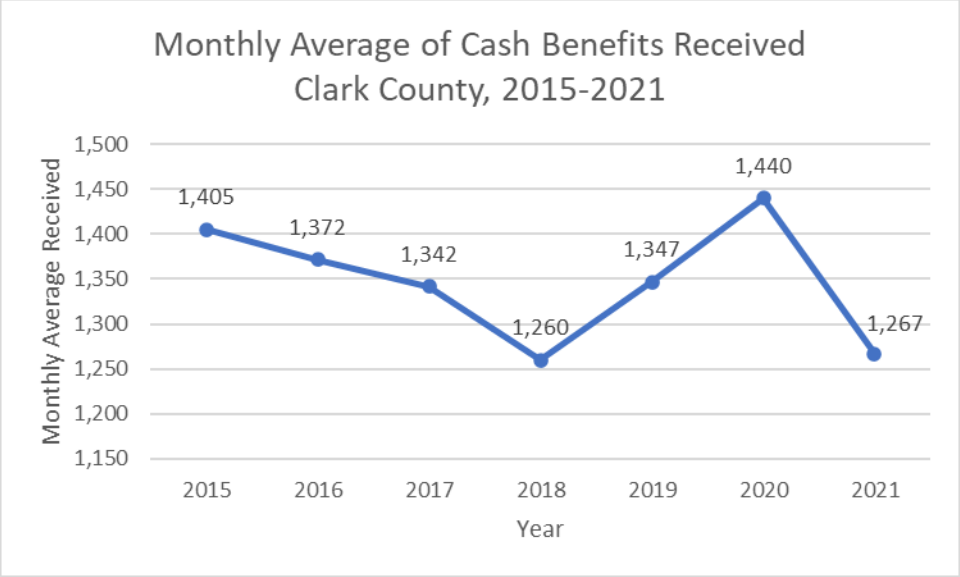


Figure 63: Monthly average of cash benefits received, Clark County, 2015-2021. Clark County Job and Family Services.

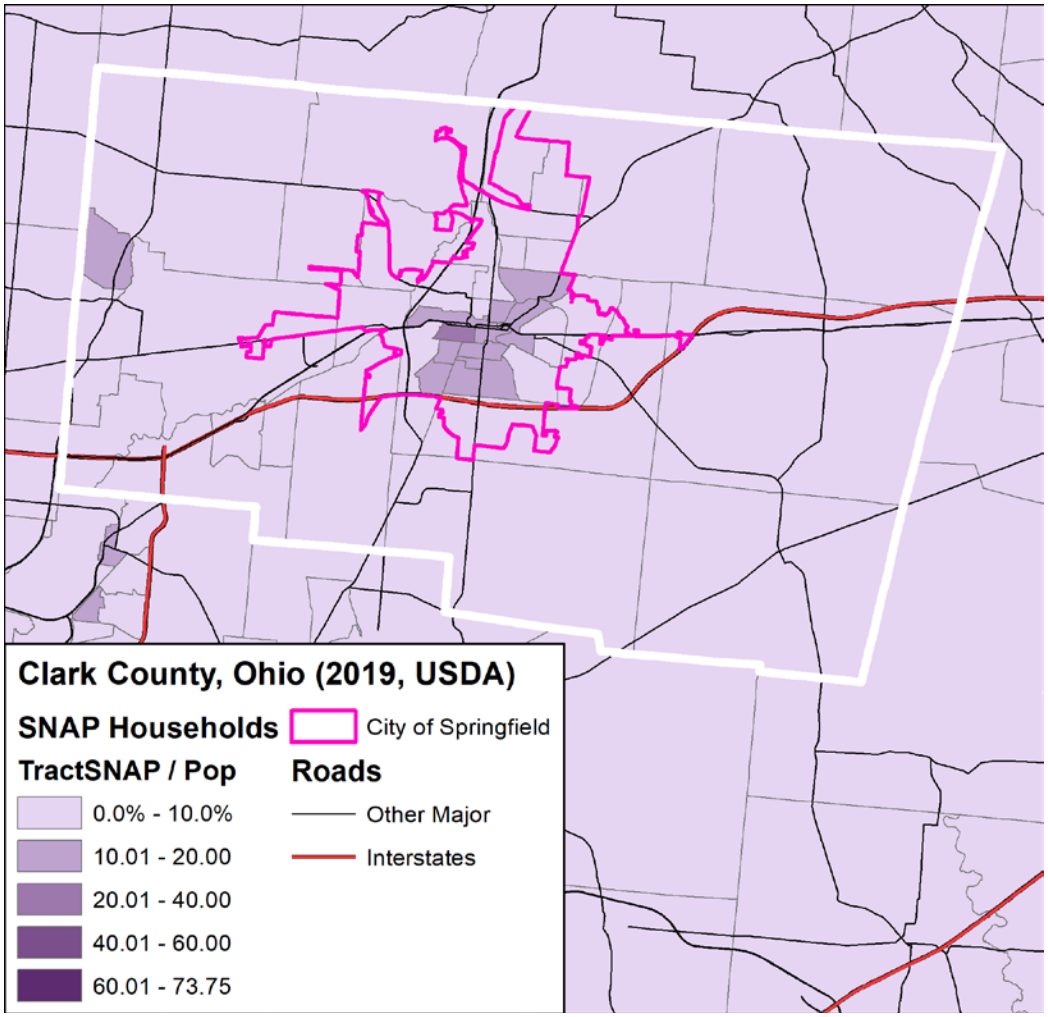


Figure 64: Percent of population receiving SNAP benefits by census tract, Clark County, 2019.

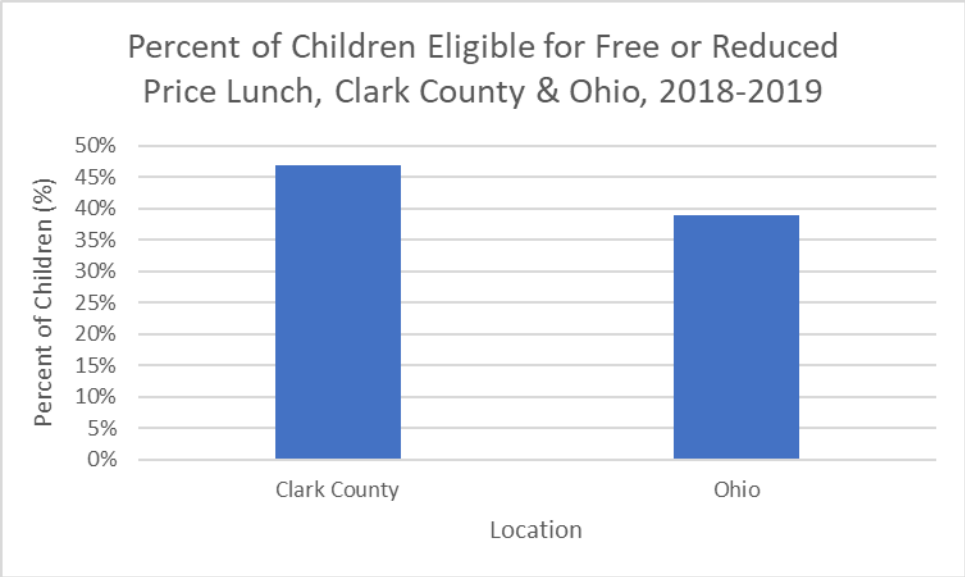


Figure 65: Percent of children enrolled in public schools that are eligible for free or reduced-price lunch, Clark County and Ohio, 2018-2019, Robert Wood Johnson Foundation County Health Rankings 2021, using data from 2019-2020.

Family and Social Support

Child support collected in Clark County between 2014 and 2021 has increased 4.9% (Figure 66). The percent of children in single-parent households in Clark County (31%) is higher than the state (27%) (Table 33).

Of all types of abuse, children in Clark County experience physical abuse more often, followed by neglect (Figure 67) for 2019, 2020, and 2021.

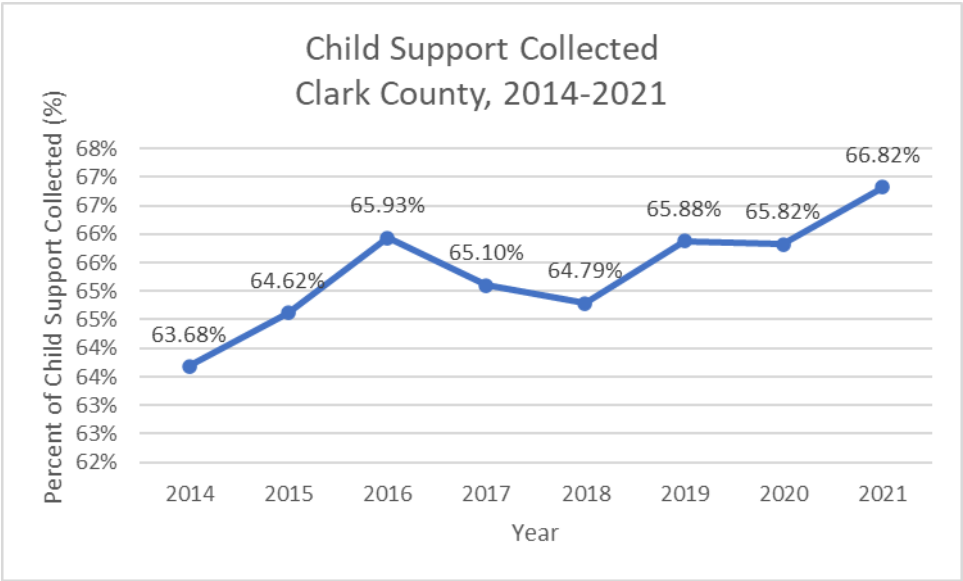


Figure 66: Percent of child support collected, 2014-2021, Clark County Job and Family Services.

Table 33: Percent of children that live in a household headed by a single parent, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021, data from 2016-2020.

	Percent of Children in Single-Parent Households
Clark County	31%
Ohio	27%

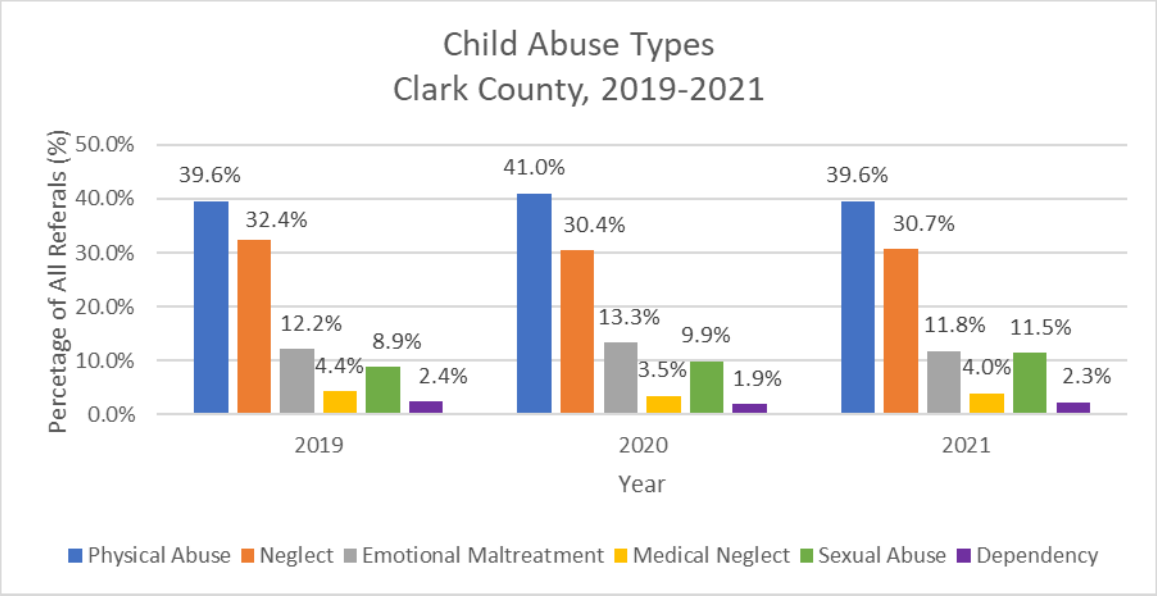


Figure 67: Number of individuals screened through Clark County Job and Family Services by Abuse Type, 2019-2021. Clark County Job and Family Services. NOTE: Children can be screened with multiple abuse types, therefore duplication may occur across abuse types.

Dependency is defined as any child: A) Who is homeless or destitute or without adequate parental care, through no fault of the child's parents, guardian, or custodian; B) Who lacks adequate parental care by reason of the mental or physical condition of the child's parents, guardian, or custodian; C) Whose condition or environment is such as to warrant the state, in the interests of the child, in assuming the child's guardianship; D) To whom both of the following apply: 1) The child is residing in a household in which a parent, guardian, custodian, or other member of the household committed an act that was the basis for an adjudication that a sibling of the child or any other child who resides in the household is an abused, neglected, or dependent child, 2) Because of the circumstances surrounding the abuse, neglect, or dependency of the sibling or other child and the other conditions in the household of the child, the child is in danger of being abused or neglected by that parent, guardian, custodian, or member of the household.

Domestic Violence

The total number of domestic violence reports with injury in Clark County increased from 2014 to 2018, but has decreased from 2018 to 2020, with an overall decline of 20.1% between 2014 to 2020. The tole number of domestic violence reports without injury increased from 2014 to 2015, but has been decreased from 2015 to 2020, with an overall decline of 39.4% between 2014 to 2020 (Figure 68).

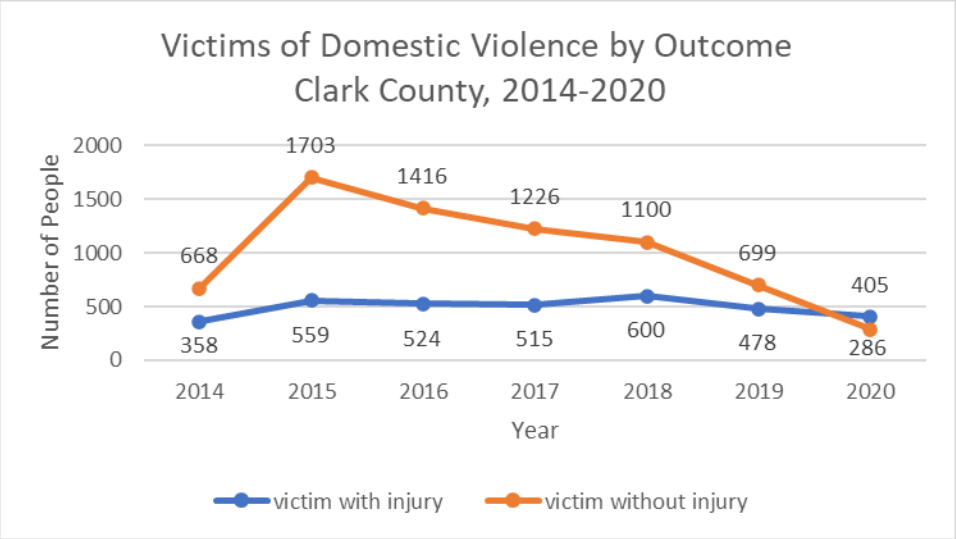


Figure 68: Victims of domestic violence by outcome, Clark County, 2014-2020, Ohio Attorney General Domestic Violence Reports, 2014-2020

Marital Status and Household Type

Households within Clark County are 44.9% married couple with family, followed by individual living alone (Figure 69). There is a greater percentage of female single parents (14.3%) than male single parents (5.6%) (Figure 69). 47.1% of Clark County residents are married, followed by 29.3% who have never been married (Figure 70)

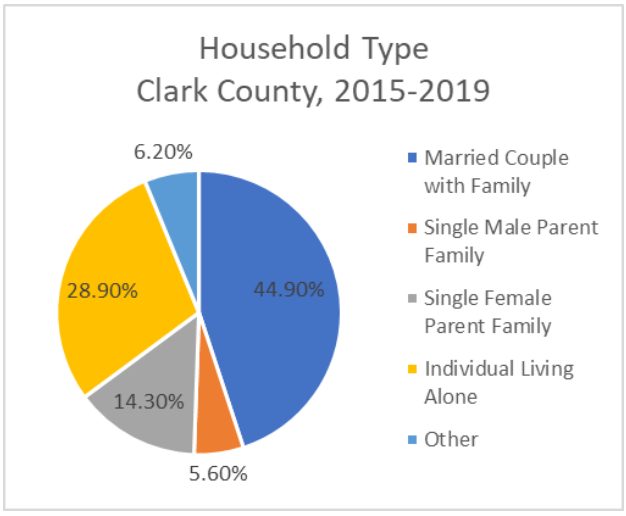


Figure 69: Household Type, Clark County, 2015-2019, American Community Survey 5-year Estimates.

