



Cleveland Clinic
Medina Hospital

Community Health Needs Assessment

2022

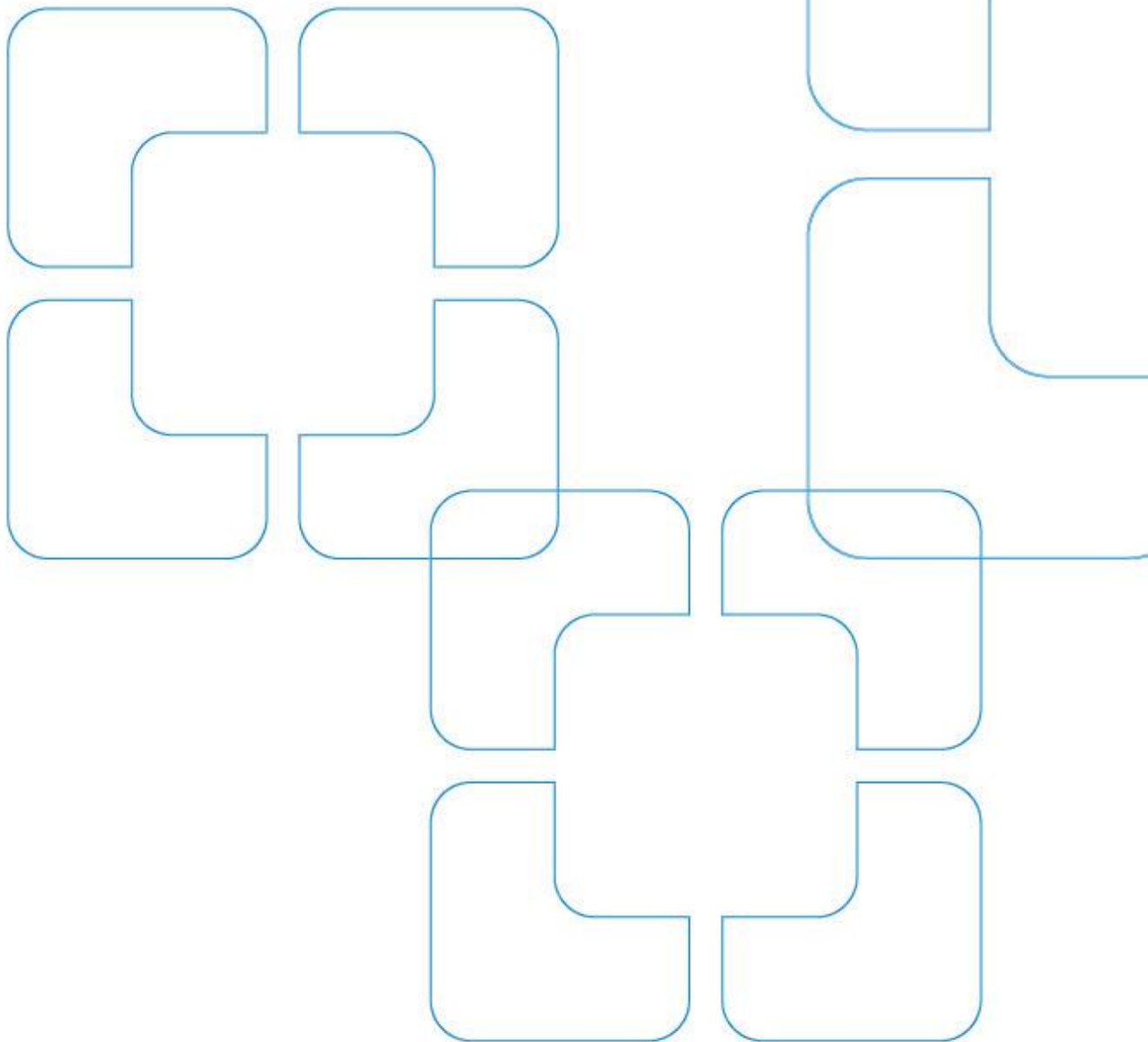


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Executive Summary

This Community Health Needs Assessment (CHNA) was conducted by Cleveland Clinic Medina Hospital (the Medina 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 Act¹.

