Community Health Needs Assessment

2022

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Executive Summary

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

Avon Hospital, nestled on the Richard E. Jacobs Campus, adjacent to Richard E. Jacobs Health Center, has 126 staffed beds[2] offering state of the art medical care in the community. Avon Hospital provides a spectrum of services, from critical care, to cardiology, orthopedic surgery and outpatient procedures. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/avon-hospital/.

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

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

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

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

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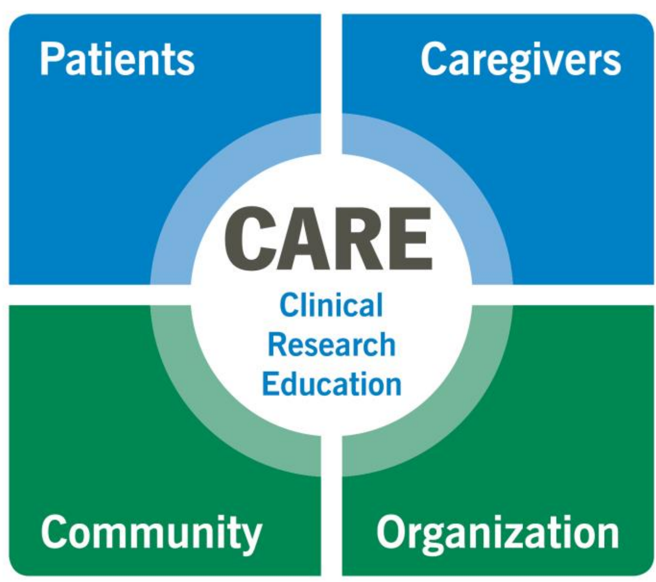
[1] Internal Revenue Service, Community Health Needs Assessment for Charitable Hospital Organizations – Section 501 (c) (3), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r
[2] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) interim financial statement is referenced for official bed count. We acknowledge that staffed bed count may fluctuate and may differ from registered or licensed bed counts reflected in other descriptions.
[3] The Cleveland Clinic Mission, Vision and Values https://my.clevelandclinic.org/about/overview/who-we-are/mission-vision-values

Figure 1: The Cleveland Clinic Care Priorities



Caring for the Community

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

Cleveland Clinic is much more than a healthcare organization. We are part of the social fabric of the community, creating opportunities for those around us and making the communities we serve healthier. We are listening to our neighbors to understand their needs, now and in the future. The health of every individual affects the broader community.

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

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

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

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

Additional information about Cleveland Clinic is available at: https://my.clevelandclinic.org/.

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

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

Community Definition

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

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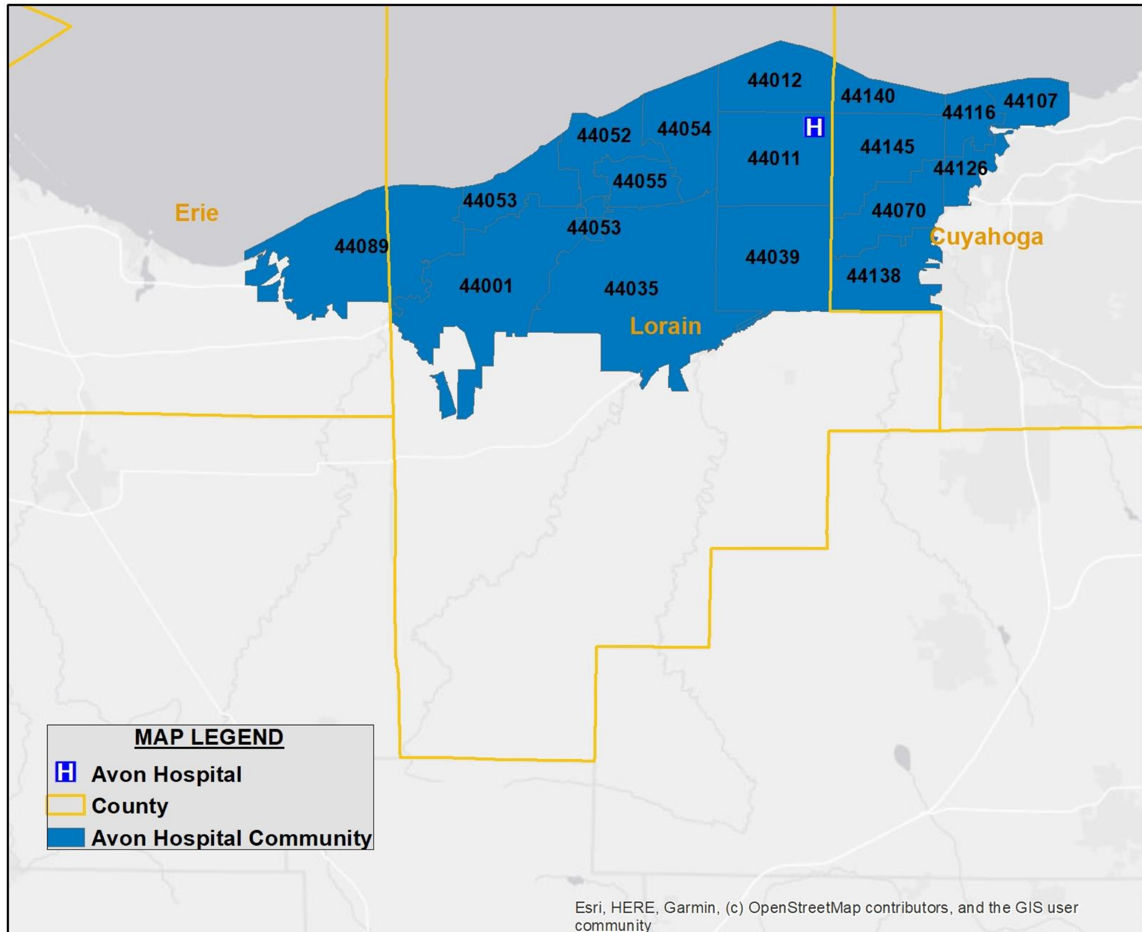
[6] Cleveland Clinic, Community Commitment, https://my.clevelandclinic.org/about/community#:~:text=Caring%20for%20the%20community%20is,and%20invest%20for%20the%20future.

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

Figure 2: Avon Hospital Community Definition



Secondary Data Summary

Secondary data used for this assessment were collected and analyzed from Conduent Healthy Communities Institute's (HCI) community indicator database. The database, maintained by researchers and analysts at HCI, includes 300 community indicators covering at least 28 topics in the areas of health, social determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, nationally set targets and to previous time periods

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

- The Avon Hospital Community Definition—an aggregate of the 17 zip codes described in the Community Definition.
- Cuyahoga, Erie and Lorain Counties—the three counties comprising the Avon Hospital Community Definition

Primary Data Summary

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

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

Prioritized Health Needs

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

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

Access to Healthcare

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

Behavioral Health

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

community, exacerbated by COVID-19 related stressors, resulting in increased alcohol and drug use starting in adolescence as a means of coping.

Chronic Disease Prevention and Management

This health topic encompasses several subtopics where information is available including Older Adult Health; Nutrition and Healthy Eating; Cancer; Chronic Diseases; Diabetes; Heart Disease and Stroke; and COVID-19. By addressing these issues in concert, the Cleveland Clinic Foundation hopes to impact chronic disease rates including those described in the Synthesis and Prioritization section of this report (page 33).

Maternal and Child Health

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

Socioeconomic Issues

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

Additional Community Health Themes

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

Health Equity

Health Equity issues in our communities were illuminated by COVID-19. They focus on the fair distribution of health determinants, outcomes and resources across communities.[8] Health Equity and reduction of health disparities are indicated as overarching themes in

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

all our prioritized needs. It is described in detail and specifically as it relates to the Avon Hospital Community in both the Disparities and Health Equity section (page 25) of the report as well as in the Synthesis and Prioritization section (page 33). Special consideration will be given to addressing prioritized health needs through a health equity lens in the Avon Hospital implementation strategy report.

Social Determinants of Health

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

Medical Research and Health Professions Education

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

COMMUNITY HEALTH NEEDS ASSESSMENT
Avon Hospital

Prioritized Health Needs

Behavioral Health

Chronic Disease Prevention & Management

Maternal and Child Health

Socioeconomic Issues

Process

Additional Community Health Themes

Health Equity

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

Systemic racism
Poverty
Gender discrimination

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

Social Determinants of Health

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

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

Medical Research and Health Professions Education

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

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

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

Demographics of the Avon Hospital Community

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

Geography and Data Sources

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

Population

According to the 2022 Claritas Pop-Facts® population estimates, the Avon Hospital community has an estimated population of 457,653 persons. Figure 3 shows the population size by each zip code, with the darkest blue representing the zip codes with the largest population. Appendix C provides the actual population estimates for each zip code. The most populated zip code area within the Avon Hospital Community is zip code 44035 (Lorain) with a population of 64,551.

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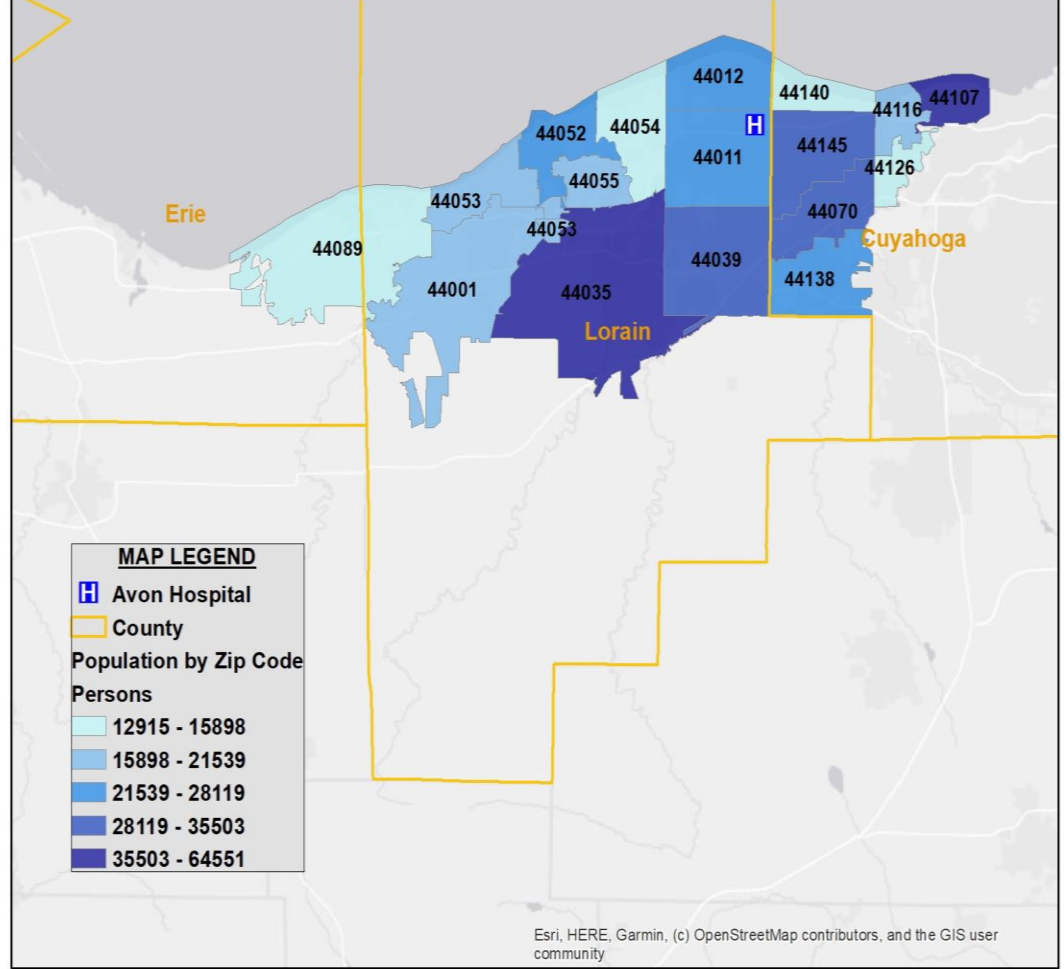
[9] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/
[10] American Community Survey. https://www.census.gov/programs-surveys/acs

Figure 3: Population by Zip Code



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

Age

Children (0-17) comprised 21.2% of the population in the Avon Hospital Community which is slightly less when compared to the state of Ohio (21.8%). The Avon Hospital Community has a higher proportion of residents aged 65+ 20.5% when compared with the state of Ohio at 18.6%. Figure 4 shows further breakdown of age categories.

Figure 4: Population by Age: Hospital and State Comparisons

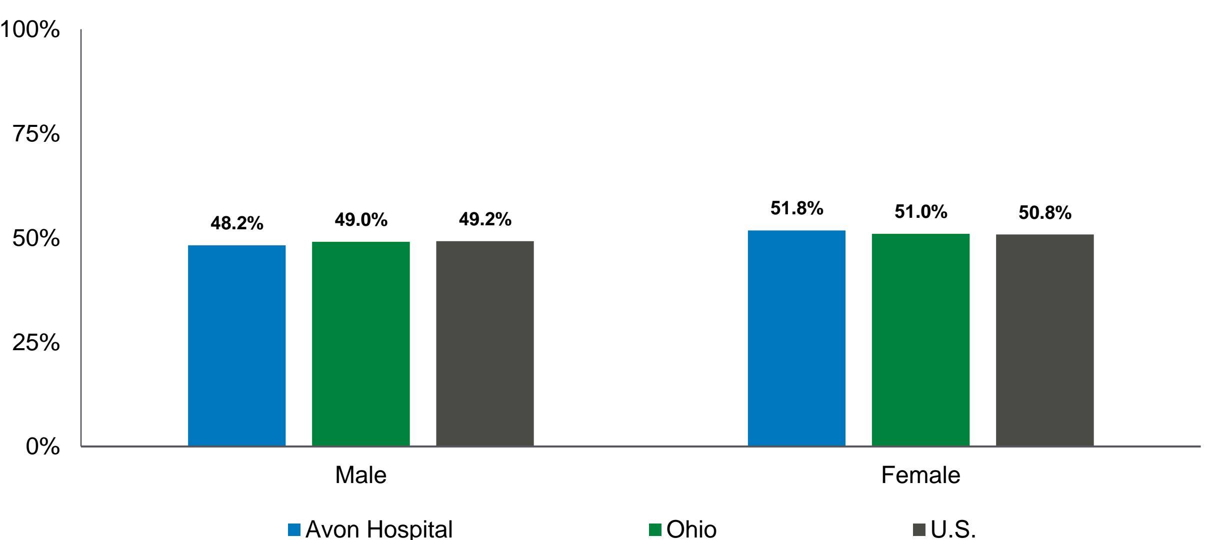
Age	Avon Hospital	Ohio
0-4	5.5%	5.9%
5-9	5.8%	5.9%
10-14	6.1%	6.1%
15-17	3.8%	3.8%
18-20	3.4%	4.1%
21-24	4.5%	5.1%
25-34	11.9%	13.0%
35-44	12.1%	12.1%
45-54	12.5%	12.0%
55-64	14.0%	13.4%
65-74	12.0%	11.1%
75-84	5.7%	5.3%
85+	2.7%	2.3%

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

Sex

Figure 5 shows the population of the Avon Hospital Community by sex. Males comprise 48.2% of the population in the Avon Hospital Community, which is less than both the Ohio (49.0%) and U.S. (49.2%) values. Whereas females comprise 51.8% of the population in the Avon Hospital Community which is slightly greater than Ohio (51.0%) and the U.S. (50.8%) values.

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



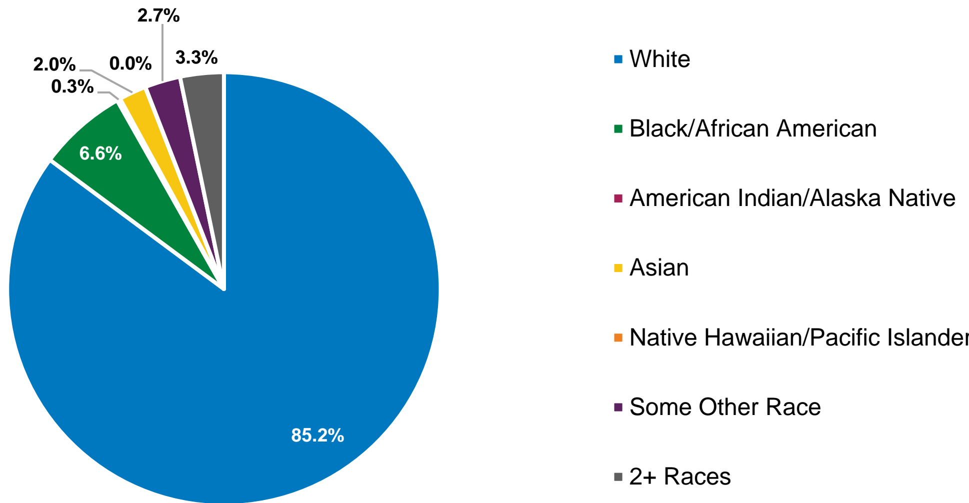
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2016-2020) estimates

Race and Ethnicity

Race and ethnicity contribute to the opportunities individuals and communities have to be healthy. The racial and ethnic composition of a population is also important in planning for future community needs, particularly for schools, businesses, community centers, healthcare, and childcare.

The racial makeup of Avon Hospital area shows 85.2% of the population identifying as White, as indicated in Figure 6. The proportion of Black/African American community members is the second largest of all races in the Avon Hospital Community at 6.6%.

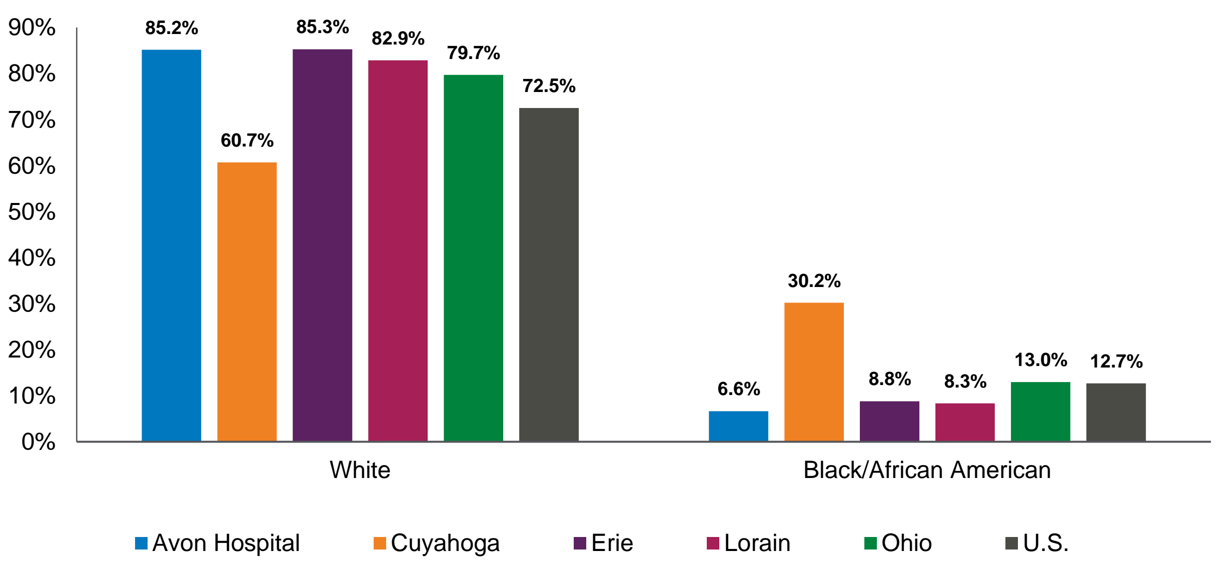
Figure 6: Population by Race: The Avon Hospital Community



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

Those community members identifying as White represent a higher proportion of the population in the Avon Hospital Community (85.2%) when compared to Ohio (79.7%) and the U.S. (72.5%), while Black/African American community members represent a lower proportion of population in the Avon Hospital Community (6.6%) when compared to Ohio (13.0%) and the U.S. (12.7%). Cuyahoga County has the largest percentage of community members identifying as Black/African American (30.2%) compared to the other counties included in the Avon Hospital Community Definition. (Figure 7)

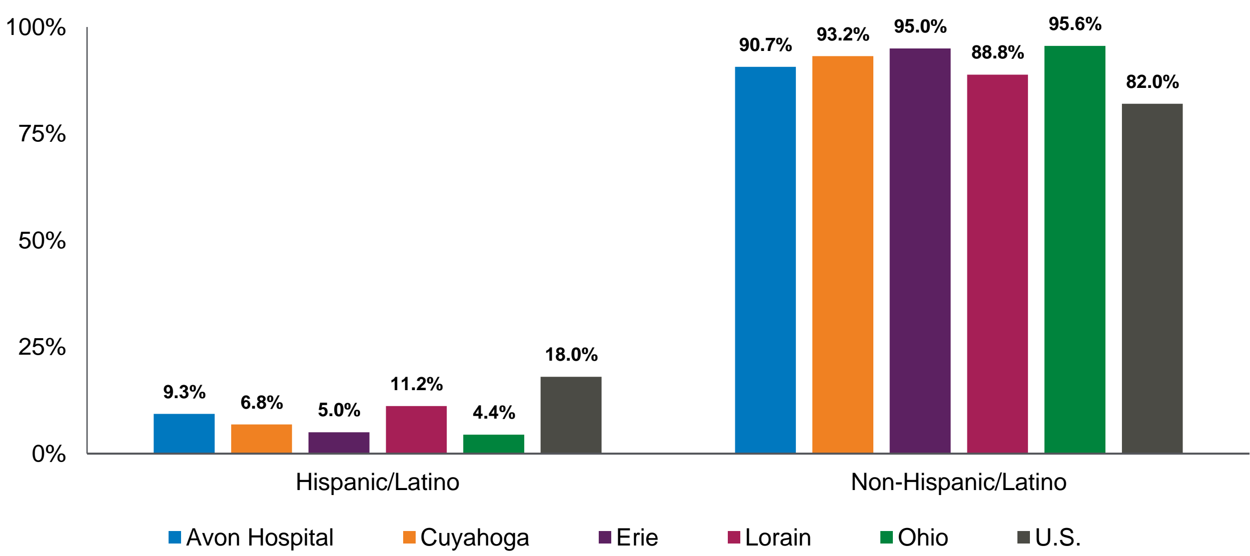
Figure 7: Population by Race: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

As shown in Figure 8, 9.3% of the population in the Avon Hospital Community identify as Hispanic/Latino. This is a larger proportion of the population when compared to Ohio (4.4%) but smaller when compared to the U.S. (18.0%). Lorain County has the largest percentage of community members who identify as Hispanic/Latino (11.2%).

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



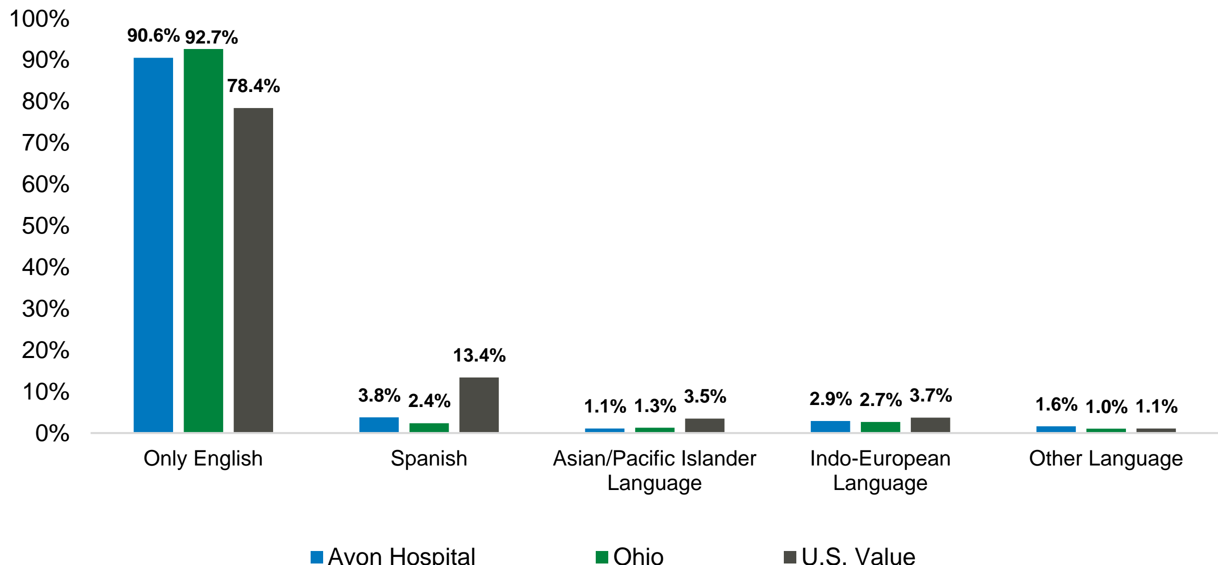
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system.

In the Avon Hospital Community, 90.6% of the population age five and older speak only English at home, which is lower than the state value of 92.7% but higher than the national value of 78.4% (Figure 9). This data indicates that 3.8% of the population in the Avon Hospital Community speak Spanish, 1.1% speak an Asian/Pacific Islander language, 2.9% speak an Indo-European Language, and 1.6% speak Other Languages at home.

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



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Highlighted Demographics: Social & Economic Determinants of Health

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

Figure 10: Healthy People 2030 Social Determinants of Health Domains

Geography and Data Sources

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

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

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

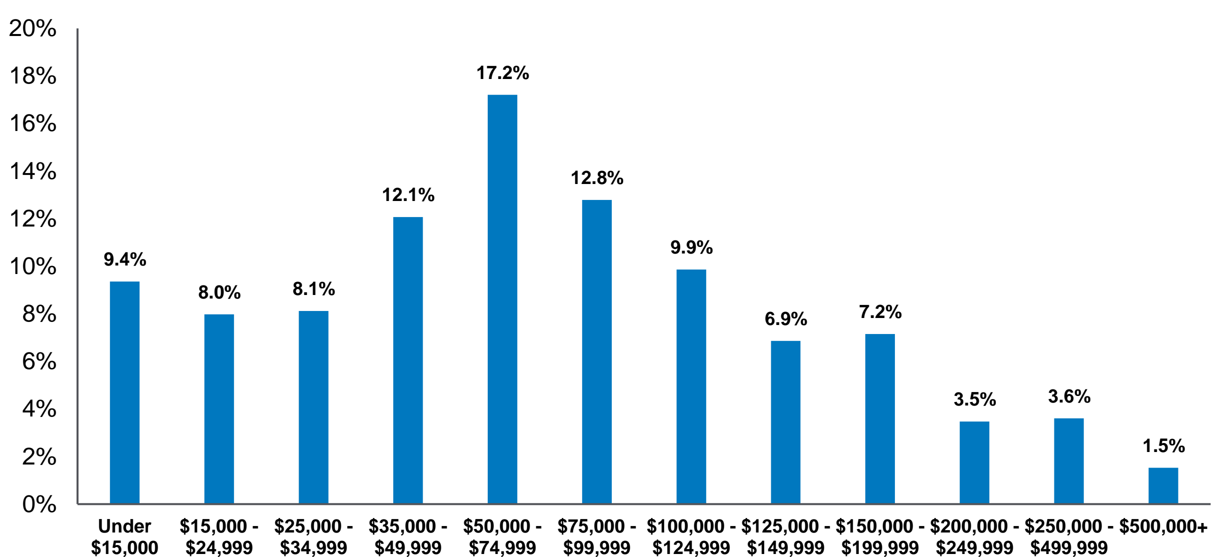
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Income

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

Figure 11 provides a breakdown of households by income in the Avon Hospital Community Definition. A household income of $50,000 - $74,999 is shared by the largest proportion of households in the Avon Hospital Community (17.2%). Households with an income of less than $15,000 make up 9.4% of households in the Avon Hospital Community.

Figure 11: Households by Income: The Avon Hospital Community



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

The median household income for the Avon Hospital Community is $70,698, which is higher than the state value of $65,070 and national value of $62,843 (Figure 12).