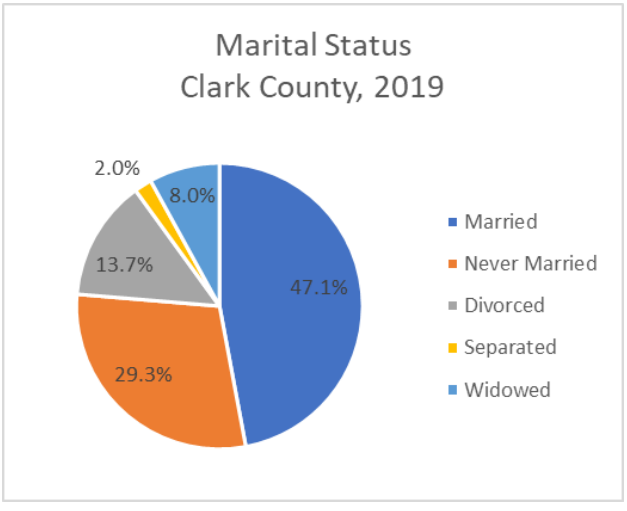


Figure 70: Marital Status, Clark County, 2019, American Community Survey 1-year Estimate.

Community Safety

Violent crimes are defined as offenses that involve face-to-face confrontation between a victim and a perpetrator, including homicide, rape, robbery, and aggravated assault. The violent crime rate for Clark County is greater than the violent crime rate for Ohio (Table 34).

Table 34: Number of reported violent crime offenses per 100,000 population, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021, data from 2014 & 2016.

	Violent Crime Rate
Clark County	368
Ohio	293

Food Insecurity

In 2019, 11% of Clark County residents were low-income and did not live close to a grocery store. This is greater than Ohio (7%) (Figure 71). Residents with low income and low food access are located centrally within Springfield, and within the southwestern part of Clark County (Figure 72). The food environment index is slightly higher for Clark County (6.9) than Ohio (6.7) (Figure 73).

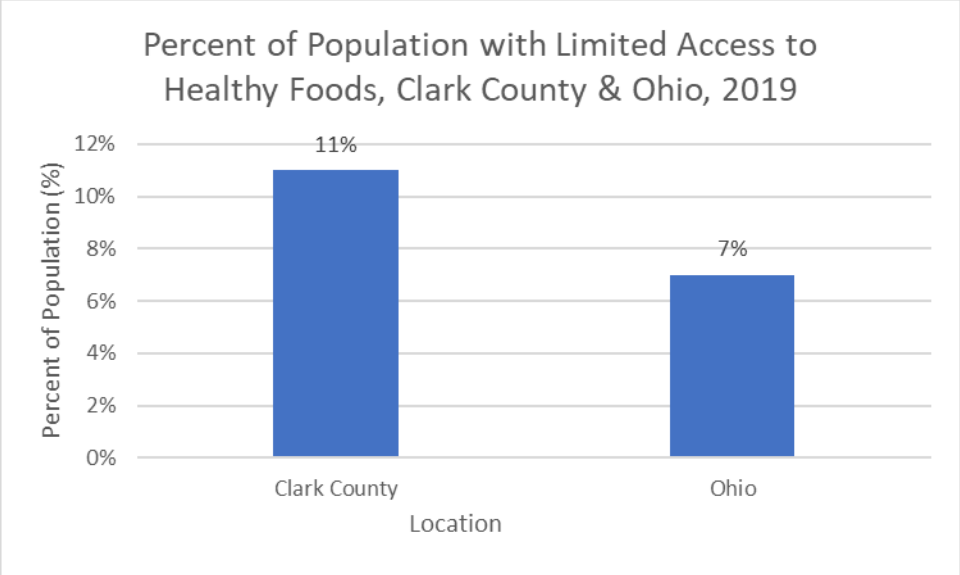


Figure 71: Percent of population who are low-income and do not live close to a grocery store, Clark County & Ohio, 2019, United States Department of Agriculture (USDA) Food Environment Atlas, 2019.

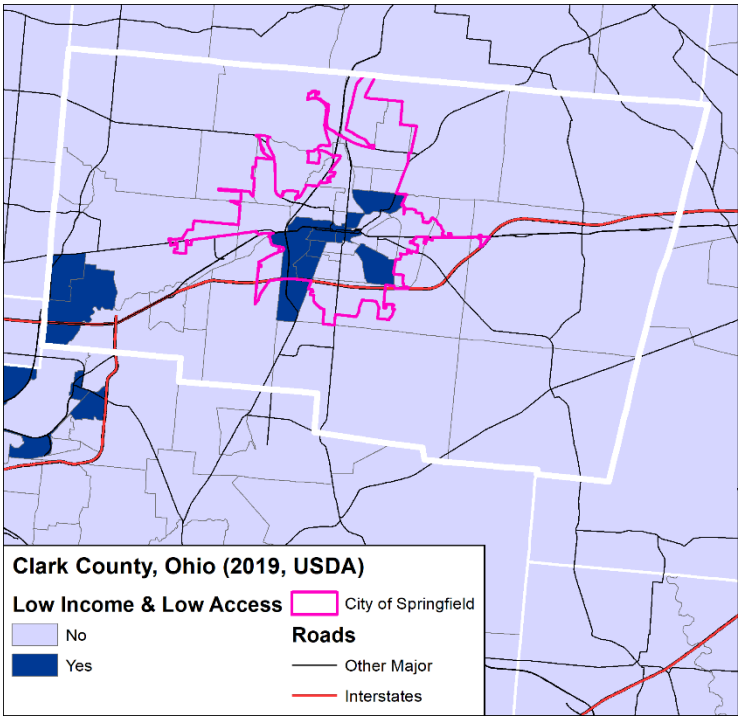


Figure 72: Clark County population with low income and low food access, 2019.

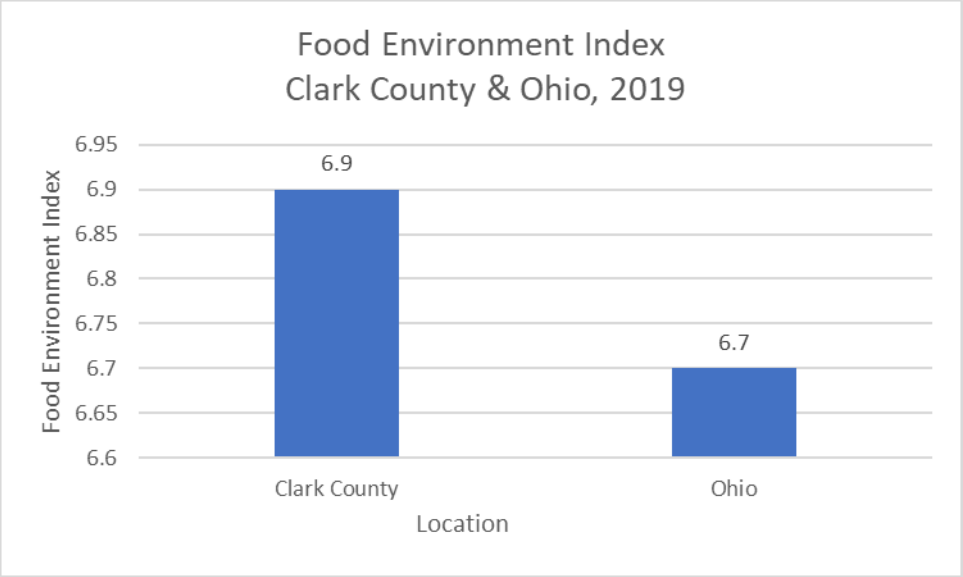


Figure 73: Food Environment Index, Clark County & Ohio, 2019, USDA Food Environment Atlas. Food Environment Index is an index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best).

Physical Environment

Air and Water Quality

Clark County has consistently had fewer good air quality days, except for in 2020, compared to the state of Ohio (Figure 74). The average daily density of air pollutants in Clark County is 10.4, compared to 9 for the state (Table 35).

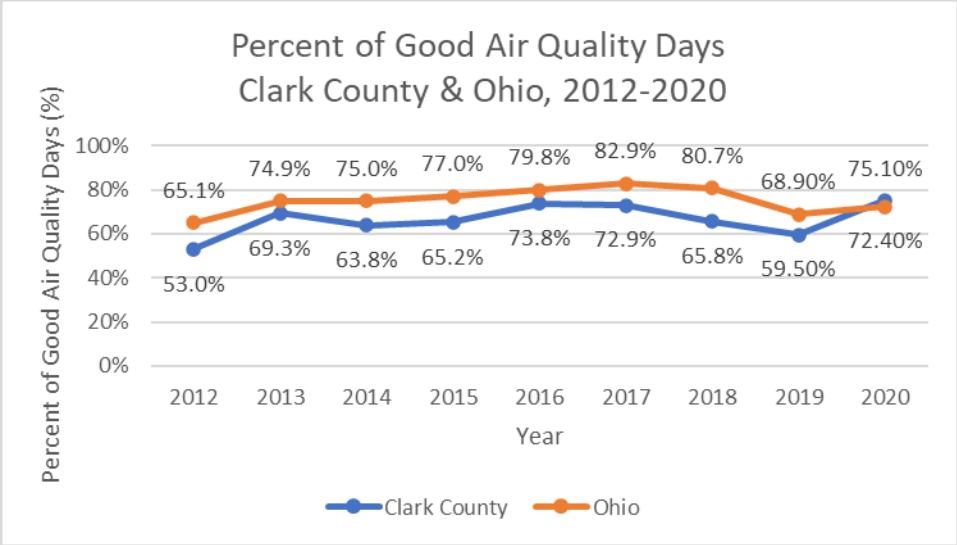


*Figure 74: Percent of good air quality days, Clark County & Ohio, 2012-2020, US Environmental Protection Agency (EPA) Air Quality Statistics. *Air quality considers multiple types of pollutants, Carbon Monoxide (CO), Lead (Pb), Nitrogen Dioxide (NO2), Ozone (O3), Particle Pollution (PM; PM 2.5, PM 10), and Sulfur Dioxide (SO2). **Ohio was calculated based on the averages of all the counties that took an AQI measurement.*

Table 35: Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5), Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021, data from 2018.

	Air Pollution - Particulate Matter
Clark County	10.4
Ohio	9

Housing

The percent of households that spend 50% or more of their household income on housing in Clark County is 13%, which is slightly lower than 15% for the state (Table 36). The percent of households that experience at least one housing problem is slightly less than the state (Table 36).

In 2014 and 2019, a majority of households in Springfield and the US were renter households with more than 1.5 persons per bedroom (Figure 76). Since 2000, the homeownership rate in Springfield has been declining, while the homeownership rate in Ohio and the US has remained relatively constant (Figure 77). While the median rent cost has been increasing since 2000, the median household income has not kept pace (Figure 78).

*Table 36: Severe housing problems and cost burden, Clark County & Ohio, Robert Wood Johnson Foundation County Health Rankings 2021, severe housing problems data from 2014-2018, severe housing cost burden data from 2016-2020. *Severe housing problems: percentage of households that spend 50% or more of their household income on housing. *Severe housing cost burden: percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.*

	Severe Housing Problems	Severe Housing Cost Burden
Clark County	13%	11%
Ohio	15%	12%

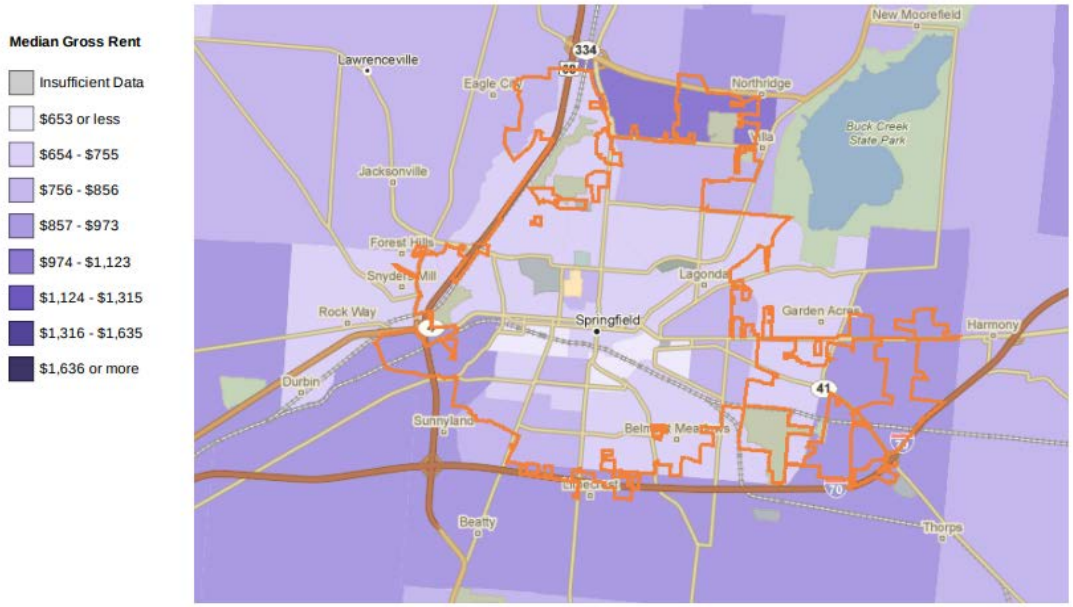


Figure 75: Median rent by neighborhood, Springfield, 2015-2019, American Community Survey 5-year Estimates.

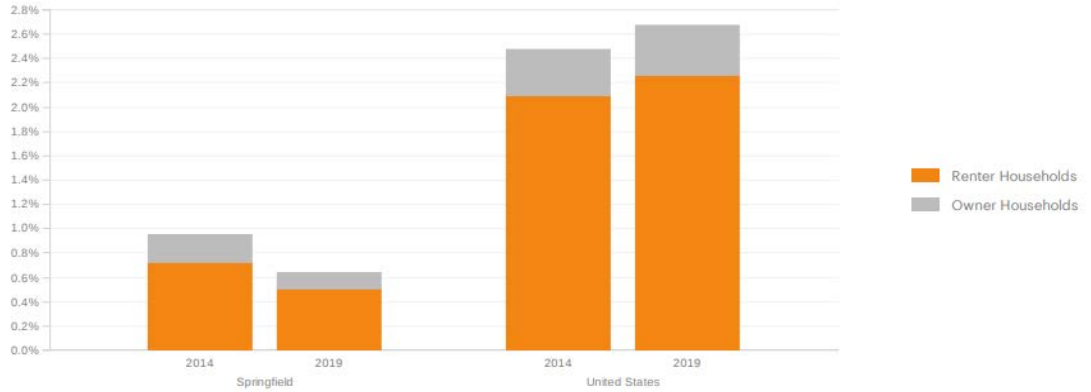


*Figure 76: Severely crowded households, Springfield & US, 2014-2019, American Community Survey 5-year Estimates. *A severely crowded home is one in which there are more than 1.5 persons per bedroom, on average.*

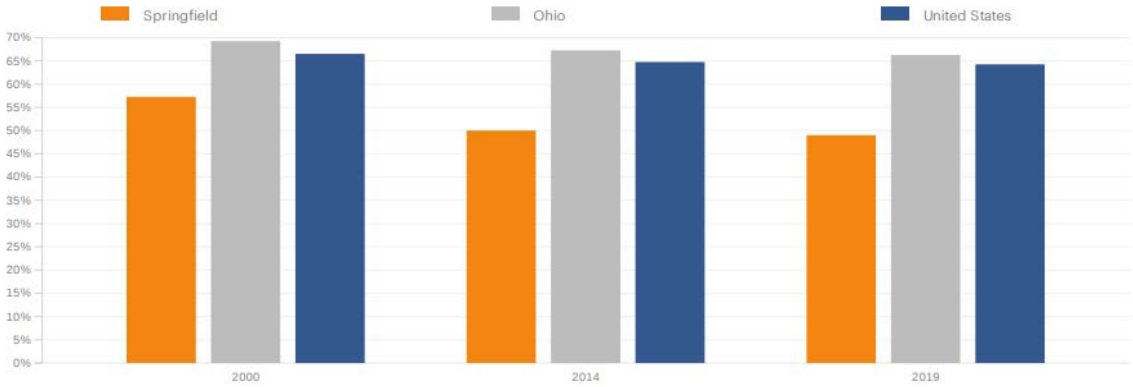


Figure 77: Homeownership rate, Springfield, Ohio & US, 2000-2019, American Community Survey 5-year Estimates.