For over 75 years, Medina Hospital has remained dedicated to the surrounding community and its patients. Located on the corridor to the Medina community, Medina Hospital is a 148 staffed bed² acute care facility. In August 2009, the hospital affiliated with Cleveland Clinic becoming the ninth regional hospital in the health system. Medina Hospital is also introducing advanced clinical treatments and therapies, personal service enhancements for patients and visitors and faster access to Cleveland Clinic's expertise and specialties. Medina Hospital's strong clinical Centers of Excellence include Emergency Department, Orthopedics and Surgery. Additional information on the hospital and its services is available at: <https://my.clevelandclinic.org/locations/medina-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

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>

- Treat the organization as our home

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

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

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 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 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 Act⁷.

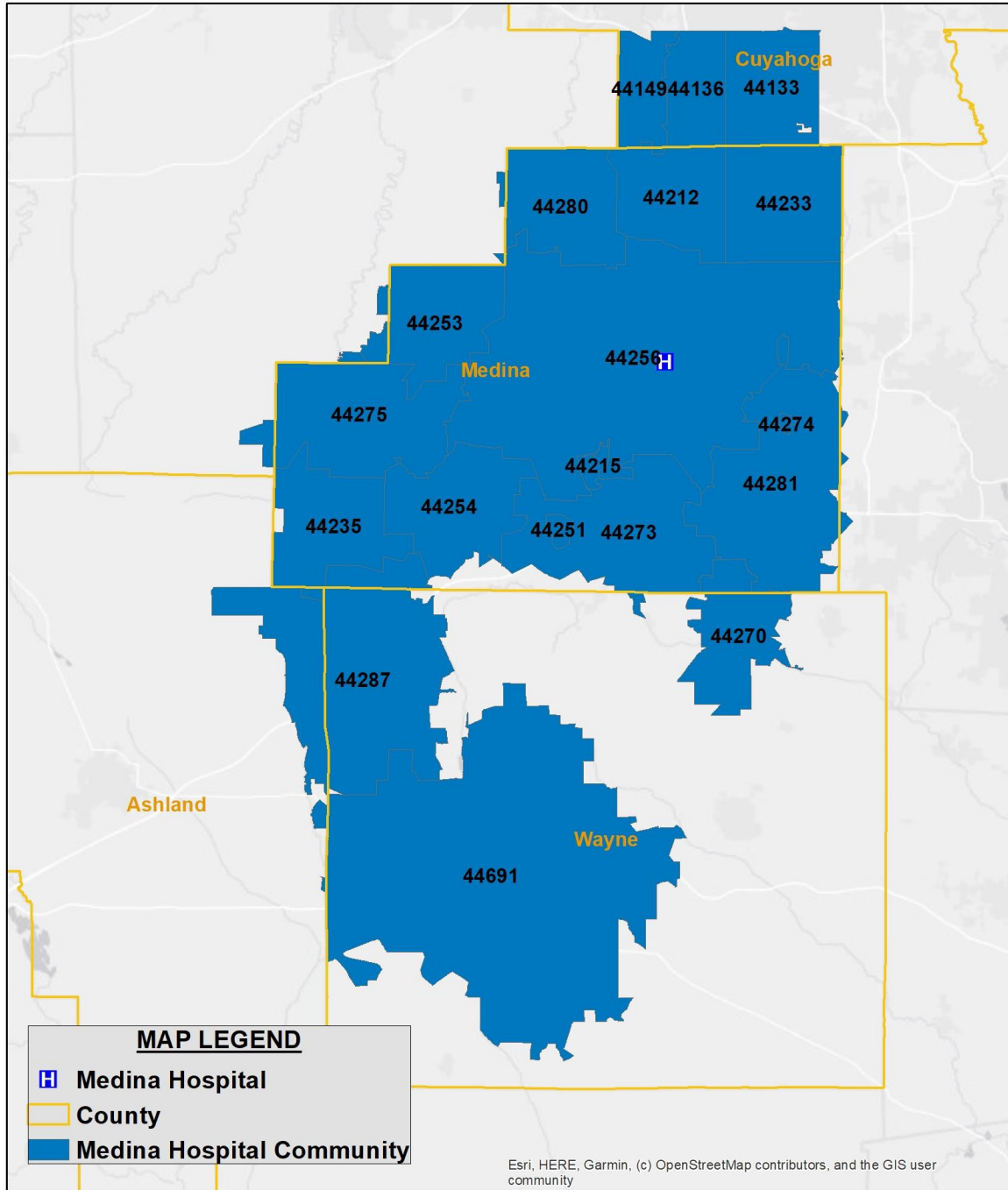
Community Definition

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

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: Medina 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 Medina Hospital Community Definition—an aggregate of the 19 zip codes described in the Community Definition.
- Cuyahoga, Medina and Wayne Counties—the three counties comprising the Medina 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 Medina 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
- 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 34).



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 all our prioritized needs. It is described in detail and specifically as it relates to the Medina Hospital Community in both the Disparities and Health Equity section (page 25)

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

of the report as well as in the Synthesis and Prioritization section (page 34). Special consideration will be given to addressing prioritized health needs through a health equity lens in the Medina 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 Medina Hospital moves toward development of the implementation strategy report.

COMMUNITY HEALTH NEEDS ASSESSMENT

Medina Hospital

Prioritized Health Needs



Access to
Healthcare



Behavioral Health



Chronic Disease Prevention
& Management



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 Medina 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 Medina Hospital Community Definition.

Geography and Data Sources

Data are presented in this section at the geographic level of the 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 Survey¹⁰ one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