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

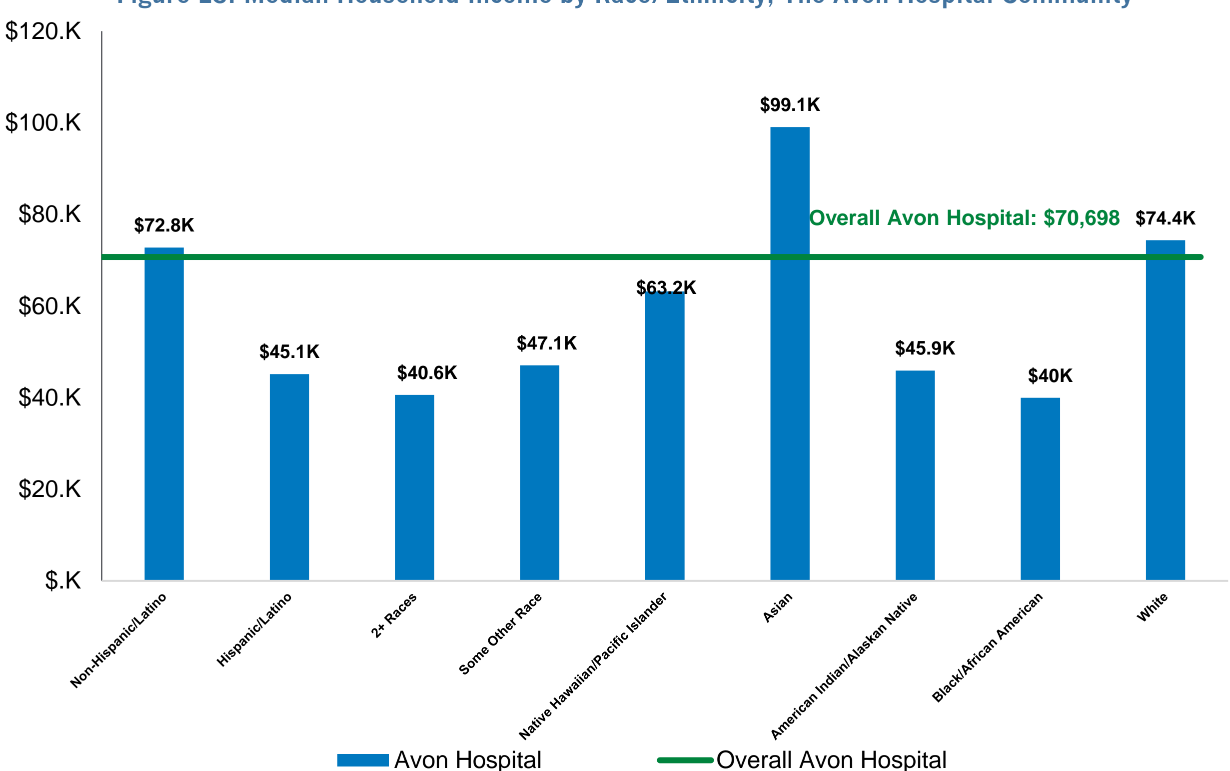
Figure 12: Household Income by: Hospital Community, County, State, and U.S. Comparisons

Avon Hospital	Cuyahoga	Erie	Lorain	Ohio	U.S. Value
$70,698	$57,563	$64,611	$64,081	$65,070	$62,843

County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Figure 13 shows the median household income by race and ethnicity. Three racial/ethnic groups – White, Asian, and Non-Hispanic/Latino– have median household incomes above the overall median value. All other races have incomes below the overall value, with the Black/African American population having the lowest median household income at $39,983.

Figure 13: Median Household Income by Race/Ethnicity, The Avon Hospital Community



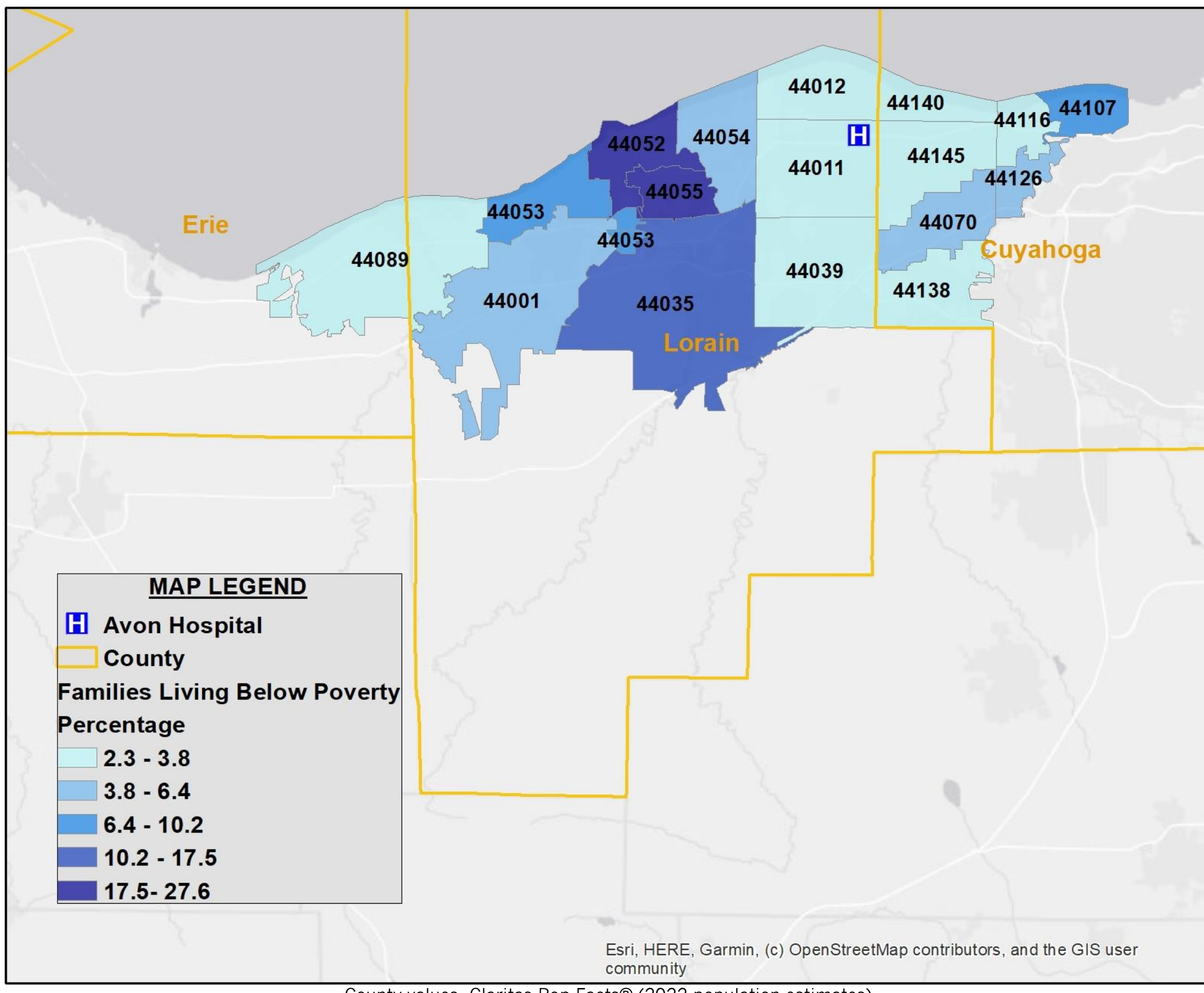
County values- Claritas Pop-Facts® (2022 population estimates)

Poverty

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

Figure 14 shows the percentage of families living below the poverty level by zip code. The darker blue colors represent a higher percentage of families living below the poverty level, with zip codes 44052 (Lorain) and 44055 (Lorain) having the highest percentages at 27.6% and 26.4%, respectively. Overall, 8.9% of families in the Avon Hospital Community live below the poverty level, which is lower than both the state value of 9.6% and the national value of 9.5%. The percentage of families living below poverty for each zip code in the Avon Hospital Community is provided in Appendix C.

Figure 14: Families Living Below Poverty



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

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

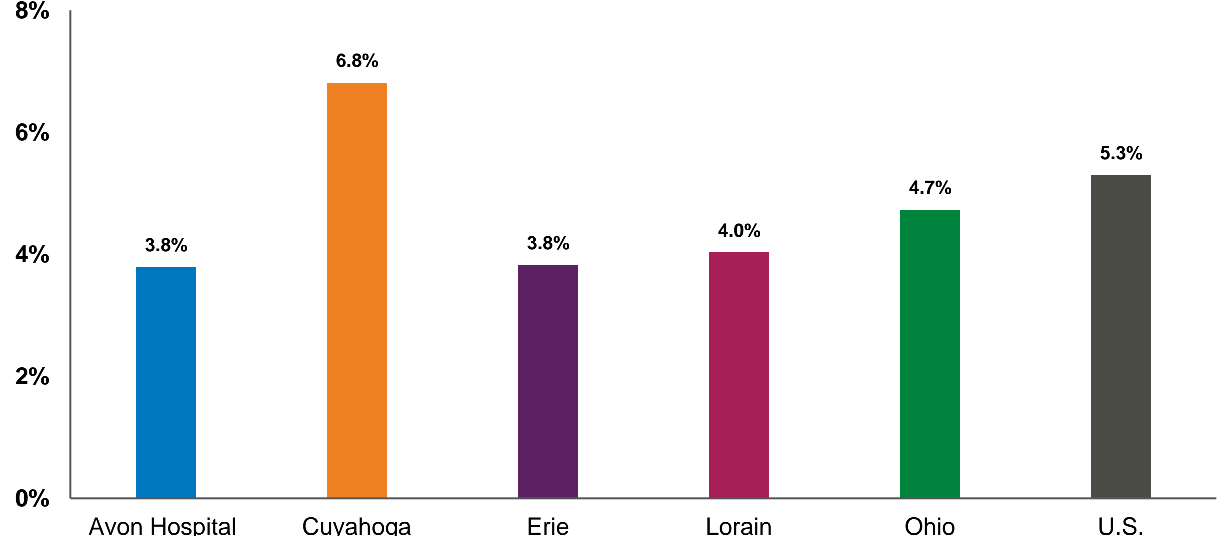
Employment

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

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

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[15]
Figure 15 shows the population aged 16 and over who are unemployed. The unemployment rate for the Avon Hospital Community is 3.8%, which is lower than both the state value of 4.7% and the national value of 5.3%.

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



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Education

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

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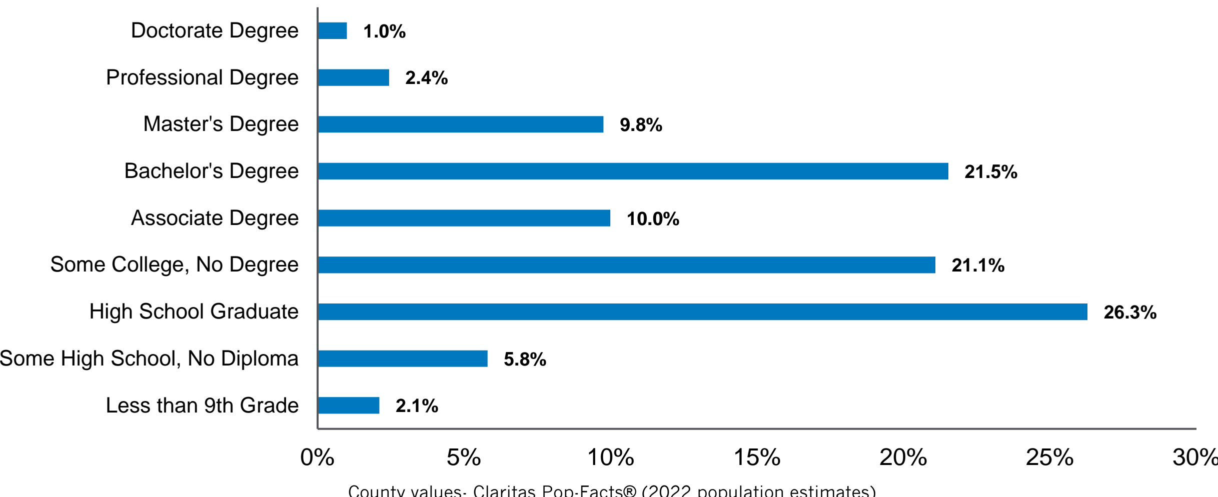
[15] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment

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

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

Figure 16: Population 25+ by Education Attainment: The Avon Hospital Community

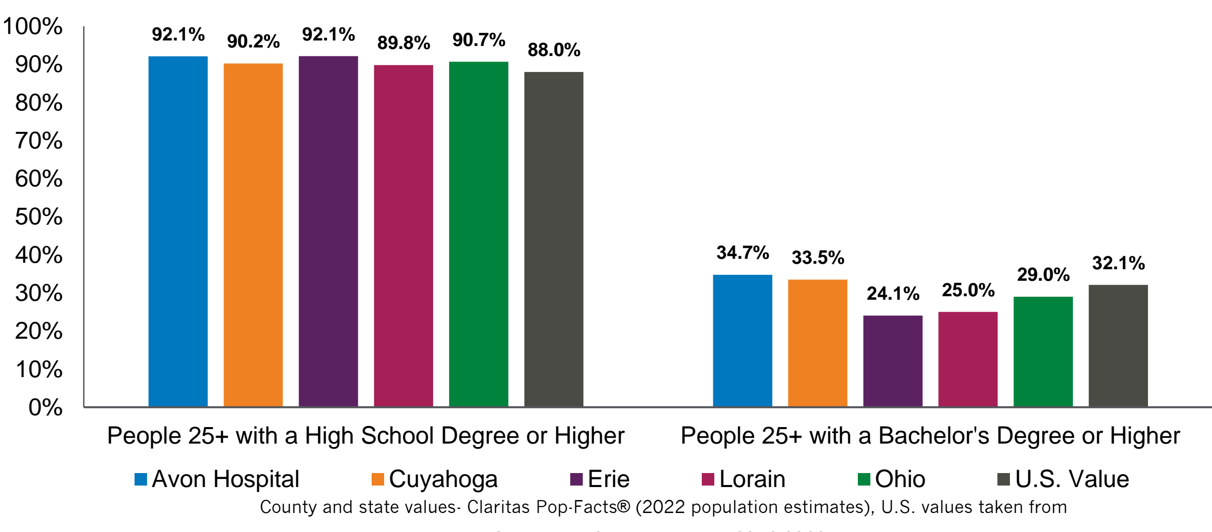


County values- Claritas Pop-Facts® (2022 population estimates)

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

Figure 17 shows that the Avon Hospital Community has a higher percentage of residents with a high school degree or higher (92.1%) and bachelor's degree or higher (34.7%) when compared to the state of Ohio value (90.7% and 29.0%) and the U.S. value (88.0% and 32.1%) respectively.

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



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

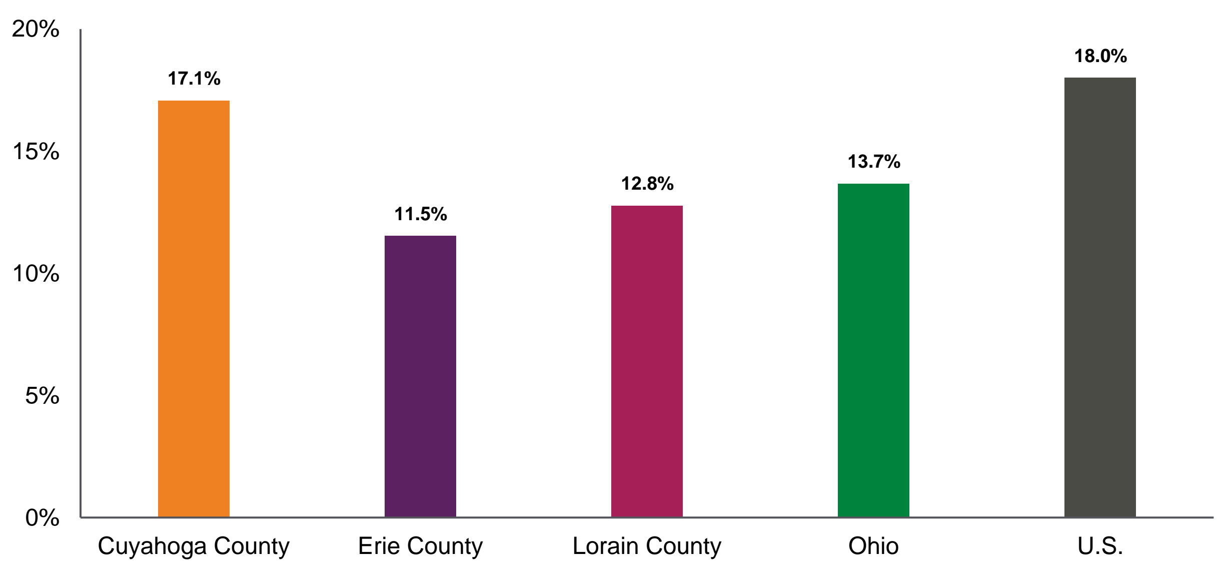
[17] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

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

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

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



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

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

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

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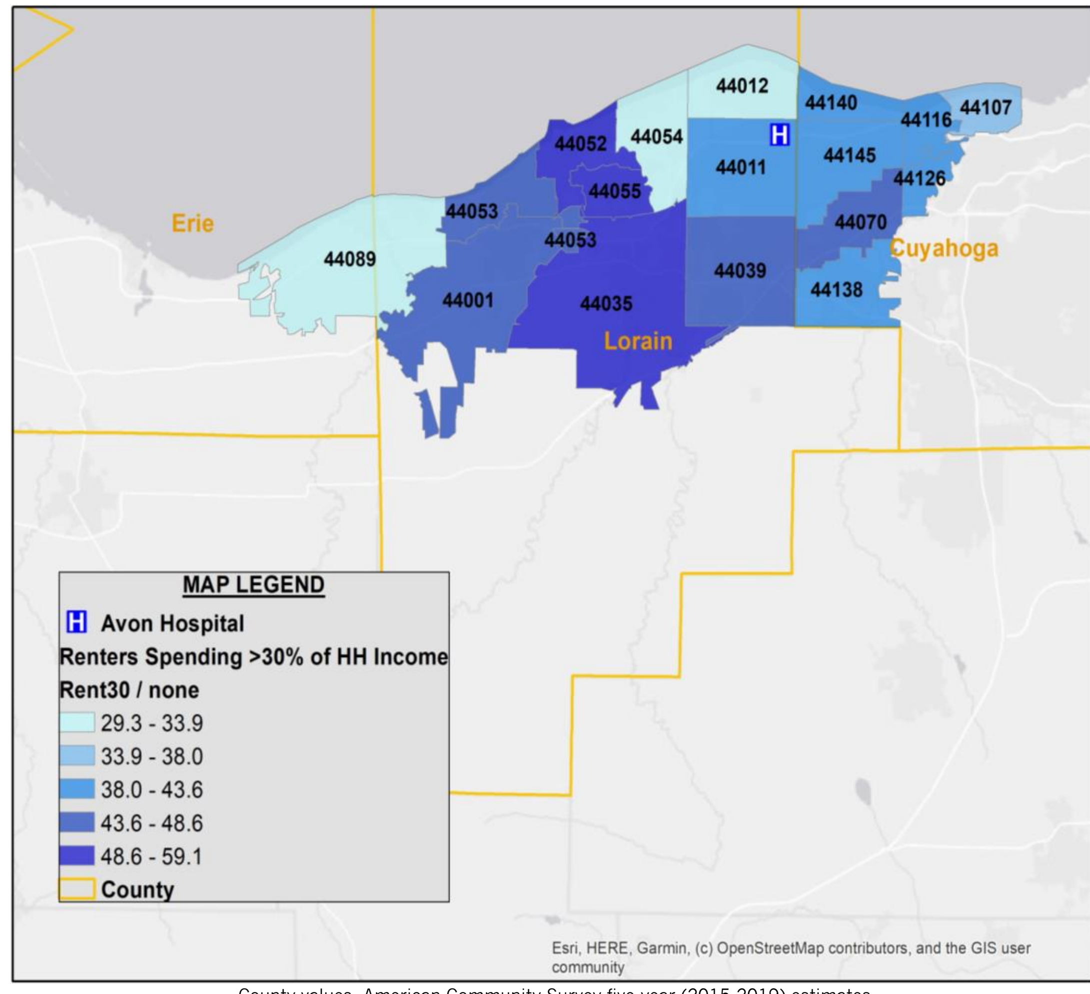
[18] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

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

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



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

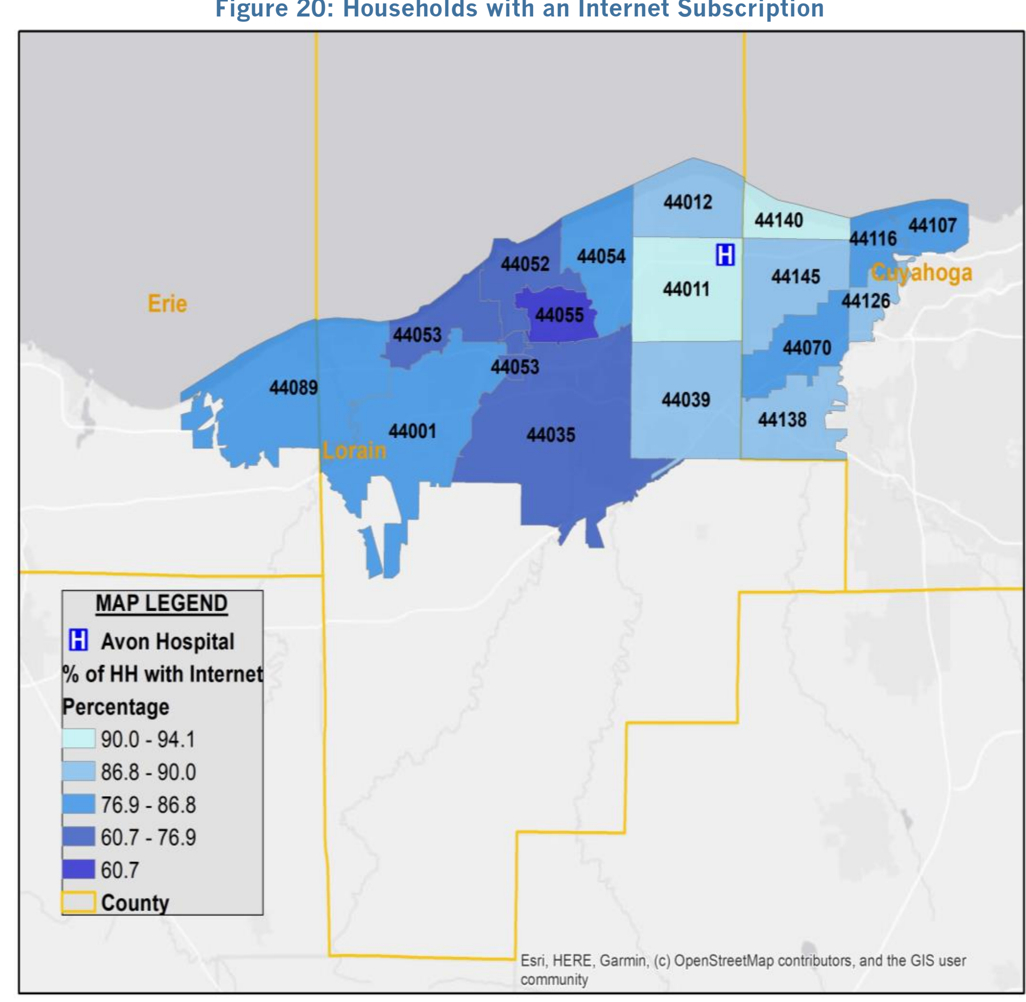
Neighborhood and Built Environment

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

Figure 20 shows the percentage of households that have an internet subscription. 44055 (Lorain) has the least percentage of households with internet connection, represented by darkest shade of blue on the map.

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

Figure 20: Households with an Internet Subscription



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

Highlighted Demographics: Disparities and Health Equity

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

Health Equity

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

Race, Ethnicity, Age & Gender Disparities

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

Secondary Data

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

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

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

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

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

Table 1: Indictors with Significant Race or Ethnic Disparities

Health Indicator	Group(s) Negatively Impacted
Age-Adjusted Death Rate due to Diabetes	Black/African American
Age-Adjusted Death rate due to Kidney Disease	Black/African American
Babies with Very Low Birth Weight	Black/African American, Hispanic/Latino
HIV/AIDS Prevalence Rate	Black/African American, Hispanic/Latino
Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Other Race, Two or More Races
Families Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, Two or More Races
People 25+ with a Bachelor's Degree or Higher	American Indian/Alaska Native, Black/African American, Other Race, Two or More Races
4th Grade Students Proficient in Math	Black/African American
People 65+ Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race
People Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, Two or More Races
Workers Commuting by Public Transportation	American Indian/Alaska Native, White (Non-Hispanic)
Young Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Native Hawaiian/Pacific Islander, Other Race, Two or More Races

The Index of Disparity analysis for Cuyahoga, Erie, and Lorain counties reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Two or More Races, and Other Race group populations are disproportionately impacted by various measures of poverty, which is often associated with poorer health outcomes. These indicators include Families Living Below Poverty Level, Children Living Below Poverty Level, People 65+ Living Below Poverty Level, Young Children Living Below Poverty Level, and People Living Below Poverty Level. Furthermore, Black/African American, and Hispanic/Latino populations are disproportionately impacted in Babies with Very Low Birth Weight and HIV/AIDS Prevalence Rates. Additionally, American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, and Two or More Race populations experience inequities related to education. These indicators include Population 25+ with a Bachelor's Degree or Higher and 4th Grade Students Proficient in Math.

Additionally, Black/African American populations experience a heavier burden related to chronic diseases, such as diabetes and kidney disease.

Finally, White (Non-Hispanic) and American Indian/Alaska Native populations are disproportionately impacted across measures of public transportation (Table 1).

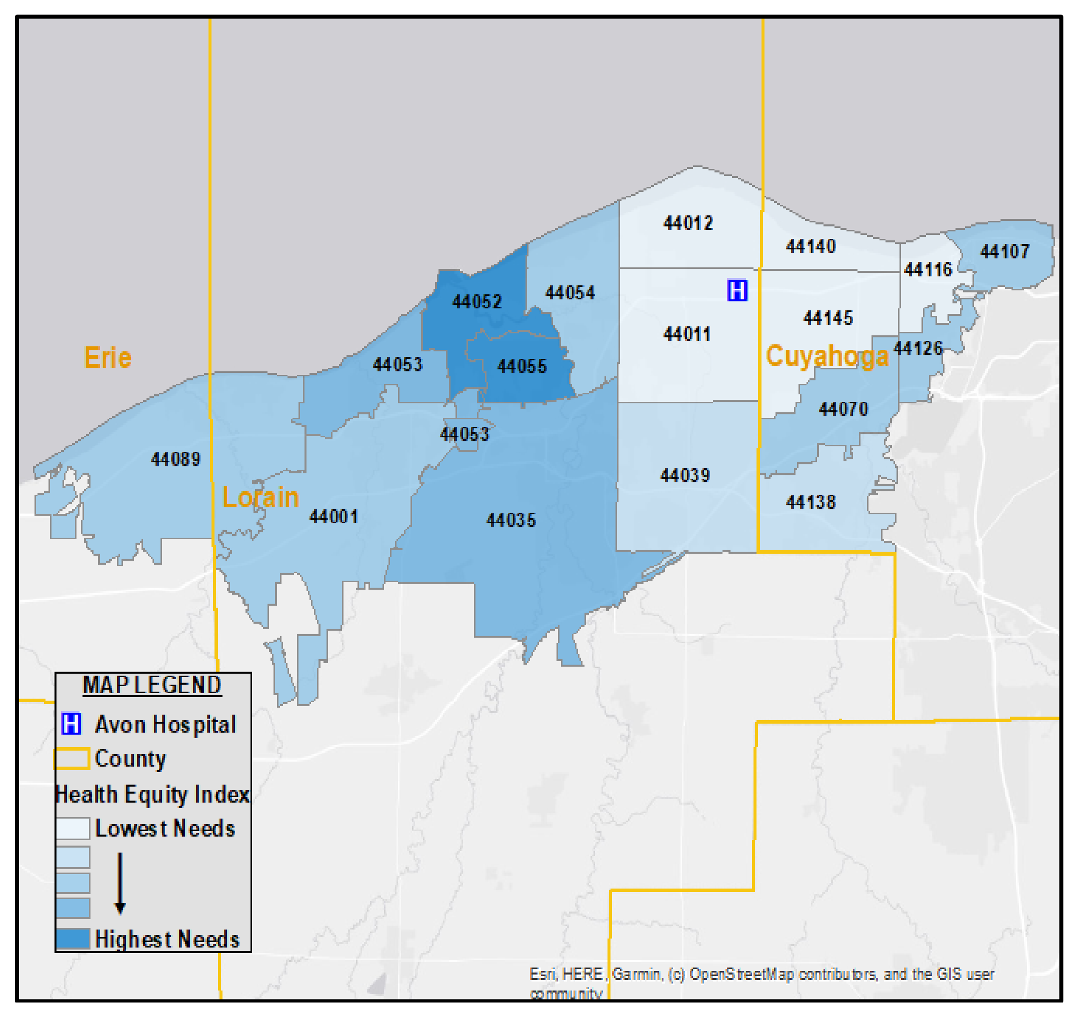
Geographic Disparities

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

Health Equity Index

Conduent's Health Equity Index (HEI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 21. The following zip codes in the Avon Hospital Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44052 and 44055 in Lorain County. Appendix A provides the index values for each zip code.