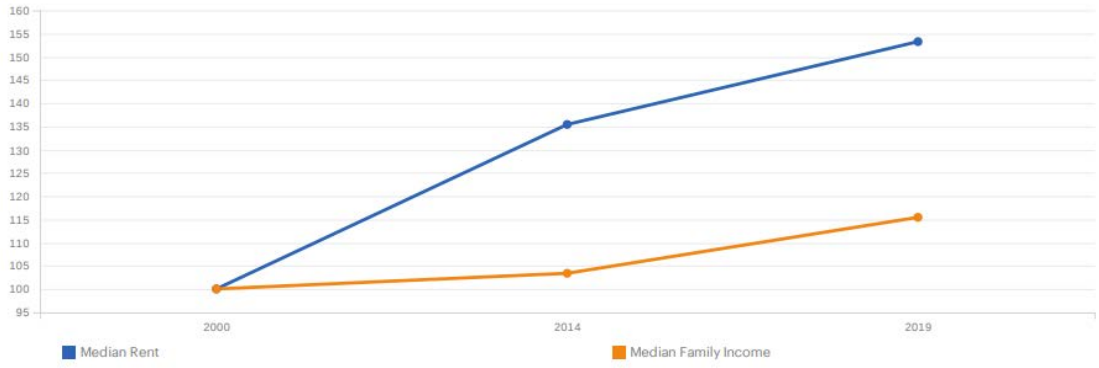


*Figure 78: Comparison of trends in rent and income indexed, Springfield, 2000-2019, American Community Survey 5-year Estimates. *Both monthly rent and annual median family income have been turned into index numbers with their year 2000 values set to 100.*

Transportation

In 2017-2018, Clark County Public Transit transported an average of 7.8 passengers per trip and in 2020-2021, the average passenger per trip decreased to 4.8 (Figure 79). There is no distinct trend on which months see the highest volume.

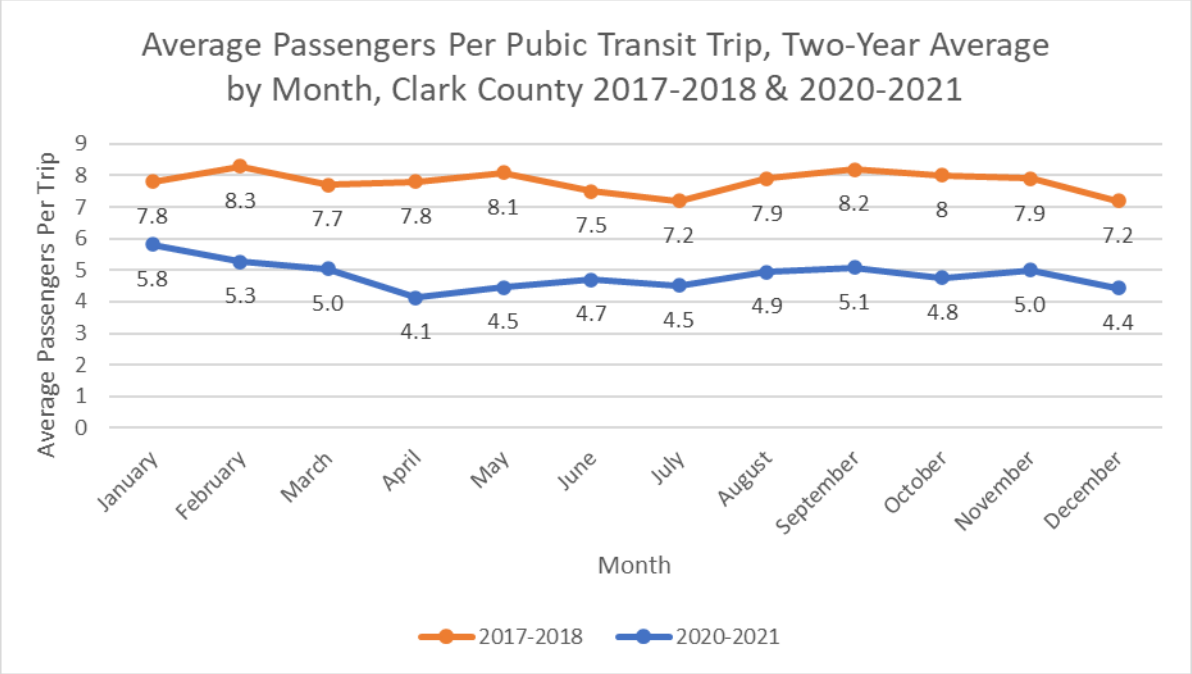


Figure 79: Average passenger per trip, two-year average by month, Clark County-Springfield Transportation Coordinating Committee, 2017-2018 and 2020-2021

Other Environmental Factors

Blood Lead Level

Blood lead levels in Clark County children have been increasing between 2015-2020, peaking in 2019 of incidence rate of 97.0. The 0–5 years old age group closely follows the total incident rate and is much higher compared to the 6-15 years old age group (Figure 80).

Within the 0-5 years old age group, there is a 6.6% difference in incidence rate between the males and females. Within the 6-15 years old age group, there is a 92.2% difference in incidence rate between the males and females (Figure 81). Males have higher incidence rates in both age groups.

The nine Clark County zip codes at risk for elevated blood lead levels are listed in Table 37.

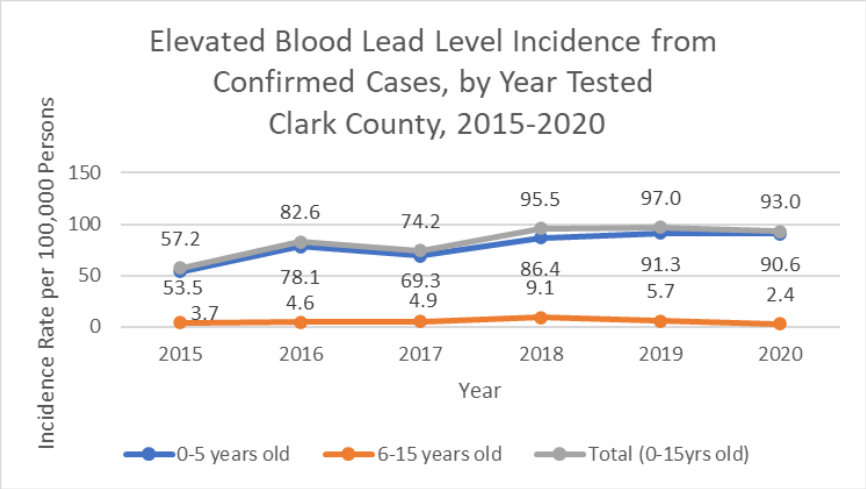


Figure 80: Elevated blood lead level incidence from confirmed cases by year tested, highest BLL test, Clark County, 2015-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

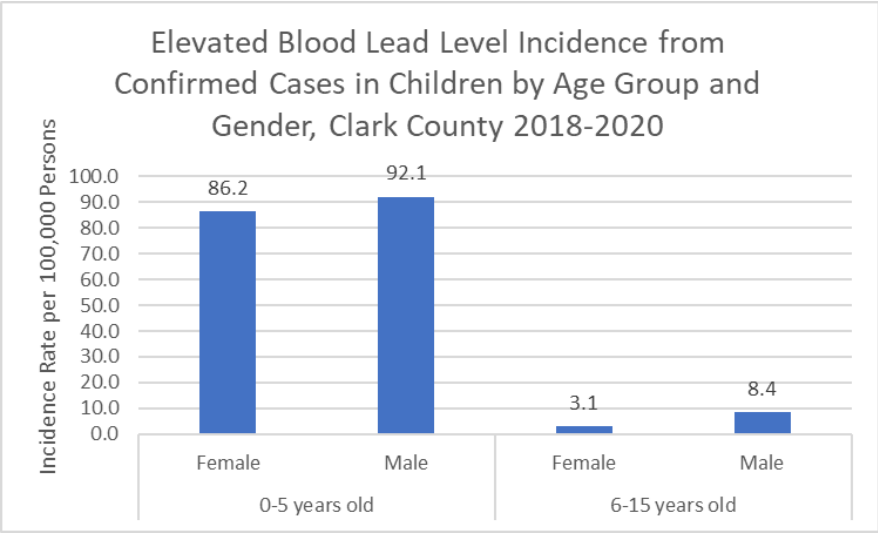


Figure 81: Elevated blood lead level incidence from confirmed cases, highest BLL test, in children by age group and gender, Clark County, 2018-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Table 37: Clark County zip codes at risk for elevated blood lead levels, 2015-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Zip Codes at Risk for Elevated Blood Lead Level
43078
43140
45502
45503
45504
45505
45506
45324
45387

Public Recreational Land Use

Figure 82 depicts recreation parks land in Clark County. The highest concentration of park areas is centrally located in Springfield.

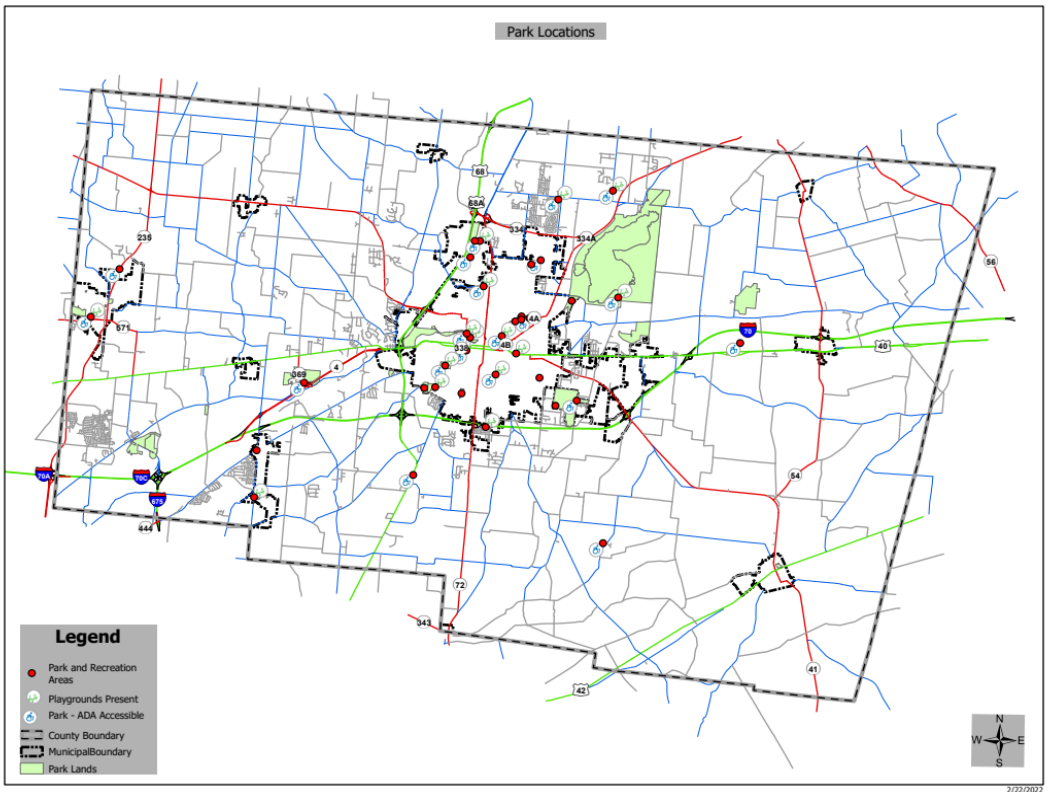


Figure 82: Park lands, Clark County Auditor's Office, 2021.

Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is a survey that monitors health behaviors that contribute to the leading causes of death and disability among 9th-12th grade students. Topics include behaviors that contribute to unintentional injuries and violence, sexual behaviors, alcohol and drug use, tobacco use, unhealthy dietary behaviors, inadequate physical activity, and the prevalence of obesity and asthma.

This report describes county-wide results of the High School YRBS and Middle School YRBS that were administered in October 2021 by the Clark County Combined Health District in collaboration with each individual school district and school to accomplish this goal. To view the full YRBS reports for high school and middle schools, please visit https://ccchd.com/nursing-health-education/health-data-reports/

Table 38: Youth Risk Behavior Survey Results, Clark County, 2021

Category	Youth Risk Indicator	Percent of High School Students	Percent of Middle School Students
COVID-19 Pandemic	Mental health was most of the time or always not good during the COVID-19 Pandemic	36.3%	26.4%
	Parent or other adult in their home lost their job, even for a short amount of time, during the COVID-19 Pandemic	21.3%	18.3%
Driving Habits	Rarely or never wore a helmet when riding a bicycle	-	71.0%
	Rarely or never wore a helmet when rollerblading or riding a skateboard	-	43.3%
	Rarely or never wore a seat belt when riding a car driven by someone else	6.7%	6.2%
	Have rode in a car driven by someone who had been drinking alcohol	-	18.7%
	Rode in a car driven by someone who had been drinking alcohol, at least once in the past 30 days	14.0%	-
	Drove a car after they had been drinking alcohol at least 1 time in the past 30 days	5.6%	-
	Texted or emailed while driving at least 1 day in the past 30 days	16.6%	-
Violence & Weapon Carrying	Carried a weapon on school property at least 1 day in the past 30 days	2.7%	-
	Carried a gun at least 1 day in the past 12 months	4.0%	-
	Did not go to school because they felt unsafe at least 1 day in the past 30 days	9.2%	-
	Threatened or injured with a weapon on school property at least once in the past 12 months	6.6%	-
	Have been involved in a physical fight	-	44.3%

Category	Youth Risk Indicator	Percent of High School Students	Percent of Middle School Students
	Involved in a physical fight at least once in the past 12 months	20.4%	-
	Involved in a physical fight on school property at least once in the past 12 months	6.1%	-
	Have been physically hurt by a parent or other adult in their home at least sometimes in their life	-	7.9%
	Seen someone get physically attacked, beaten, stabbed, or shot in their neighborhood	22.7%	25.2%
Sexual Violence	Forced into having sexual intercourse	9.8%	-
	Forced by anyone into doing sexual things at least once in the past 12 months	10.8%	18.1%
	Forced into doing sexual things by someone they were dating at least once in the past 12 months	5.4%	-
	Physically hurt by someone they were dating at least once in the past 12 months	5.3%	-
Bullying	Bullied on school property in the past 12 months	16.3%	43.1%
	Electronically bullied in the past 12 months	15.9%	33.8%
	Victim of teasing or name calling because of race or ethnic background in the past 12 months	11.8%	17.3%
	Victim of teasing or name calling because of LGBTQ+ status in the past 12 months	16.2%	-
Depression & Suicide	Hurt themselves without wanting to kill themselves at least once in the past 12 months	24.3%	25.3%
	Felt sad or hopeless for two weeks or more in a row in the past 12 months	40.1%	-
	Seriously considered attempting suicide in the past 12 months	20.6%	26.3%
	Made a plan to attempt suicide in the past 12 months	17.2%	18.8%
	Attempted suicide at least once in the past 12 months	9.3%	11.0%
	Had to be treated after a suicide attempt in the past 12 months	2.2%	-
Tobacco	Tried smoking a cigarette	20.6%	10.7%
	Smoked a cigarette before age 10 years old	-	3.4%
	Smoked a cigarette before age 13 years old	8.9%	-
	Smoked cigarettes at least 1 day in the past 30 days	6.2%	3.0%
	Smoked cigarettes on at least 20 days in the past 30 days	1.0%	0.4%

Category	Youth Risk Indicator	Percent of High School Students	Percent of Middle School Students
	Smoked at least 1 cigarette per day in the past 30 days	-	3.7%
	Smoked more than 10 cigarettes per day in the past 30 days	0.5%	-
	Tried an electronic vapor product	35.8%	16.8%
	Smoked an electronic vapor product at least once in the past 30 days	21.1%	10.6%
	Smoked an electronic vapor product 20 or more days in the past 30 days	7.3%	-
	Got their electronic vapor products from a store (a vape shop, gas station, etc.) in the past 30 days	4.0%	-
	Used chewing tobacco, snuff, snus, etc. 1 day or more in the past 30 days	3.6%	2.0%
	Smoked cigars, cigarillos, or little cigars on 1 day or more in the past 30 days	3.7%	2.6%
	Did not try to quit using all tobacco products in the past 12 months	12.6%	-
Alcohol	Had least one drink of alcohol	-	20.7%
	Had their first drink of alcohol before age 10 years old	-	4.9%
	Had their first drink of alcohol before age 13 years old	15.7%	-
	Had at least one drink of alcohol on at least 1 day in the past 30 days	23.3%	-
	Had 4 drinks or more (female) or 5 drinks or more (male) on at least 1 day in the past 30 days	17.3%	-
	Had 5 drinks or more in row in the past 30 days	8.3%	-
	Usually got their alcohol from someone else in the past 30 days	10.0%	-
Marijuana	Had used marijuana at least once in their life	28.4%	8.4%
	Tried marijuana for the first time before age 10 years old	-	0.9%
	Tried marijuana for the first time before age 13 years old	6.9%	-
	Used marijuana at least once in the past 30 days	17.0%	-
Drugs	Have used synthetic marijuana at least once in their life	9.0%	-
	Have taken non-prescribed pain medication or misused it at least once in their life	12.7%	10.0%
	Have used any form of cocaine at least once in their life	3.0%	0.6%
	Have sniffed glue, aerosols, paints to get high at least once in their life	7.1%	3.5%