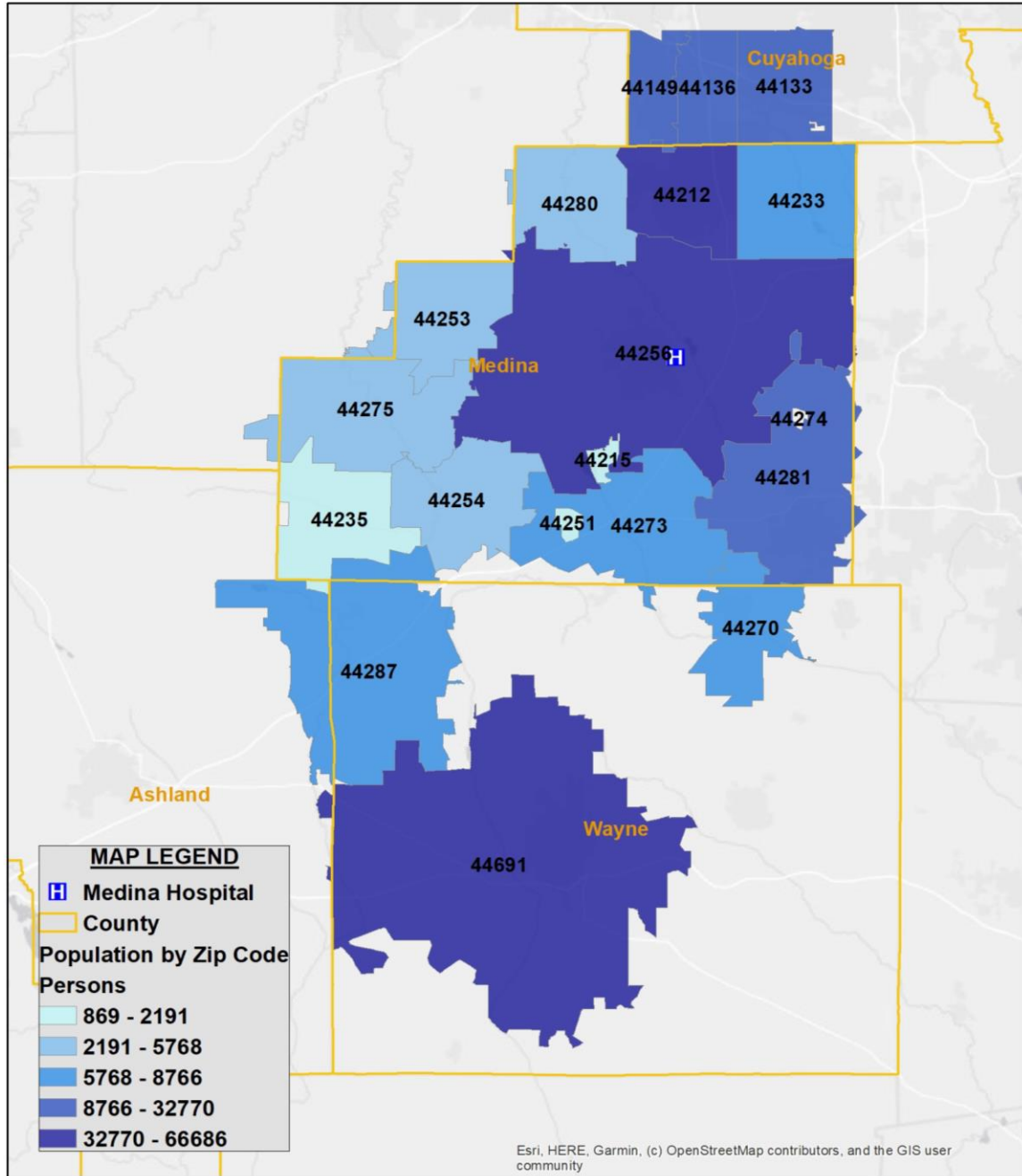
Population

According to the 2022 Claritas Pop-Facts® population estimates, the Medina Hospital community has an estimated population of 112,335 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 Medina Hospital Community is zip code 44256 (Medina) with a population of 66,686.