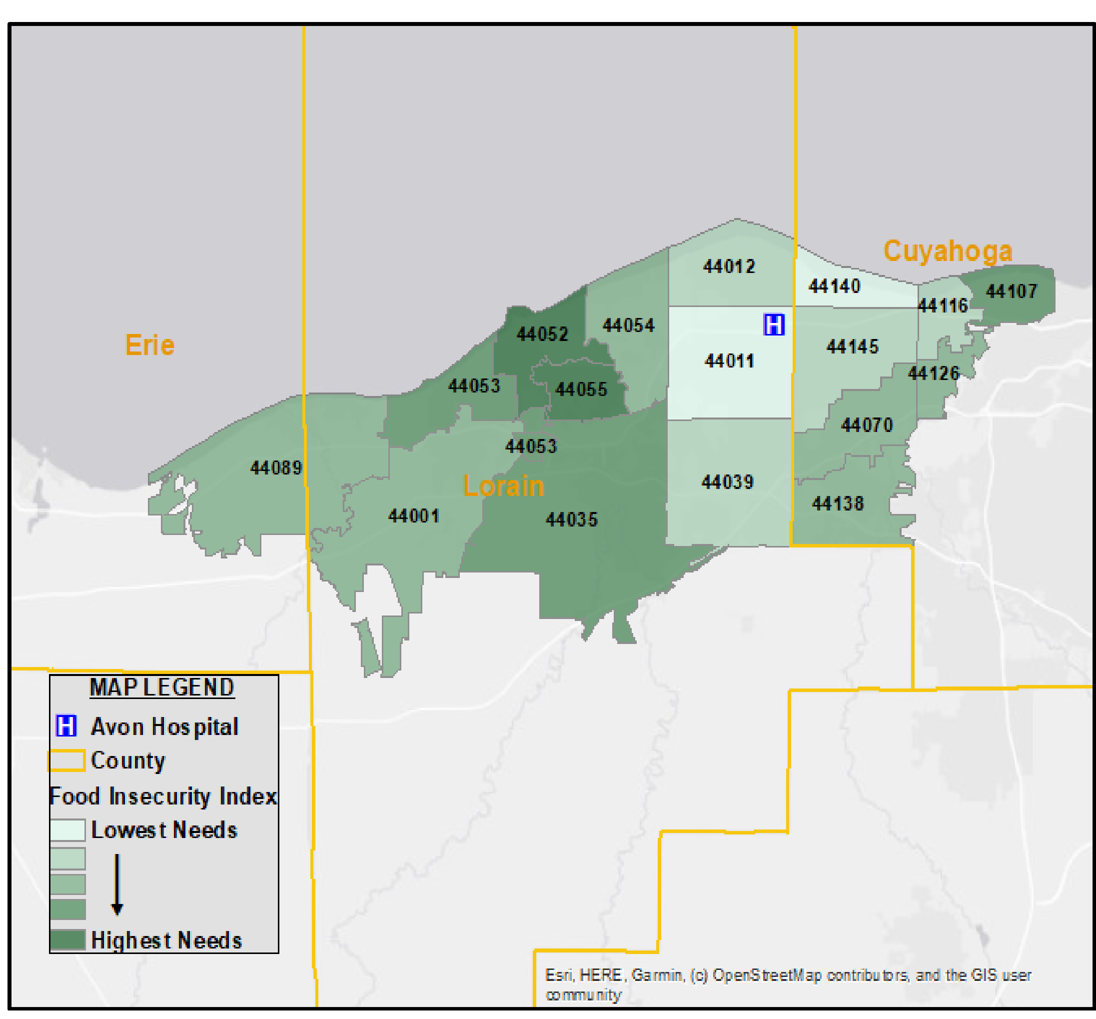
Figure 21: Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 44052 and 44055 in Lorain County and 44107 in Cuyahoga County. Appendix A provides the index values for each zip code.

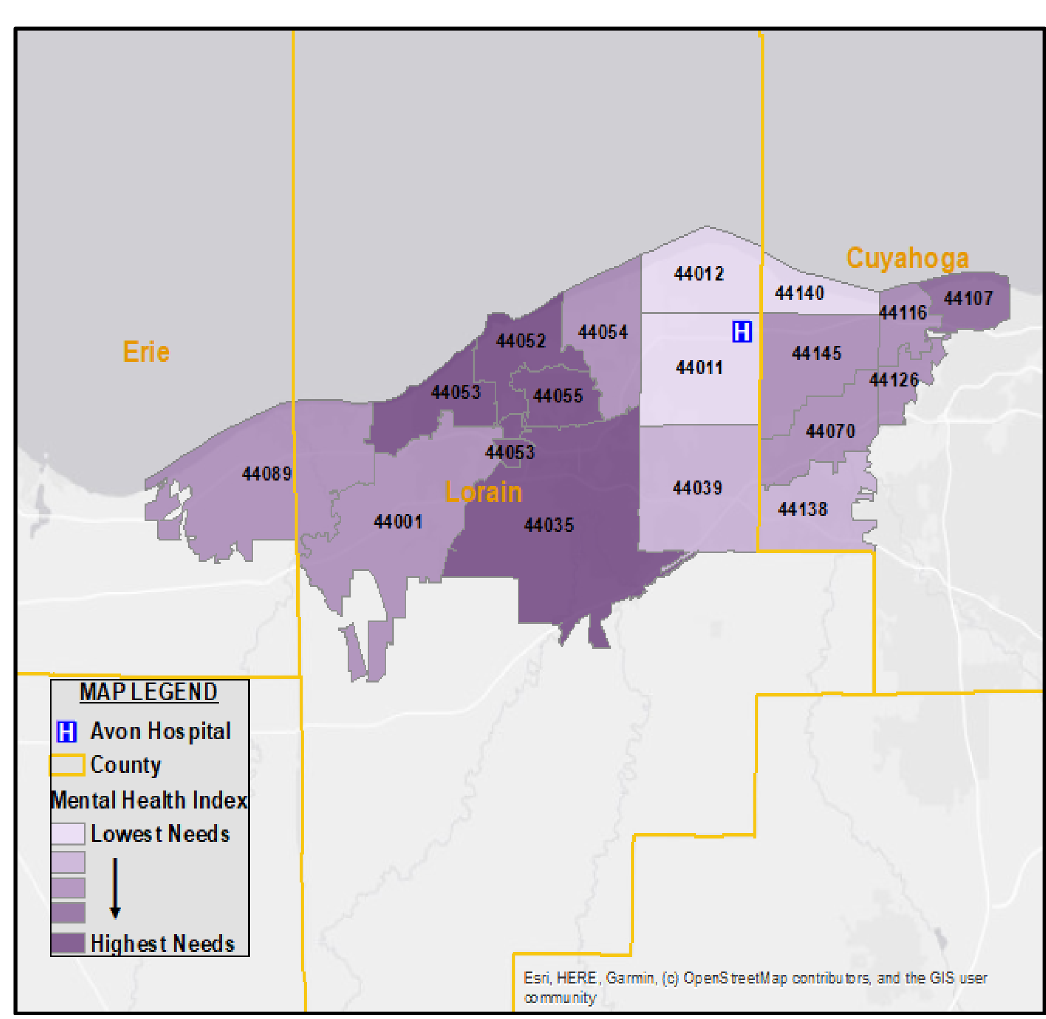
Figure 22: Food Insecurity Index



Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Zip codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 44107 in Cuyahoga County and 44052, 44053, 44055, and 44035 in Lorain County. Appendix A provides the index values for all zip codes within the Avon Hospital Community.

Figure 23: Mental Health Index



Highlighted Demographics: COVID-19 Impacts Snapshot

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

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

COVID-19 Pandemic

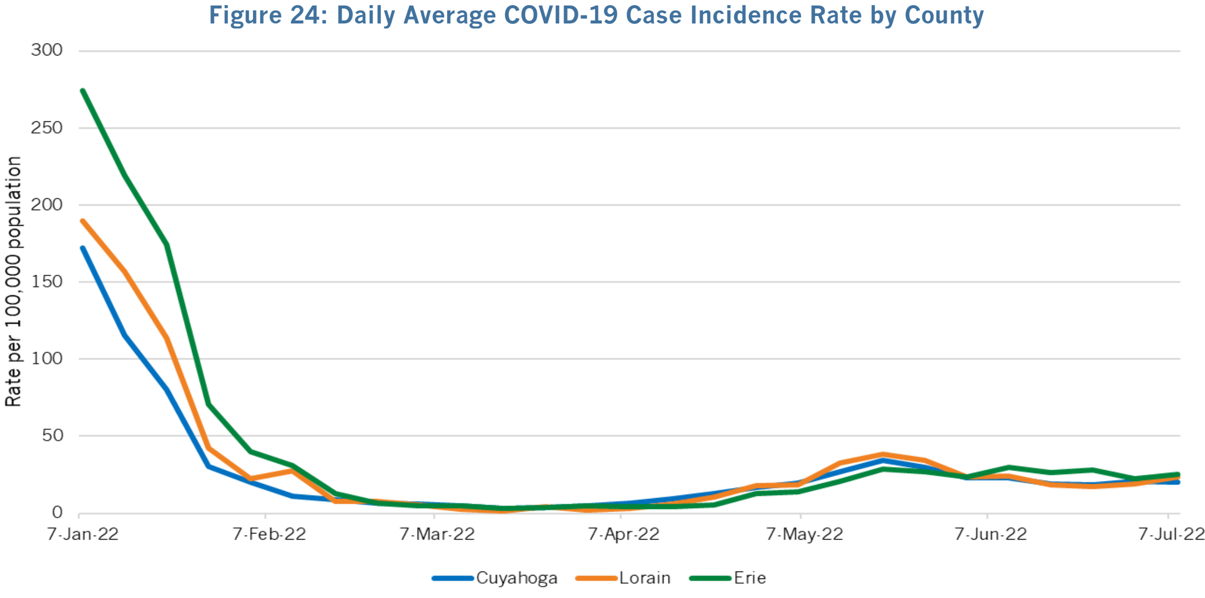
Community Input

Key stakeholder interviews and the Avon Hospital Community Engagement Session served to assess the impact of the COVID-19 pandemic by asking respondents to describe how the pandemic has impacted community health outputs. Top responses focused on mental health challenges that spanned all age groups. Older adult health suffered both because of isolation borne of the fear of exposure to the COVID-19 virus, followed by sense of well-being, security, or hope, and social support/connection.

The COVID-19 Daily Average Case Incidence Rate by County

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

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



Vaccination Rates

As of June 2022, at least 59% of the population residing in counties within the Avon Hospital Community Definition are fully vaccinated against COVID-19. Cuyahoga County has the highest vaccination rates (65.5%), followed by Lorain County (64.5%), and Erie County (59.7%).

Unemployment Rates

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

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

	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021
Cuyahoga	4.7%	5.1%	7.2%	22.9%	18.1%	15.2%	13.1%	11.7%	11.3%	7.4%	6.5%	8.3%	7.9%	5.3%	5.4%	5.1%	5.7%	7.1%	6.4%	5.8%	4.6%	4.1%
Erie	6.9%	6.0%	6.6%	25.4%	20.2%	12.9%	9.8%	9.2%	8.7%	6.9%	7.1%	6.6%	8.1%	7.5%	6.2%	7.3%	7.8%	8.6%	7.0%	5.7%	5.2%	4.5%
Lorain	5.2%	5.6%	7.7%	24.8%	18.9%	13.7%	11.7%	9.9%	9.4%	6.1%	5.5%	7.5%	7.3%	4.6%	4.2%	4.5%	5.0%	6.3%	5.8%	5.1%	4.1%	3.6%
Ohio	5.0%	4.7%	5.4%	17.3%	13.5%	11.1%	9.2%	8.8%	8.0%	5.8%	5.2%	5.3%	6.0%	5.6%	4.9%	4.8%	5.0%	6.3%	5.9%	5.1%	4.3%	3.8%
U.S.	4.0%	3.8%	4.5%	14.4%	13.0%	11.2%	10.5%	8.5%	7.7%	6.6%	6.4%	6.5%	6.8%	6.6%	6.2%	5.7%	5.5%	6.1%	5.7%	5.3%	4.6%	4.3%

Synthesis and Prioritization

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

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

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

Figure 26: 2022 Prioritized Health Needs

Access to Healthcare

Behavioral Health

Chronic Disease Prevention and Management

Maternal and Child Health

Socioeconomic Issues

Prioritized Health Topic #1: Access to Healthcare

Access to Healthcare

Secondary Data Score: **1.39**

Key Themes from Community Input

- COVID-19 impact: delays in preventative care, chronic conditions increased: heart disease, cancer, diabetes
- Difficulties navigating health care system due to lack of broadband access/computer knowledge, no prior experience as a healthcare consumer/history of accessing the system
- Gentrification/Built Environment reduces accessibility to services
- Health disparities most prevalent in the community:
  - access to care due to transportation barriers, issues of trust, not enough providers located in the city of Lorain
- Issues of discrimination/bias create mistrust in healthcare: having doctors that look like the people they're serving, building a sustainable presence in the community, mobile health units, easily available translators, culturally responsive health care providers to implement trauma-informed care/gender-affirming care
- Lack of investment in local public health/preventive care as hospitals are focused on revenue coming from speciality/surgical care
- Racial, economical, geographical, educational, environmental inequities all affect access to care, disproportionately impacting communities of color
- Red lined communities have decreased healthcare access
- Systemic inequities in payment structures: conditions that communities of color were experiencing are reimbursed at lower rates than the conditions that White people are reimbursed for

Warning Indicators

- Consumer Expenditures: Health Insurance
- Consumer Expenditures: Medical Services
- Consumer Expenditures: Medical Supplies
- Consumer Expenditures: Prescription and Non-Prescription Drugs
- Persons without Health Insurance

Primary Data: Key Stakeholder Interviews and Community Engagement Session

The Avon Hospital Community Advisory Council members participating in the Community Engagement Session described Access to Healthcare as the most important health need behind addressing Mental Health and Mental Disorders. Access-related topics of particular concern included high wait times for appointments, proximity to care providers and limited knowledge of how to advocate for and manage personal health needs. Lack of reliable and affordable transportation options was noted as the second most important problem in the community that needed to be addressed and served as a primary barrier to accessing healthcare.

So providing [Women, Infants and Children (WIC) program benefits] to clients we saw a lot of challenges when the state allowed us to go to telehealth appointments. Not being able to touch and weigh those children and actually have that face to face and hands on approach [yielded poorer health outcomes]. We did a study, with students from Kent on the health and welfare over just a year and it showed a decline on the child's health. The hard part is now that patients have to come back in to the clinic, we have people that are dropping WIC rather than actually going back to a face to face because it's less convenient than a virtual option.

- Community Engagement Session Participant

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

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

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

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

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

Secondary Data

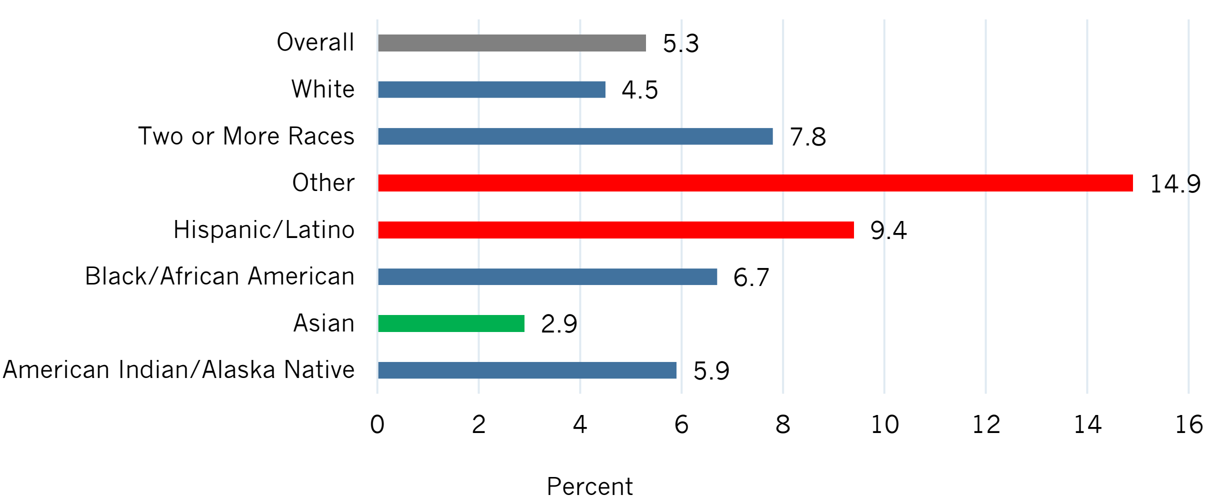
From the secondary data scoring results, Health Care Access & Quality ranked as the 16th highest scoring health need, with a score of 1.39. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

The average dollar amount per consumer unit for health insurance in Erie County is $4,419, which is higher than the average dollar amount spent on health insurance in the state of Ohio, where that amount is $4,371.70 dollars per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. For this indicator, Erie and Lorain counties fell in the worst 25% of all counties in the nation. Additionally, in Cuyahoga County, 89.8% of adults have health insurance, compared to 90.6% in the United States. Medical costs in the United States are high. Therefore, people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. [24]Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.[25]

The rising costs of medical care and lack of insurance affects all races and ethnicities. Although not identified as a high disparity in the Avon hospital community, disparities do exist in Cuyahoga County for persons without health insurance. In Cuyahoga County, people identifying as Hispanic/Latino and Some Other Race are disproportionately affected (see red below in Figure 27).

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

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



Source: American Community Survey, 2019

Prioritized Health Topic #2: Behavioral Health

Behavioral Health: Mental Health

Secondary Data Score:

Key Themes from Community Input

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

Warning Indicators

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

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

Members of the Avon Hospital Community Advisory Council, representing a range of organizations within the community, who attended the Community Engagement session ranked Mental Health the most important health problem in the community. They also reported a strong association between mental health and substance use suggesting that community members increasingly abuse alcohol, illicit drugs and prescription drugs as a form of self-medication to cope with stress. Further, about a quarter of attendees considered isolation a key issue in the community that needed to be addressed. Similarly, approximately a quarter of participants thought that parents with children and associated childcare and parental support needs were a key issue that needed to be addressed. Finally, 13% of participants thought that persons who experienced physical and/or emotional trauma also required additional community resources to help address the need.

Key stakeholders frequently cited mental health resources, and the availability of mental health providers as disproportionate to community need. Overall, lack of mental health providers and resources, and navigation and/or knowledge about available services were all mentioned as barriers. Participants emphasized the need to examine the root causes leading to mental health issues within the community including poverty and an unequal

playing field in terms of investment in education in low-income communities. Furthermore, LGBTQ+ community members experience disproportionate mental health issues as evidenced by the larger risk of suicide Transgender patients have as a result of discrimination, bigotry and isolation. Stakeholders recommended an increase in meaningful investment in community health programming.

Secondary Data: Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders had the 11th highest data score of all topic areas, with a score of 1.52. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

The Age-Adjusted Death Rate due to Suicide is a top area of concern related to Mental Health & Mental Disorders in Lorain County. Lorain County has a rate of 17.5 deaths per 100,000 population and the trend over the last four years is increasing significantly. Depression within the Medicare population in Lorain County also ranked poorly. While not significantly, this indicator is also increasing in Lorain County.

Alzheimer's disease in the Medicare Population and deaths due to Alzheimer's disease are areas of concern for Erie County, with an Age-Adjusted Death Rate due to Alzheimer's Disease of 45.7 deaths per 100,000 population and 11.2% of Medicare beneficiaries have been treated for Alzheimer's disease.

Substance Use

Behavioral Health: Substance Use

1.61

Key Themes from Community Input

- Addiction as "self-medication" an outcome of mental health challenges
- Lack of providers/treatment sites to meet the needs of those with substance use disorder
- Overall increases in alcohol intake and drug use (opiates) during COVID-19
- Substance abuse treatment was one of the places hit hardest during COVID due to difficulties moving to a virtual visit system (so much of the recovery from substance use disorder is about relationships and being connected)

Warning Indicators

- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
- Alcohol-Impaired Driving Deaths
- Consumer Expenditures: Alcoholic Beverages
- Death Rate due to Drug Poisoning
- Mothers who Smoked During Pregnancy

Primary Data: Key Stakeholder Interviews and Community Engagement Sessions (Substance Use)

Members of the Avon Hospital Community Advisory Council attending the Community Engagement session described alcohol and drug abuse as the third most important health problem in the community. Discussions captured addiction as an outcome of mental health challenges and mental disorders wherein substances are used as a means of coping with stressors.

Key stakeholders noted an overall increase in alcohol intake and opioid use during the COVID-19 pandemic. They asserted that there was a lack of space in treatment sites and low access to outpatient provider services to meet the needs of those suffering from substance use disorder further exacerbating a worsening issue.

> I think substance abuse treatment is one of the places hit the hardest during COVID and really had a difficult time moving to a virtual kind of visit system, because so much of the recovery from substance use disorder is about relationships and being connected.
>
> - Key Stakeholder

Secondary Data

From the secondary data scoring results, Alcohol & Drug Use had the 8th highest score at 1.61. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Cuyahoga County fared worse than all other counties for the indicator Death Rate due to Drug Poisoning. In 2017-2019, there were 42.6 deaths due to drug poisoning per 100,000 people, which is higher than both the state and national values, and in the worst quartile (25%) of counties in the U.S. Additionally, this indicator scored poorly in Lorain County and Erie County where there were 38.4 and 34.9 deaths due to drug poisoning, respectively. Even more concerning, the rate of deaths due to drug poisoning is increasing significantly in both counties.

Alcohol-Impaired Driving Deaths was the worst performing indicator in County. Lorain County's score in the worst 25% of both Ohio counties and counties across the nation. Fortunately, Lorain County's value is decreasing over time.

Prioritized Health Topic #3: Chronic Disease Prevention and Management

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

Primary Data: Key Stakeholder Interviews and Community Engagement Session

NUTRITION & HEALTHY EATING

Nutrition & Healthy Eating

Secondary Data Score: **1.39**

Key Themes from Community Input

- Access to healthy food limited by transportation, minimal grocery stores nearby, built environment, affordability
- Effects of redlining are still seen—these are the neighborhoods that do not always have grocery stores in a close mile radius
- COVID-19 impacted the need for food and levels of food insecurity: i.e. homebound individuals, children reliant on school breakfast/lunch
- High incidence of chronic health conditions like heart disease, diabetes, obesity, cancer in communities without high quality food access as these conditions are all inherently tied to healthy food accessibility, built environment/walkability, safety, access to care
- Low-income communities are disproportionately lacking stores with healthy fresh food and often don't have internet access to order food online

Warning Indicators

- Consumer Expenditures: Fast Food Restaurants
- Consumer Expenditures: Fruits and Vegetables
- Consumer Expenditures: High Sugar Foods

Participants in the Avon Hospital Community Engagement Session described rates of food insecurity in the community that increased proportionately with unemployment rates during the pandemic. Just under 20% of participants agreed that nutrition and healthy eating was one of the most important health problems in the community. Immediately followed by diabetes (16%) and heart disease and stroke (13%). Over a quarter agreed that food insecurity and hunger were issues in the community that needed immediate attention with 10% indicating a need for healthy food options at restaurants, stores and markets in the community. Participants recommended addressing the connection between health and hunger as well as collaborations between community organizations to leverage and maximize resource availability to address this and other issues in the community.

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

Furthermore, key informants advised medical institutions to advocate for better pay for employees, as food banks are seeing employees from these very institutions show up at their doors. Thus, these institutions are poised to prevent food insecurity within the walls of their hospital. COVID-19 greatly impacted the need for food as seen by elevated levels of food insecurity throughout the community. Conditions such as hypertension, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease are all related to the quality of food community members have access to[26].

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

- Key Stakeholder

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

Older Adult Health & Other Conditions

Secondary Data Score: **1.75** (Older Adults) **2.00** (Other Conditions)

Key Themes from Community Input

- Affordable assisted living facilities in familiar neighborhoods are scarce
- Aging at home brings increased care requirements and isolation
- Difficulties navigating health care system due to lack of broadband access/computer knowledge
- Lower income older adults disproportionately affected by chronic conditions, access to healthy food, poor housing conditions
- Older adults ranked #2 most underserved population (tied with children and refugees)

Warning Indicators

- Adults 65+ with Total Tooth Loss
- Adults with Arthritis
- Adults with Kidney Disease
- Age-Adjusted Death Rate due to Falls
- Age-Adjusted Death Rate due to Kidney Disease
- Alzheimer's Disease or Dementia: Medicare Population
- Asthma: Medicare Population
- Atrial Fibrillation: Medicare Population
- Cancer: Medicare Population
- Chronic Kidney Disease: Medicare Population
- Colon Cancer Screening
- COPD: Medicare Population
- Depression: Medicare Population
- Heart Failure: Medicare Population
- Hyperlipidemia: Medicare Population
- Hypertension: Medicare Population
- Ischemic Heart Disease: Medicare Population
- Osteoporosis: Medicare Population
- People 65+ Living Alone
- People 65+ with Low Access to a Grocery Store
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population
- Stroke: Medicare Population

Community Engagement Session conversations described older adults as the most underserved population in the community. Over a quarter of participants agreed that service availability for the elderly was one of the most important health problems in the community. Further, the older adult population is adversely and disproportionately affected by the two key barriers to improving health in the community—transportation and access to healthcare.

Key stakeholders focused on lower income older adults who are disproportionately affected by chronic conditions, access to healthy food and poor housing conditions—supporting the conclusions drawn and assertions made during the Avon Hospital Community Engagement Session. Furthermore, difficulties navigating telehealth services as well as arranging in-person visits are attributed to lack of broadband access or lack of comfort with technologies required to access services like smart phones, computers and tablet devices in the older adult population.

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

- Key Stakeholder

Secondary Data

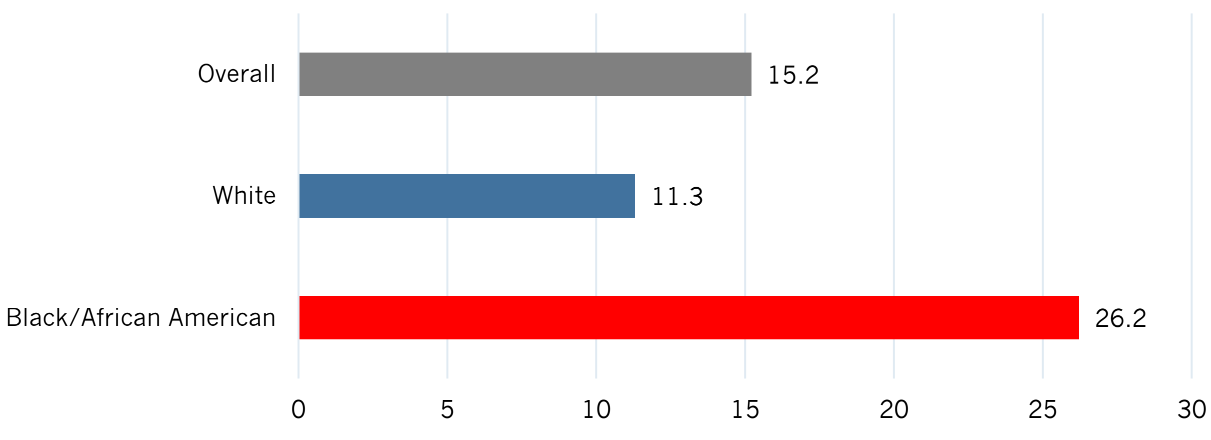
Nutrition & Healthy Eating had the 15th highest data score of all topic areas with a score of 1.39. Older Adult Health topic area had the fourth highest score at 1.75 and the related Other Conditions health topic ranked second with a score of 2.00. All topic areas in this group demonstrate need per as they each scored above 1.5. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Atrial fibrillation and cancer in the Medicare population area areas of concern for Erie County where 10% of Medicare beneficiaries have been treated for atrial fibrillation and 9.6% have been treated for cancer. For both indicators, the trend is increasing.

In Lorain County, the Age-Adjusted Death Rate due to Falls and Rheumatoid Arthritis or Osteoarthritis: Medicare Population are the worst performing indicators, both scoring a 2.75 out of a possible 3.00.