Category	Youth Risk Indicator	Percent of High School Students	Percent of Middle School Students
	Have used heroin at least once in their life	2.5%	-
	Have used methamphetamines at least once in their life	2.7%	-
	Have used ecstasy at least once in their life	4.0%	-
	Used a needle to inject an illegal drug at least once	2.2%	-
	Had been offered, sold, or given an illegal drug on school property	10.9%	-
	Lived with someone who was having a problem with alcohol or drug use	31.6%	25.4%
Sexual Behavior	Have had sexual intercourse	31.7%	5.7%
	First had sexual intercourse before age 10 years old	-	1.1%
	First had sexual intercourse before age 13 years old	3.5%	-
	Had sex with 4 or more people in their life	1.0%	0.5%
	Had sex with at least one person in the past 3 months	25.0%	-
	Used alcohol or drugs the last time before sex	5.1%	-
	Used a condom when they last had sex	15.2%	2.6%
	Did not use any method to prevent pregnancy when they last had sex	4.0%	-
	Have been or gotten someone pregnant at least once	1.9%	-
	Had sexual contact with both males and females	5.5%	-
	Are non-heterosexual (LGBTQ+)	16.5%	-
Body Weight	Self-describe as slightly or very overweight	37.2%	34.4%
	Not trying to do anything with their weight	18.7%	22.6%
	Tried to lose or keep from gaining weight in the past 30 days by not eating, taking diet pills, vomiting, taking laxatives or skipping meals	25.4%	22.6%
Dietary Behavior	Did not drink 100% fruit juice in the past 7 days	37.3%	-
	Did not eat fruit in the past 7 days	17.3%	-
	Did not eat green salad in the past 7 days	49.9%	-
	Did not eat potatoes in the past 7 days	39.1%	-

Category	Youth Risk Indicator	Percent of High School Students	Percent of Middle School Students
	Did not eat carrots in the past 7 days	59.7%	-
	Did not eat other vegetables in the past 7 days	26.6%	-
	Drank a soda or pop at least once per day in the past 7 days	27.0%	-
	Did not drink a glass of milk at least once in the past 7 days	34.2%	-
	Did not eat breakfast on at least 1 day during the past 7 days	78.1%	72.1%
Physical Activity	Were active for 60 minutes per day less than 5 days in the past 7 days	49.5%	45.2%
	Spent at least 3 hours a day in front of a TV, computer, other electronic device watching shows or videos playing games or on the internet on an average school day	69.1%	67.4%
	Did not go to PE classes at school in an average week	-	57.0%
	Do not play on any sports teams in the past 12 months	44.8%	45.1%
	Got a concussion from playing a sport or being active at least once in the past 12 months	14.0%	16.3%
Miscellaneous	Have ever had sex education in school	68.0%	14.4%
	At least sometimes went hungry because there wasn't enough food at home in the last 30 days	10.3%	8.3%
	Have ever been tested for HIV	5.1%	-
	Have ever been tested for a STD other than HIV in the past 12 months	4.3%	-
	Have not seen a dentist at least once in 12 months or more	24.9%	-
	Mental health was often not good at least most of the time during the past 30 days	29.2%	21.4%
	Get 4 hours or less of sleep on a school night	11.3%	12.2%
	Often felt at least most of the time that they were able to talk to an adult about their feelings	-	17.0%
	Slept somewhere else besides their parent/guardians, family member or friends house in the past 30 days	5.7%	4.6%
	Did not have a usual place to sleep during the past 30 days	0.4%	0.7%
	Rarely or never felt safe and secure in their neighborhood	6.3%	7.3%

Factors Contributing to Inequities

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. The following section aims at identifying and describing factors that contribute to inequities in Clark County.

Ohio Opportunity Index

The Ohio Opportunity Index helps us understand where we need to target resources aimed at improving conditions for Ohioans who are the most vulnerable (Ohio Opportunity Index, 2021). This map of Clark County shows us opportunity level from very high to very low measuring seven factors that impact health and well-being (Figure 83). The higher the level in the index, the better the opportunities to thrive. These types of Opportunity Index maps can help guide the delivery of crucial public health services.

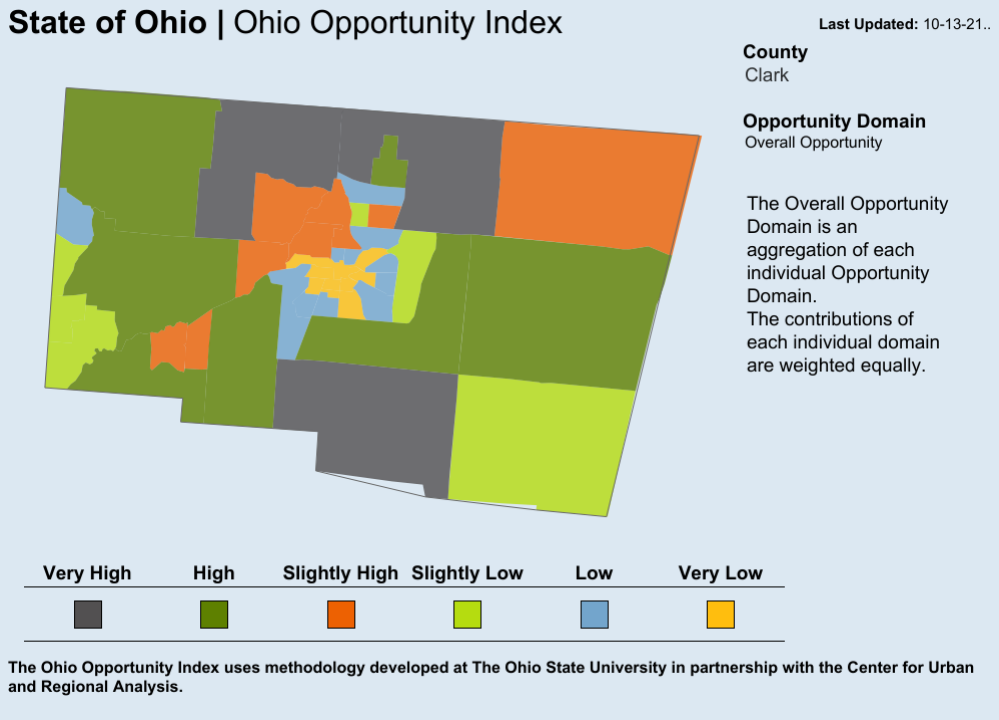


Figure 83: Ohio Opportunity Index, Clark County, 2021

Social Vulnerability Index

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 U.S. census variables to help identify communities that may need support before, during, or after disasters (CDC/ATSDR, 2020).

Every community must prepare for and respond to hazardous events, whether a natural disaster like a tornado or a disease outbreak, or an anthropogenic event such as a harmful chemical spill. The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

ATSDR's Geospatial Research, Analysis, & Services Program (GRASP) created the Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index (CDC/ATSDR SVI or simply SVI) to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event.

SVI indicates the relative vulnerability of every U.S. Census tract. SVI ranks the tracts on 16 social factors, including unemployment, racial and ethnic minority status, and disability, and further groups them into four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation.

Figure 84:CDC/ATSDR Overall Social Vulnerability Index, Clark County, 2020

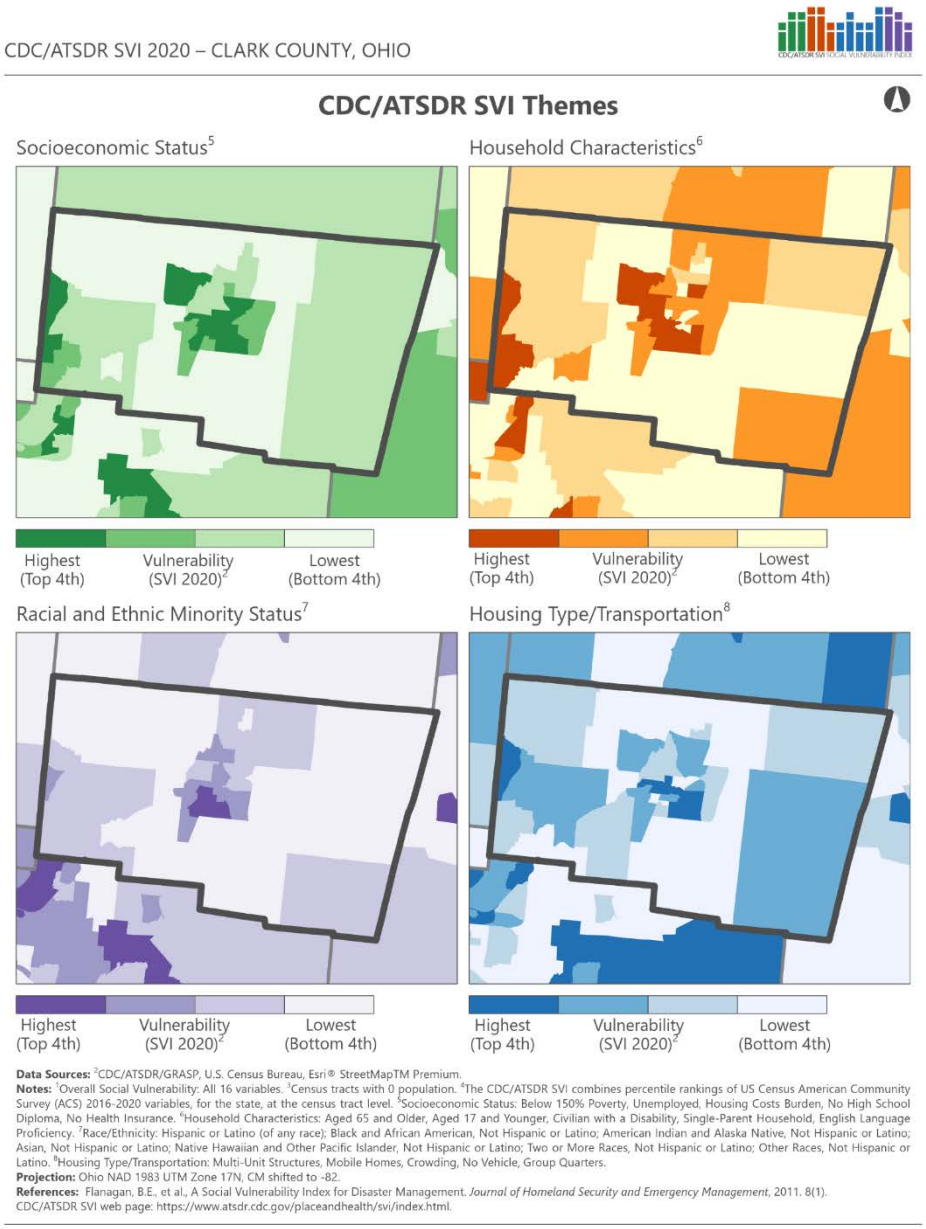


Figure 85: CDC/ATSDR Social Vulnerability Index Themes, Clark County, 2020

Ohio Health Improvement Zones

Ohio Health Improvement Zones (OHIZ) refers to the socioeconomic and demographic factors that affect the resilience of individuals and communities – the ability to prevent human suffering and financial loss in a disaster. By understanding where these populations are located and what factors contribute to their levels of risk, Ohio Health Improvement Zones can aid in all phases of improving health in communities. The Ohio Department of Health's OHIZ tool contains both county-level and US Census Tract-level data on Health Improvement Zones. This tool uses Social Vulnerability Index (SVI) created by the US Centers for Disease Control and Prevention (CDC), using the most current data available from the

US Census Bureau American Community Survey 5-year estimates (2014-2018). The SVI is a score ranging from 0 – 1, detailing areas of high SVI (darker colors and higher scores) and areas of low SVI (lighter colors and lower scores). The SVI is comprised of 15 indicators grouped into 4 themes, as defined by CDC (Figure 84). For detailed information on individual census tract level Social Vulnerability Index data, visit https://odh.ohio.gov/know-our-programs/health-equity/health-improvement-zones

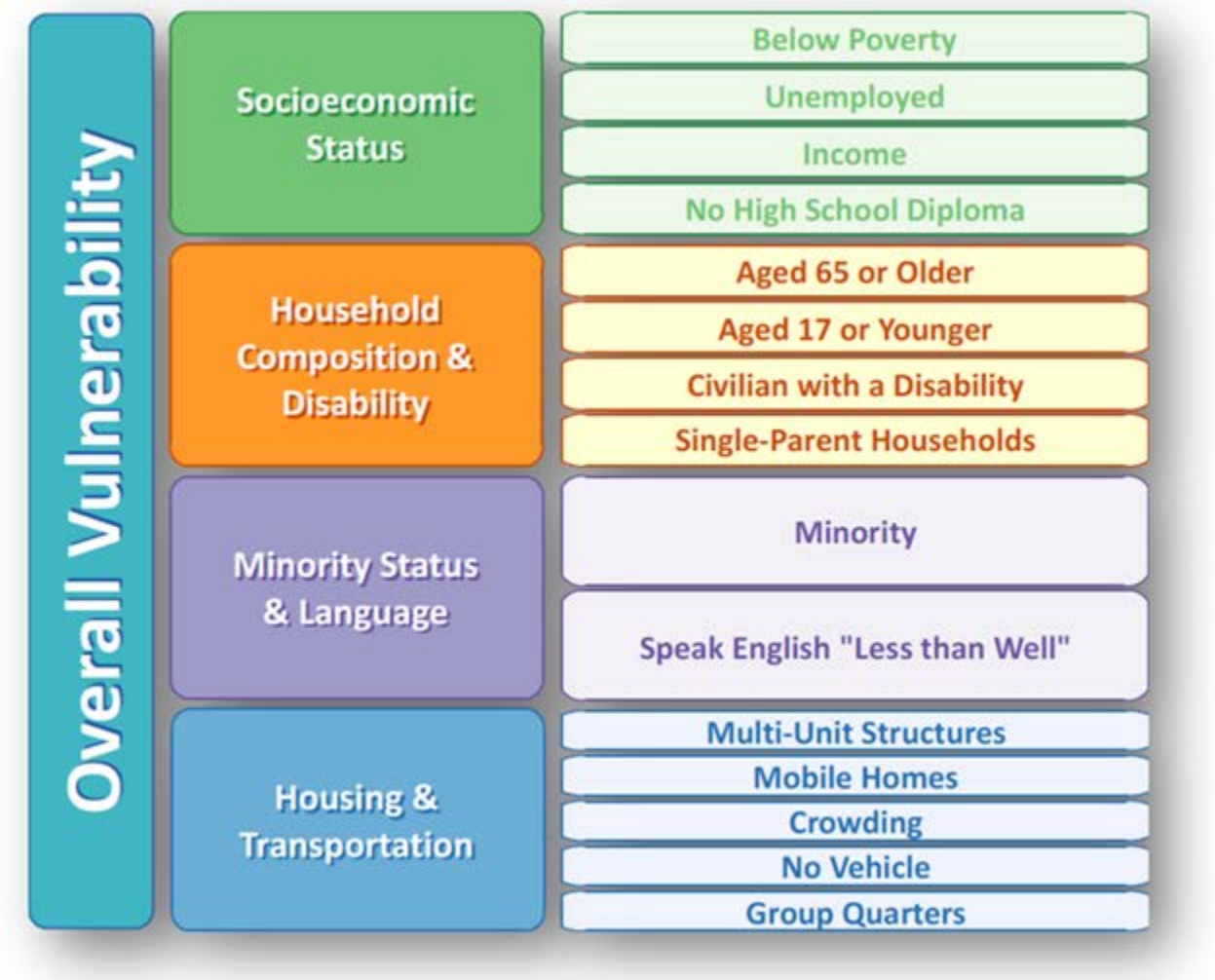


Figure 86: Social Vulnerability Index (SVI) Indicators and themes. https://odh.ohio.gov/know-our-programs/health-equity/health-improvement-zones