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

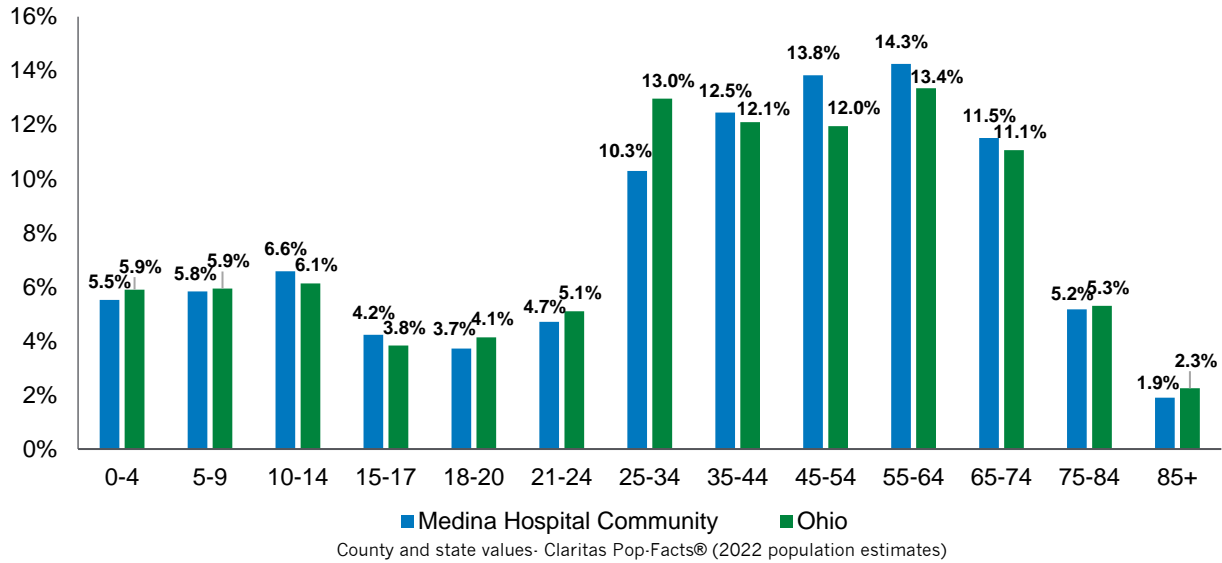


County values- Claritas Pop-Facts® (2022 population estimates)

Age

Children (0-17) comprised 22.2% of the population in the Medina Hospital Community which is slightly higher when compared to the state of Ohio (21.8%). The Medina Hospital Community has similar proportion of residents aged 65+ (18.6%) when compared with the state of Ohio at 18.6%. Figure 4 shows further breakdown of age categories.

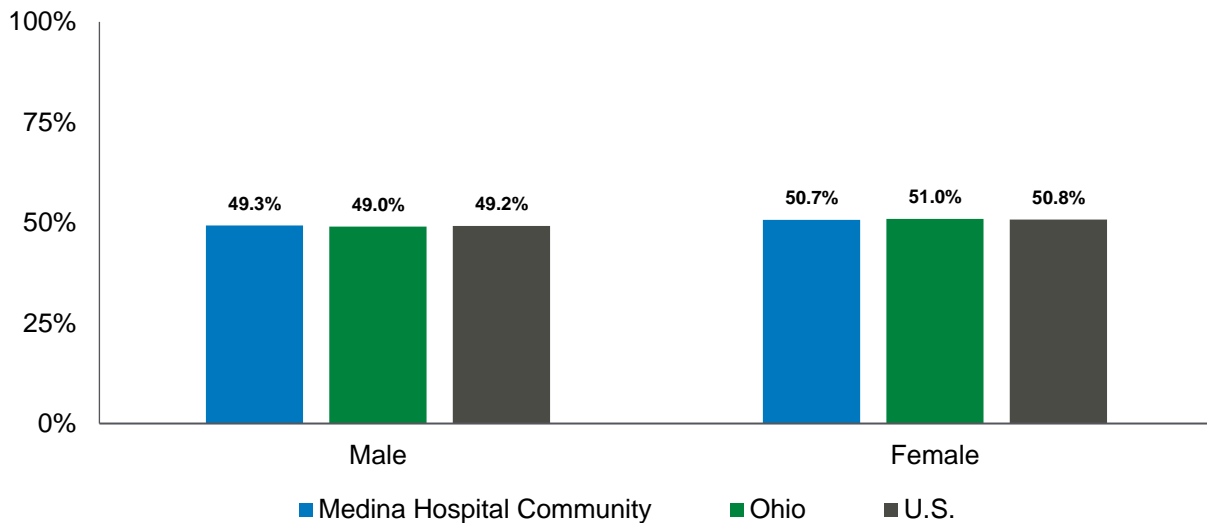
Figure 4: Population by Age: Hospital and State Comparisons



Sex

Figure 5 shows the population of the Medina Hospital Community by sex. Males comprise 49.3% of the population in the Medina Hospital Community, which is higher than both the Ohio (49.0%) and U.S. (49.2%) values. Whereas females comprise 50.7% of the population in the Medina Hospital Community which is slightly less than Ohio (51.0%) and the U.S. (50.8%) values.