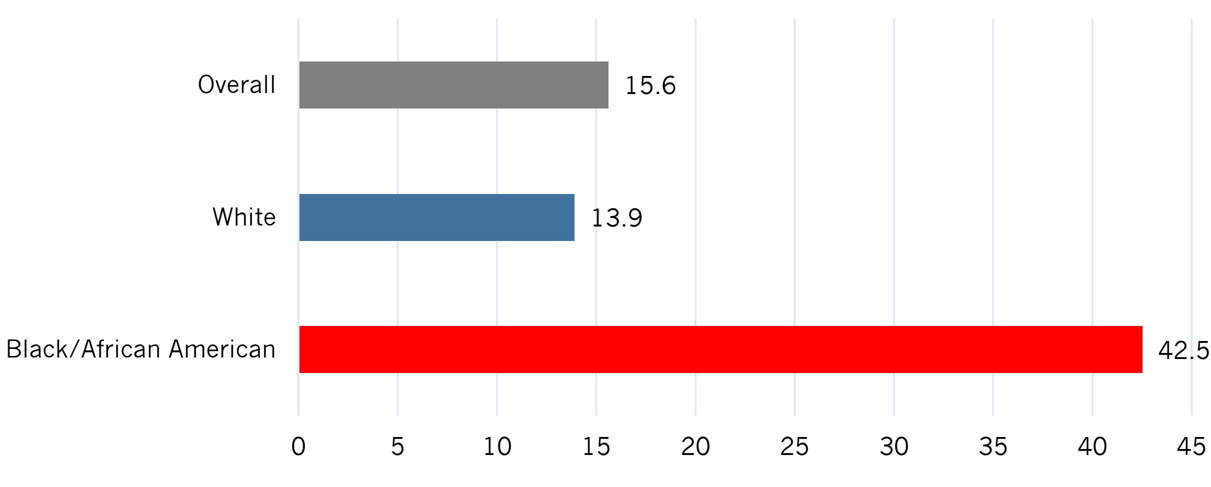
Disparities also exist within the Avon Hospital Community Definition and Chronic Diseases. Black/African American residents of both Cuyahoga and Lorain County experience worse rates of Age-Adjusted Death Rate due to Kidney Disease than their White peers (see red in figures below). Figure 28 shows Black/African Americans in Cuyahoga County have a death rate due to Kidney Disease of 26.2 deaths per 100,000 population compared to the overall rate of 15.2. Similarly, Figure 29 shows Black/African Americans in Lorain County have a Kidney Disease death rate of 42.5 deaths per 100,000 compared to the overall value of 15.6.

Figure 28. Age-Adjusted Death Rate due to Kidney Disease by Race/Ethnicity in Cuyahoga County



Deaths/ 100,000 population
Source: Centers for Disease Control and Prevention, 2017-2019

Figure 29. Age-Adjusted Death Rate due to Kidney Disease by Race/Ethnicity in Lorain County



Deaths/ 100,000 population
Source: Centers for Disease Control and Prevention, 2017-2019

Prioritized Health Topic #4: Maternal and Child Health

Maternal & Child Health

Secondary Data Score: **1.57**

Key Themes from Community Input

- All issues are disproportionately impacting poor children
- Many AAPI (Asian American and Pacific Islander) families made the decision that their kids were safer at home, not necessarily from COVID-19, but from physical, anti-Asian hostilities. So, they kept their kids at home and that's devastating because engagement in learning is extremely difficult in that remote setting
- Opportunity for payer community to pay for food for pregnant people experiencing food insecurity to have better pregnancy outcomes
- Red lined communities are also most impacted by lead and infant mortality
- Rising behavioral health issues amongst children which was exacerbated by COVID-19
- Specialized resources need to be allocated to communities most impacted by infant mortality, prematurity, early pregnancy loss which in Cleveland, is African American families to promote true health equity
- There needs to be more intentional funding of maternal/infant health programs in the community from the hospital using an equity lens
- Top issues: lead poisoning, mental/behavioral health, infant mortality, food insecurity, delays in preventative care, learning loss

Warning Indicators

- Babies with Low Birth Weight
- Babies with Very Low Birth Weight
- Blood Lead Levels in Children (>=10 micrograms per deciliter)
- Blood Lead Levels in Children (>=5 micrograms per deciliter)
- Child Food Insecurity Rate
- Children with Low Access to a Grocery Store
- Infant Mortality Rate
- Mothers who Received Early Prenatal Care
- Mothers who Smoked During Pregnancy
- Preterm Births
- Projected Child Food Insecurity Rate
- Substantiated Child Abuse Rate

Primary Data: Key Stakeholder Interviews and Community Engagement Session

Maternal and Child Health has dominated community discussions for multiple assessment cycles. High maternal and infant mortality rates across communities served by enterprise hospitals have been of particular concern. Implementation strategies precipitated investments in community health focused on reducing maternal and infant mortality.

Key stakeholder interviews acknowledged the persistence of high infant mortality rates as well as the continuance of lead poisoning as a contributor to poor children's health outcomes. During the COVID-19 pandemic, long periods time spent indoors increased exposures and worsened lead related incidents and outcomes. Stakeholders noted that there is an opportunity for the payer community to pay for food for pregnant people experiencing food insecurity as a way to ensure better pregnancy outcomes. Similarly, stakeholders pointed out that to promote health equity, the way in which medical institutions utilizes and allocates resources to a community must be based on need. In a community like Cleveland and Cuyahoga County where the largest percentage of families

that experience infant mortality, prematurity, and early pregnancy loss are African American, then it stands to reason that most new resources go to this population.

Children across the service area suffered some learning loss during the pandemic as classrooms went remote and parents were often unable to provide time away from work to attend to their child's educational needs. Parents identifying as Asian American and Pacific Islander (AAPI) reportedly opted to continue with remote options even after in-person learning resumed for fear of anti-Asian sentiment being expressed to their children by classmates. Related to learning loss and pandemic associated isolation, mental and behavioral health has challenged children at increasingly younger ages. Isolation also kept parents from seeking primary care services for their children, including immunizations and well visits. Finally, key stakeholders expressed disparities among low-income children that exacerbated nearly all health outcomes discussed.

Secondary Data

Among all health topics, Maternal, Fetal and Infant Health ranked ninth with a score of 1.57. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Consumer Expenditures: Childcare is the worst-performing indicator in Lorain County, where residents spend an average of $336.90 per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. This data captures childcare, day care, nursery school, preschool, and non-institutional day camps. [27]Childcare is a major household expense for families with young children. Access to affordable and high-quality childcare is essential for parents to be able to provide sufficient income for their family while ensuring all their children's social and educational needs are met. In regions where childcare costs are high, family budgets are strained, and parents may be forced to sacrifice the quality of childcare arrangements they select for their children. [28]

Child Food Insecurity Rate, Babies with Low Birth Weight, and Babies with Very Low Birth Weight are some of the worst-performing indicators in Cuyahoga County. When looking at Babies with Low and Very Low Birth Weights, Cuyahoga County ranks in the worst 25% of Ohio counties. Black/African American residents in Cuyahoga County see a higher rate of Babies with Very Low Birth Weight, as shown in Figure 30. Similarly, in Lorain County, Black/African American residents and Hispanic/Latino residents are affected more than other racial and ethnic groups, as shown in Figure 31.

[27] Claritas Consumer Buying Power
[28] Center for American Progress, 2021

Figure 30. Babies with Very Low Birth Weight by Race/Ethnicity in Cuyahoga County

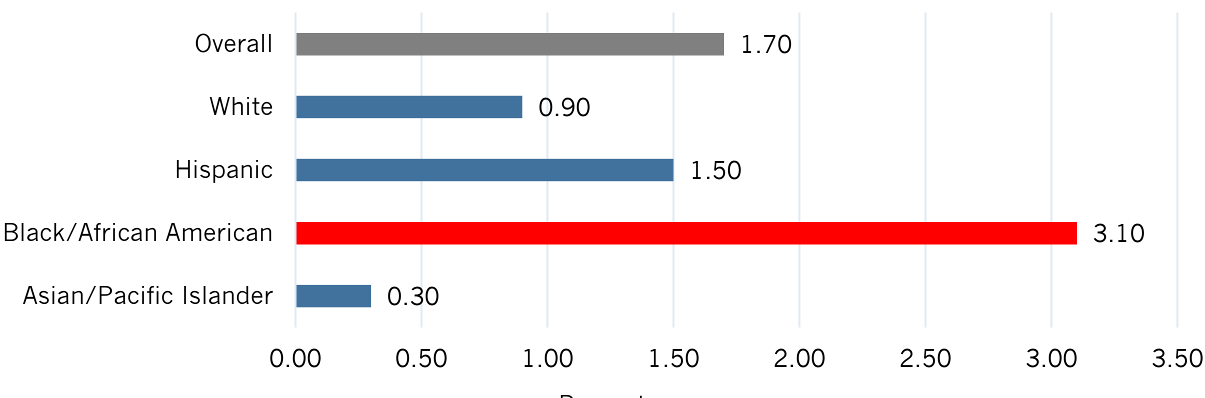
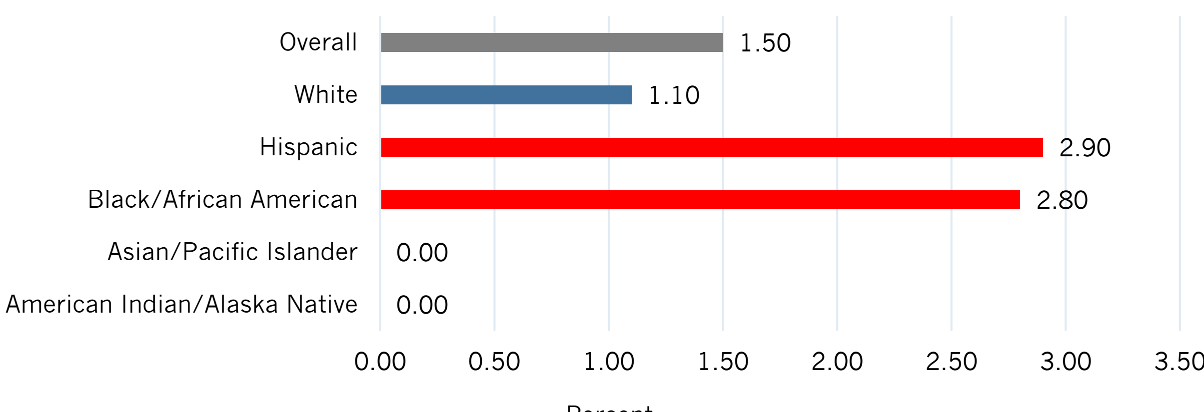


Figure 31. Babies with Very Low Birth Weight by Race/Ethnicity in Lorain County



Prioritized Health Topic #5: Socioeconomic Issues

Prevention and Safety

Secondary Data Score: **2.01**

Key Themes from Community Input

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

Warning Indicators

- Age-Adjusted Death Rate due to Falls
- Adults with Current Asthma
- Age-Adjusted Death Rate due to Unintentional Injuries
- Age-Adjusted Death Rate due to Unintentional Poisonings
- Annual Ozone Air Quality
- Asthma: Medicare Population
- Blood Lead Levels in Children (>=10 micrograms per deciliter)
- Blood Lead Levels in Children (>=5 micrograms per deciliter)
- Children with Low Access to a Grocery Store
- Death Rate due to Drug Poisoning
- Farmers Market Density
- Fast Food Restaurant Density
- Food Environment Index
- Houses Built Prior to 1950
- Low-Income and Low Access to a Grocery Store
- PBT Released
- People 65+ with Low Access to a Grocery Store
- Physical Environment Ranking
- WIC Certified Stores

Primary Data: Key Stakeholder Interviews and Community Engagement Session

Participants in the Avon Hospital Community Engagement Session noted several community challenges related to housing and safety. Employment and housing for underserved communities as well as associated disparities was the top issue that needed to be addressed in the community. Over 16% of respondents also considered homelessness and lack of affordable housing key issues to be addressed while just under 7% agreed that crime and crime prevention, including violent crimes, should be addressed.

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

> The biggest disparities that we are working on right now are infant mortality, lead poisoning, community violence and behavioral health. There is inequity imbedded into our economic and educational system that so greatly impact health outcomes.
>
> - Key Stakeholder

Secondary Data

Prevention & Safety ranked first among all health topics with a score of 2.01. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

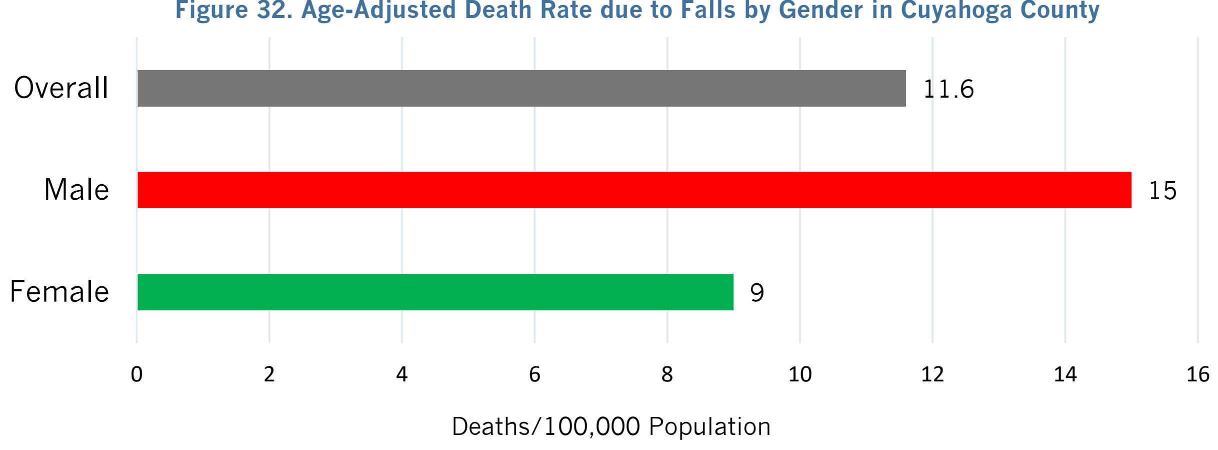
Age-Adjusted Death Rate due to Falls ranks poorly in Lorain County with an indicator score of 2.75 and 14.5 deaths per 100,000 population. For this indicator, Lorain County falls in the worst 25% of Ohio counties and the rate is increasing significantly.

Death Rate due to Drug Poisoning ranked highest in this topic area for Cuyahoga County with a death rate of 42.6 deaths per 100,000 population, compared to Ohio's rate of 38.1 and the U.S. rate of 21. This indicator is also increasing significantly in Cuyahoga County.

The worst performing indicators under this topic area for Erie County are Age-Adjusted Death Rate due to Unintentional Injuries and Age-Adjusted Death Rate due to Unintentional Poisonings. For both indicators, the rates in Erie County are increasing significantly.

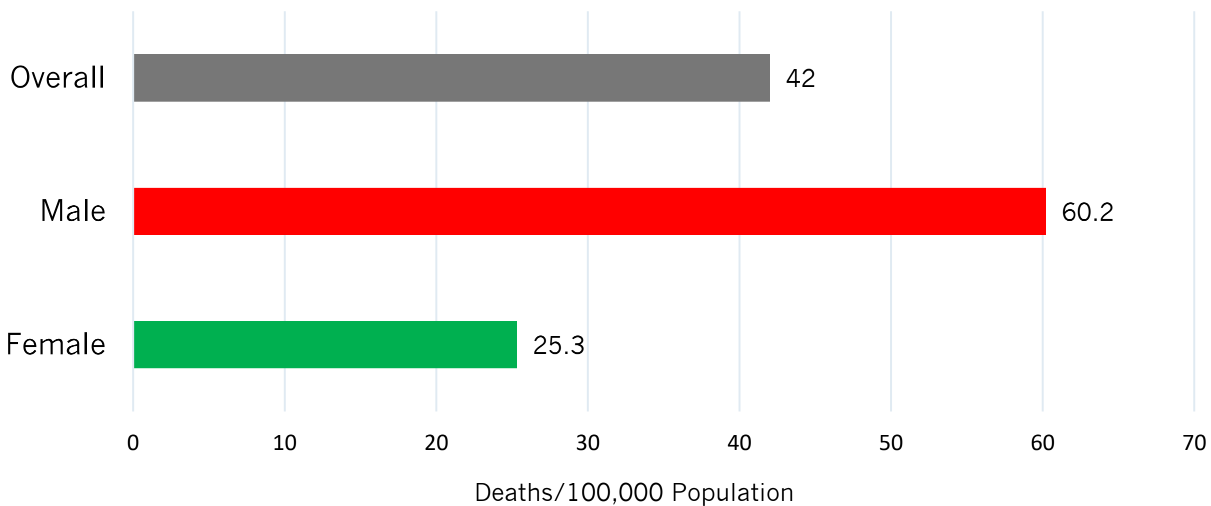
In Cuyahoga County, disparities exist for males in the following indicators: Age-Adjusted Death Rate due to Falls, Age-Adjusted Death Rate due to Unintentional Poisonings, and Age-Adjusted Death Rate due to Unintentional Injuries as seen in Figures 32, 33 and 34.

Figure 32. Age-Adjusted Death Rate due to Falls by Gender in Cuyahoga County



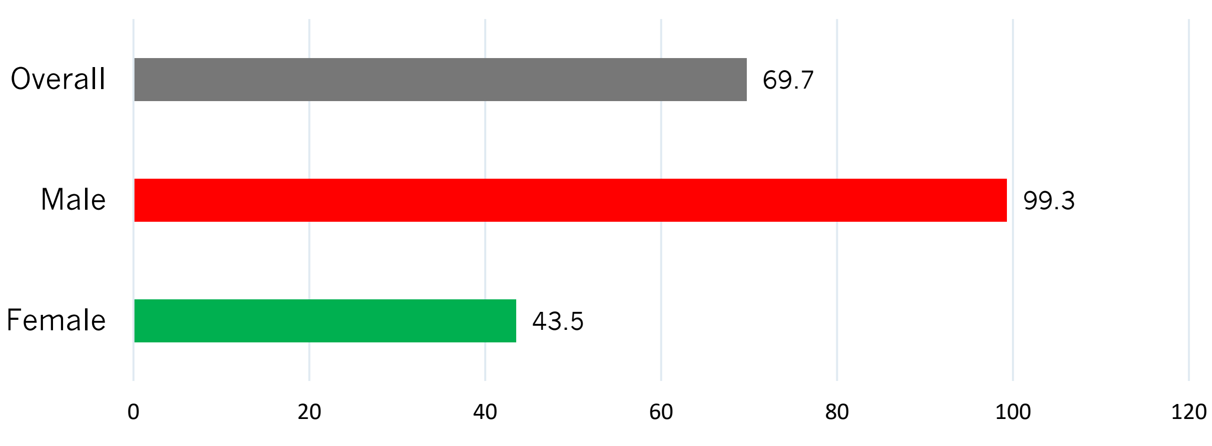
Source: Centers for Disease Control and Prevention, 2017-2019

Figure 33. Age-Adjusted Death Rate due to Unintentional Poisonings by Gender in Cuyahoga County



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

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



Deaths/100,000 Population

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

2022 Avon Hospital CHNA Alignment

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

Figure 35. Avon Hospital CHNA Alignment

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

Appendices Summary

A. Methodology

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

B. Impact Evaluation

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

C. Secondary Data Methodology and Scoring Tables

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

D. Community Input Assessment Tools

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

- Community Engagement Session Questions
- Key Stakeholder Interview Questions
- Key Stakeholder and Community Organizations

E. Community Partners and Resources

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

F. Acknowledgements

Appendix A: Methodology

Overview

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

Secondary Data Sources & Analysis

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

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

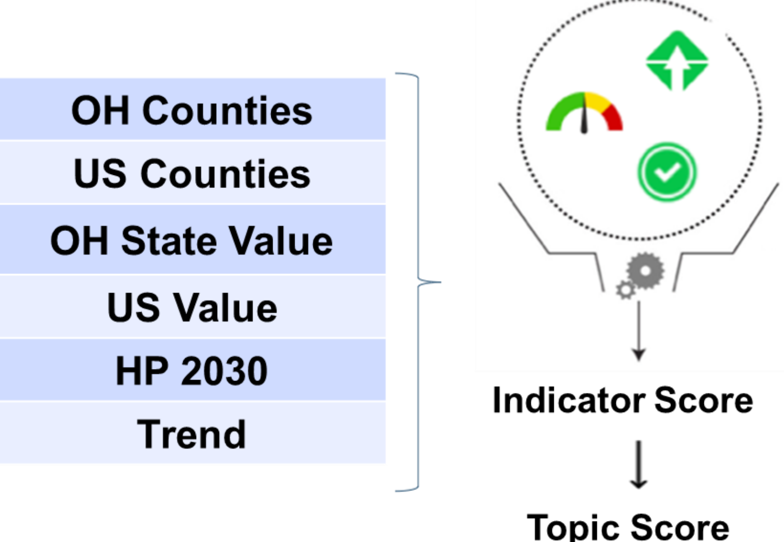
- Ohio Department of Health, Vital Statistics
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food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

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

Secondary Data Scoring

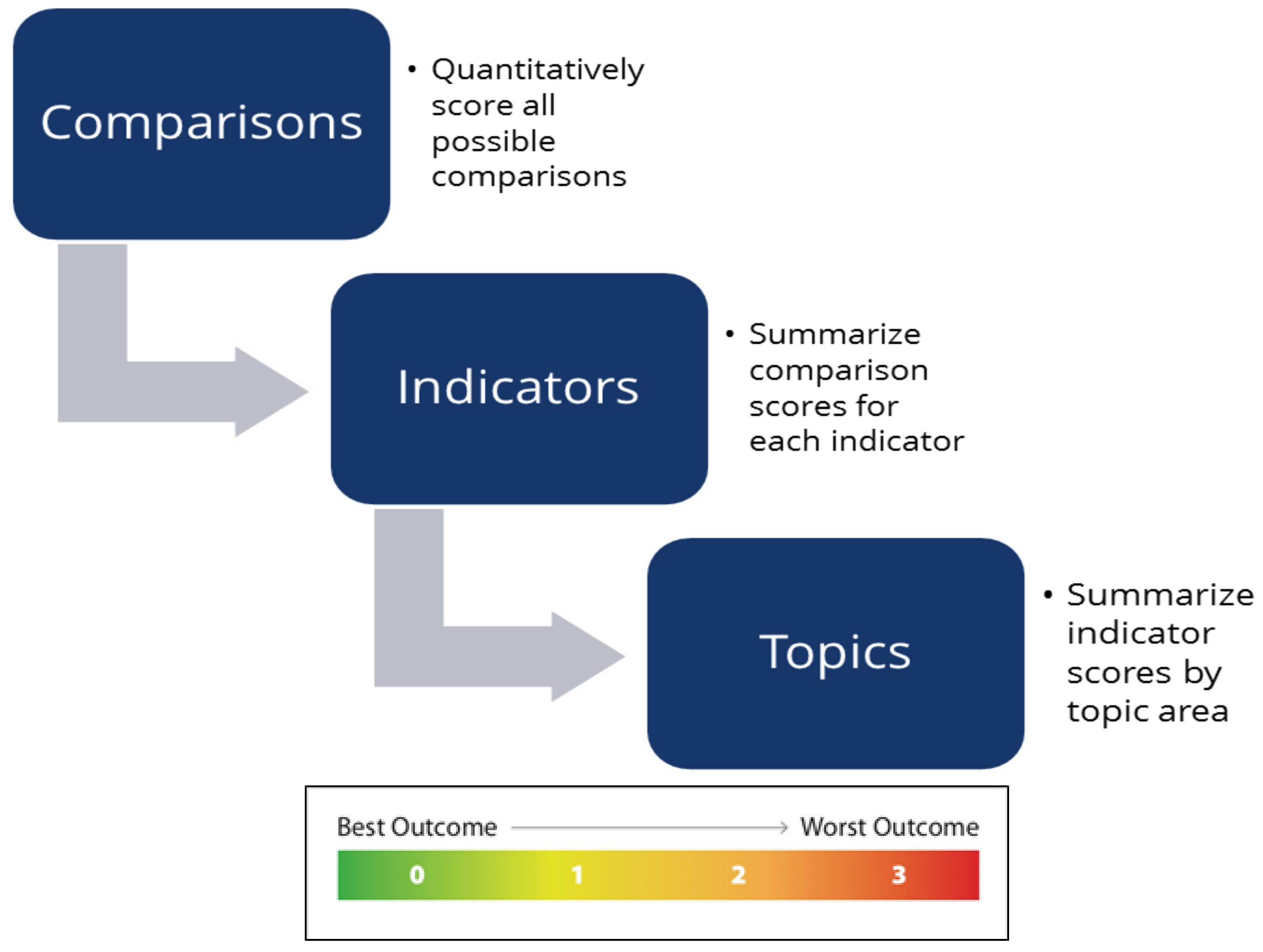
HCI's Data Scoring Tool (Figure 36) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national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

Figure 36: Summary of Topic Scoring Analysis



Secondary Data Scoring

Data scoring is done in three stages:



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

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

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

Comparison to Values: State, National, and Targets

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

Trend over Time

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

Missing Values

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

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

Indicator Scoring

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

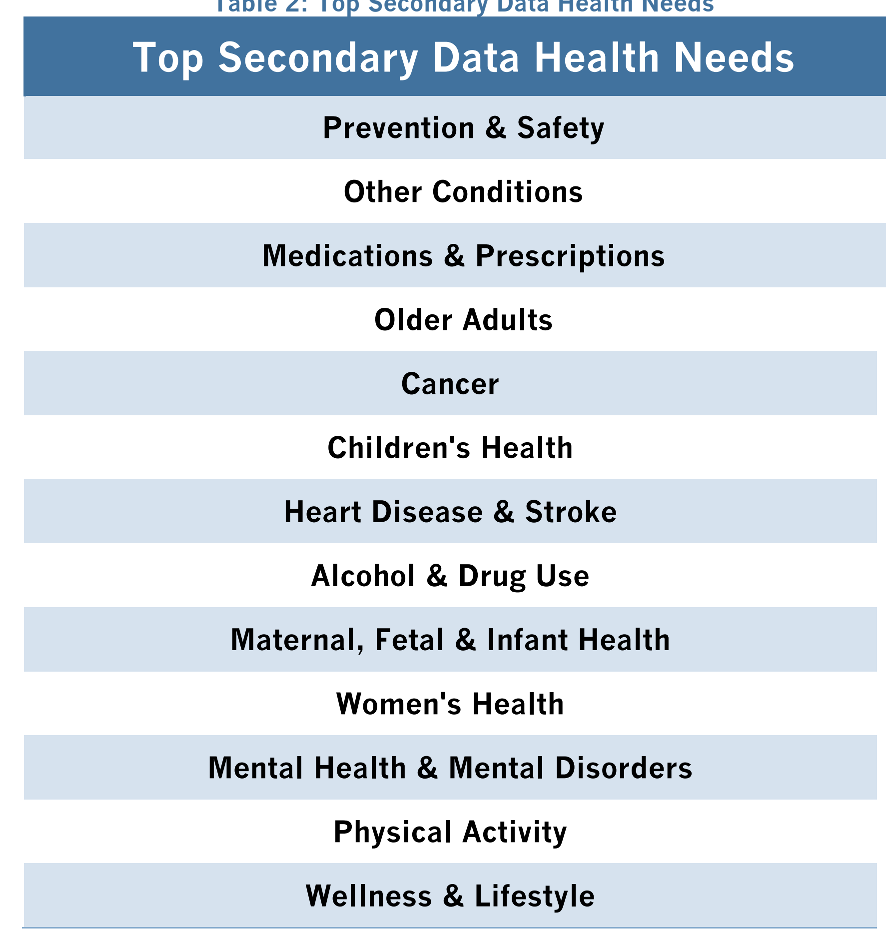
Topic Scoring

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

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

Table 2 shows the health and quality of life topic scoring results for the Avon Hospital Community, ranked in order of highest need. Prevention & Safety scored as the poorest performing topic area with a score of 2.01, followed by Other Conditions with a score of 2.00. Topics that received a score of 1.50 or higher were considered a significant health need. Thirteen topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 2: Top Secondary Data Health Needs



Top Secondary Data Health Needs
Prevention & Safety
Other Conditions
Medications & Prescriptions
Older Adults
Cancer
Children's Health
Heart Disease & Stroke
Alcohol & Drug Use
Maternal, Fetal & Infant Health
Women's Health
Mental Health & Mental Disorders
Physical Activity
Wellness & Lifestyle

Index of Disparity

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

Health Equity Index

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

How is the index value calculated?

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

What do the ranks and colors mean?

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

Food Insecurity Index

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

How is the index value calculated?

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

What do the ranks and colors mean?

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

Mental Health Index

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

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

How is the index value calculated?

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

What do the ranks and colors mean?

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

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

Table 3: HEI, FII and MHI Values for Zip Codes within the Avon Hospital Community

Zip Code	HEI Value	FII Value	MHI Value
44001	29.9	28.5	67.6
44011	4.4	7.8	21
44012	5	12.9	30
44035	75.4	74	93.9
44039	15.6	15.8	49.1
44052	94.4	93.8	95.6
44053	59.4	61	91.3
44054	20.7	29.4	65.3
44055	97.2	94.7	96.5
44070	25	25.1	64.7
44089	29.7	36.3	65.9
44107	35.3	50.8	77
44116	6.4	15.2	61.1
44126	20.8	26.2	62
44138	13.3	24.4	51.6
44140	2.6	3.7	29.4
44145	7.8	10.8	62.8

Data Considerations

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

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

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

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

Primary Data Collection & Analysis

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

Community Engagement Session Methodology and Results

Avon Hospital invited members of the hospital Community Advisory Council (CAC) to participate in a community engagement session. The session was held virtually on May 3, 2022. Participants answered four questions including:

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

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

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

Figure 37: Community Engagement Session Findings

Top health issues	Barriers/Social Determinants of Health	Populations most impacted
• Mental Health (social isolation, anxiety, depression, suicide, trauma) • Access to Affordable Healthcare • Alcohol & Drug Use • Weight Status/Nutrition & Heathy Eating/Food Security • Inequities for underserved populations • Senior services	• Transportation • Access to Heathcare • Lack of providers/Telemedicine • Education (K-12, 4 year) • Funding • Affordable housing • Barriers to Education • Childcare support	• Seniors/Older Adults • Rural • African American • Hispanic/Latino • Homeless • Children • Low-income

Key Stakeholder Interviews Methodology and Results

The project team also captured detailed transcripts of the key stakeholder interviews. Table 4 describes the key stakeholder organizations contributing to the primary data collection process.