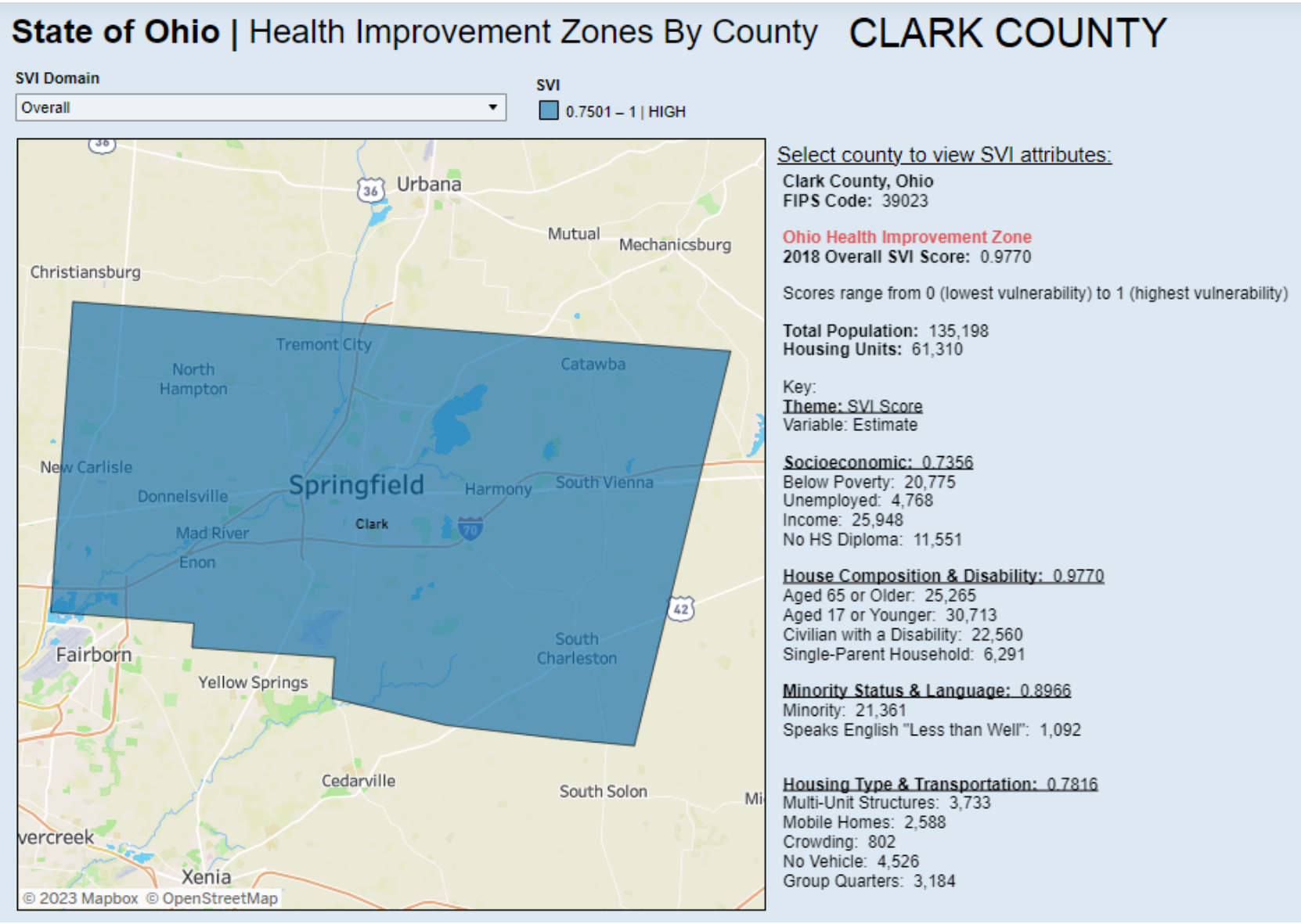


Figure 87: Ohio Health Improvement Zone by County, Clark County, 2018

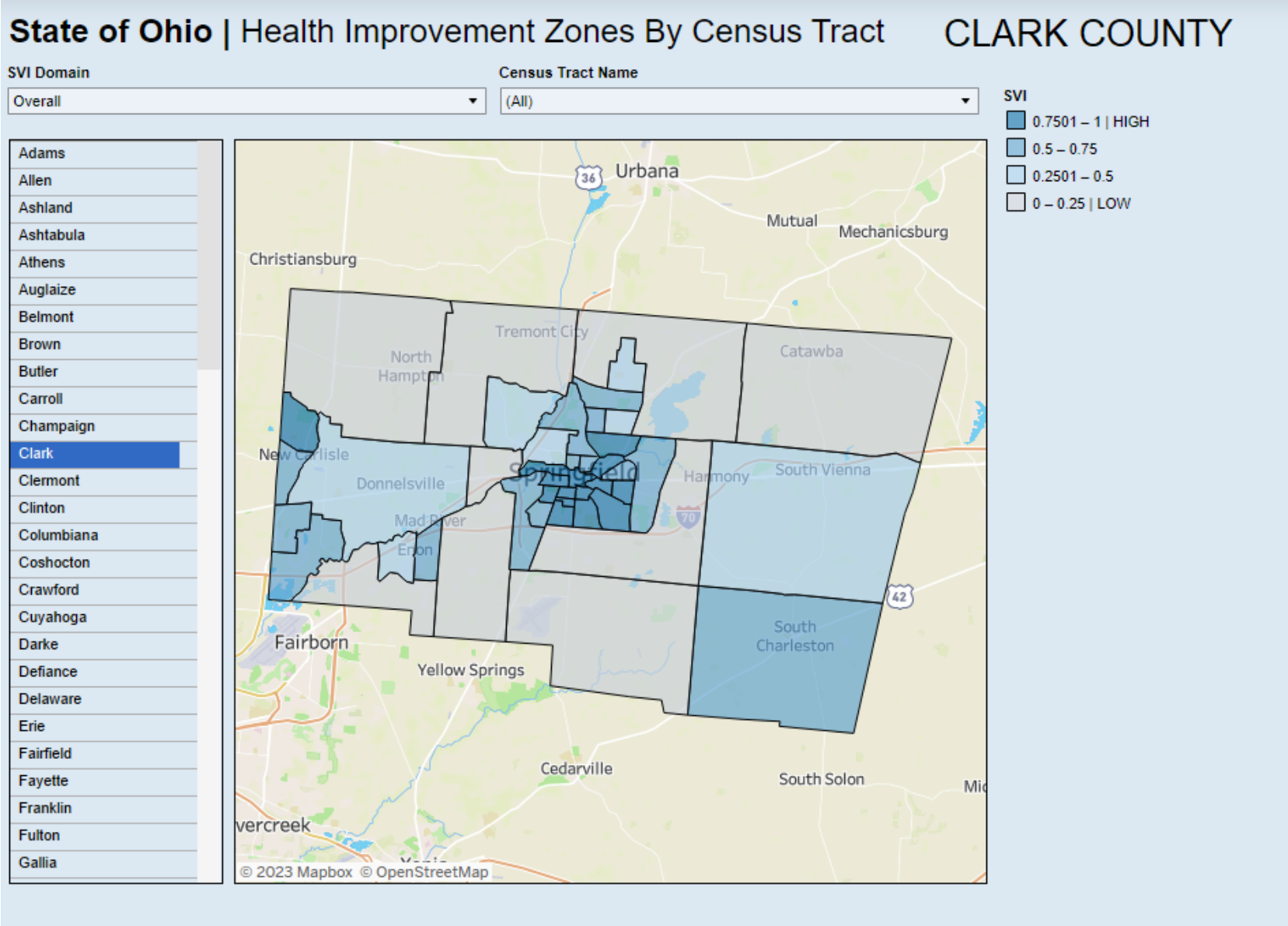


Figure 88: Ohio Health Improvement Zone by Census Tract, Clark County, 2018

Identification and Mobilization of Community Assets

In March of 2000, Dr. Patricia Sharpe et al published an article in Public Health Reports entitled "Assets-Oriented Community Assessment" (Sharpe, et al., 2000). Dr. Sharpe explains that to determine how to promote community health partners, must first assess where the community stands through assets-oriented assessment methods rather than problem-focused or needs-based approaches. An asset-based assessment orientation allows agencies to identify, support, and mobilize existing community resources to create a shared vision of change while encouraging greater creativity.

Along the same lines of Dr. Sharpe's promotion of an asset-based assessment, the next iteration of the MAPP process (MAPP 2.0) the "Community Partners Assessment" will focus on health equity capacity, community engagement, resources, and community linkages in addition to several other domains. The Community Partners Assessment will provide structure for all community partners to look critically within their own systems and processes, reflect on their role in the community's health and well-being, and understand the degree to which they are addressing or perpetuating health inequities across a spectrum of action ranging from the individual to systemic and structural levels. It will offer an assessment instrument which will be inclusive of but not be grounded in the 10 Essential Public Health Services to broaden its relevance to community partners outside health and human service sectors. Clark County intends to use this new MAPP process during the next Community Health Assessment and Community Health Improvement Plan cycle.

A community asset (also called a community resource) is anything that can be used to improve the quality of community health and life. Community assets can be people, physical structures, social service, or businesses. In Clark County, community assets that can and will be involved in community health improvement include local neighborhood organizations/coalitions, community centers, seniors' groups, local officials/politicians/leaders, local public schools, universities, community colleges, public hospitals, federally qualified health centers, publicly funded or private educational institutions, municipal libraries, law enforcement, emergency response personnel, funding foundations, parks and municipal activity centers, housing organizations, food kitchens, emergency housing shelters, substance use homes, domestic violence shelters, churches, outpatient clinics and counseling centers, advocacy groups, banks and financial institutions, chamber of commerce, business associations, and local businesses.

Identify Strategic Issues

The CHA/CHIP Steering Committee met on July 13, 2022 for MAPP Phase 4 and to identify strategic issues. The issues identified will build the foundation for the CHIP and subsequent task forces in the community. After reviewing the preliminary data collected during the four assessments, the members of the Steering Committee were asked to carefully examine the 2019 CHA strategic issues and consider priority topics, priority outcomes, and cross-cutting factors. The Committee elevated previous "cross-cutting" factors to strategic issues based on the Forces of Change and primary/secondary data.

Strategic Issues

The ultimate goal of the MAPP is to identify strategic issues after reviewing all preliminary data collected during the four assessments (Community Themes and Strengths, Forces of Change, Local Public Health System, and Community Health Status). Three priority topics are typically selected. The group identified the following strategic issues for the next three-year CHA/CHIP cycle (Figure 81):

→ Maternal, infant, and sexual health (continuation from last CHA/CHIP cycle)
→ Chronic Disease (continuation from last CHA/CHIP cycle but with a new/increased focus on food access)
→ Mental health (continuation from last CHA/CHIP cycle but with a new/increased focus on crime)
→ Housing that is affordable, safe/healthy, sustainable (personal finance, education/jobs, etc.), accessible (ADA), and paired with support services/case management.

Cross-cutting Factors

The Community Health Assessment (CHA) highlights powerful underlying drivers of wellbeing. From the CHA data, the Community Health Improvement Plan takes a comprehensive approach to improving health priorities by identifying cross-cutting factors that impact multiple outcomes. While these factors can be involved in setting goals and establishing strategies in each priority area, cross-cutting factors can be elevated to priority areas and vice versus over multiple CHA/CHIP cycles. The Steering Committee suggested the creation of a "watch list" of items that may transition from cross-cutting factors to strategic issues. Identified cross-cutting factors included (Figure 83):

→ Health equity and minority access
→ Capacity/infrastructure building
→ Education

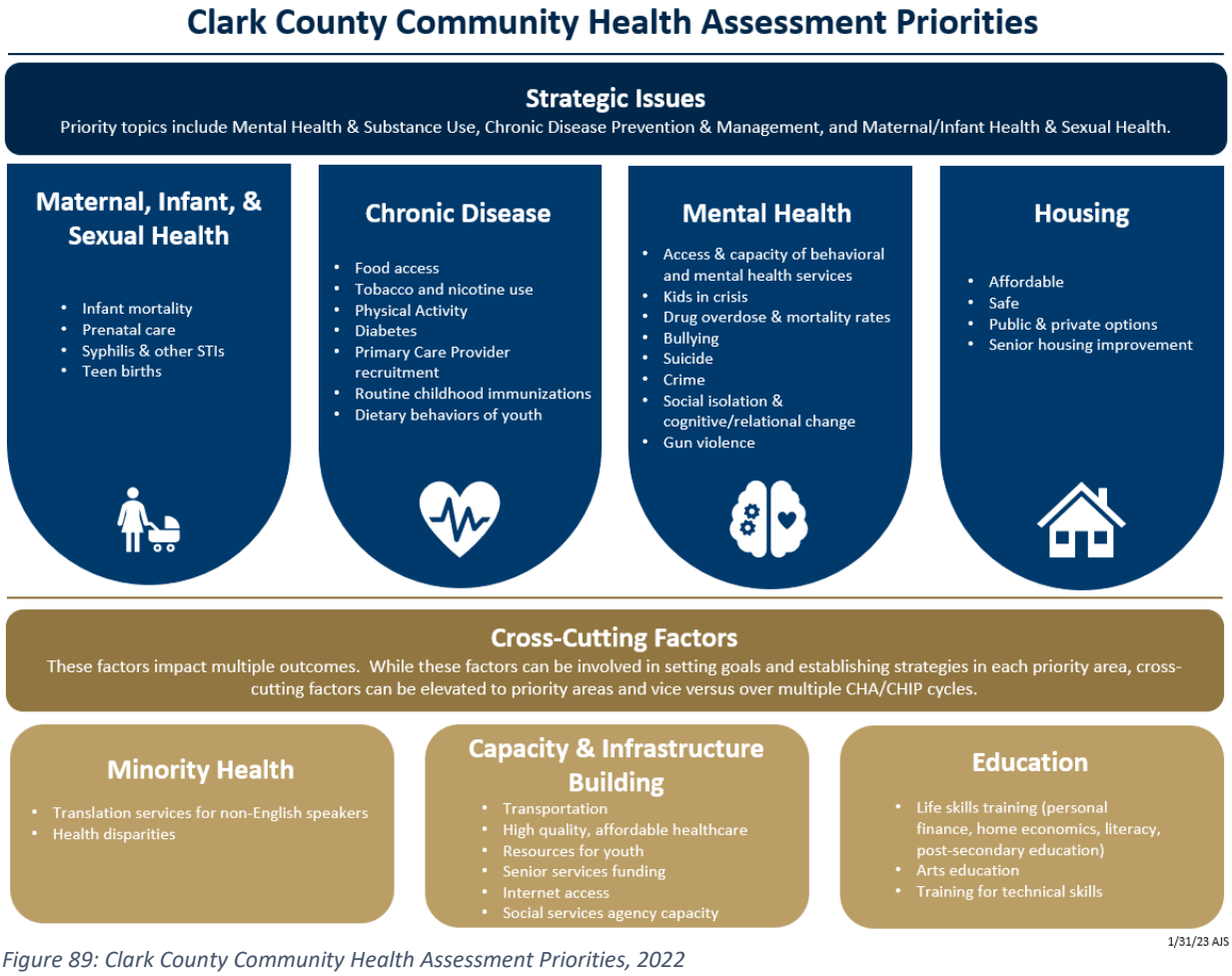


Figure 89: Clark County Community Health Assessment Priorities, 2022

Next Steps

Using results from the Community Health Assessment, the next steps in the MAPP process are:

1. Formulate goals and strategies (phase 5). During this phase, goals and strategies will be created for each priority area identified in MAPP phase 4.
2. Action cycle (phase 6). During this phase the community will plan, implement, and evaluate each of the strategies implemented to achieve the goals identified in phase 4 and phase 5.

The Community Health Improvement Plan will be a separate report that expands upon MAPP phase 4 and 5 by describing the strategic issues identified during the CHA process and presenting the implementation and evaluate plans for each priority topic.

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Appendix A: Forces of Change Assessment Results

Theme Area	Forces	Threats	Opportunities
Crime	Neighborhood safety	Undesirable place to live and raise a family, money spent outside county	Reestablishment of neighborhood watch task forces
	Identify theft, burglary, crime	Drives away new business and new families	Law enforcement partnerships
	Domestic violence	Insufficient capacity for domestic violence shelters	Behavioral and family counseling
Development/ Economy	New hotel planned	New landing location for homeless population	Spending money in the county economy
	New grocery store	Time to build trust, higher prices	Reduction of food deserts, accessible healthy food, WIC access
	High gas prices	Higher cost to travel to/access healthcare, less money to spend on healthcare, less money to spend in economy	Community transportation options
	Inflation	Higher healthcare, housing, and food prices, widening gap between healthy and unhealthy	Free healthcare, donation opportunities
	Supply chain issues	Delays in getting resources, higher prices	Alternative resources, innovation
	Technology	Loss of jobs, changing job skills, need for new training and education, higher costs for goods and services	Increased efficiency, new types of jobs, better data and systems
Education	Home schooling	Decreased socialization, mental health issues, loss of funding for schools	Entry into career earlier with different skill set, opportunities for new home-based programs
	Inequity of funding schools	Families moving out of districts, inequitable access to STEM opportunities	New state funding models, innovation, private funding
	Undereducated adult population	Harder for employers to find adequate workforce, social determinant of health, poorer health choices, brain drain in county	Technical school and community college expansion, GED offerings, employer

Theme Area	Forces	Threats	Opportunities
			based training and educational advancement incentives
Employment	Declining number of people in trades	Harder for employers to find adequate workforce, higher cost and competition for employees, aversion of new companies to settle in county	Technical school and community college expansion, higher wages for employees from competition
	Unemployment rate	Harder for employers to find anyone willing to work at all, less money to spend in local economy, mental health, expansion of Medicaid-eligible population, higher tax burden on working class	Technical school and community college expansion, higher wages for employees from competition
	Entry level jobs below living wage	Employers cannot find workers, higher cost of goods and services	Creativity in benefit offerings, economic competition
	Lack of workforce diversity	Deepening socioeconomic rift between racial groups, fewer opportunities, less desirable place for minorities to live	Employers that hire for diversity will be unique
	Workforce shortages	Smaller pool of candidates for jobs, greater competition for workers, businesses may close, reduced services, increased prices to consumer	Higher wages for employees, better benefit offerings
	High retirement rates	Lack of experience and expertise, drain on retirement systems for longer times	Employees can move up quicker, higher wages, better benefits
	Paid maternity leave	Inconsistent application of benefit across employers	Employers who offer benefit can stand out above others, better for long term physical and emotional health of employees
	Remote work	Loss of commercial buildings/tax revenue, social isolation, less in-person customer service, longer work hours	Work/life balance for employees, employee retention, infection control
Environment/ Infrastructure	Access to green spaces	Business and housing expansion	Intentional designation of areas for non-development
	Air quality and asthma	Business development, political parties with less focus on environmental protection	Pandemic; refocus on indoor air quality improvement

Theme Area	Forces	Threats	Opportunities
	Clean water supply	Tremont City barrel fill, waste disposal, sewage systems malfunctioning	Cleanup, inventory of systems and Operation and Maintenance program
	Climate change	Altered ecosystem	Schools with focus on environment
	Public transportation	Cost, limited options for work transportation	Enhancement of public transportation to major employers, job opportunities with Uber and Lyft
Family/Youth	Lack of quality/affordable childcare	High costs for limited numbers of childcare centers, vulnerable population, parents cannot work, kids left home alone	New business starts, grandparents as caretakers
	Children in poverty	Poor health outcomes, trouble getting to school, challenge with access to healthcare	Higher wages for employees, better benefit offerings
	High number of children eligible for free or reduced school lunch	Grace period for free or reduced lunch shortened or ending, partisan politics may change policy	Hungry children being fed, consistent better weekday diet, better test/educational outcomes
	Children behind in learning curve	Continuing pandemic restrictions	Continued enhancement and use of virtual technology to deliver instruction
	Child abuse	Opportunities for child abuse from staying at home more during pandemic	Respite for parents, community activities
	Need for summer programs and after school programs	Population alone and vulnerable, filling free time with unsafe activities	New programming and funding opportunities from federal agencies, church community involvement
Food Security	Access to healthy food	Chronic disease increase, increase in use of processed food, hunger, food deserts	New business starts, satellite food pantries
	Access to affordable food	Chronic disease increase, hunger, overwhelmed pantries	Continuation and expansion of food pantries, SNAP benefits expansion, community gardens, food co-ops, donation centers

Theme Area	Forces	Threats	Opportunities
	Limited availability in grocery stores	Higher prices, hoarding, less money for other goods/services	New business starts, satellite food pantries
Healthcare	Lack of primary care physicians taking new patients	Unmanaged chronic conditions, overuse of emergency departments, higher healthcare costs	New provider practices, additional urgent care, community telehealth locations
	Telehealth	People without internet access	Lower cost to patients and healthcare system, expanded access to care
	Increased health care costs	People avoiding healthcare, unmanaged chronic conditions, alternative dangerous healthcare options, higher premiums	Telehealth, expansion of prevention programs, Medicaid enrollment and expansion
	Shortage of dentists and primary care physicians	Poor health outcomes, long term dental problems, expensive healthcare through emergency departments, increase in health insurance costs to everyone	Loan forgiveness to new providers operating in HPSA, public health prevention, fluoridation of water
	New hospital opening	Unequal distribution of Medicaid and no insurance patients, provider and support staff recruitment competition, volume of patients insufficient for both hospitals	Choice of provider location, market competition for workers and higher wages, better and more innovative healthcare, cost effective solutions to health problems
	Vaccine mandates	Legislators, laws/rules, decrease in uptake of all vaccines, poor health outcomes, increase vaccine-preventable disease	Educate legislators and providers, advertise new locations for vaccines (pharmacies)
	Healthcare worker burnout	Inadequate workforce, substandard quality care, worker competition	Incentives for new graduates, additional undergraduate and graduate programs, higher wages
	Shortage of health care workers, nurses, and support staff	Inadequate workforce, substandard quality care, worker competition	Incentives for new graduates, additional undergraduate and graduate programs, higher wages

Theme Area	Forces	Threats	Opportunities
	Lack of wellness and prevention programs	Unhealthy workforce, no incentive to prevent chronic conditions, increased healthcare costs	Creativity in benefit offerings, economic competition
	High costs of prescriptions	Splitting pills, delaying filling prescriptions, chronic conditions out of control, misuse of emergency departments	Prescription card programs, lower costs alternative generic drugs, employers offering full coverage of prescriptions
	Overweight/obesity trends	Chronic conditions out of control, higher healthcare costs, generational obesity, increase in diabetes	Prevention programs, diabetes awareness education programs, health education in schools
	COVID implications	Burned out workforce, long COVID, unknown complications, increased death rates, ongoing vaccine costs	Novel vaccines and treatment options
Housing	Lack of affordable housing, homelessness	Homeless population living on the streets/hotels, less transitional housing available, increased numbers of people living in tents, working population leaving the county	Rehab old houses, HUD housing, new developments, apartment/condo opportunities
	Lack of desirable housing (leaky roofs, lead paint, asbestos)	Families living in unhealthy conditions, increased maternal and child health issues, segregation	Grant opportunities from HUD, community block grants
	Landlord accountability	House foreclosures, abandonment of houses, degradation of existing homes	Improve existing structures, tax incentives, economic development
	Sewage regulations	Economic hardships, reduced commercial development	Extension of municipal water and sewer, attraction of new businesses that want municipal water and sewer
Inclusion	Better acceptance of LGBTQ community	Segregation, isolation, poor health outcomes, health inequity	Social service agency outreach events, healthcare provider outreach, political policy prioritization

Theme Area	Forces	Threats	Opportunities
	Cultural diversity, racism	Workforce that does not reflect population served, political leaders out of touch, segregation/isolation, new form of redlining, movement out of county	Intentional hiring practices, houses of worship community outreach
	Immigration	Segregation, prejudice, health inequities, distrust of government, overuse of emergency systems, hiring practices	Church outreach, safe havens, healthcare regardless of immigration status
	Aging population	Elderly neglect, lack of senior housing, shortage of long-term care facilities and staff, increased healthcare costs, younger workers absent from workforce to care for aging family	Non-profit agency and church outreach, volunteerism, employment opportunities for caretakers
Mental health	Lack of mental health care coverage	Increased violent and non-violent crime, suicide, breakdown of family nucleus, generational mental health issues	Employment opportunities for mental health professionals, alternative mental healthcare, telehealth
	Long waitlists for mental health services	Lack of trust in healthcare system, leaving county for mental health needs, feeling of despair and ensuing suicide attempts	Group mental health services to serve more people at the same time, telehealth, layperson training
	Covid impact	Social isolation, distrust of health experts and government	Community unity, houses of worship impacting community, layperson training
Other	Distrust of news and scientific information	Poor health outcomes, avoiding treatment, anti-vaccine movement, political isolation	Health education in schools, informatics classes, rebuilding trust in health experts
Policy/ Governance	Un-fluoridated water	Poor dental health outcomes for children and adults, poor nutrition later in life, increased healthcare costs, overuse of emergency departments	Fluoridate the water, health education, political leaders drawing attention to and supporting fluoridation

Theme Area	Forces	Threats	Opportunities
	Tightening restrictions on women's reproductive rights	Health inequity, political isolation, civil unrest	Promotion of sexual health clinic and reproductive life planning, houses of worship outreach and support, political movement
	Gun law challenges	Mass fatality incidents, balance of rights and life, mental health challenges, violent protests	Education, political movement, policy change
	Political tensions, elections	Civil unrest, violence, family division, distrust in government, segregation, racism	Political science in schools, de-escalation training, peaceful debate
	Changes in covid benefits	Increased tax burden in the future, lack of workforce incentives, unprepared public health system	Support public health infrastructure, employer healthcare benefits, remote workforce
	Medicaid/Medicare reimbursements and requirement changes	Instability in benefits, growing unemployed workforce needing benefits, healthcare providers not accepting M/M patients, lack of providers for M/M patients	Federally Qualified Health Centers enhanced Medicaid reimbursement and expansion of services
	War	Economic instability, political isolation and instability, supply chain interruption, inflation	New supply chains, long term economic gains
Premature Life Loss	Drug abuse/addiction	Businesses leaving county, public perception/image, overuse of emergency services, high mortality rate	More treatment programs, prevention and Narcan services, breaking stigma, education on behavioral health component
	Infant mortality	Greatest loss of life, mental health, maternal health degradation, inequities	Health education, outreach programs, case management, grief counseling rapid response

Appendix B: Local Public Health System Assessment Results

Table 39: Local Public Health System Assessment Full Results

	I don't think this has been significantly addressed in our community and it's still a need	Our system is actively working on this and needs to continue	We've made great strides and I wouldn't consider this a major weakness	This has completely moved from a weakness to a strength	This should be removed from the list of opportunities for other reasons
ES1 Opportunities for Improvement					
Make the CHA/CHIP easier to understand & consider literacy levels	1	3	5	2	0
Ownership of the CHA/CHIP among other agencies besides the health department	0	5	3	3	0
Share the CHA/CHIP with more people and get media coverage	1	5	3	2	0
Find additional data sources for underreported topics	3	6	0	2	0
Centralize data resources	3	7	1	0	0
ES1 Overall Rating	8	26	12	9	0
ES2 Opportunities for Improvement					
Improve overall communication between system partners	1	4	3	3	0
Share and communicate emergency response plans between system partners	1	3	3	4	0

	I don't think this has been significantly addressed in our community and it's still a need	Our system is actively working on this and needs to continue	We've made great strides and I wouldn't consider this a major weakness	This has completely moved from a weakness to a strength	This should be removed from the list of opportunities for other reasons
Regularly update agency contacts for program continuity (due to personnel turnover)	1	9	1	0	0
ES2 Overall Rating	3	16	7	7	0
ES3 Opportunities for Improvement					
Move towards long term health improvement goals	1	6	3	0	1
Share and update data through a collaborative platform	1	8	2	0	0
Find additional financial and human resources to advance health	3	6	2	0	0
ES3 Overall Rating	5	20	7	0	1
ES4 Opportunities for Improvement					
Create centralized location for resources (for example, a resource hub)	3	6	1	0	1
Create protocols for obtaining and sharing data among partners	5	4	1	0	1
Enhance ownership and investment in population health to increase participation	3	7	1	0	0

	I don't think this has been significantly addressed in our community and it's still a need	Our system is actively working on this and needs to continue	We've made great strides and I wouldn't consider this a major weakness	This has completely moved from a weakness to a strength	This should be removed from the list of opportunities for other reasons
ES4 Overall Rating	11	17	3	0	2
ES5 Opportunities for Improvement					
Create a community policy review team and conduct biannual reviews	7	2	2	0	0
Educate community partner agencies on national policy initiatives	5	4	2	0	0
Incorporate role in the local public health system into partner strategic plans	2	7	1	0	1
ES5 Overall Rating	14	13	5	0	1
ES6 Opportunities for Improvement					
Increase proactive law/rule review	3	4	4	0	0
Increase impact of public health enforcement when needed		6	5		
ES6 Overall Rating	3	10	9	0	0
ES7 Opportunities for Improvement					
Build data on where to reach at-risk populations	0	7	3	1	0
Increase transportation resources to access healthcare services	3	7	0	1	0

	I don't think this has been significantly addressed in our community and it's still a need	Our system is actively working on this and needs to continue	We've made great strides and I wouldn't consider this a major weakness	This has completely moved from a weakness to a strength	This should be removed from the list of opportunities for other reasons
Central referral system and central case management	8	2	0	1	0
ES7 Overall Rating	11	16	3	3	0
ES8 Opportunities for Improvement					
Develop a workforce assessment tool	7	2	1	0	0
ES8 Overall Rating	7	2	1	0	0
ES9 Opportunities for Improvement					
Ability to implement change quickly	1	5	2	3	0
Evaluate data more frequently	1	5	4	1	0
Flexibility to reallocate money and resources if a different direction/outcome is needed	1	6	2	2	0
Share research studies/findings and involve more partner agencies in research	4	6	0	1	0
ES9 Overall Rating	7	22	8	7	0

Appendix C: Additional Data

Cancer Detection by Stage

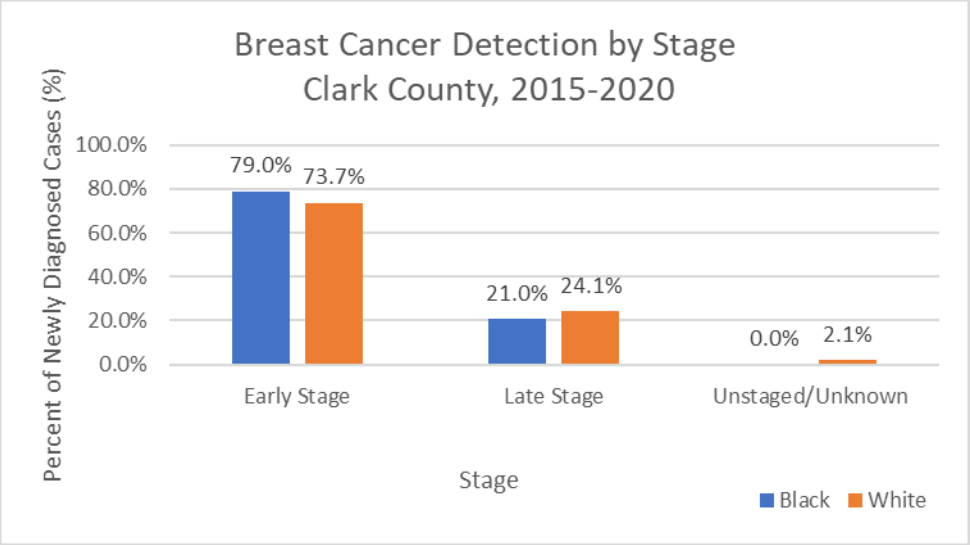

Figure 90: Breast cancer detection by stage, Clark County, 2015-2020, Data queried from the Ohio Cancer Incidence Surveillance System (OCISS). The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

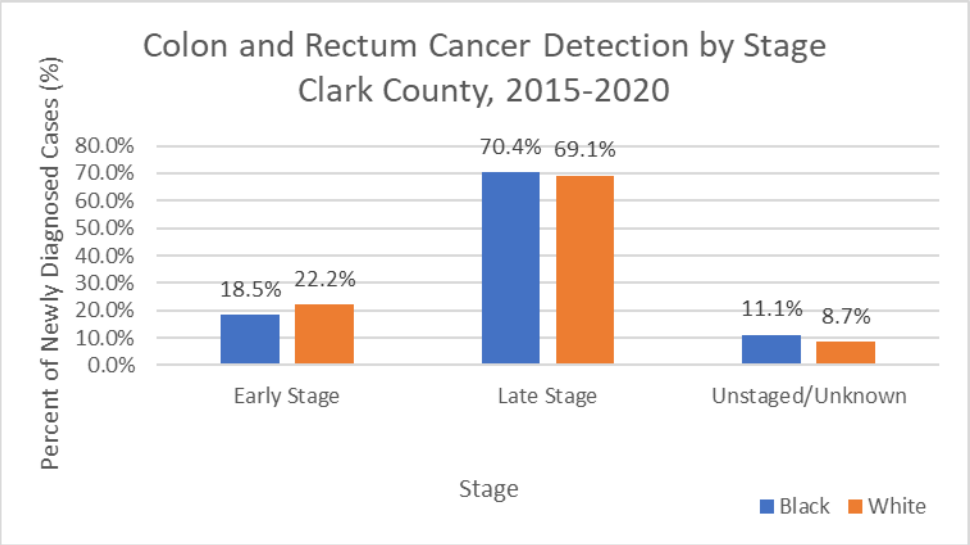

Figure 91: Colon and rectum cancer detection by stage, Clark County, 2015-2020, Data queried from the Ohio Cancer Incidence Surveillance System (OCISS). The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