Table 4: Avon Hospital Key Stakeholder Organizations

Key Stakeholder and Community Organizations	
• City of Cleveland Department of Public Health • Cuyahoga County Board of Health • Lorain County Public Health • Medina County Health Department • Avon Hospital Community Advisory Council	• Neighborhood Family Practice • Birthing Beautiful Communities • Lead Safe Cleveland Coalition • Better Health Partnerships • NAMI Greater Cleveland • Asian Services in Action (ASIA) • Cleveland Clinic LGBTQ+ Care • Benjamin Rose Institute on Aging • Greater Cleveland Food Bank • The Gathering Place • Cuyahoga Metropolitan Housing Authority • Esperanza • The Centers for Families and Children

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

Figure 38: Key Stakeholder Findings

Most Important Health Problems	Barriers/Challenges to Improving Health	Underserved Populations
• Access to Quality Healthcare • Health System Navigation • Mental Health • Nutrition & Healthy Eating • Older Adults • Housing • Public safety/crime	• COVID-19 • SDOH • Built Environment/ Infrastructure • Impacts of historical red-lining • Poverty • Transportation • Health Disparities • Education	• African American • Low-income • Children • Older Adults • LGBTQ

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

Appendix B: Impact Evaluation

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

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

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

Actions Taken Since Previous CHNA

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

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

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

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

Addiction and Mental Health

Actions and Highlighted Impacts:

a. Through Cleveland Clinic's Opioid Awareness Center, provided intervention and treatment for substance abuse disorders to Cleveland Clinic caregivers and their families.
    - Opioid misuse continues to be a public health emergency, contributing to over 50,000 U.S. deaths a year. About 40% of those deaths involve prescription opioids. Our comprehensive efforts to improve opioid prescribing have yielded reductions in these prescriptions by our providers for two years running, including a large improvement in 2021.

b. Through the Opioid Awareness Center, participated in the Northeast Ohio Hospital Opioid Consortium and Lorain's County Opiate Task Forces, and community-based classes and presentations. Cleveland Clinic provided preventative education and share evidence-based practices.

c. Collected unused opioid and controlled substance medications through community-based drop boxes and a collection service

d. Cleveland Clinic developed suicide and self-harm policies procedures and screening tools for patients in a variety of care settings.
    - Screened patients over age 12 for clinical depression, as well as in pediatric behavioral health
    - In collaboration with the Nord Center, Clear Vista, Lorain County Health and Dentistry, and the Mental Health, Addiction and Recovery Services Board of Lorain County, promoted mental health and suicide prevention education.

e. Provided school-based prevention programs and promote policies to increase the perception of risk of marijuana use for youth, decrease underage binge-drinking, tobacco use, and vaping.

f. Improved identification of substance abuse disorders, streamline treatment referrals, and improve gaps in access to treatment through partnerships
    - Connected patients with substance abuse disorders to local peer counselors.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

a. Improve management of chronic conditions through Chronic Care Clinics employing a specialized model of care

- COVID 19 created a delay in treatment for many community members. We launched an effort to connect patients with care, proactively contacting over 300,000 patients and scheduling 57,000 appointments. This outreach is prompting more patients to complete recommended screening tests, allowing earlier detection of cancers and other diseases when they are most treatable. For example, 1,700 precancerous lesions of the colon have been detected earlier as a result — a key part of preventing colon cancer.
- Many in-person community programs were paused by COVD 19. When COVID-19 vaccines became available, we co-led a nationwide campaign to encourage adults to get vaccinated. The coalition of 60 top hospitals and healthcare institutions communicated the vaccines' safety and effectiveness through diverse digital and traditional media. Throughout the years, our health experts explained and advocated the benefits of vaccination at every opportunity, from patient visits to national media appearances. In late 2021, when cases of the omicron variant surged and hospitals filled with unvaccinated patients, we joined with five other Northeast Ohio hospital systems in an advertising campaign urging the public to get vaccinated and take other precautions.

b. Promoted early cancer detection through community outreach and education related to breast, colon, cervical, lung, and prostate cancers.

- Participated in community event with local hospitals and healthcare providers, *United Against Colon Cancer*, to provide cancer education, screenings and resources.

c. Provided health screenings through community events, including screening for pre-diabetes and diabetes.

- Community Health fair offered at the Lorain Family Health Center, with free screenings and health information for community members.
- Multiple community screening events in the cities of Lorain and Elyria to screen for cancer and to educate on HPV vaccinations.
- Supported Ukrainian refugee health and resource fairs, connected families to primary care resources.

d. Implemented health promotion messaging, health education, and outreach programs related to reducing behavioral risk factors, increasing access to healthy foods, and increasing physical activity.

e. Through the Healthy Communities Initiative (HCI), partner to fund programs designed to improve health outcomes in four core areas: physical activity, nutrition, smoking, and lifestyle management.

- Prior to COVID 19, Healthy Communities Initiative provided in 23 programs in 59 NE Ohio zip codes with total participation of 2,813 community residents. Results indicated decreased blood pressure abnormality, increased physical activity and increased healthy eating behaviors.

Infant Mortality

Actions and Highlighted Impacts:

a. Provided expanded evidence-based health education to expecting mothers and families.
   - Cleveland Clinic provided community education in efforts to support pregnant persons with resources and best practices to reduce infant and maternal health and have a successful pregnancy.

b. Participated in First Year Cleveland, the Cuyahoga County Infant Mortality Task Force to gather data, align programs, and coordinate a systemic approach to improving infant mortality.
   - In 2020 and 2021 Cleveland Clinic physicians provided clinical and administrative expertise on the Executive Board of First Year Cleveland.

c. Expanded the Centering Pregnancy group prenatal care model to expecting mothers and increase the number of families who participate in evidence-based home visiting programs.
   - Cleveland Clinic is acting to address health disparities and give all infants a healthy start. We expanded Centering programs to bring new mothers together for supportive prenatal care and parenting education. Centering Pregnancy groups provided in-person, virtually and hybrid in Cuyahoga, Summit and Lorain Counties. Bilingual program was implemented at the Lorain Family Health Center.
   - Cleveland Clinic is providing obstetric navigators to promote maternity care and help parents with food, transport and other socioeconomic needs.

d. Partnered with EL Centro, a Latino nonprofit advocacy organization, to increase community knowledge and access re maternal and infant health.

e. Outreach events like Community Baby Showers provided health information to families in specific high-risk geographical areas and encouraged enrollment in supportive evidence-based programs. Community health education continued through virtual education and Centering programs.

Socioeconomic Concerns

Actions and Highlighted Impacts:

a. Cleveland Clinic implemented a system-wide social determinants screening tool for adult patients to identify needs such as alcohol abuse, depression, financial strain, food insecurity, intimate partner violence, and stress.

b. We implemented a common community referral data platform to coordinate services and ensure optimal communication.

- Cleveland Clinic collaborated with Unite Ohio to build a coordinated care network of health and social service providers. Cleveland Clinic went live on the platform on July 2021 and has sent nearly 2,000 referrals with a gap closure of 44%.

c. Through community partnerships, continue efforts to improve early childhood learning.

- Partnered with the Lorain County chapter of the Dolly Parton Imagination Library. Participated in *Reach Out and Read* program to provide young children with books at well-child visits and encourage early literacy.

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

- Cleveland Clinic created initiatives to develop a skilled community youth workforce in vulnerable communities aligning with Health Anchor Network (HAN) and Placed-based Initiatives. Examples include:
  - Partnership with the Urban League of Lorain County to offer summer internships to underrepresented minority students in high school and college.
  - Engagement with the Lorain County Business Advisory Council to provide educators with information on healthcare careers. Creation of on-site engagement to offer students a behind the scenes look at healthcare jobs and operations.
  - Participation in the Cleveland Clinic ASPIRE program, a pathway for students interested in nursing, respiratory therapy, surgical technology and sterile processing.
- Connected Career Rounds provided 4,233 middle and high school students from 76 schools across 7 states including Ohio. Louis Stokes Summer Internships provided high school interns a paid experience with exposure to clinical and non-clinical healthcare roles.

Access to Affordable Health Care

Actions and Highlighted Impacts:

a. Patient Financial Advocates assisted patients in evaluating eligibility for financial assistance or public health insurance programs.

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

b. Supported the Lorain Free Clinic financially and through the provision of free radiology and laboratory clinical services.

c. Provided walk-in care at Express Care Clinics and offer evening and weekend hours.

d. Utilizing medically secure online and mobile platforms, connect patients with Cleveland Clinic providers for telehealth and virtual visits.

    - In 2021, Cleveland Clinic provided 841,000 virtual visits.

Medical Research and Health Professions Education

Actions and Highlighted Impacts:

a. Through medical research, advance clinical techniques, devices and treatment protocols in the areas of cancer, heart disease, diabetes, and others.

    - Research into diseases and potential cures is an investment in people's long-term health.
    - In 2020, COVID-19 highlighted the significance of research in community health. Cleveland Clinic research findings increased knowledge about the virus and how best to respond to it. Our researchers developed the world's first COVID-19 risk-prediction model, enabling healthcare providers to calculate an individual patient's likelihood of testing positive for infection as well as their probable outcome from the disease.
    - For 2021, Cleveland Clinic's community benefit in support of research was $101 million.

b. Through the Center for Populations Health Research, informed clinical interventions, healthcare policy, and community partnerships.

c. Sponsored high-quality medical education training programs for physicians, nurses, and allied health professionals via Graduate Medical Education programs, and internships and residencies.

    - Cleveland Clinic provided a wide range of high-quality medical education that includes accredited training programs for residents, physicians, nurses and allied health professionals. By educating medical professionals, we ensure that the public receives the highest level of medical care and will have access to highly trained health professionals in the future. For 2021, Cleveland Clinic's community benefit in support of education was $322 million.

Community Feedback from Preceding CHNA & Implementation Plan

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

Appendix C: Secondary Data Scoring Tables

Table 5: Avon Hospital Community Definition

Zip code	Postal Name
44001	Amherst
44011	Avon
44012	Avon Lake
44035	Elyria
44039	North Ridgeville
44052	Lorain
44053	Lorain
44054	Sheffield
44055	Lorain
44070	North Olmsted
44089	Vermilion
44107	Lakewood
44116	Rocky River
44126	Cleveland
44138	Olmsted Falls
44140	Bay Village
44145	Westlake

Table 6: Population Estimates for Each Zip Code

Zip code	City	Population
44001	Amherst	21,539
44011	Avon	25,407
44012	Avon Lake	25,634
44035	Elyria	64,551
44039	North Ridgeville	35,503
44052	Lorain	28,119

44053	Lorain	20,084
44054	Sheffield	12,915
44055	Lorain	19,113
44070	North Olmsted	31,168
44089	Vermilion	15,898
44107	Lakewood	50,128
44116	Rocky River	19,724
44126	Cleveland	15,738
44138	Olmsted Falls	23,771
44140	Bay Village	14,895
44145	Westlake	33,466

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

Zip Code	City	Families Below Poverty Level (%)
44001	Amherst	5.6%
44011	Avon	2.4%
44012	Avon Lake	2.6%
44035	Elyria	17.6%
44039	North Ridgeville	3.6%
44052	Lorain	27.6%
44053	Lorain	10.3%
44054	Sheffield	4.5%
44055	Lorain	26.4%
44070	North Olmsted	6.4%
44089	Vermilion	3.3%
44107	Lakewood	9.6%
44116	Rocky River	2.4%
44126	Cleveland	4.4%
44138	Olmsted Falls	2.3%

44140	Bay Village	2.8%
44145	Westlake	3.8%

Table 8: Secondary Data Results by Health Topic—Cuyahoga, Erie, and Lorain Counties

HEALTH TOPICS	CUYAHOGA	ERIE	LORAIN	AVG
Alcohol & Drug Use	1.73	1.40	1.70	1.61
Cancer	1.71	1.68	1.57	1.65
Children's Health	1.72	1.72	1.48	1.64
Diabetes	1.17	1.73	1.33	1.41
Health Care Access & Quality	1.21	1.38	1.57	1.39
Heart Disease & Stroke	1.35	1.80	1.70	1.62
Immunizations & Infectious Diseases	1.20	1.06	1.20	1.15
Maternal, Fetal & Infant Health	1.56	1.46	1.69	1.57
Medications & Prescriptions	1.72	1.89	2.33	1.98
Mental Health & Mental Disorders	1.39	1.68	1.48	1.52
Nutrition & Healthy Eating	1.31	1.28	1.58	1.39
Older Adults	1.65	1.82	1.77	1.75
Oral Health	1.14	1.61	1.14	1.30
Other Conditions	1.83	1.99	2.17	2.00
Physical Activity	1.39	1.59	1.56	1.51
Prevention & Safety	2.21	1.83	2.00	2.01
Respiratory Diseases	1.23	1.42	1.39	1.35
Tobacco Use	1.19	1.65	1.23	1.36
Wellness & Lifestyle	1.49	1.57	1.43	1.50
Women's Health	1.46	1.33	1.82	1.54

QUALITY OF LIFE TOPIC		SCORE		
Community	1.66	1.39	1.50	1.52
Economy	1.68	1.32	1.34	1.45
Education	1.55	1.42	1.71	1.56
Environmental Health	1.53	1.56	1.39	1.49

Secondary Data Scoring Indicators of Concern

From the secondary data scoring results, Health Care Access & Quality ranked as the 16th highest scoring health need, with a score of 1.39. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 9 below. For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. The legend (Figure 39) on the right shows how to interpret the distribution gauges and trend icons used in the data scoring results for each health topic by county.

Figure 39: Prioritized Health Needs

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

Table 9. Data Scoring Results for Healthcare Access & Quality for the Avon Hospital Community

Cuyahoga County

SCORE	HEALTH CARE ACCESS & QUALITY	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.83	Adults with Health Insurance: 18+	89.8		90.2	90.6			...
1.83	Consumer Expenditures: Medical Services	1057.6		1098.6	1047.4			...
1.83	Consumer Expenditures: Medical Supplies	199.2		204.8	194.9			...
1.50	Adults who Visited a Dentist	51.3		51.6	52.9			...
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	627.2		638.9	609.6			...

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

Lorain County

SCORE	HEALTH CARE ACCESS & QUALITY	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend

SCORE		Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.33	Consumer Expenditures: Medical Services	1181.4		1098.6	1047.4			...
2.33	Consumer Expenditures: Medical Supplies	217.8		204.8	194.9			...
2.33	Consumer Expenditures: Prescription and Non-Prescription Drugs	687.1		638.9	609.6			...
2.17	Consumer Expenditures: Health Insurance	4676.2		4371.7	4321.1			...
1.75	Adults without Health Insurance	13.7			13			...
1.72	Primary Care Provider Rate	54.6		76.7				
1.56	Persons without Health Insurance	6.1		6.6		...	...	

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

Erie County

SCORE	HEALTH CARE ACCESS & QUALITY	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend

2.00	Consumer Expenditures: Health Insurance	4419		4371.7	4321.1			...
2.00	Consumer Expenditures: Prescription and Non-Prescription Drugs	654		638.9	609.6			...
1.89	Persons without Health Insurance	7.9		6.6		...	...	
1.83	Consumer Expenditures: Medical Services	1051.5		1098.6	1047.4			...
1.83	Consumer Expenditures: Medical Supplies	195.8		204.8	194.9			...
1.50	Adults who Visited a Dentist	51.4		51.6	52.9			...
1.50	Adults with Health Insurance	87.9		90.9	87.1	...	...	...

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

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

From the secondary data scoring results, Mental Health & Mental Disorders had the 11th highest data score of all topic areas, with a score of 1.52. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 10 below.

Cuyahoga County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4		10.4	10.8			
1.83	Poor Mental Health: Average Number of Days	5		4.8	4.1			...
1.75	Depression: Medicare Population	18.5		20.4	18.4			
1.75	Poor Mental Health: 14+ Days	16			13.6			...
1.61	Age-Adjusted Death Rate due to Suicide	14	12.8	15.1	14.1			

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

Lorain County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.67	Age-Adjusted Death Rate due to Suicide	17.5	12.8	15.1	14.1			

1.92	Depression: Medicare Population	19.9		20.4	18.4			
1.67	Poor Mental Health: Average Number of Days	4.8		4.8	4.1			...
1.64	Alzheimer's Disease or Dementia: Medicare Population	10.4		10.4	10.8			
1.58	Poor Mental Health: 14+ Days	15.7			13.6			...

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

Erie County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Age-Adjusted Death Rate due to Alzheimer's Disease	45.7		34	30.5			
2.42	Alzheimer's Disease or Dementia: Medicare Population	11.2		10.4	10.8			
1.83	Poor Mental Health: Average Number of Days	4.9		4.8	4.1			...

1.64	Depression: Medicare Population	19.7		20.4	18.4			
1.58	Poor Mental Health: 14+ Days	15.3			13.6			···
1.56	Age-Adjusted Death Rate due to Suicide	14.7	12.8	15.1	14.1			
1.50	Self-Reported General Health Assessment: Good or Better	84.1		85.6	86.5			···

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

Table 11. Data Scoring Results for Behavioral Health (Alcohol & Drug Use) for the Avon Hospital Community

From the secondary data scoring results, Alcohol & Drug Use had the 8th highest score at 1.61. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 11 below.

Cuyahoga County

SCORE	ALCOHOL & DRUG USE	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.64	Death Rate due to Drug Poisoning	42.6		38.1	21			

SCORE	ALCOHOL & DRUG USE	County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.44	Alcohol-Impaired Driving Deaths	41.4	28.3	32.2	27			
2.00	Adults who Drink Excessively	19.6		18.5	19			...
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	43.8		42	22.8			...
1.67	Consumer Expenditures: Alcoholic Beverages	637.1		651.5	701.9			...

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

Lorain County

SCORE	ALCOHOL & DRUG USE	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.44	Alcohol-Impaired Driving Deaths	39.7	28.3	32.2	27			
2.31	Death Rate due to Drug Poisoning	38.4		38.1	21			
2.00	Consumer Expenditures: Alcoholic Beverages	679.4		651.5	701.9			...

1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	44.3		42	22.8			...

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

Erie County

SCORE	**ALCOHOL & DRUG USE**	**Erie County**	**HP2030**	**Ohio**	**U.S.**	**Ohio Counties**	**U.S. Counties**	**Trend**
2.14	Death Rate due to Drug Poisoning	34.9		38.1	21			
2.03	Mothers who Smoked During Pregnancy	16.6	4.3	11.5	5.5		...	
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	45.4		42	22.8			...

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

Table 12: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #3: Chronic Disease Prevention & Management

Nutrition & Healthy Eating had the 15th highest data score of all topic areas with a score of 1.39. Older Adult Health topic area had the fourth highest score at 1.75 and the related Other Conditions health topic ranked second with a score of 2.00. All topic areas in this group demonstrate need per as they each scored above 1.5. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 12, 13 and 14.

Cuyahoga County

SCORE	NUTRITION & HEALTHY EATING	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.67	Consumer Expenditures: Fruits and Vegetables	838.8		864.6	1002.1			---
1.50	Consumer Expenditures: High Sugar Foods	502.1		519	530.2			---

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

Lorain County

SCORE	NUTRITION & HEALTHY EATING	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Consumer Expenditures: High Sugar Foods	548.3		519	530.2			---
2.00	Consumer Expenditures: Fast Food Restaurants	1521.4		1461	1638.9			---
1.83	Consumer Expenditures: High Sugar Beverages	330.4		319.7	357			---

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

Erie County

SCORE	NUTRITION & HEALTHY EATING	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.83	Consumer Expenditures: Fruits and Vegetables	817.9		864.6	1002.1			...
1.50	Consumer Expenditures: High Sugar Foods	506.7		519	530.2			...

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

Table 13. Data Scoring Results for Older Adults for the Avon Hospital Community

Cuyahoga County

SCORE	OLDER ADULTS	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.64	People 65+ Living Alone	34.8		28.8	26.1			
2.47	People 65+ Living Below Poverty Level	10.9		8.1	9.3			
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			

2.31	Cancer: Medicare Population	9		8.4	8.4			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4		10.4	10.8			
2.14	Atrial Fibrillation: Medicare Population	9		9	8.4			
2.08	Osteoporosis: Medicare Population	6.3		6.2	6.6			...
2.03	Asthma: Medicare Population	5.2		4.8	5			
1.92	Chronic Kidney Disease: Medicare Population	25.2		25.3	24.5			
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	35.4		36.1	33.5			
1.75	Adults 65+ who Received Recommended Preventive Services: Females	28.6			28.4			...
1.75	Depression: Medicare Population	18.5		20.4	18.4			

1.69	Heart Failure: Medicare Population	15.3		14.7	14			
1.67	Colon Cancer Screening	63.7	74.4		66.4			...
1.67	People 65+ with Low Access to a Grocery Store	3.4						...
1.58	Adults 65+ with Total Tooth Loss	15.5			13.5			...

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

Lorain County

SCORE	OLDER ADULTS	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.75	Age-Adjusted Death Rate due to Falls	14.5		10.5	9.5			
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	38.4		36.1	33.5			
2.64	Atrial Fibrillation: Medicare Population	10.2		9	8.4			

2.64	Stroke: Medicare Population	4.7		3.8	3.8			
2.58	Osteoporosis: Medicare Population	6.8		6.2	6.6			
2.47	Hyperlipidemia: Medicare Population	53.1		49.4	47.7			…
2.31	Cancer: Medicare Population	8.9		8.4	8.4			
2.25	Chronic Kidney Disease: Medicare Population	25.8		25.3	24.5			
2.19	Ischemic Heart Disease: Medicare Population	30.6		27.5	26.8			
2.00	COPD: Medicare Population	14.5		13.2	11.5			
1.97	Hypertension: Medicare Population	61.2		59.5	57.2			
1.92	Depression: Medicare Population	19.9		20.4	18.4			

SCORE	OLDER ADULTS	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.83	People 65+ with Low Access to a Grocery Store	4						...
1.81	People 65+ Living Alone	27.5		28.8	26.1			
1.75	Adults with Arthritis	31.1			25.1			...
1.75	Heart Failure: Medicare Population	14.2		14.7	14			
1.64	Alzheimer's Disease or Dementia: Medicare Population	10.4		10.4	10.8			
1.50	Colon Cancer Screening	64.5	74.4		66.4			...

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

Erie County

SCORE	OLDER ADULTS	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.92	Atrial Fibrillation: Medicare Population	10		9	8.4			

2.64	Cancer: Medicare Population	9.6		8.4	8.4			
2.64	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	43.6		36.1	33.5			
2.50	Age-Adjusted Death Rate due to Alzheimer's Disease	45.7		34	30.5			
2.47	Hyperlipidemia: Medicare Population	53.7		49.4	47.7			
2.42	Alzheimer's Disease or Dementia: Medicare Population	11.2		10.4	10.8			
2.36	Stroke: Medicare Population	4.3		3.8	3.8			
2.14	Chronic Kidney Disease: Medicare Population	26.9		25.3	24.5			
2.14	COPD: Medicare Population	14.2		13.2	11.5			
2.00	Colon Cancer Screening	61.1	74.4		66.4			...

2.00	People 65+ with Low Access to a Grocery Store	5						...
1.81	Hypertension: Medicare Population	59.8		59.5	57.2			
1.81	Osteoporosis: Medicare Population	6.5		6.2	6.6			
1.75	Adults with Arthritis	31.8			25.1			...
1.69	Asthma: Medicare Population	4.9		4.8	5			
1.69	Diabetes: Medicare Population	28.2		27.2	27			
1.64	Depression: Medicare Population	19.7		20.4	18.4			
1.58	Adults 65+ who Received Recommended Preventive Services: Females	29.6			28.4			...
1.58	Adults 65+ who Received Recommended Preventive Services: Males	31.7			32.4			...

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Table 14. Data Scoring Results for Other Conditions for the Avon Hospital Community

Cuyahoga County

SCORE	OTHER CONDITIONS	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.08	Osteoporosis: Medicare Population	6.3		6.2	6.6			...
1.92	Adults with Kidney Disease	3.6			3.1			...
1.92	Chronic Kidney Disease: Medicare Population	25.2		25.3	24.5			
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	35.4		36.1	33.5			
1.69	Age-Adjusted Death Rate due to Kidney Disease	15.2		14.5	12.9			

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Lorain County

SCORE	OTHER CONDITIONS	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend

2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	38.4		36.1	33.5			
2.58	Osteoporosis: Medicare Population	6.8		6.2	6.6			
2.25	Age-Adjusted Death Rate due to Kidney Disease	15.6		14.5	12.9			
2.25	Chronic Kidney Disease: Medicare Population	25.8		25.3	24.5			
1.75	Adults with Arthritis	31.1			25.1			...

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

Erie County

SCORE	OTHER CONDITIONS	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.64	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	43.6		36.1	33.5			
2.14	Chronic Kidney Disease: Medicare Population	26.9		25.3	24.5			

1.92	Adults with Kidney Disease	3.5			3.1			...
1.81	Osteoporosis: Medicare Population	6.5		6.2	6.6			
1.75	Adults with Arthritis	31.8			25.1			...
1.69	Age-Adjusted Death Rate due to Kidney Disease	15.4		14.5	12.9			

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

Table 15: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #4: Maternal and Child Health

Among all health topics, Maternal, Fetal and Infant Health ranked ninth with a score of 1.57. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 15 below. See Appendix C for the full list of indicators categorized within this topic.

Cuyahoga County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.11	Babies with Low Birth Weight	10.8		8.5	8.2		...	

2.11	Babies with Very Low Birth Weight	1.7		1.4	1.3		...	
1.78	Infant Mortality Rate	8.6	5	6.9		...	...	

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

Lorain County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Consumer Expenditures: Childcare	336.9		301.6	368.2			...
2.06	Babies with Very Low Birth Weight	1.5		1.4	1.3		...	
2.06	Mothers who Received Early Prenatal Care	67		68.9	76.1		...	
1.89	Preterm Births	10.5	9.4	10.3			...	
1.75	Babies with Low Birth Weight	9		8.5	8.2		...	

1.53	Teen Birth Rate: 15-17	6.9		6.8			...	

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

Erie County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.67	Babies with Low Birth Weight	9.9		8.5	8.2		...	
2.06	Infant Mortality Rate	8.1	5	6.9		...	...	
2.03	Mothers who Smoked During Pregnancy	16.6	4.3	11.5	5.5		...	
1.56	Mothers who Received Early Prenatal Care	70.6		68.9	76.1		...	

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

Table 16: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #5: Socioeconomic Issues

Prevention & Safety ranked first among all health topics with a score of 2.01. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 16 below. See Appendix C for the full list of indicators categorized within this topic.

Cuyahoga County

SCORE	PREVENTION & SAFETY	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.6		2.8	2.5	...	...	...
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	69.7	43.2	68.8	48.9			
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	42		40.2	21.4			
2.64	Death Rate due to Drug Poisoning	42.6		38.1	21			

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

Lorain County

SCORE	PREVENTION & SAFETY	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.75	Age-Adjusted Death Rate due to Falls	14.5		10.5	9.5			

2.39	Age-Adjusted Death Rate due to Unintentional Injuries	71.1	43.2	68.8	48.9			
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	41.2		40.2	21.4			
2.31	Death Rate due to Drug Poisoning	38.4		38.1	21			
1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	2.7		2.8	2.5	---	---	---

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

Erie County

SCORE	PREVENTION & SAFETY	Erie County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.39	Age-Adjusted Death Rate due to Unintentional Injuries	71.7	43.2	68.8	48.9			
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	43.6		40.2	21.4			
2.14	Death Rate due to Drug Poisoning	34.9		38.1	21			

2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	4.1		2.8	2.5	...	...	...