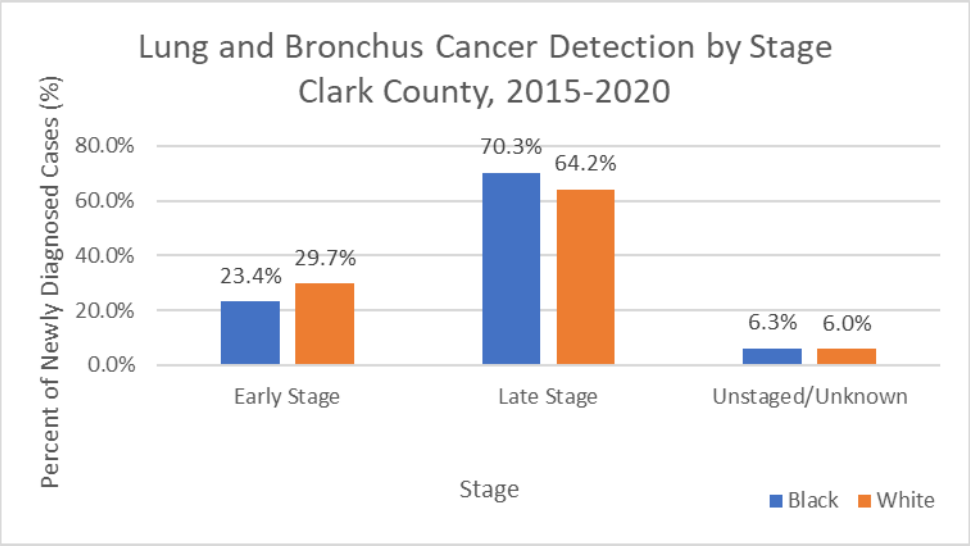

Figure 92: Lung and bronchus cancer detection by stage, Clark County, 2015-2020, Data queried from the Ohio Cancer Incidence Surveillance System (OCISS). The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

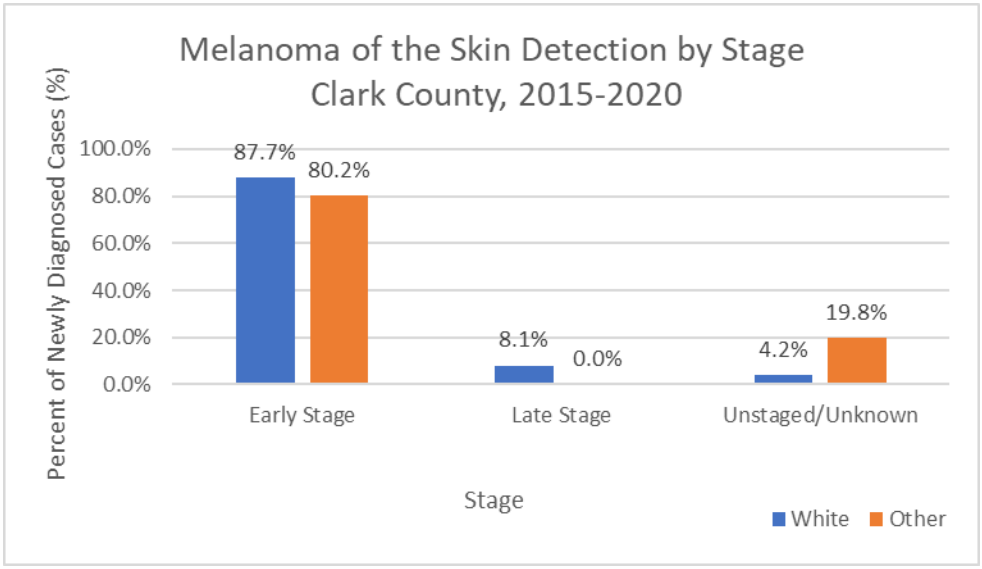

Figure 93: Melanoma of the skin detection by stage, Clark County, 2015-2020, Data queried from the Ohio Cancer Incidence Surveillance System (OCISS). The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

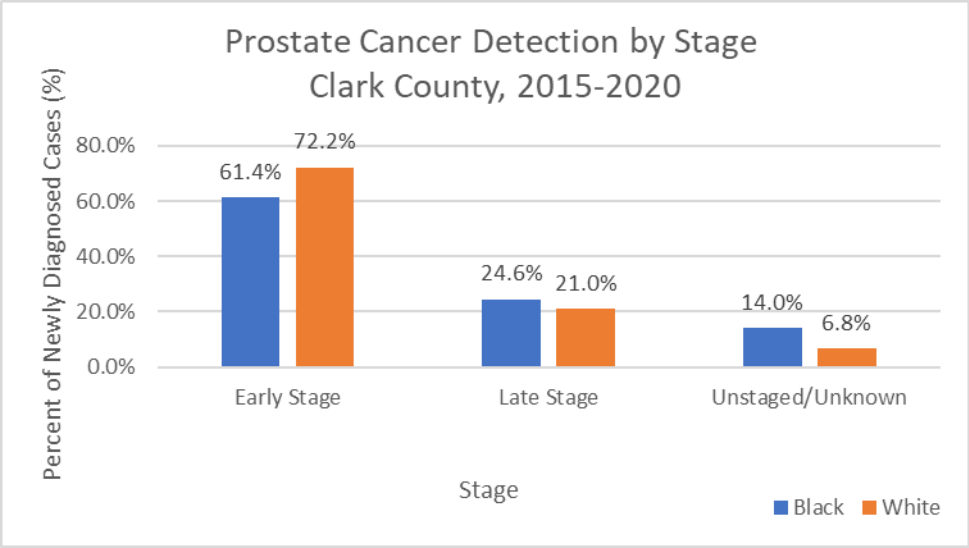

Figure 94: Prostate cancer detection by stage, Clark County, 2015-2020, Data queried from the Ohio Cancer Incidence Surveillance System (OCISS). The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Disability

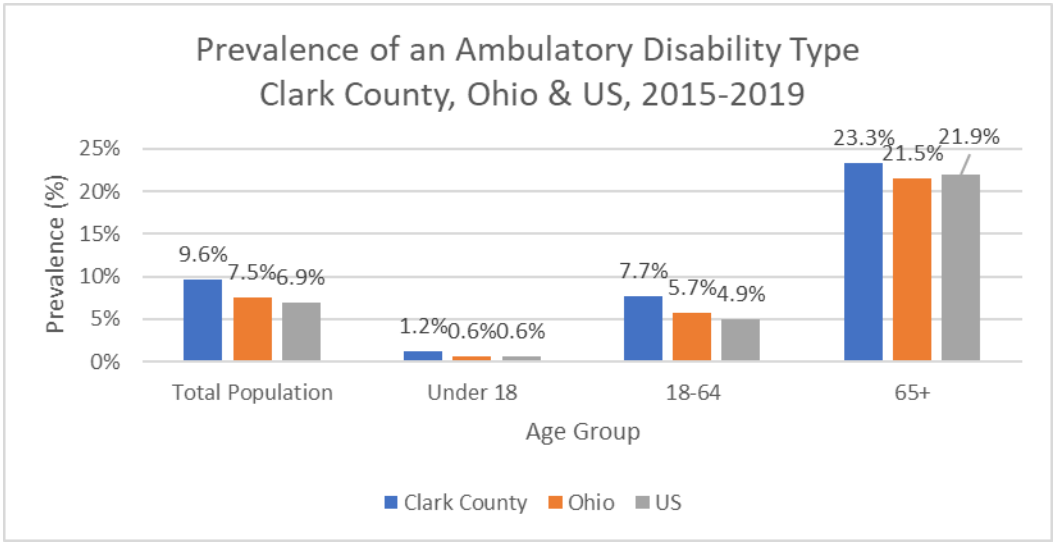

Figure 95: Prevalence of an ambulatory disability type, Clark County, Ohio & US, American Community Survey 5-year estimates, 2015-2019.

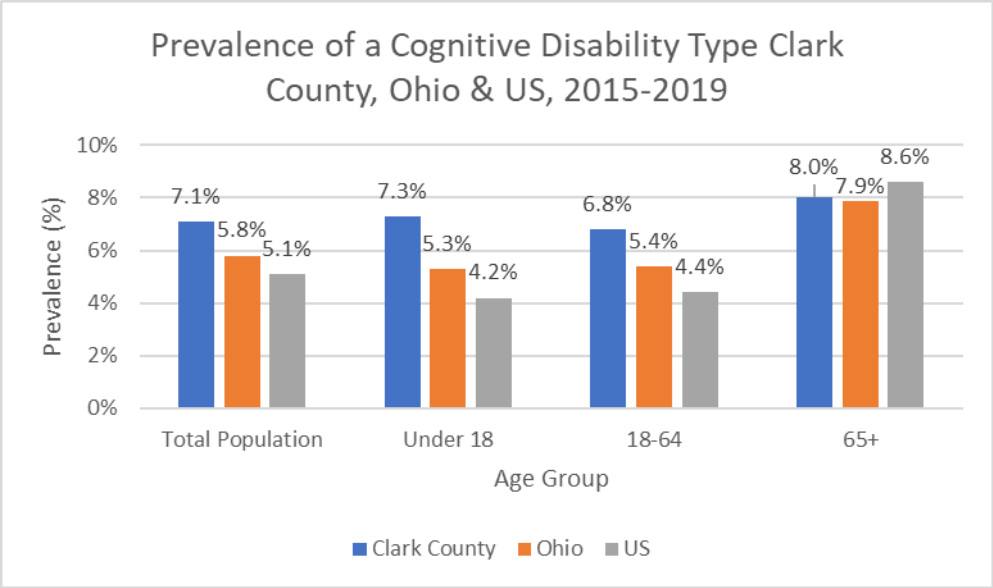

Figure 96: Prevalence of a cognitive disability type, Clark County, Ohio & US, American Community Survey 5-year estimates, 2015-2019.

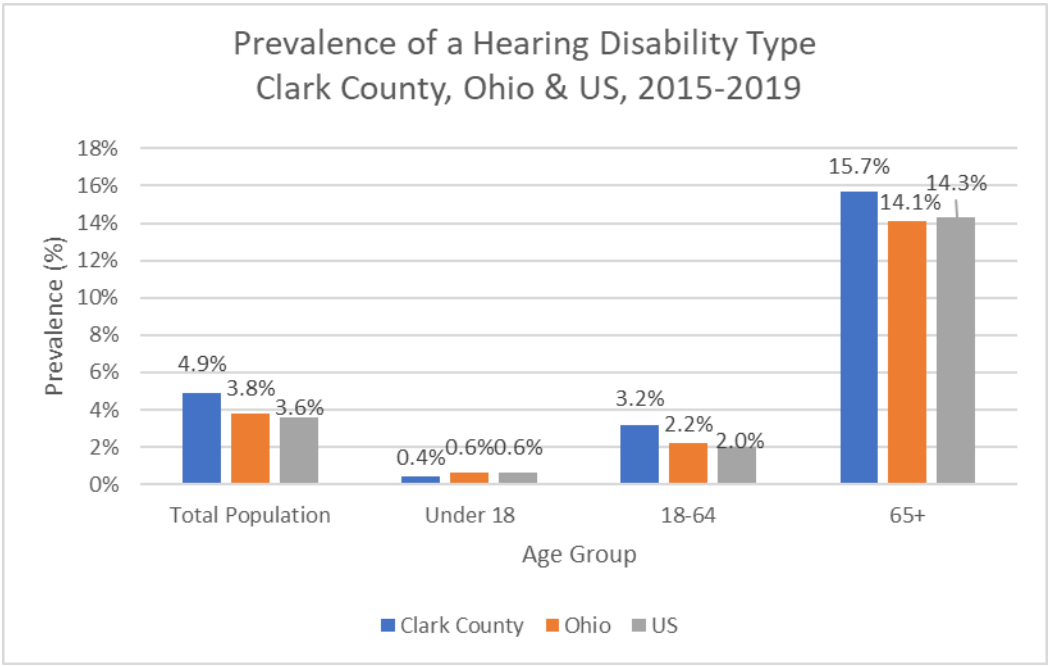

Figure 97: Prevalence of a hearing disability type, Clark County, Ohio & US, American Community Survey 5-year estimates, 2015-2019.

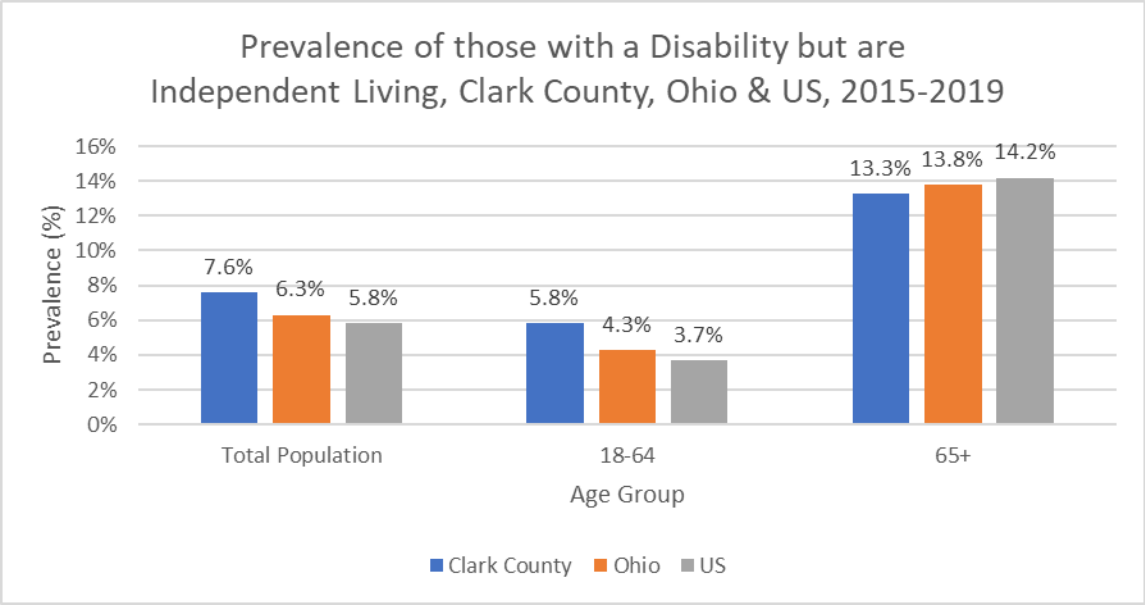

Figure 98: Prevalence of those with a disability but are independent living, Clark County, Ohio & US, American Community Survey 5-year estimates, 2015-2019.

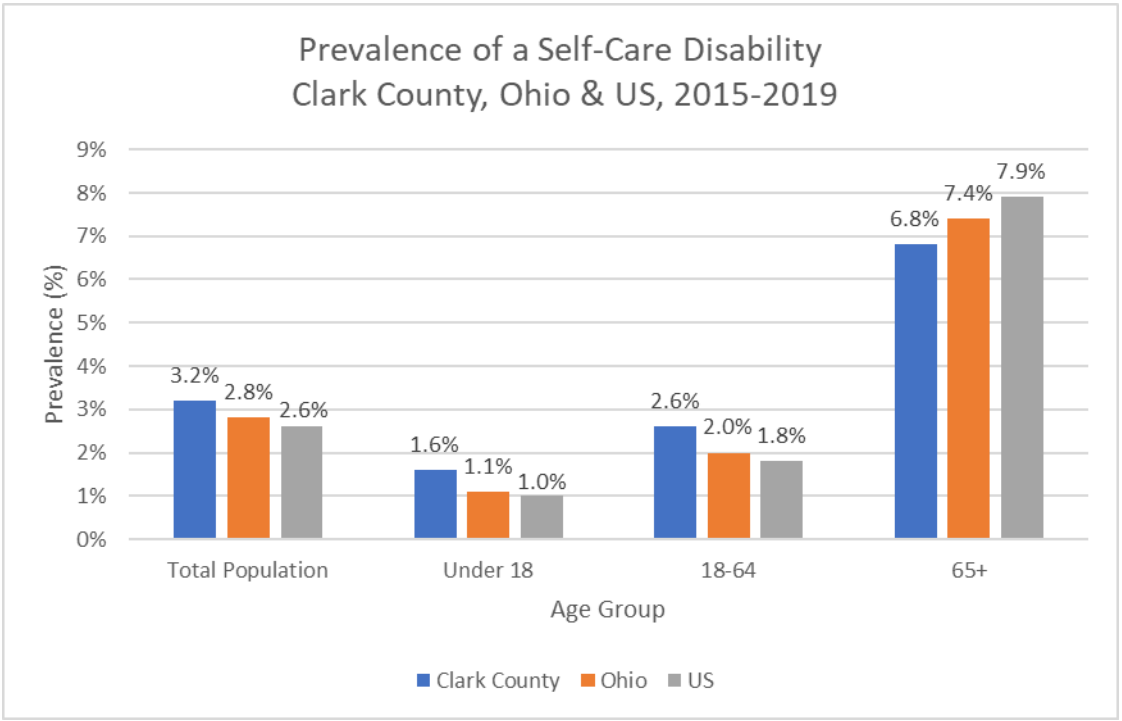

Figure 99: Prevalence of a self-care disability, Clark County, Ohio & US, American Community Survey 5-year Estimates, 2015-2019.