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

Table 17: Secondary Data Scoring Results by Health Topic for The Avon Hospital Community in Rank Order by Topic Score

HEALTH TOPICS	AVG
Prevention & Safety	2.01
Other Conditions	2.00
Medications & Prescriptions	1.98
Older Adults	1.75
Cancer	1.65
Children's Health	1.64
Heart Disease & Stroke	1.62
Alcohol & Drug Use	1.61
Maternal, Fetal & Infant Health	1.57
Women's Health	1.54
Mental Health & Mental Disorders	1.52
Physical Activity	1.51
Wellness & Lifestyle	1.50
Diabetes	1.41
Nutrition & Healthy Eating	1.39
Health Care Access & Quality	1.39
Tobacco Use	1.36
Respiratory Diseases	1.35
Oral Health	1.30
Immunizations & Infectious Diseases	1.15
QUALITY OF LIFE TOPIC	**SCORE**
Education	1.56
Community	1.52
Environmental Health	1.49
Economy	1.45

SCORE	ALCOHOL & DRUG USE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.6		38.1	21	*2017-2019*	9
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	41.4	28.3	32.2	27	*2015-2019*	9
2.00	Adults who Drink Excessively	*percent*	19.6		18.5	19	*2018*	9
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	43.8		42	22.8	*2017-2019*	5
1.67	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	637.1		651.5	701.9	*2021*	7
1.42	Health Behaviors Ranking	*ranking*	31				*2021*	9
1.31	Liquor Store Density	*stores/ 100,000 population*	6.4		5.6	10.5	*2019*	22
1.25	Adults who Binge Drink	*percent*	16			16.7	*2019*	4
0.92	Mothers who Smoked During Pregnancy	*percent*	6.1	4.3	11.5	5.5	*2020*	17

SCORE	CANCER	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.72	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	23.8	16.9	19.4	18.9	*2015-2019*	12
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.8		129.6	126.8	*2014-2018*	12
2.36	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	128		107.2	106.2	*2014-2018*	12
2.31	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.6	15.3	21.6	19.9	*2015-2019*	12
2.25	All Cancer Incidence Rate	*cases/ 100,000 population*	479.7		467.5	448.6	*2014-2018*	12
2.14	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	44.2		41.3	38	*2014-2018*	12
1.78	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	171	122.7	169.4	152.4	*2015-2019*	12
1.67	Colon Cancer Screening	*percent*	63.7	74.4		66.4	*2018*	4
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	42.9	25.1	45	36.7	*2015-2019*	12
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		67.3	57.3	*2014-2018*	12
1.28	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.5	8.9	14.8	13.4	*2015-2019*	12

1.25	Adults with Cancer	*percent*	7.5			7.1	*2019*	4
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.2	11.9	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	75.2	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.3	84.3		84.7	*2018*	4
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.4		7.9	7.7	*2014-2018*	12

SCORE	CHILDREN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Child Food Insecurity Rate	*percent*	20.7		17.4	14.6	*2019*	10
2.08	Projected Child Food Insecurity Rate	*percent*	23.4		18.5		*2021*	10
1.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10	8.7	6.8		*2020*	3
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.7		0.5		*2020*	19
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.8		1.9		*2020*	19

1.50	Children with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.33	Children with Health Insurance	*percent*	97.1		95.2	94.3	*2019*	1
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7

SCORE	COMMUNITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	*percent*	34.8		28.8	26.1	*2015-2019*	1
2.50	Single-Parent Households	*percent*	37.6		27.1	25.5	*2015-2019*	1
2.47	Homeownership	*percent*	50.9		59.4	56.2	*2015-2019*	1
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	41.4	28.3	32.2	27	*2015-2019*	9
2.39	Violent Crime Rate	*crimes/ 100,000 population*	637		303.5	394	*2017*	18
2.31	Social Associations	*membership associations/ 10,000 population*	9.2		11	9.3	*2018*	9
2.14	Linguistic Isolation	*percent*	2.9		1.4	4.4	*2015-2019*	1
2.08	Households without a Vehicle	*percent*	12.8		7.9	8.6	*2015-2019*	1

2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.6		2.8	2.5	*2015-2019*	5
2.00	People Living Below Poverty Level	*percent*	17.5	8	14	13.4	*2015-2019*	1
1.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10	8.7	6.8		*2020*	3
1.92	Children Living Below Poverty Level	*percent*	25.5		19.9	18.5	*2015-2019*	1
1.75	Median Household Income	*dollars*	50366		56602	62843	*2015-2019*	1
1.75	Social and Economic Factors Ranking	*ranking*	72				*2021*	9
1.75	Young Children Living Below Poverty Level	*percent*	27.3		23	20.3	*2015-2019*	1
1.75	Youth not in School or Working	*percent*	2.3		1.8	1.9	*2015-2019*	1
1.69	Voter Turnout: Presidential Election	*percent*	71		74		*2020*	20
1.67	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	122.3		121.7	148.8	*2021*	7
1.67	Households with an Internet Subscription	*percent*	79.1		82.4	83	*2015-2019*	1

1.67	Households with One or More Types of Computing Devices	*percent*	87.4		89.1	90.3	*2015-2019*	1
1.53	Mean Travel Time to Work	*minutes*	24.3		23.7	26.9	*2015-2019*	1
1.50	Adults with Internet Access	*percent*	94.3		94.5	95	*2021*	8
1.50	Households with a Computer	*percent*	84.2		85.2	86.3	*2021*	8
1.50	Persons with an Internet Subscription	*percent*	84		86.2	86.2	*2015-2019*	1
1.36	Solo Drivers with a Long Commute	*percent*	32.3		31.1	37	*2015-2019*	9
1.33	Households with a Smartphone	*percent*	80.3		80.5	81.9	*2021*	8
1.06	Workers Commuting by Public Transportation	*percent*	4.6	5.3	1.6	5	*2015-2019*	1
1.03	Workers who Drive Alone to Work	*percent*	79.3		82.9	76.3	*2015-2019*	1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
0.83	Households with Wireless Phone Service	*percent*	97.2		96.8	97	*2020*	8

0.69	Workers who Walk to Work	*percent*	2.7		2.2	2.7	*2015-2019*	1
0.58	Per Capita Income	*dollars*	33114		31552	34103	*2015-2019*	1
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1

SCORE	DIABETES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.50	Adults 20+ with Diabetes	*percent*	9				*2019*	5
1.14	Diabetes: Medicare Population	*percent*	25.3		27.2	27	*2018*	6
0.86	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	22.4		25.3	21.5	*2017-2019*	5

SCORE	ECONOMY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.47	Homeownership	*percent*	50.9		59.4	56.2	*2015-2019*	1
2.47	People 65+ Living Below Poverty Level	*percent*	10.9		8.1	9.3	*2015-2019*	1
2.17	Child Food Insecurity Rate	*percent*	20.7		17.4	14.6	*2019*	10
2.17	Income Inequality		0.5		0.5	0.5	*2015-2019*	1
2.08	Persons with Disability Living in Poverty (5-year)	*percent*	33.9		29.5	26.1	*2015-2019*	1

2.08	Projected Child Food Insecurity Rate	*percent*	23.4		18.5		*2021*	10
2.00	Adults who Feel Overwhelmed by Financial Burdens	*percent*	15.1		14.6	14.4	*2021*	8
2.00	Food Insecurity Rate	*percent*	13.9		13.2	10.9	*2019*	10
2.00	Households that are Below the Federal Poverty Level	*percent*	17.7		13.8		*2018*	25
2.00	People Living Below Poverty Level	*percent*	17.5	8	14	13.4	*2015-2019*	1
1.92	Children Living Below Poverty Level	*percent*	25.5		19.9	18.5	*2015-2019*	1
1.92	Families Living Below Poverty Level	*percent*	13		9.9	9.5	*2015-2019*	1
1.92	Projected Food Insecurity Rate	*percent*	15.6		14.1		*2021*	10
1.83	Renters Spending 30% or More of Household Income on Rent	*percent*	48.4		44.9	49.6	*2015-2019*	1
1.75	Households with Cash Public Assistance Income	*percent*	3.1		2.9	2.4	*2015-2019*	1
1.75	Median Household Income	*dollars*	50366		56602	62843	*2015-2019*	1

1.75	Severe Housing Problems	*percent*	17.1	13.7	18	*2013-2017*	9
1.75	Social and Economic Factors Ranking	*ranking*	72			*2021*	9
1.75	Young Children Living Below Poverty Level	*percent*	27.3	23	20.3	*2015-2019*	1
1.75	Youth not in School or Working	*percent*	2.3	1.8	1.9	*2015-2019*	1
1.67	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	58.8	61.6		*2018*	25
1.64	Size of Labor Force	*persons*	582791			*44440*	21
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9			*2017*	23
1.50	Households with a Savings Account	*percent*	67.7	68.8	70.2	*2021*	8
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.42	People Living 200% Above Poverty Level	*percent*	64.7	68.8	69.1	*2015-2019*	1
1.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7600	7828	8900.1	*2021*	7

1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	23.5		24.5		*2018*	25
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.31	Overcrowded Households	*percent of households*	1.2		1.4		*2015-2019*	1
1.25	Unemployed Workers in Civilian Labor Force	*percent*	4.6		4.3	4.6	*Sep-21*	21
1.17	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3928.7		3798.7	5460.2	*2021*	7
1.00	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	22.7		19.7	26.5	*2019*	1
0.58	Per Capita Income	*dollars*	33114		31552	34103	*2015-2019*	1
0.58	Students Eligible for the Free Lunch Program	*percent*	12.9				*2019-2020*	13

SCORE	EDUCATION	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

1.86	4th Grade Students Proficient in English/Language Arts	*percent*	46.6		63.3		*2018-2019*	15
1.86	4th Grade Students Proficient in Math	*percent*	52.5		74.3		*2018-2019*	15
1.86	8th Grade Students Proficient in English/Language Arts	*percent*	43.1		58.3		*2018-2019*	15
1.86	8th Grade Students Proficient in Math	*percent*	39.5		57.3		*2018-2019*	15
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7
1.67	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1196.7		1200.4	1492.4	*2021*	7
1.44	High School Graduation	*percent*	89.5	90.7	92		*2019-2020*	15
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1
1.81	Student-to-Teacher Ratio	*students/ teacher*	16.5				*2019-2020*	13

SCORE	ENVIRONMENTAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.25	Adults with Current Asthma	*percent*	11		8.9	*2019*	4
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9			*2016*	23
2.08	Houses Built Prior to 1950	*percent*	39.2	26.2	17.5	*2015-2019*	1
2.03	Asthma: Medicare Population	*percent*	5.2	4.8	5	*2018*	6
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.7	0.5		*2020*	19
1.75	Annual Ozone Air Quality		F			*2017-2019*	2
1.75	Physical Environment Ranking	*ranking*	88			*2021*	9
1.75	Severe Housing Problems	*percent*	17.1	13.7	18	*2013-2017*	9
1.67	Farmers Market Density	*markets/ 1,000 population*	0			*2018*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4			*2015*	23
1.64	Number of Extreme Precipitation Days	*days*	34			*2019*	14
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9			*2017*	23

1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.8	1.9		*2020*	19
1.53	Food Environment Index	*index*	7.3	6.8	7.8	*2021*	9
1.50	Children with Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.44	Annual Particle Pollution		B			*2017-2019*	2
1.36	Number of Extreme Heat Days	*days*	12			*2019*	14
1.36	Number of Extreme Heat Events	*events*	6			*2019*	14
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	0			*2020*	14
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.31	Grocery Store Density	*stores/ 1,000 population*	0.2			*2016*	23
1.31	Liquor Store Density	*stores/ 100,000 population*	6.4	5.6	10.5	*2019*	22
1.31	Overcrowded Households	*percent of households*	1.2	1.4		*2015-2019*	1
1.08	PBT Released	*pounds*	234591.7			*2020*	24

1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.50	Access to Exercise Opportunities	*percent*	97.5		83.9	84	*2020*	9

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Adults with Health Insurance: 18+	*percent*	89.8		90.2	90.6	*2021*	8
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1057.6		1098.6	1047.4	*2021*	7
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	199.2		204.8	194.9	*2021*	7
1.50	Adults who Visited a Dentist	*percent*	51.3		51.6	52.9	*2021*	8
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	627.2		638.9	609.6	*2021*	7
1.42	Adults without Health Insurance	*percent*	13			13	*2019*	4
1.39	Persons without Health Insurance	*percent*	5.3		6.6		*2019*	1

1.33	Adults with Health Insurance	*percent*	92.2		90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	97.1		95.2	94.3	*2019*	1
1.33	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4238.3		4371.7	4321.1	*2021*	7
1.25	Adults who have had a Routine Checkup	*percent*	78.2			76.6	*2019*	4
1.25	Clinical Care Ranking		10				*2021*	9
0.61	Primary Care Provider Rate	*providers/ 100,000 population*	112.7		76.7		*2018*	9
0.33	Dentist Rate	*dentists/ 100,000 population*	109.6		64.2		*2019*	9
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	401.4		261.3		*2020*	9
0.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	180.6		108.9		*2020*	9

SCORE	HEART DISEASE & STROKE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.14	Atrial Fibrillation: Medicare Population	*percent*	9		9	8.4	*2018*	6

1.92	Adults who Experienced a Stroke	*percent*	4.2			3.4	*2019*	4
1.69	Heart Failure: Medicare Population	*percent*	15.3		14.7	14	*2018*	6
1.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	107.8	71.1	101.4	90.5	*2017-2019*	5
1.50	High Blood Pressure Prevalence	*percent*	35.4	27.7		32.6	*2019*	4
1.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	36.6	33.4	42.5	37.2	*2017-2019*	5
1.42	Adults who Experienced Coronary Heart Disease	*percent*	7.4			6.2	*2019*	4
1.36	Stroke: Medicare Population	*percent*	3.8		3.8	3.8	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	57.2		59.5	57.2	*2018*	6
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.7			76.2	*2019*	4

1.25	Cholesterol Test History	*percent*	86.3			87.6	*2019*	4
1.00	Hyperlipidemia: Medicare Population	*percent*	45.2		49.4	47.7	*2018*	6
1.00	Ischemic Heart Disease: Medicare Population	*percent*	25.8		27.5	26.8	*2018*	6
0.92	High Cholesterol Prevalence: Adults 18+	*percent*	32.2			33.6	*2019*	4
0.58	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.3		55.4		*2019*	14

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.39	Chlamydia Incidence Rate	*cases/ 100,000 population*	949.5		561.9	551	*2019*	16
2.39	Gonorrhea Incidence Rate	*cases/ 100,000 population*	432.9		224	187.8	*2019*	16
1.61	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.2	1.4	1.1		*2020*	16
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-22*	11
1.31	Overcrowded Households	*percent of households*	1.2		1.4		*2015-2019*	1

1.17	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.6		48.6	49.4	*2021*	8
0.83	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	10	11.1	12.9		*2018*	16
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	62.8				*28-Jan-22*	5
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	11.1		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.6		128.4	177.3	*28-Jan-22*	11

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.11	Babies with Low Birth Weight	*percent*	10.8		8.5	8.2	*2020*	17
2.11	Babies with Very Low Birth Weight	*percent*	1.7		1.4	1.3	*2020*	17
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7
1.78	Infant Mortality Rate	*deaths/ 1,000 live births*	8.6	5	6.9		*2019*	17

SCORE		UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.00	Mothers who Received Early Prenatal Care	*percent*	72.4		68.9	76.1	*2020*	17
0.92	Mothers who Smoked During Pregnancy	*percent*	6.1	4.3	11.5	5.5	*2020*	17
1.67	Preterm Births	*percent*	11.4	9.4	10.3		*2020*	17
1.53	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.2		6.8		*2020*	17
1.58	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	23.9		19.5		*2016*	17

SCORE	MEDICATIONS & PRESCRIPTIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1057.6		1098.6	1047.4	*2021*	7
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	199.2		204.8	194.9	*2021*	7
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	627.2		638.9	609.6	*2021*	7

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

1.42	Adults Ever Diagnosed with Depression	*percent*	20.9			18.8	*2019*	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21		34	30.5	*2017-2019*	5
1.61	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	14	12.8	15.1	14.1	*2017-2019*	5
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.4		10.4	10.8	*2018*	6
1.75	Depression: Medicare Population	*percent*	18.5		20.4	18.4	*2018*	6
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	401.4		261.3		*2020*	9
1.75	Poor Mental Health: 14+ Days	*percent*	16			13.6	*2019*	4
1.83	Poor Mental Health: Average Number of Days	*days*	5		4.8	4.1	*2018*	9
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8

SCORE	NUTRITION & HEALTHY EATING	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

SCORE		UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.67	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	838.8		864.6	1002.1	*2021*	7
1.50	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	502.1		519	530.2	*2021*	7
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.1		41.5	41.2	*2021*	8
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1415.1		1461	1638.9	*2021*	7
1.17	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	310.6		319.7	357	*2021*	7
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6		80.9	80.4	*2021*	8

SCORE	OLDER ADULT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	*percent*	34.8		28.8	26.1	*2015-2019*	1
2.47	People 65+ Living Below Poverty Level	*percent*	10.9		8.1	9.3	*2015-2019*	1

2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.6	10.5	9.5	*2017-2019*	5
2.31	Cancer: Medicare Population	*percent*	9	8.4	8.4	*2018*	6
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.4	10.4	10.8	*2018*	6
2.14	Atrial Fibrillation: Medicare Population	*percent*	9	9	8.4	*2018*	6
2.08	Osteoporosis: Medicare Population	*percent*	6.3	6.2	6.6	*2018*	6
2.03	Asthma: Medicare Population	*percent*	5.2	4.8	5	*2018*	6
1.92	Chronic Kidney Disease: Medicare Population	*percent*	25.2	25.3	24.5	*2018*	6
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4	36.1	33.5	*2018*	6
1.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	28.6		28.4	*2018*	4

1.75	Depression: Medicare Population	*percent*	18.5		20.4	18.4	*2018*	6
1.69	Heart Failure: Medicare Population	*percent*	15.3		14.7	14	*2018*	6
1.67	Colon Cancer Screening	*percent*	63.7	74.4		66.4	*2018*	4
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4				*2015*	23
1.58	Adults 65+ with Total Tooth Loss	*percent*	15.5			13.5	*2018*	4
1.42	Adults with Arthritis	*percent*	29.3			25.1	*2019*	4
1.36	Stroke: Medicare Population	*percent*	3.8		3.8	3.8	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	57.2		59.5	57.2	*2018*	6
1.14	Diabetes: Medicare Population	*percent*	25.3		27.2	27	*2018*	6
1.00	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	20.8		20.5	34.3	*2021*	7
1.00	Hyperlipidemia: Medicare Population	*percent*	45.2		49.4	47.7	*2018*	6

1.00	Ischemic Heart Disease: Medicare Population	*percent*	25.8		27.5	26.8	*2018*	6
0.97	COPD: Medicare Population	*percent*	11.2		13.2	11.5	*2018*	6
0.92	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	34.5			32.4	*2018*	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21		34	30.5	*2017-2019*	5

SCORE	ORAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.58	Adults 65+ with Total Tooth Loss	*percent*	15.5			13.5	*2018*	4
1.50	Adults who Visited a Dentist	*percent*	51.3		51.6	52.9	*2021*	8
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.2	11.9	*2014-2018*	12
0.33	Dentist Rate	*dentists/ 100,000 population*	109.6		64.2		*2019*	9

SCORE	OTHER CONDITIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.08	Osteoporosis: Medicare Population	*percent*	6.3		6.2	6.6	*2018*	6
1.92	Adults with Kidney Disease	*Percent of adults*	3.6			3.1	*2019*	4
1.92	Chronic Kidney Disease: Medicare Population	*percent*	25.2		25.3	24.5	*2018*	6
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4		36.1	33.5	*2018*	6
1.69	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	15.2		14.5	12.9	*2017-2019*	5
1.42	Adults with Arthritis	*percent*	29.3			25.1	*2019*	4

SCORE	PHYSICAL ACTIVITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.22	Adults 20+ who are Obese	*percent*	34.2	36			*2019*	5
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
1.67	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4				*2015*	23

1.64	Adults 20+ who are Sedentary	*percent*	25.1			*2019*	5
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9			*2017*	23
1.53	Food Environment Index	*index*	7.3	6.8	7.8	*2021*	9
1.50	Children with Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.42	Health Behaviors Ranking	*ranking*	31			*2021*	9
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.31	Grocery Store Density	*stores/ 1,000 population*	0.2			*2016*	23
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3			*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1			*2016*	23
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6	80.9	80.4	*2021*	8

0.69	Workers who Walk to Work	*percent*	2.7		2.2	2.7	*2015-2019*	1
0.50	Access to Exercise Opportunities	*percent*	97.5		83.9	84	*2020*	9

SCORE	PREVENTION & SAFETY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.6		10.5	9.5	*2017-2019*	5
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.6		2.8	2.5	*2015-2019*	5
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.7	43.2	68.8	48.9	*2017-2019*	5
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42		40.2	21.4	*2017-2019*	5
2.64	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.6		38.1	21	*2017-2019*	9
1.75	Severe Housing Problems	*percent*	17.1		13.7	18	*2013-2017*	9

SCORE	RESPIRATORY DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.25	Adults with Current Asthma	*percent*	11			8.9	*2019*	4

2.03	Asthma: Medicare Population	*percent*	5.2		4.8	5	*2018*	6
2.00	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	485.5		487.9	422.4	*2021*	7
1.61	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.2	1.4	1.1		*2020*	16
1.58	Adults with COPD	*Percent of adults*	8.6			6.6	*2019*	4
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-22*	11
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	42.9	25.1	45	36.7	*2015-2019*	12
1.42	Adults who Smoke	*percent*	20.9	5	21.4	17	*2018*	9
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		67.3	57.3	*2014-2018*	12
0.97	COPD: Medicare Population	*percent*	11.2		13.2	11.5	*2018*	6
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4		4.3	4.1	*2021*	8
0.81	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	38.4		47.8	39.6	*2017-2019*	5

SCORE		UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.2		2.2	2	*2021*	8
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	11.1		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.6		128.4	177.3	*28-Jan-22*	11

SCORE	TOBACCO USE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	485.5		487.9	422.4	*2021*	7
1.42	Adults who Smoke	*percent*	20.9	5	21.4	17	*2018*	9
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4		4.3	4.1	*2021*	8
0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.2		2.2	2	*2021*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Insufficient Sleep	*percent*	44.9	31.4	40.6	35	*2018*	9

1.75	Morbidity Ranking	*ranking*	76				*2021*	9
1.67	Poor Physical Health: Average Number of Days	*days*	4.2		4.1	3.7	*2018*	9
1.58	Poor Physical Health: 14+ Days	*percent*	14.3			12.5	*2019*	4
1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.1			18.6	*2019*	4
1.50	High Blood Pressure Prevalence	*percent*	35.4	27.7		32.6	*2019*	4
1.50	Life Expectancy	*years*	77		77	79.2	*2017-2019*	9
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.1		41.5	41.2	*2021*	8
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1415.1		1461	1638.9	*2021*	7
1.17	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.6		48.6	49.4	*2021*	8
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8

0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6		80.9	80.4	*2021*	8

SCORE	WOMEN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.8		129.6	126.8	*2014-2018*	12
2.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.6	15.3	21.6	19.9	*2015-2019*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	75.2	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.3	84.3		84.7	*2018*	4
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.4		7.9	7.7	*2014-2018*	12

Cuyahoga Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles

9 County Health Rankings
10 Feeding America
11 Healthy Communities Institute
12 National Cancer Institute
13 National Center for Education Statistics
14 National Environmental Public Health Tracking Network
15 Ohio Department of Education
16 Ohio Department of Health, Infectious Diseases
17 Ohio Department of Health, Vital Statistics
18 Ohio Department of Public Safety, Office of Criminal Justice Services
19 Ohio Public Health Information Warehouse
20 Ohio Secretary of State
21 U.S. Bureau of Labor Statistics
22 U.S. Census - County Business Patterns
23 U.S. Department of Agriculture - Food Environment Atlas
24 U.S. Environmental Protection Agency
25 United For ALICE

SCORE	ALCOHOL & DRUG USE	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	39.7	28.3	32.2	27	*2015-2019*	9
2.31	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	38.4		38.1	21	*2017-2019*	9
2.00	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	679.4		651.5	701.9	*2021*	7
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	44.3		42	22.8	*2017-2019*	5
1.42	Adults who Binge Drink	*percent*	16.2			16.7	*2019*	4
1.42	Health Behaviors Ranking	*ranking*	25				*2021*	9
1.42	Mothers who Smoked During Pregnancy	*percent*	12.6	4.3	11.5	5.5	*2020*	17
1.19	Liquor Store Density	*stores/ 100,000 population*	7.1		5.6	10.5	*2019*	22
1.17	Adults who Drink Excessively	*percent*	18		18.5	19	*2018*	9

SCORE	CANCER	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.8		129.6	126.8	*2014-2018*	12
2.31	Cancer: Medicare Population	*percent*	8.9		8.4	8.4	*2018*	6
2.25	All Cancer Incidence Rate	*cases/ 100,000 population*	475.8		467.5	448.6	*2014-2018*	12
2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.2	15.3	21.6	19.9	*2015-2019*	12
2.22	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	9.2		7.9	7.7	*2014-2018*	12
2.00	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	115.9		107.2	106.2	*2014-2018*	12
1.78	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	45.4	25.1	45	36.7	*2015-2019*	12
1.61	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	167.8	122.7	169.4	152.4	*2015-2019*	12
1.50	Colon Cancer Screening	*percent*	64.5	74.4		66.4	*2018*	4
1.39	Cervical Cancer Screening: 21-65	*Percent*	84.3	84.3		84.7	*2018*	4
1.25	Adults with Cancer	*percent*	7.7			7.1	*2019*	4

1.11	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	13.8	8.9	14.8	13.4	*2015-2019*	12
1.08	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	65.8		67.3	57.3	*2014-2018*	12
1.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	17.5	16.9	19.4	18.9	*2015-2019*	12
0.97	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.2		12.2	11.9	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.9	77.1		74.8	*2018*	4
0.75	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	39.1		41.3	38	*2014-2018*	12

SCORE	CHILDREN'S HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	336.9		301.6	368.2	*2021*	7
1.83	Children with Low Access to a Grocery Store	*percent*	6.7				*2015*	23
1.56	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.1	8.7	6.8		*2020*	3

1.50	Child Food Insecurity Rate	*percent*	17.1		17.4	14.6	*2019*	10
1.42	Projected Child Food Insecurity Rate	*percent*	18.7		18.5		*2021*	10
1.33	Children with Health Insurance	*percent*	96.1		95.2	94.3	*2019*	1
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.4		1.9		*2020*	19

SCORE	COMMUNITY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	39.7	28.3	32.2	27	*2015-2019*	9
2.25	Social Associations	*membership associations/ 10,000 population*	9.5		11	9.3	*2018*	9
2.19	Single-Parent Households	*percent*	29.4		27.1	25.5	*2015-2019*	1
2.19	Youth not in School or Working	*percent*	2.6		1.8	1.9	*2015-2019*	1

2.17	Young Children Living Below Poverty Level	*percent*	27.6		23	20.3	*2015-2019*	1
1.97	Workers who Walk to Work	*percent*	2		2.2	2.7	*2015-2019*	1
1.81	Mean Travel Time to Work	*minutes*	24.6		23.7	26.9	*2015-2019*	1
1.81	People 65+ Living Alone	*percent*	27.5		28.8	26.1	*2015-2019*	1
1.69	Solo Drivers with a Long Commute	*percent*	35.6		31.1	37	*2015-2019*	9
1.69	Voter Turnout: Presidential Election	*percent*	72.6		74		*2020*	20
1.58	Children Living Below Poverty Level	*percent*	20.6		19.9	18.5	*2015-2019*	1
1.58	Social and Economic Factors Ranking	*ranking*	49				*2021*	9
1.56	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.1	8.7	6.8		*2020*	3
1.53	Linguistic Isolation	*percent*	1.5		1.4	4.4	*2015-2019*	1
1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.7		2.8	2.5	*2015-2019*	5

1.50	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	121.5		121.7	148.8	*2021*	7
1.50	Households with a Smartphone	*percent*	80.1		80.5	81.9	*2021*	8
1.50	Households with an Internet Subscription	*percent*	80.8		82.4	83	*2015-2019*	1
1.50	Persons with an Internet Subscription	*percent*	84.5		86.2	86.2	*2015-2019*	1
1.44	People Living Below Poverty Level	*percent*	13.5	8	14	13.4	*2015-2019*	1
1.44	Workers Commuting by Public Transportation	*percent*	0.7	5.3	1.6	5	*2015-2019*	1
1.39	Violent Crime Rate	*crimes/ 100,000 population*	242		303.5	394	*2017*	18
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.1				*2015*	23
1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	24.9		28.3	32.1	*2015-2019*	1

1.25	Workers who Drive Alone to Work	*percent*	83.3		82.9	76.3	*2015-2019*	1
1.17	Adults with Internet Access	*percent*	94.5		94.5	95	*2021*	8
1.17	Households with a Computer	*percent*	85.5		85.2	86.3	*2021*	8
1.17	Households with Wireless Phone Service	*percent*	96.6		96.8	97	*2020*	8
1.08	Per Capita Income	*dollars*	30928		31552	34103	*2015-2019*	1
0.92	Median Household Income	*dollars*	58427		56602	62843	*2015-2019*	1
0.83	Households with One or More Types of Computing Devices	*percent*	90.4		89.1	90.3	*2015-2019*	1
0.75	Households without a Vehicle	*percent*	6.8		7.9	8.6	*2015-2019*	1
0.25	Homeownership	*percent*	66.3		59.4	56.2	*2015-2019*	1

SCORE	DIABETES	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Adults 20+ with Diabetes	*percent*	11.5				*2019*	5

SCORE		UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.14	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	21.6		25.3	21.5	*2017-2019*	5
0.86	Diabetes: Medicare Population	*percent*	26.3		27.2	27	*2018*	6

SCORE	ECONOMY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Households with Cash Public Assistance Income	*percent*	3.2		2.9	2.4	*2015-2019*	1
2.33	Renters Spending 30% or More of Household Income on Rent	*percent*	49.9		44.9	49.6	*2015-2019*	1
2.19	Youth not in School or Working	*percent*	2.6		1.8	1.9	*2015-2019*	1
2.17	Young Children Living Below Poverty Level	*percent*	27.6		23	20.3	*2015-2019*	1
2.00	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	8253.1		7828	8900.1	*2021*	7
1.69	Families Living Below Poverty Level	*percent*	10		9.9	9.5	*2015-2019*	1

1.67	Households that are Below the Federal Poverty Level	*percent*	14.2	13.8		*2018*	25
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.9			*2015*	23
1.64	Income Inequality		0.5	0.5	0.5	*2015-2019*	1
1.64	Size of Labor Force	*persons*	148191			*44470*	21
1.58	Children Living Below Poverty Level	*percent*	20.6	19.9	18.5	*2015-2019*	1
1.58	Social and Economic Factors Ranking	*ranking*	49			*2021*	9
1.53	Persons with Disability Living in Poverty (5-year)	*percent*	28.2	29.5	26.1	*2015-2019*	1
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7			*2017*	23
1.50	Child Food Insecurity Rate	*percent*	17.1	17.4	14.6	*2019*	10
1.50	Food Insecurity Rate	*percent*	12.4	13.2	10.9	*2019*	10
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23

1.44	People Living Below Poverty Level	*percent*	13.5	8	14	13.4	*2015-2019*	1
1.42	Projected Child Food Insecurity Rate	*percent*	18.7		18.5		*2021*	10
1.33	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	63.7		61.6		*2018*	25
1.25	Projected Food Insecurity Rate	*percent*	13.5		14.1		*2021*	10
1.17	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.1		14.6	14.4	*2021*	8
1.17	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	22.1		24.5		*2018*	25
1.08	Per Capita Income	*dollars*	30928		31552	34103	*2015-2019*	1
1.00	Households with a Savings Account	*percent*	69.6		68.8	70.2	*2021*	8
0.92	Median Household Income	*dollars*	58427		56602	62843	*2015-2019*	1

0.86	Overcrowded Households	*percent of households*	0.9	1.4		*2015-2019*	1
0.75	People Living 200% Above Poverty Level	*percent*	71.2	68.8	69.1	*2015-2019*	1
0.75	Severe Housing Problems	*percent*	12.8	13.7	18	*2013-2017*	9
0.75	Students Eligible for the Free Lunch Program	*percent*	20.4			*2019-2020*	13
0.75	Unemployed Workers in Civilian Labor Force	*percent*	3.6	3.8	4.3	*Oct-21*	21
0.67	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3419.6	3798.7	5460.2	*2021*	7
0.53	People 65+ Living Below Poverty Level	*percent*	7	8.1	9.3	*2015-2019*	1
0.50	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.6	19.7	26.5	*2019*	1
0.25	Homeownership	*percent*	66.3	59.4	56.2	*2015-2019*	1

SCORE	EDUCATION	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	336.9		301.6	368.2	*2021*	7
1.97	4th Grade Students Proficient in Math	*percent*	55.6		59.4		*2020-2021*	15
1.83	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1217.2		1200.4	1492.4	*2021*	7
1.81	4th Grade Students Proficient in English/Language Arts	*percent*	55.3		56		*2020-2021*	15
1.69	Student-to-Teacher Ratio	*students/ teacher*	17.1				*2019-2020*	13
1.67	8th Grade Students Proficient in Math	*percent*	39.8		42.6		*2020-2021*	15
1.50	8th Grade Students Proficient in English/Language Arts	*percent*	53.5		52.7		*2020-2021*	15
1.50	High School Graduation	*percent*	91.5	90.7	92		*2019-2020*	15

SCORE		UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	24.9		28.3	32.1	*2015-2019*	1

SCORE	ENVIRONMENTAL HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Children with Low Access to a Grocery Store	*percent*	6.7				*2015*	23
1.83	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4				*2015*	23
1.75	Adults with Current Asthma	*percent*	10.2			8.9	*2019*	4
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.9				*2015*	23
1.64	Food Environment Index	*index*	7.5		6.8	7.8	*2021*	9
1.64	Number of Extreme Heat Events	*events*	10				*2019*	14
1.64	Number of Extreme Precipitation Days	*days*	36				*2019*	14

1.64	PBT Released	*pounds*	18388.7	*2020*	24
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7	*2017*	23
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2	*2016*	23
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1	*2016*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1	*2016*	23
1.42	Annual Ozone Air Quality		B	*2017-2019*	2
1.36	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.6	*2016*	23
1.36	Number of Extreme Heat Days	*days*	15	*2019*	14
1.36	Recognized Carcinogens Released into Air	*pounds*	5610.5	*2020*	24
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	0	*2020*	14
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.1	*2015*	23
1.25	Annual Particle Pollution		A	*2017-2019*	2

1.25	Physical Environment Ranking	*ranking*	3				*2021*	9
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
1.19	Houses Built Prior to 1950	*percent*	21.7		26.2	17.5	*2015-2019*	1
1.19	Liquor Store Density	*stores/ 100,000 population*	7.1		5.6	10.5	*2019*	22
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.4		1.9		*2020*	19
0.86	Overcrowded Households	*percent of households*	0.9		1.4		*2015-2019*	1
0.83	Access to Exercise Opportunities	*percent*	90.9		83.9	84	*2020*	9
0.75	Severe Housing Problems	*percent*	12.8		13.7	18	*2013-2017*	9

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1181.4	1098.6	1047.4	*2021*	7
2.33	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	217.8	204.8	194.9	*2021*	7
2.33	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	687.1	638.9	609.6	*2021*	7
2.17	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4676.2	4371.7	4321.1	*2021*	7
1.75	Adults without Health Insurance	*percent*	13.7		13	*2019*	4
1.72	Primary Care Provider Rate	*providers/ 100,000 population*	54.6	76.7		*2018*	9
1.56	Persons without Health Insurance	*percent*	6.1	6.6		*2019*	1
1.42	Clinical Care Ranking	*ranking*	40			*2021*	9
1.33	Adults with Health Insurance	*percent*	91	90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	96.1	95.2	94.3	*2019*	1

1.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	66.2		108.9		*2020*	9
1.25	Adults who have had a Routine Checkup	*percent*	78.4			76.6	*2019*	4
1.17	Dentist Rate	*dentists/ 100,000 population*	51		64.2		*2019*	9
1.17	Mental Health Provider Rate	*providers/ 100,000 population*	177.8		261.3		*2020*	9
1.00	Adults who Visited a Dentist	*percent*	52.9		51.6	52.9	*2021*	8
1.00	Adults with Health Insurance: 18+	*percent*	90.9		90.2	90.6	*2021*	8

SCORE	HEART DISEASE & STROKE	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Atrial Fibrillation: Medicare Population	*percent*	10.2		9	8.4	*2018*	6
2.64	Stroke: Medicare Population	*percent*	4.7		3.8	3.8	*2018*	6
2.47	Hyperlipidemia: Medicare Population	*percent*	53.1		49.4	47.7	*2018*	6

2.19	Ischemic Heart Disease: Medicare Population	*percent*	30.6		27.5	26.8	*2018*	6
2.00	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40	33.4	42.5	37.2	*2017-2019*	5
1.97	Hypertension: Medicare Population	*percent*	61.2		59.5	57.2	*2018*	6
1.75	Heart Failure: Medicare Population	*percent*	14.2		14.7	14	*2018*	6
1.58	Adults who Experienced a Stroke	*percent*	3.8			3.4	*2019*	4
1.58	Adults who Experienced Coronary Heart Disease	*percent*	7.6			6.2	*2019*	4
1.58	Adults who Have Taken Medications for High Blood Pressure	*percent*	77.9			76.2	*2019*	4
1.50	High Blood Pressure Prevalence	*percent*	35.1	27.7		32.6	*2019*	4

1.42	Cholesterol Test History	*percent*	85.3			87.6	*2019*	4
1.08	High Cholesterol Prevalence: Adults 18+	*percent*	32.6			33.6	*2019*	4
0.58	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	41.8		55.4		*2019*	14
0.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	82.1	71.1	101.4	90.5	*2017-2019*	5

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.92	Gonorrhea Incidence Rate	*cases/ 100,000 population*	227.2		262.6		*2020*	16
1.92	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	17.4	11.1	13.7		*2019*	16
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.3		0.3	1.6	*4-Feb-22*	11
1.36	Chlamydia Incidence Rate	*cases/ 100,000 population*	437		504.8		*2020*	16
1.28	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.6	1.4	1.1		*2020*	16

1.03	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.5		14.4	13.8	*2017-2019*	5
1.00	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.2		48.6	49.4	*2021*	8
0.86	Overcrowded Households	*percent of households*	0.9		1.4		*2015-2019*	1
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	62.1				*4-Feb-22*	5
0.53	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	27.6		36.7	67.6	*4-Feb-22*	11

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	336.9		301.6	368.2	*2021*	7
2.06	Babies with Very Low Birth Weight	*percent*	1.5		1.4	1.3	*2020*	17
2.06	Mothers who Received Early Prenatal Care	*percent*	67		68.9	76.1	*2020*	17

1.89	Preterm Births	*percent*	10.5	9.4	10.3		*2020*	17
1.75	Babies with Low Birth Weight	*percent*	9		8.5	8.2	*2020*	17
1.53	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	6.9		6.8		*2020*	17
1.42	Mothers who Smoked During Pregnancy	*percent*	12.6	4.3	11.5	5.5	*2020*	17
1.25	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	19.9		19.5		*2016*	17
1.08	Infant Mortality Rate	*deaths/ 1,000 live births*	4.3	5	6.9		*2019*	17

SCORE	MEDICATIONS & PRESCRIPTIONS	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1181.4		1098.6	1047.4	*2021*	7
2.33	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	217.8		204.8	194.9	*2021*	7
2.33	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	687.1		638.9	609.6	*2021*	7

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.67	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	17.5	12.8	15.1	14.1	*2017-2019*	5
1.92	Depression: Medicare Population	*percent*	19.9		20.4	18.4	*2018*	6
1.67	Poor Mental Health: Average Number of Days	*days*	4.8		4.8	4.1	*2018*	9
1.64	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.4		10.4	10.8	*2018*	6
1.58	Poor Mental Health: 14+ Days	*percent*	15.7			13.6	*2019*	4
1.25	Adults Ever Diagnosed with Depression	*percent*	20.3			18.8	*2019*	4
1.17	Mental Health Provider Rate	*providers/ 100,000 population*	177.8		261.3		*2020*	9
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8

SCORE		UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
0.42	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	28.8		34	30.5	*2017-2019*	5

SCORE	NUTRITION & HEALTHY EATING	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	548.3		519	530.2	*2021*	7
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1521.4		1461	1638.9	*2021*	7
1.83	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	330.4		319.7	357	*2021*	7
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.9		41.5	41.2	*2021*	8
1.17	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	905.9		864.6	1002.1	*2021*	7

SCORE		UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.7		80.9	80.4	*2021*	8

SCORE	OLDER ADULT HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.5		10.5	9.5	*2017-2019*	5
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	38.4		36.1	33.5	*2018*	6
2.64	Atrial Fibrillation: Medicare Population	*percent*	10.2		9	8.4	*2018*	6
2.64	Stroke: Medicare Population	*percent*	4.7		3.8	3.8	*2018*	6
2.58	Osteoporosis: Medicare Population	*percent*	6.8		6.2	6.6	*2018*	6
2.47	Hyperlipidemia: Medicare Population	*percent*	53.1		49.4	47.7	*2018*	6

2.31	Cancer: Medicare Population	*percent*	8.9	8.4	8.4	*2018*	6
2.25	Chronic Kidney Disease: Medicare Population	*percent*	25.8	25.3	24.5	*2018*	6
2.19	Ischemic Heart Disease: Medicare Population	*percent*	30.6	27.5	26.8	*2018*	6
2.00	COPD: Medicare Population	*percent*	14.5	13.2	11.5	*2018*	6
1.97	Hypertension: Medicare Population	*percent*	61.2	59.5	57.2	*2018*	6
1.92	Depression: Medicare Population	*percent*	19.9	20.4	18.4	*2018*	6
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4			*2015*	23
1.81	People 65+ Living Alone	*percent*	27.5	28.8	26.1	*2015-2019*	1
1.75	Adults with Arthritis	*percent*	31.1		25.1	*2019*	4
1.75	Heart Failure: Medicare Population	*percent*	14.2	14.7	14	*2018*	6

1.64	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.4		10.4	10.8	*2018*	6
1.50	Colon Cancer Screening	*percent*	64.5	74.4		66.4	*2018*	4
1.42	Adults 65+ with Total Tooth Loss	*percent*	15.2			13.5	*2018*	4
1.33	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	21.9		20.5	34.3	*2021*	7
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
0.86	Diabetes: Medicare Population	*percent*	26.3		27.2	27	*2018*	6
0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	33.6			28.4	*2018*	4
0.75	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	36			32.4	*2018*	4

SCORE		UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
0.53	People 65+ Living Below Poverty Level	*percent*	7		8.1	9.3	*2015-2019*	1
0.42	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	28.8		34	30.5	*2017-2019*	5

SCORE	ORAL HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.42	Adults 65+ with Total Tooth Loss	*percent*	15.2			13.5	*2018*	4
1.17	Dentist Rate	*dentists/ 100,000 population*	51		64.2		*2019*	9
1.00	Adults who Visited a Dentist	*percent*	52.9		51.6	52.9	*2021*	8
0.97	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.2		12.2	11.9	*2014-2018*	12

SCORE	OTHER CONDITIONS	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	38.4		36.1	33.5	*2018*	6

2.58	Osteoporosis: Medicare Population	*percent*	6.8		6.2	6.6	*2018*	6
2.25	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	15.6		14.5	12.9	*2017-2019*	5
2.25	Chronic Kidney Disease: Medicare Population	*percent*	25.8		25.3	24.5	*2018*	6
1.75	Adults with Arthritis	*percent*	31.1			25.1	*2019*	4
1.42	Adults with Kidney Disease	*Percent of adults*	3.3			3.1	*2019*	4

SCORE	PHYSICAL ACTIVITY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.03	Adults 20+ who are Obese	*percent*	36.6	36			*2019*	5
1.97	Workers who Walk to Work	*percent*	2		2.2	2.7	*2015-2019*	1
1.83	Children with Low Access to a Grocery Store	*percent*	6.7				*2015*	23
1.83	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23

1.83	People 65+ with Low Access to a Grocery Store	*percent*	4			*2015*	23
1.69	Adults 20+ who are Sedentary	*percent*	25.7			*2019*	5
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.9			*2015*	23
1.64	Food Environment Index	*index*	7.5	6.8	7.8	*2021*	9
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7			*2017*	23
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2			*2016*	23
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1			*2016*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.42	Health Behaviors Ranking		25			*2021*	9
1.36	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.6			*2016*	23
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.1			*2015*	23

SCORE		UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.7		80.9	80.4	*2021*	8
0.83	Access to Exercise Opportunities	*percent*	90.9		83.9	84	*2020*	9

SCORE	PREVENTION & SAFETY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.5		10.5	9.5	*2017-2019*	5
2.39	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	71.1	43.2	68.8	48.9	*2017-2019*	5
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	41.2		40.2	21.4	*2017-2019*	5
2.31	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	38.4		38.1	21	*2017-2019*	9
1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.7		2.8	2.5	*2015-2019*	5

0.75	Severe Housing Problems	*percent*	12.8		13.7	18	*2013-2017*	9

SCORE	RESPIRATORY DISEASES	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.03	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	56.2		47.8	39.6	*2017-2019*	5
2.00	COPD: Medicare Population	*percent*	14.5		13.2	11.5	*2018*	6
1.78	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	45.4	25.1	45	36.7	*2015-2019*	12
1.75	Adults with COPD	*Percent of adults*	9.2			6.6	*2019*	4
1.75	Adults with Current Asthma	*percent*	10.2			8.9	*2019*	4
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	474.5		487.9	422.4	*2021*	7
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.3		0.3	1.6	*4-Feb-22*	11
1.42	Adults who Smoke	*percent*	20.7	5	21.4	17	*2018*	9

1.28	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.6	1.4	1.1		*2020*	16
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
1.08	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	65.8		67.3	57.3	*2014-2018*	12
1.03	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.5		14.4	13.8	*2017-2019*	5
1.00	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.1		2.2	2	*2021*	8
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.9		4.3	4.1	*2021*	8
0.53	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	27.6		36.7	67.6	*4-Feb-22*	11

SCORE	TOBACCO USE	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

SCORE		UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	474.5		487.9	422.4	*2021*	7
1.42	Adults who Smoke	*percent*	20.7	5	21.4	17	*2018*	9
1.00	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.1		2.2	2	*2021*	8
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.9		4.3	4.1	*2021*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1521.4		1461	1638.9	*2021*	7
1.75	Insufficient Sleep	*percent*	39.3	31.4	40.6	35	*2018*	9
1.67	Poor Physical Health: Average Number of Days	*days*	4.2		4.1	3.7	*2018*	9
1.58	Poor Physical Health: 14+ Days	*percent*	14.4			12.5	*2019*	4

1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.1			18.6	*2019*	4
1.50	High Blood Pressure Prevalence	*percent*	35.1	27.7		32.6	*2019*	4
1.42	Morbidity Ranking	*ranking*	40				*2021*	9
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.9		41.5	41.2	*2021*	8
1.33	Life Expectancy	*years*	77.7		77	79.2	*2017-2019*	9
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.7		80.9	80.4	*2021*	8
1.00	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.2		48.6	49.4	*2021*	8
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8

SCORE	WOMEN'S HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.8		129.6	126.8	*2014-2018*	12
2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.2	15.3	21.6	19.9	*2015-2019*	12
2.22	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	9.2		7.9	7.7	*2014-2018*	12
1.39	Cervical Cancer Screening: 21-65	*Percent*	84.3	84.3		84.7	*2018*	4
0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.9	77.1		74.8	*2018*	4

Lorain County Data Sources

Key	Data Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
12	National Cancer Institute

13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

SCORE	ALCOHOL & DRUG USE	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	34.9		38.1	21	*2017-2019*	8
2.03	Mothers who Smoked During Pregnancy	*percent*	16.6	4.3	11.5	5.5	*2020*	16
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	45.4		42	22.8	*2017-2019*	4
1.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	27.1	28.3	32.2	27	*2015-2019*	8
1.42	Health Behaviors Ranking	*ranking*	28				*2021*	8
1.17	Adults who Drink Excessively	*percent*	17.8		18.5	19	*2018*	8
1.00	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	572		651.5	701.9	*2021*	6
0.92	Adults who Binge Drink	*percent*	15			16.7	*2019*	3

0.53	Liquor Store Density	*stores/ 100,000 population*	5.4		5.6	10.5	*2019*	21

SCORE	CANCER	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Cancer: Medicare Population	*percent*	9.6		8.4	8.4	*2018*	5
2.47	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.4		12.2	11.9	*2014-2018*	11
2.44	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	18.9	8.9	14.8	13.4	*2015-2019*	11
2.25	Adults with Cancer	*percent*	8.8			7.1	*2019*	3
2.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	20.5	16.9	19.4	18.9	*2015-2019*	11
2.03	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	46.2		41.3	38	*2014-2018*	11
2.00	Colon Cancer Screening	*percent*	61.1	74.4		66.4	*2018*	3
1.94	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.3	15.3	21.6	19.9	*2015-2019*	11
1.69	All Cancer Incidence Rate	*cases/ 100,000 population*	478.8		467.5	448.6	*2014-2018*	11
1.61	Mammogram in Past 2 Years: 50-74	*percent*	72.3	77.1		74.8	*2018*	3
1.47	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.8		67.3	57.3	*2014-2018*	11
1.17	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7.7		7.4	7.5	*2010-2014*	11
1.11	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	165.3	122.7	169.4	152.4	*2015-2019*	11
1.11	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	40.5	25.1	45	36.7	*2015-2019*	11
1.03	Breast Cancer Incidence Rate	*cases/ 100,000 females*	119.4		129.6	126.8	*2014-2018*	11
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.4	84.3		84.7	*2018*	3
0.69	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	90.6		107.2	106.2	*2014-2018*	11

SCORE	CHILDREN'S HEALTH	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.9		0.5		*2020*	18
2.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	3.2		1.9		*2020*	18
2.00	Child Food Insecurity Rate	*percent*	18		17.4	14.6	*2019*	9
1.92	Projected Child Food Insecurity Rate	*percent*	20.6		18.5		*2021*	9
1.83	Children with Low Access to a Grocery Store	*percent*	6.2				*2015*	22
1.56	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.1	8.7	6.8		*2020*	2
1.33	Children with Health Insurance	*percent*	95.5		95.2	94.3	*2019*	1
0.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	196.2		301.6	368.2	*2021*	6

SCORE	COMMUNITY	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Workers who Drive Alone to Work	*percent*	85.4		82.9	76.3	*2015-2019*	1
2.50	Single-Parent Households	*percent*	30.3		27.1	25.5	*2015-2019*	1
2.47	Workers who Walk to Work	*percent*	1.3		2.2	2.7	*2015-2019*	1
2.25	Homeownership	*percent*	57		59.4	56.2	*2015-2019*	1
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	4.1		2.8	2.5	*2013-2017*	4
1.67	Adults with Internet Access	*percent*	93		94.5	95	*2021*	7
1.67	Households with a Computer	*percent*	83.1		85.2	86.3	*2021*	7
1.67	Households with a Smartphone	*percent*	76.5		80.5	81.9	*2021*	7
1.67	Households with Wireless Phone Service	*percent*	96		96.8	97	*2020*	7
1.58	Social and Economic Factors Ranking	*ranking*	46				*2021*	8
1.58	Youth not in School or Working	*percent*	2		1.8	1.9	*2015-2019*	1

1.56	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.1	8.7	6.8		*2020*	2
1.50	Households with an Internet Subscription	*percent*	81.1		82.4	83	*2015-2019*	1
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.8				*2015*	22
1.50	Persons with an Internet Subscription	*percent*	85		86.2	86.2	*2015-2019*	1
1.47	Voter Turnout: Presidential Election	*percent*	75.3		74		*2020*	19
1.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	27.1	28.3	32.2	27	*2015-2019*	8
1.44	Workers Commuting by Public Transportation	*percent*	1.1	5.3	1.6	5	*2015-2019*	1
1.42	People 25+ with a Bachelor's Degree or Higher	*percent*	23.2		28.3	32.1	*2015-2019*	1
1.36	Young Children Living Below Poverty Level	*percent*	22		23	20.3	*2015-2019*	1
1.33	Households with One or More Types of Computing Devices	*percent*	89.2		89.1	90.3	*2015-2019*	1
1.25	Median Household Income	*dollars*	54226		56602	62843	*2015-2019*	1
1.25	Social Associations	*membership associations/ 10,000 population*	12.6		11	9.3	*2018*	8
0.97	Linguistic Isolation	*percent*	0.5		1.4	4.4	*2015-2019*	1
0.86	Children Living Below Poverty Level	*percent*	17.9		19.9	18.5	*2015-2019*	1
0.86	Households without a Vehicle	*percent*	6.3		7.9	8.6	*2015-2019*	1
0.83	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	107.5		121.7	148.8	*2021*	6
0.81	Mean Travel Time to Work	*minutes*	21.1		23.7	26.9	*2015-2019*	1
0.78	People Living Below Poverty Level	*percent*	11.7	8	14	13.4	*2015-2019*	1
0.78	Violent Crime Rate	*crimes/ 100,000 population*	117.8		303.5	394	*2017*	17
0.75	People 65+ Living Alone	*percent*	26		28.8	26.1	*2015-2019*	1

SCORE		UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
0.58	Per Capita Income	*dollars*	32790		31552	34103	*2015-2019*	1
0.08	Solo Drivers with a Long Commute	*percent*	21.1		31.1	37	*2015-2019*	8

SCORE	DIABETES	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.97	Adults 20+ with Diabetes	*percent*	10.1				*2019*	4
1.69	Diabetes: Medicare Population	*percent*	28.2		27.2	27	*2018*	5
1.53	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	24.9		25.3	21.5	*2017-2019*	4

SCORE	ECONOMY	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.25	Homeownership	*percent*	57		59.4	56.2	*2015-2019*	1
2.00	Child Food Insecurity Rate	*percent*	18		17.4	14.6	*2019*	9
2.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	29.5		24.5		*2018*	24
1.92	Projected Child Food Insecurity Rate	*percent*	20.6		18.5		*2021*	9
1.92	Unemployed Workers in Civilian Labor Force	*percent*	4.5		3.8	4.3	*October, 2021*	20
1.83	Income Inequality		0.5		0.5	0.5	*2015-2019*	1
1.83	Low-Income and Low Access to a Grocery Store	*percent*	9.1				*2015*	22
1.75	Projected Food Insecurity Rate	*percent*	14.6		14.1		*2021*	9
1.67	Food Insecurity Rate	*percent*	13		13.2	10.9	*2019*	9
1.67	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	58.8		61.6		*2018*	24
1.67	Households with a Savings Account	*percent*	66.7		68.8	70.2	*2021*	7

1.64	Households with Cash Public Assistance Income	*percent*	2.6		2.9	2.4	*2015-2019*	1
1.64	Size of Labor Force	*persons*	36328				*44470*	20
1.58	Social and Economic Factors Ranking	*ranking*	46				*2021*	8
1.58	Youth not in School or Working	*percent*	2		1.8	1.9	*2015-2019*	1
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.2				*2016*	22
1.36	Young Children Living Below Poverty Level	*percent*	22		23	20.3	*2015-2019*	1
1.33	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3993.5		3798.7	5460.2	*2021*	6
1.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7464.5		7828	8900.1	*2021*	6
1.31	Renters Spending 30% or More of Household Income on Rent	*percent*	42.6		44.9	49.6	*2015-2019*	1
1.25	Median Household Income	*dollars*	54226		56602	62843	*2015-2019*	1
1.17	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.1		14.6	14.4	*2021*	7
1.17	Households that are Below the Federal Poverty Level	*percent*	11.7		13.8		*2018*	24
1.14	Overcrowded Households	*percent of households*	0.7		1.4		*2015-2019*	1
1.14	Persons with Disability Living in Poverty (5-year)	*percent*	26.1		29.5	26.1	*2015-2019*	1
1.03	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*	22
0.86	Children Living Below Poverty Level	*percent*	17.9		19.9	18.5	*2015-2019*	1
0.86	Students Eligible for the Free Lunch Program	*percent*	18.5				*2019-2020*	12
0.78	People Living Below Poverty Level	*percent*	11.7	8	14	13.4	*2015-2019*	1

0.75	People Living 200% Above Poverty Level	*percent*	70.6		68.8	69.1	*2015-2019*	1
0.69	Severe Housing Problems	*percent*	11.5		13.7	18	*2013-2017*	8
0.58	Families Living Below Poverty Level	*percent*	8.6		9.9	9.5	*2015-2019*	1
0.58	Per Capita Income	*dollars*	32790		31552	34103	*2015-2019*	1
0.50	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.1		19.7	26.5	*2019*	1
0.08	People 65+ Living Below Poverty Level	*percent*	5		8.1	9.3	*2015-2019*	1

SCORE	EDUCATION	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	8th Grade Students Proficient in Math	*percent*	36.9		42.6		*2020-2021*	14
1.83	4th Grade Students Proficient in Math	*percent*	58.3		59.4		*2020-2021*	14
1.83	8th Grade Students Proficient in English/Language Arts	*percent*	48.2		52.7		*2020-2021*	14
1.64	4th Grade Students Proficient in English/Language Arts	*percent*	57.5		56		*2020-2021*	14
1.53	Student-to-Teacher Ratio	*students/ teacher*	16.5				*2019-2020*	12
1.42	People 25+ with a Bachelor's Degree or Higher	*percent*	23.2		28.3	32.1	*2015-2019*	1
1.00	Consumer Expenditures: Education	*average dollar amount per consumer unit*	889.8		1200.4	1492.4	*2021*	6
0.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	196.2		301.6	368.2	*2021*	6
0.72	High School Graduation	*percent*	96.1	90.7	92		*2019-2020*	14

SCORE	ENVIRONMENTAL HEALTH	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.47	Houses Built Prior to 1950	*percent*	30		26.2	17.5	*2015-2019*	1