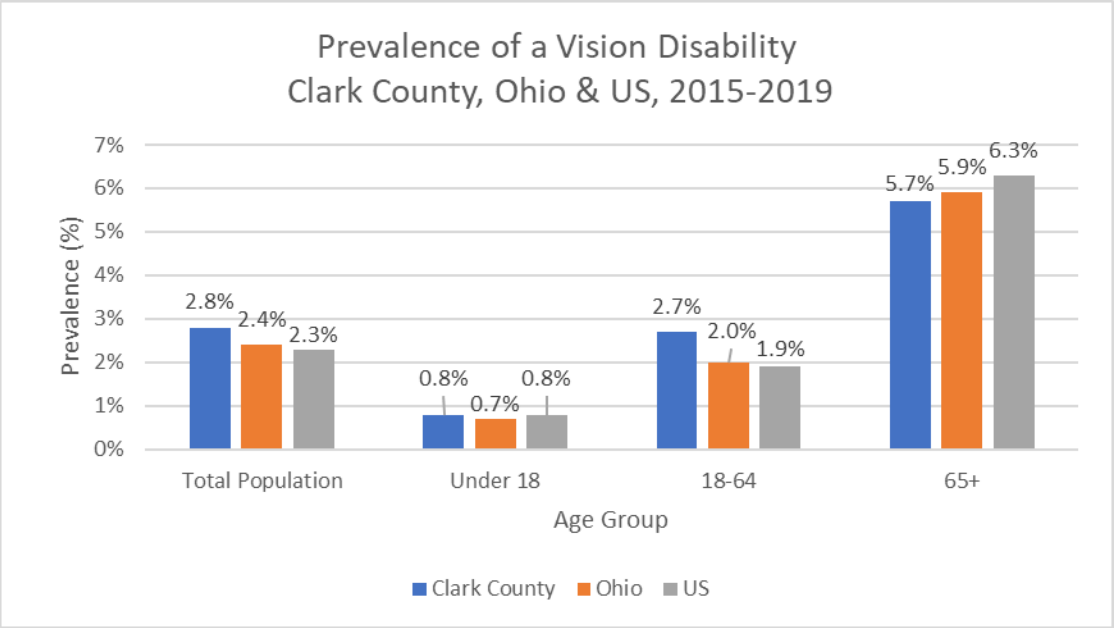

Figure 100: Prevalence of a vision disability, Clark County, Ohio & US, American Community Survey 5-year Estimates, 2015-2019.

Reportable Communicable Diseases

Reportable Condition	2012		2013		2014		2015		2016		2017		2018		2019		2020		2021	
	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*
Enteric Diseases																				
Amebiasis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Botulism, foodborne (call health department immediately)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Campylobacteriosis	12	13	20	25	11	15	13	17	16	31	13	27	15	28	11	33	0	13	3	22
Cryptosporidiosis	1	3	1	4	0	0	1	3	15	16	7	7	11	12	4	4	0	1	5	6
Cyclosporiasis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	2	0	0
E. coli, Shiga Toxin-Producing (O157:H7, Not O157, Unknown Serotype)	0	0	0	0	0	0	6	7	3	7	0	4	2	7	2	7	2	4	2	6
Giardiasis	1	1	5	12	5	5	2	2	8	8	6	7	3	6	7	9	1	4	0	2
Hepatitis A	0	0	0	5	0	4	0	1	0	2	0	7	29	38	49	62	0	5	0	2
Listeriosis	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2	2	1	1
Salmonellosis	14	14	13	13	13	13	15	16	18	18	23	23	10	10	13	15	9	14	6	12
Shigellosis	30	34	19	31	1	1	5	6	4	6	0	0	0	3	0	1	2	2	0	0
Typhoid fever	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Vibriosis (not cholera)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	0	4	0	3
Yersiniosis	1	1	1	1	1	1	1	1	2	2	0	0	1	2	1	2	1	1	0	0
Hepatitis B & C																				
Hepatitis B - Investigation	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Hepatitis B - Perinatal Infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hepatitis B (including delta) - acute	2	3	0	8	0	2	2	6	4	6	1	1	2	3	2	5	1	2	4	5
Hepatitis B (including delta) - chronic	3	23	2	30	7	37	5	49	6	40	11	53	7	83	11	53	3	44	4	38
Hepatitis C - acute	0	1	0	0	1	1	0	0	1	3	4	5	0	3	3	7	0	0	1	1
Hepatitis C - chronic	118	143	100	118	144	152	187	224	169	275	104	209	107	198	89	176	54	121	52	125
Hepatitis C - Perinatal Infection	0	0	0	0	0	0	0	0	0	0	0	0	0	4	1	1	0	0	0	0
Sexually Transmitted Infections																				
Chlamydia infection	520	520	701	701	628	628	660	660	719	719	745	745	883	883	854	854	682	682	595	595

Reportable Condition	2012		2013		2014		2015		2016		2017		2018		2019		2020		2021	
	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*
Gonococcal infection	175	175	212	213	154	154	150	150	287	287	333	333	377	377	390	390	459	459	363	363
Herpes - congenital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HIV†	2	7	4	8	0	7	0	5	8	10	1	7	9	10	7	7	5	5	12	13
Syphilis - congenital	0	0	0	0	0	0	0	0	0	0	0	1	0	3	0	0	0	2	0	1
Syphilis - early	0	0	0	0	0	9	0	6	0	11	0	5	0	8	0	5	0	13	0	19
Syphilis - late latent (>1 year) asymptomatic	5	5	0	4	0	9	0	12	0	12	0	12	-	-	-	-	-	-	-	-
Syphilis - primary	2	2	0	1	1	7	0	13	0	4	0	4	0	3	0	3	0	14	0	13
Syphilis - secondary	3	3	0	1	0	4	0	13	0	11	0	11	0	8	0	9	0	23	0	30
Syphilis - unknown duration or late	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0	18	0	26	0	39
Syphilis - All Stages	10	10	0	6	1	29	0	44	0	38	0	33	0	32	0	35	0	78	0	102
Vaccine-Preventable Diseases																				
Haemophilus influenzae (invasive disease)	2	2	3	4	1	1	3	3	3	3	4	4	3	4	1	2	2	2	0	0
Influenza - ODH Lab Results	0	0	0	0	11	11	0	3	5	5	22	24	3	5	3	3	4	4	0	0
Influenza A - novel virus infection (call health department immediately)	3	10	0	0	0	0	0	0	2	2	1	1	0	0	0	0	0	0	0	0
Influenza-associated hospitalization	35	36	35	36	139	139	49	52	66	67	173	174	275	278	230	243	144	147	13	13
Influenza-associated pediatric mortality	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
Measles - indigenous/imported Status Not Determined	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Meningitis - aseptic/viral	5	5	5	6	3	4	4	7	4	4	3	3	3	4	4	5	1	1	1	3
Meningitis - bacterial (Not N. meningitidis)	0	2	1	2	2	4	0	1	1	1	0	2	2	4	0	3	1	1	1	3
Meningococcal disease - Neisseria meningitidis (call health department immediately)	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mumps	0	0	0	0	0	8	0	0	0	3	0	0	0	2	0	3	0	0	0	0
Pertussis	7	15	99	209	40	67	5	10	7	14	8	14	2	9	6	20	0	1	0	7
Streptococcal - Group A - invasive	1	1	6	6	8	8	3	3	8	8	6	6	11	12	9	9	14	14	11	12

Reportable Condition	2012		2013		2014		2015		2016		2017		2018		2019		2020		2021	
	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*
Streptococcal - Group B - in newborn	1	1	1	1	1	1	0	0	3	3	1	2	1	1	2	2	0	0	1	1
Streptococcus pneumoniae - invasive antibiotic resistance unknown or non-resistant	24	24	11	11	10	10	10	10	7	8	17	17	11	12	18	18	3	3	7	7
Streptococcus pneumoniae - invasive antibiotic resistant/intermediate	4	4	4	4	5	5	1	1	4	4	4	4	7	7	8	8	1	1	4	4
Varicella	1	11	3	6	1	5	5	15	0	11	7	16	4	10	1	2	0	0	1	4
Vector-borne and Zoonotic Diseases																				
Anaplasmosis-Anaplasma phagocytophilum	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Babesiosis	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Brucellosis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Chikungunya virus	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Ehrlichiosis-Ehrlichia chaffeensis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Lyme Disease	1	3	1	5	0	1	0	2	0	8	0	8	2	11	0	8	2	14	3	9
Other arthropod-borne disease	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Q fever, acute	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Spotted Fever Rickettsiosis, including Rocky Mountain spotted fever (RMSF)	0	0	0	1	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1
West Nile virus disease (also current infection)	2	13	0	0	0	0	0	0	0	0	0	1	0	2	0	0	0	0	0	2
Zika virus infection	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Other Reportable Infectious Diseases																				
Coccidioidomycosis	0	2	1	2	1	1	0	0	2	3	0	0	0	4	1	3	0	1	0	0
Covid-19 (SARS-CoV-2)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8,615	9,774	13,073	16,535
CP-CRE	0	0	0	0	0	0	0	0	0	0	0	0	9	9	4	5	5	8	8	18
Creutzfeldt-Jakob Disease	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1
Cytomegalovirus -congenital (CMV)	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Immigrant Investigation	0	4	0	1	0	0	0	0	0	6	0	1	0	1	0	1	0	0	0	0
Legionellosis - Legionnaires' Disease	4	4	5	5	4	4	8	8	10	10	4	4	14	14	21	21	15	15	20	21
MIS-C associated with COVID-19†	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	7	7
Mycobacterial disease - other than tuberculosis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staphylococcal aureus - intermediate resistance to vancomycin (VISA)	1	1	2	2	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0

Reportable Condition	2012		2013		2014		2015		2016		2017		2018		2019		2020		2021	
	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*	Confirmed	Grand Total*
Toxic shock syndrome (TSS)	0	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0
Tuberculosis	2	2	1	1	1	1	0	0	0	0	3	3	1	1	1	1	2	2	3	3
Total	**994**	**1,102**	**1,257**	**1,484**	**1,195**	**1,354**	**1,136**	**1,351**	**1,383**	**1,668**	**1,503**	**1,781**	**1,804**	**2,122**	**1,758**	**2,062**	**10,033**	**11,514**	**14,201**	**18,049**
Non-covid Total	**994**	**1,102**	**1,257**	**1,484**	**1,195**	**1,354**	**1,136**	**1,351**	**1,383**	**1,668**	**1,503**	**1,781**	**1,804**	**2,122**	**1,758**	**2,062**	**1,418**	**1,740**	**1,128**	**1,514**

*Grand total numbers include all Confirmed, Probable, and Suspect cases.
†HIV data were collected from ODRS and not from ODH HIV Surveillance.

Smoking During Pregnancy

Table 40: Individuals who smoked during pregnancy by trimester, Clark County & Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Year	Clark County			Ohio		
	1st Trimester	2nd Trimester	3rd Trimester	1st Trimester	2nd Trimester	3rd Trimester
2012	24.3%	21.8%	20.3%	16.5%	14.3%	13.7%
2013	24.4%	21.7%	20.3%	16.2%	14.0%	13.3%
2014	22.0%	19.3%	18.3%	15.8%	13.6%	13.0%
2015	23.2%	20.2%	19.1%	14.8%	12.7%	12.1%
2016	20.4%	18.1%	17.0%	14.0%	12.0%	11.4%
2017	20.5%	17.8%	17.1%	13.5%	11.6%	11.1%
2018	18.3%	16.0%	15.2%	12.9%	11.2%	10.7%
2019	16.8%	14.4%	13.5%	11.6%	10.0%	9.6%
2020	17.5%	15.3%	15.3%	11.2%	9.7%	9.2%

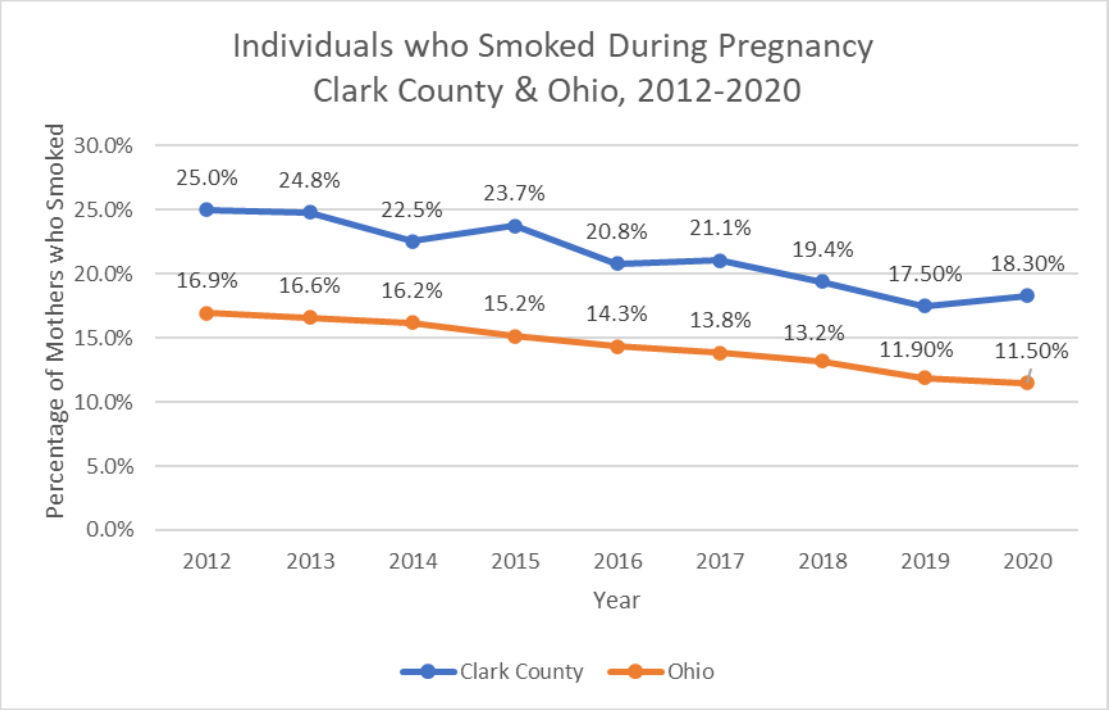

Figure 101: Individuals who smoked during pregnancy by trimester, Clark County & Ohio, 2012-2020. Data queried from the Ohio Department of Health Public Health Information Warehouse. The Ohio Department of Health specifically disclaims responsibility for any analysis, interpretations, or conclusions.

Domestic Violence

Table 41: Victims of domestic violence by outcome and relationship of persons involved, Clark County, Ohio Attorney General Domestic Violence Reports, 2016-2020.

Year	Outcome	Relationships of Persons Involved									
		Wife	Husband	Parent	Non-Spousal Relationship with Child Involved	Child or Children	Other Family	Former Spouse	Live-in Partner	Other	Total
2020	Victim with Injury	33	9	45	119	11	42	2	137	7	405
	Victim with No Injury	46	12	29	74	10	33	5	71	6	286
	Victim Fatal Injury	0	0	0	0	0	0	0	0	0	0
	Total Victims	79	21	74	0	21	75	7	208	13	691
2019	Victim with Injury	40	10	52	118	26	62	5	160	5	478
	Victim with No Injury	122	45	85	145	38	63	15	178	8	699
	Victim Fatal Injury	0	0	0	0	0	0	0	0	0	0
	Total Victims	162	55	137	0	64	125	20	338	13	1177
2018	Victim with Injury	66	28	71	139	26	88	8	174	0	600
	Victim with No Injury	182	59	126	205	44	120	26	331	7	1100
	Victim Fatal Injury	2	0	0	0	0	1	0	0	0	3
	Total Victims	250	87	197	344	70	209	34	505	7	1703
2017	Victim with Injury	55	20	47	119	14	86	5	159	10	515
	Victim with No Injury	200	75	78	227	31	216	28	274	97	1226
	Victim Fatal Injury	0	0	0	0	0	0	0	0	0	0
	Total Victims	255	95	125	346	45	302	33	433	107	1741
2016	Victim with Injury	64	22	54	123	28	66	5	146	16	524
	Victim with No Injury	274	67	198	263	66	134	32	315	67	1416
	Victim Fatal Injury	0	0	0	0	0	0	0	0	0	0
	Total Victims	338	89	252	386	94	200	37	461	83	1940

Additional Demographics

Table 42: Sex of Clark County residents, 2021 American Community Survey 5-year estimates

Sex	Clark County
Male	48.70%
Female	51.30%

Table 43: Speaks a language other than English at home, Clark County, Ohio, 2016 and 2021 American Community Survey 5-year estimates

	Clark		Ohio	
	2016	**2021**	**2016**	**2021**
Spanish	2.5%	2.0%	2.2%	2.3%
Other Indo-European Languages	0.8%	0.7%	2.5%	2.7%
Asian and Pacific Island Languages	0.5%	0.3%	1.2%	1.3%
Other Languages	0.1%	0.3%	0.9%	1.0%