2.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.9	0.5		*2020*	18
2.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	3.2	1.9		*2020*	18
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	1.1			*2016*	22
2.00	People 65+ with Low Access to a Grocery Store	*percent*	5			*2015*	22
1.92	Number of Extreme Precipitation Days	*days*	37			*2019*	13
1.92	PBT Released	*pounds*	1283.1			*2020*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.2			*2015*	22
1.83	Low-Income and Low Access to a Grocery Store	*percent*	9.1			*2015*	22
1.81	Food Environment Index	*index*	7.3	6.8	7.8	*2021*	8
1.69	Asthma: Medicare Population	*percent*	4.9	4.8	5	*2018*	5
1.67	Farmers Market Density	*markets/ 1,000 population*	0			*2018*	22
1.64	Number of Extreme Heat Events	*events*	10			*2019*	13
1.64	Weeks of Moderate Drought or Worse	*weeks per year*	2			*2020*	13
1.58	Adults with Current Asthma	*percent*	9.8		8.9	*2019*	3
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2			*2016*	22
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.8			*2015*	22
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.2			*2016*	22
1.42	Physical Environment Ranking	*ranking*	28			*2021*	8
1.36	Number of Extreme Heat Days	*days*	19			*2019*	13
1.36	Recognized Carcinogens Released into Air	*pounds*	60789.8			*2020*	23
1.14	Overcrowded Households	*percent of households*	0.7	1.4		*2015-2019*	1

1.03	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*	22
0.86	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	22
0.83	Access to Exercise Opportunities	*percent*	85.5		83.9	84	*2020*	8
0.69	Severe Housing Problems	*percent*	11.5		13.7	18	*2013-2017*	8
0.53	Liquor Store Density	*stores/ 100,000 population*	5.4		5.6	10.5	*2019*	21

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4419		4371.7	4321.1	*2021*	6
2.00	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	654		638.9	609.6	*2021*	6
1.89	Persons without Health Insurance	*percent*	7.9		6.6		*2019*	1
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1051.5		1098.6	1047.4	*2021*	6
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	195.8		204.8	194.9	*2021*	6
1.50	Adults who Visited a Dentist	*percent*	51.4		51.6	52.9	*2021*	7
1.50	Adults with Health Insurance	*percent*	87.9		90.9	87.1	*2019*	1
1.42	Clinical Care Ranking	*ranking*	24				*2021*	8
1.33	Children with Health Insurance	*percent*	95.5		95.2	94.3	*2019*	1
1.17	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	97		108.9		*2020*	8
1.08	Adults without Health Insurance	*percent*	12.2			13	*2019*	3
1.06	Dentist Rate	*dentists/ 100,000 population*	66		64.2		*2019*	8
1.00	Adults with Health Insurance: 18+	*percent*	90.8		90.2	90.6	*2021*	7
0.94	Primary Care Provider Rate	*providers/ 100,000 population*	75.1		76.7		*2018*	8
0.92	Adults who have had a Routine Checkup	*percent*	80			76.6	*2019*	3

SCORE		UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
0.67	Mental Health Provider Rate	*providers/ 100,000 population*	247.8		261.3		*2020*	8

SCORE	HEART DISEASE & STROKE	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.92	Atrial Fibrillation: Medicare Population	*percent*	10		9	8.4	*2018*	5
2.67	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	112	71.1	101.4	90.5	*2017-2019*	4
2.47	Hyperlipidemia: Medicare Population	*percent*	53.7		49.4	47.7	*2018*	5
2.36	Stroke: Medicare Population	*percent*	4.3		3.8	3.8	*2018*	5
2.17	High Blood Pressure Prevalence	*percent*	39.3	27.7		32.6	*2019*	3
1.92	Adults who Experienced a Stroke	*percent*	4.2			3.4	*2019*	3
1.92	Adults who Experienced Coronary Heart Disease	*percent*	8.3			6.2	*2019*	3
1.92	High Cholesterol Prevalence: Adults 18+	*percent*	36.1			33.6	*2019*	3
1.81	Hypertension: Medicare Population	*percent*	59.8		59.5	57.2	*2018*	5
1.42	Heart Failure: Medicare Population	*percent*	13.4		14.7	14	*2018*	5
1.31	Ischemic Heart Disease: Medicare Population	*percent*	26.6		27.5	26.8	*2018*	5
1.25	Cholesterol Test History	*percent*	86.4			87.6	*2019*	3
1.11	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	38.1	33.4	42.5	37.2	*2017-2019*	4
0.92	Adults who Have Taken Medications for High Blood Pressure	*percent*	80			76.2	*2019*	3
0.86	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.7		55.4		*2019*	13

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.56	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	13.5	11.1	13.7		*2019*	15
1.53	Chlamydia Incidence Rate	*cases/ 100,000 population*	498.2		504.8		*2020*	15
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.6		0.3	1.6	*4-Feb-22*	10
1.53	Gonorrhea Incidence Rate	*cases/ 100,000 population*	250.5		262.6		*2020*	15
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.4		48.6	49.4	*2021*	7
1.14	Overcrowded Households	*percent of households*	0.7		1.4		*2015-2019*	1
0.92	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	15
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	58.1				*4-Feb-22*	4
0.25	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.8		36.7	67.6	*4-Feb-22*	10
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	9.9		14.4	13.8	*2017-2019*	4

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.67	Babies with Low Birth Weight	*percent*	9.9		8.5	8.2	*2020*	16
2.06	Infant Mortality Rate	*deaths/ 1,000 live births*	8.1	5	6.9		*2019*	16
2.03	Mothers who Smoked During Pregnancy	*percent*	16.6	4.3	11.5	5.5	*2020*	16
1.56	Mothers who Received Early Prenatal Care	*percent*	70.6		68.9	76.1	*2020*	16
1.17	Preterm Births	*percent*	9.4	9.4	10.3		*2020*	16
1.03	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	6		6.8		*2020*	16
1.03	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	17.1		19.5		*2016*	16

SCORE		UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
0.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	196.2		301.6	368.2	*2021*	6
0.78	Babies with Very Low Birth Weight	*percent*	1		1.4	1.3	*2020*	16

SCORE	MEDICATIONS & PRESCRIPTIONS	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	654		638.9	609.6	*2021*	6
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1051.5		1098.6	1047.4	*2021*	6
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	195.8		204.8	194.9	*2021*	6

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	45.7		34	30.5	*2017-2019*	4
2.42	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.2		10.4	10.8	*2018*	5
1.83	Poor Mental Health: Average Number of Days	*days*	4.9		4.8	4.1	*2018*	8
1.64	Depression: Medicare Population	*percent*	19.7		20.4	18.4	*2018*	5
1.58	Poor Mental Health: 14+ Days	*percent*	15.3			13.6	*2019*	3
1.56	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	14.7	12.8	15.1	14.1	*2017-2019*	4
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.1		85.6	86.5	*2021*	7
1.42	Adults Ever Diagnosed with Depression	*percent*	20.7			18.8	*2019*	3
0.67	Mental Health Provider Rate	*providers/ 100,000 population*	247.8		261.3		*2020*	8

SCORE	NUTRITION & HEALTHY EATING	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	817.9		864.6	1002.1	*2021*	6
1.50	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	506.7		519	530.2	*2021*	6
1.17	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1323.1		1461	1638.9	*2021*	6
1.17	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	309.4		319.7	357	*2021*	6
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.9		80.9	80.4	*2021*	7
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	39.5		41.5	41.2	*2021*	7

SCORE	OLDER ADULTS	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.92	Atrial Fibrillation: Medicare Population	*percent*	10		9	8.4	*2018*	5
2.64	Cancer: Medicare Population	*percent*	9.6		8.4	8.4	*2018*	5
2.64	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	43.6		36.1	33.5	*2018*	5
2.50	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	45.7		34	30.5	*2017-2019*	4
2.47	Hyperlipidemia: Medicare Population	*percent*	53.7		49.4	47.7	*2018*	5
2.42	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.2		10.4	10.8	*2018*	5
2.36	Stroke: Medicare Population	*percent*	4.3		3.8	3.8	*2018*	5
2.14	Chronic Kidney Disease: Medicare Population	*percent*	26.9		25.3	24.5	*2018*	5

2.14	COPD: Medicare Population	*percent*	14.2		13.2	11.5	*2018*	5
2.00	Colon Cancer Screening	*percent*	61.1	74.4		66.4	*2018*	3
2.00	People 65+ with Low Access to a Grocery Store	*percent*	5				*2015*	22
1.81	Hypertension: Medicare Population	*percent*	59.8		59.5	57.2	*2018*	5
1.81	Osteoporosis: Medicare Population	*percent*	6.5		6.2	6.6	*2018*	5
1.75	Adults with Arthritis	*percent*	31.8			25.1	*2019*	3
1.69	Asthma: Medicare Population	*percent*	4.9		4.8	5	*2018*	5
1.69	Diabetes: Medicare Population	*percent*	28.2		27.2	27	*2018*	5
1.64	Depression: Medicare Population	*percent*	19.7		20.4	18.4	*2018*	5
1.58	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	29.6			28.4	*2018*	3
1.58	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	31.7			32.4	*2018*	3
1.42	Adults 65+ with Total Tooth Loss	*percent*	15.1			13.5	*2018*	3
1.42	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	8.8		10.5	9.5	*2017-2019*	4
1.42	Heart Failure: Medicare Population	*percent*	13.4		14.7	14	*2018*	5
1.31	Ischemic Heart Disease: Medicare Population	*percent*	26.6		27.5	26.8	*2018*	5
1.17	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	21.2		20.5	34.3	*2021*	6
0.75	People 65+ Living Alone	*percent*	26		28.8	26.1	*2015-2019*	1
0.08	People 65+ Living Below Poverty Level	*percent*	5		8.1	9.3	*2015-2019*	1

SCORE	ORAL HEALTH	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.47	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.4		12.2	11.9	*2014-2018*	11
1.50	Adults who Visited a Dentist	*percent*	51.4		51.6	52.9	*2021*	7
1.42	Adults 65+ with Total Tooth Loss	*percent*	15.1			13.5	*2018*	3
1.06	Dentist Rate	*dentists/ 100,000 population*	66		64.2		*2019*	8

SCORE	OTHER CONDITIONS	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	43.6		36.1	33.5	*2018*	5
2.14	Chronic Kidney Disease: Medicare Population	*percent*	26.9		25.3	24.5	*2018*	5
1.92	Adults with Kidney Disease	*Percent of adults*	3.5			3.1	*2019*	3
1.81	Osteoporosis: Medicare Population	*percent*	6.5		6.2	6.6	*2018*	5
1.75	Adults with Arthritis	*percent*	31.8			25.1	*2019*	3
1.69	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	15.4		14.5	12.9	*2017-2019*	4

SCORE	PHYSICAL ACTIVITY	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.47	Workers who Walk to Work	*percent*	1.3		2.2	2.7	*2015-2019*	1
2.17	Adults 20+ who are Obese	*percent*	37.8	36			*2019*	4
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	1.1				*2016*	22
2.00	People 65+ with Low Access to a Grocery Store	*percent*	5				*2015*	22
1.83	Children with Low Access to a Grocery Store	*percent*	6.2				*2015*	22
1.83	Low-Income and Low Access to a Grocery Store	*percent*	9.1				*2015*	22

1.81	Food Environment Index	*index*	7.3		6.8	7.8	*2021*	8
1.67	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	22
1.53	Adults 20+ who are Sedentary	*percent*	25.3				*2019*	4
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	22
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.8				*2015*	22
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.2				*2016*	22
1.42	Health Behaviors Ranking	*ranking*	28				*2021*	8
1.03	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*	22
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.9		80.9	80.4	*2021*	7
0.86	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	22
0.83	Access to Exercise Opportunities	*percent*	85.5		83.9	84	*2020*	8

SCORE	**PREVENTION & SAFETY**	**UNITS**	**ERIE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.39	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	71.7	43.2	68.8	48.9	*2017-2019*	4
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	43.6		40.2	21.4	*2017-2019*	4
2.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	34.9		38.1	21	*2017-2019*	8
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	4.1		2.8	2.5	*2013-2017*	4
1.42	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	8.8		10.5	9.5	*2017-2019*	4
0.69	Severe Housing Problems	*percent*	11.5		13.7	18	*2013-2017*	8

SCORE	**RESPIRATORY DISEASES**	**UNITS**	**ERIE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	507.3		487.9	422.4	*2021*	6

2.17	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	60.5		47.8	39.6	*2017-2019*	4
2.14	COPD: Medicare Population	*percent*	14.2		13.2	11.5	*2018*	5
1.92	Adults who Smoke	*percent*	22.4	5	21.4	17	*2018*	8
1.75	Adults with COPD	*Percent of adults*	9.8			6.6	*2019*	3
1.69	Asthma: Medicare Population	*percent*	4.9		4.8	5	*2018*	5
1.58	Adults with Current Asthma	*percent*	9.8			8.9	*2019*	3
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.6		0.3	1.6	*4-Feb-22*	10
1.50	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.5		2.2	2	*2021*	7
1.47	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.8		67.3	57.3	*2014-2018*	11
1.11	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	40.5	25.1	45	36.7	*2015-2019*	11
0.92	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	15
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.9		4.3	4.1	*2021*	7
0.25	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.8		36.7	67.6	*4-Feb-22*	10
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	9.9		14.4	13.8	*2017-2019*	4

SCORE	TOBACCO USE	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	507.3		487.9	422.4	*2021*	6
1.92	Adults who Smoke	*percent*	22.4	5	21.4	17	*2018*	8

1.50	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.5		2.2	2	*2021*	7
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.9		4.3	4.1	*2021*	7

SCORE	WELLNESS & LIFESTYLE	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	High Blood Pressure Prevalence	*percent*	39.3	27.7		32.6	*2019*	3
1.92	Insufficient Sleep	*percent*	40.2	31.4	40.6	35	*2018*	8
1.92	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.7			18.6	*2019*	3
1.83	Life Expectancy	*years*	76.9		77	79.2	*2017-2019*	8
1.75	Poor Physical Health: 14+ Days	*percent*	14.9			12.5	*2019*	3
1.67	Poor Physical Health: Average Number of Days	*days*	4.3		4.1	3.7	*2018*	8
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.4		48.6	49.4	*2021*	7
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.1		85.6	86.5	*2021*	7
1.42	Morbidity Ranking	*ranking*	42				*2021*	8
1.17	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1323.1		1461	1638.9	*2021*	6
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.9		80.9	80.4	*2021*	7
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	39.5		41.5	41.2	*2021*	7

SCORE	WOMEN'S HEALTH	UNITS	ERIE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

1.94	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.3	15.3	21.6	19.9	*2015-2019*	11
1.61	Mammogram in Past 2 Years: 50-74	*percent*	72.3	77.1		74.8	*2018*	3
1.17	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7.7		7.4	7.5	*2010-2014*	11
1.03	Breast Cancer Incidence Rate	*cases/ 100,000 females*	119.4		129.6	126.8	*2014-2018*	11
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.4	84.3		84.7	*2018*	3

Erie County Data Sources

Key	Data Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse

20 Ohio Secretary of State
21 U.S. Bureau of Labor Statistics
22 U.S. Census - County Business Patterns
23 U.S. Department of Agriculture - Food Environment Atlas
24 U.S. Environmental Protection Agency
25 United For ALICE

Appendix D: Community Input Assessment Tools

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health and Well-being

- From your perspective, what does a community need to be healthy?
- What do you believe are the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

Section #3: Barriers to Health

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

Section #4: COVID-19

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

Section #5: Addressing the Challenges & Solutions

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

Section #6: Conclusion

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

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

Appendix E: Community Partners and Resources

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

Federally Qualified Health Centers

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

- Asian Services in Action, Inc.Asian Services in Action, Inc.
- Care Alliance
- Erie County Health Department
- Family Health Services of Erie County
- Health Source of Ohio
- Lorain County Health & Dentistry
- MetroHealth Community Health Centers (MHCHC)
- Neighborhood Family Practice
- Northeast Ohio Neighborhood Health Services[30]
- Signature Health, Inc.
- The Centers

Hospitals

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

[29] Ohio Association of Community Health Centers, https://www.ohiochc.org/page/178
[30] Data search August 15, 2022

- Firelands Regional Medical Center
- Grace Hospital
- Mercy Health (Multiple Locations)
- MetroHealth Medical Centers (Multiple Locations)
- St. Vincent Charity Medical Center
- University Hospitals (Multiple Locations)

Other Community Resources

A wide range of agencies, coalitions, and organizations that provide health and social services is available in the region served by Avon. United Way 2-1-1 Ohio maintains a large, online database to help refer individuals in need to health and human services in Ohio. This is a service of the Ohio Department of Social Services and is provided in partnership with the Council of Community Services, The Planning Council, and United Way chapters in Cleveland. United Way 2-1-1 Ohio contains information on organizations and resources in the following categories:

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

Additional information about these resources is available at: http://www.211oh.org/

Appendix F: Acknowledgements

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

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Implementation Strategy Report

2022

AVON HOSPITAL 2022 IMPLEMENTATION STRATEGY REPORT

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

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AVON HOSPITAL 2022 IMPLEMENTATION STRATEGY REPORT

I. INTRODUCTION AND PURPOSE

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

A. Description of Hospital

Avon Hospital, nestled on the Richard E. Jacobs Campus, adjacent to Richard E. Jacobs Health Center, has 126 staffed beds,[31] offering state of the art medical care in the community. Avon Hospital provides a spectrum of services, from critical care to cardiology, orthopedic surgery, and outpatient procedures. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/avon-hospital/.

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

Avon Hospital's mission is:

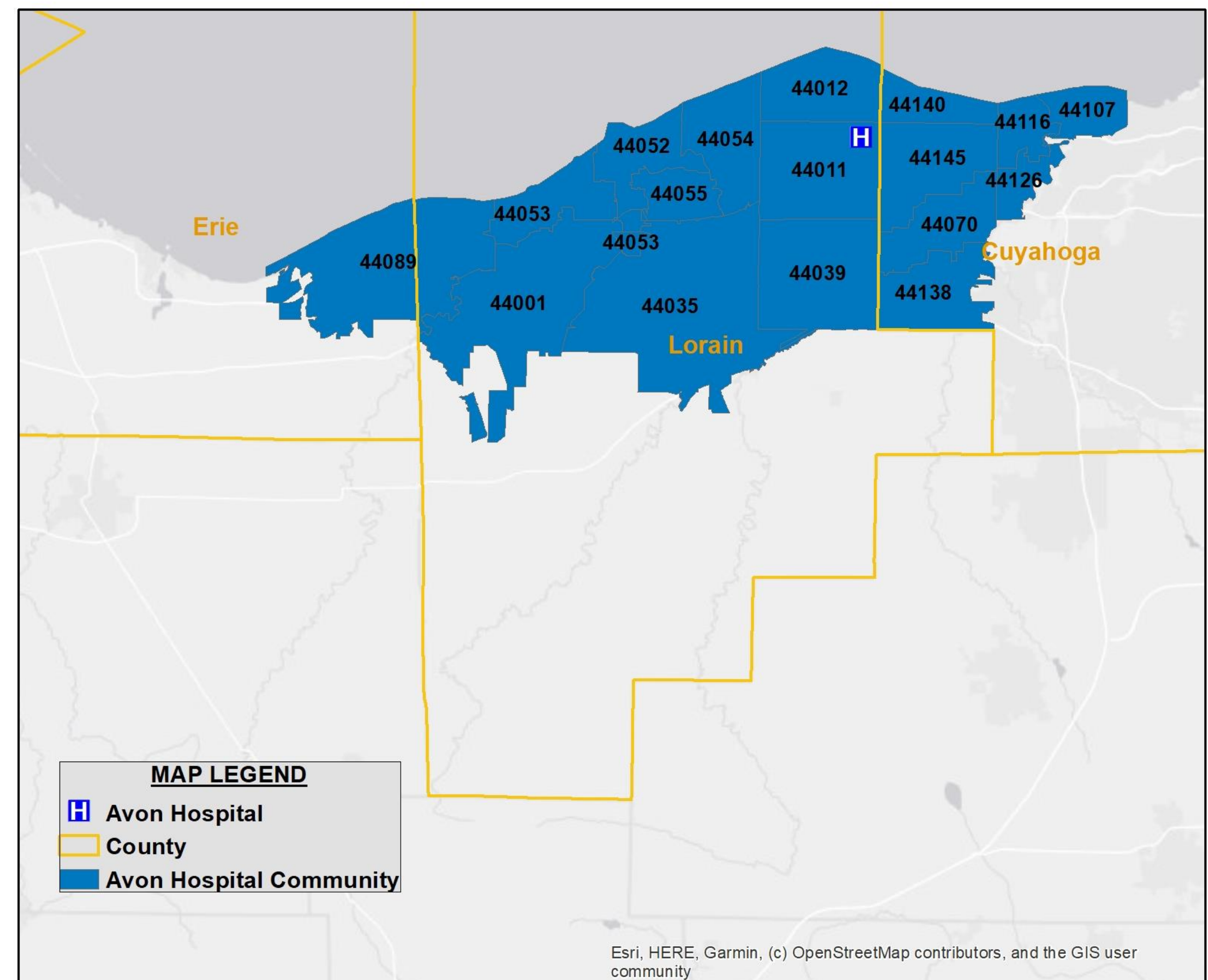
Caring for life, researching for health, and educating those who serve.

II. COMMUNITY DEFINITION

For purposes of this report, the Avon Hospital community definition is an aggregate of 17 zip codes in Cuyahoga, Erie and Lorain Counties comprising approximately 75% of inpatient, outpatient and emergency department visits in 2021 (Figure 1).

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

Figure 1: Avon Hospital Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of leadership at Avon Hospital and Cleveland Clinic representing several departments of the organizations, including clinical administration, medical operations, nursing, finance, population health, and community relations. This team incorporated input from the hospital's community and local non-profit organizations to prioritize selected strategies and determine possible collaborations. Alignment with county Community Health Assessments (CHA) as well as the State Health Assessment (SHA), was considered.

In addition, Avon Hospital collaborated with local hospitals, community based organizations (CBOs), health departments, and community residents in the Lorain County Community Health Improvement Plan (CHIP) for 2023 through 2025. Aligned strategies are reflected in this report. To view the full Lorain County CHIP please visit https://www.loraincountyhealth.com/cha. Leadership at Avon Hospital will utilize this Implementation Strategy to determine whether changes should be made to better address the health needs of its communities.

IV. SUMMARY OF THE COMMUNITY HEALTH NEEDS IDENTIFIED

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

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

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

COVID-19 Considerations

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

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

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

V. NEEDS HOSPITAL WILL ADDRESS

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

Strategies within the ISRs are included according to the prioritized list of needs developed during the 2022 CHNA. These hospitals' community health initiatives combine Cleveland Clinic and local non-profit

organizations' resources in unified efforts to improve health and health equity for our community members, especially low-income, underserved, and vulnerable populations.

A. Access to Healthcare

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

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

Access to Healthcare Initiatives for 2023-2025 include:

	Initiatives Including Collaborations and Resources Allocated	**Anticipated Impacts**
A	Patient Financial Advocates assist patients in evaluating eligibility for financial assistance or public health insurance programs	Increase the proportion of eligible individuals who are enrolled in various assistance programs
B	Support the Lorain Free Clinic financially through the charity care benefit and caregiver clinical support	Increase the number of individuals with a regular source of care, improve screening rates, improve chronic care management, increase medication adherence, and improve access to medical testing and specialized care
C	Address digital equity, utilize medically secure online and mobile platforms, connect patients with Cleveland Clinic providers for telehealth and virtual visits	Overcome geographical and transportation barriers, improve access to specialized care

B. Behavioral Health

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

Behavioral Health Initiatives for 2023-2025 include:

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Through the Opioid Awareness Center, participation in the Northeast Ohio Hospital Opioid Consortium, and participation in the Lorain County Opioid Task Force, Cleveland Clinic will provide preventative education and share evidence-based practices	Reduce the number of individuals with opioid addiction and dependence. Reduction of Opioid prescriptions
B	Collect unused medications through community-based drop boxes and a collection service	Reduce the availability of unused controlled substance prescriptions within the community
C	In collaboration with the Nord Center, Clear Vista, Lorain County Health and Dentistry, and the Mental Health, Addiction, and Recovery Services Board of Lorain County, promote mental health and suicide prevention education	Reduce suicide rates, increase the number of individuals who seek mental health treatment, minimize the impact of trauma and violence on overall health and wellbeing, increase resilience, decrease stigma
D	In collaboration with Lorain County, continue to provide school-based prevention programs and promote policies to increase the perception of risk of marijuana use for youth, decrease underage binge drinking, tobacco use, and vaping	Decrease youth marijuana, tobacco, and alcohol use
E	Provide screenings and connect community residents with substance abuse disorder peer counselors and the *Let's Get Real* Program	Improve access to treatment services, reduce overdose rates, improve access to recovery support, and decrease gaps in access to treatment through partnerships

C. Chronic Disease Prevention & Management

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

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

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Promote early cancer detection through community outreach and education related to breast, colon, cervical, lung, and prostate cancer	Increase cancer screening rates, improve screening follow-up rates, and reduce the number of patients who present with late-stage cancers
B	Provide health screenings through community events, including screening for pre-diabetes and diabetes	Improve diabetes and prediabetes screening rates, increase the number of individuals with prediabetes who seek treatment, decrease diabetes incidence rates
C	Implement health promotion messaging, health education, and outreach programs related to reducing behavioral risk factors, increasing access to healthy foods, and increasing physical activity	Decrease smoking, improve physical activity, improve nutrition, decrease stress levels, decrease diabetes incidence rates, improve awareness of heart disease risk factors, decrease female heart disease mortality rates
D	Implement free or low-cost community fitness programs such as *United We Sweat* and *Silver Sneakers* in partnership with Lorain County Health Department.	Improve physical activity, improve awareness of sedentary lifestyle risk factors, promote social connectedness

D. Maternal & Child Health

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

Maternal and Child Health initiatives for 2023-2025 include:

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Provide expanded evidence-based health education to expecting mothers and families, aligning effort with Lorain County	Stop the upward trend of preterm births through a systems approach to care linkages, prevention and education.
B	Participate in *First Year Cleveland*, the Cuyahoga County and the Lorain County Infant Mortality Task Forces to gather data, align programs, and coordinate a systemic approach to improving infant mortality	Reduce infant mortality inequity, improve the preterm birth rate, decrease sleep related infant deaths
C	Explore expansion of the Centering Pregnancy group prenatal care model to expecting mothers and increase the number of families who participate in evidence-based home visiting programs	Improve the preterm birth rate, increase pregnancy spacing, and reduce preterm birth inequity
D	Outreach events like Community Baby Showers provide health information to families in specific high-risk geographical areas and encourage enrollment in supportive evidence-based programs, provide healthy nutrition to expecting mothers.	Improve the number of mothers who receive adequate prenatal care and improve breastfeeding rates

E. Socioeconomic Issues

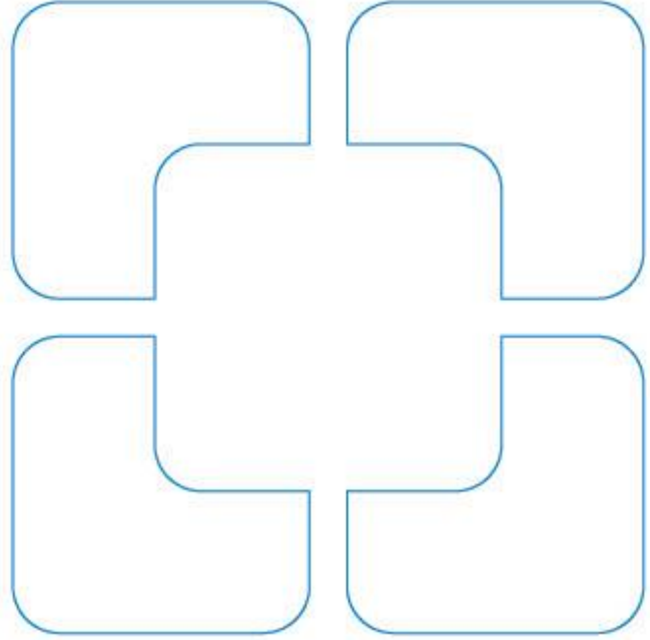
Avon Hospital's 2022 CHNA demonstrated that health needs are multifaceted, involving medical as well as socioeconomic concerns. The assessment identified food security, affordable housing, employment, transportation, health literacy, structural racism, poverty, and environmental risk factors as significant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

The socioeconomic initiatives highlighted for 2023 – 2025 include:

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Continue Cleveland Clinic patient navigation programming using Community Health Workers and/or the co-location of community organizations with hospital facilities	Ensure connection to medical, social, and behavioral services; Improve health equity
B	Continue a Cleveland Clinic common community referral data platform to coordinate services and ensure optimal communication	Improve active referrals to community-based organizations, non-profits, and other healthcare facilities; track referral outcomes
C	Through community partnerships, improve early childhood learning with focus on Lorain County's kindergarten readiness program	Increase kindergarten readiness assessment rates
D	Provide workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders	Increase diversity within the healthcare workforce, improve trust in providers, improve local provider shortages
E	Partner with community-based organizations to improve equitable access to healthy foods	Improve self-efficacy associated with healthy eating, improve nutrition

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

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



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