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



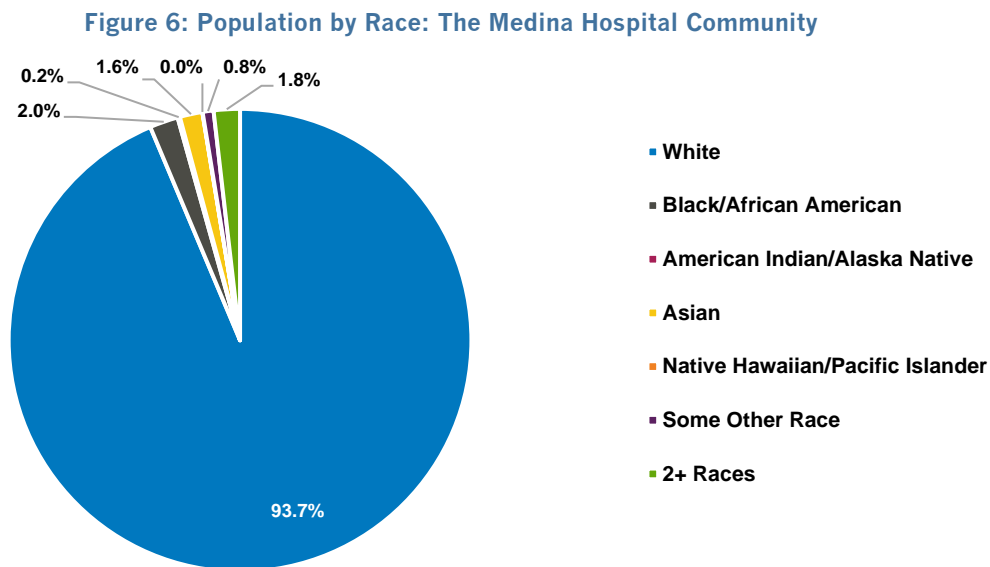
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2015-2019) estimates

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.

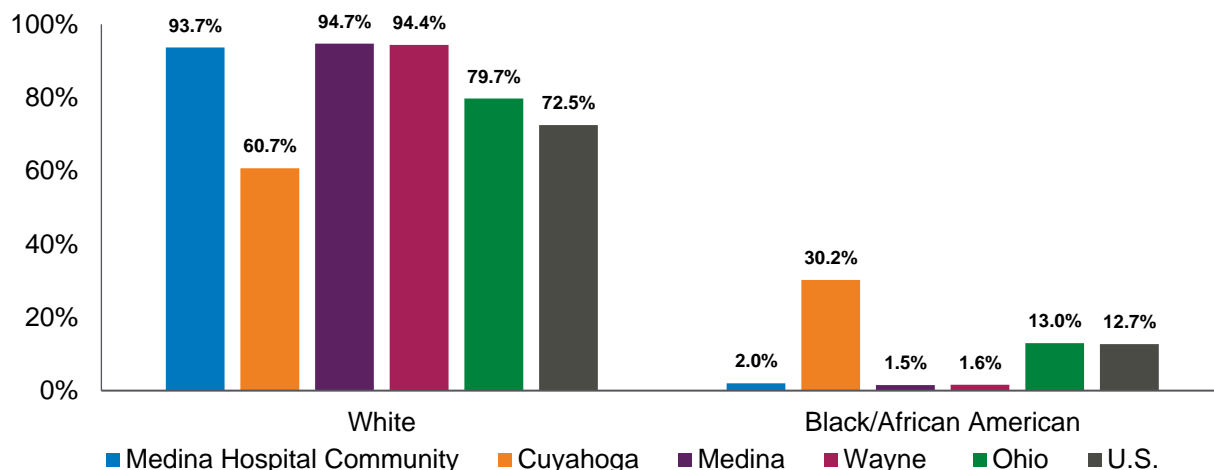
The racial makeup of Medina Hospital area shows 93.7% of the population identifying as White, as indicated in Figure 6. The proportion of Black/African American community members is the second largest of all races in the Medina Hospital Community at 2.0%.



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

Those community members identifying as White represent a higher proportion of the population in the Medina Hospital Community (93.7%) 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 Medina Hospital Community (2.0%) 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 Medina Hospital Community Definition. (Figure 7)

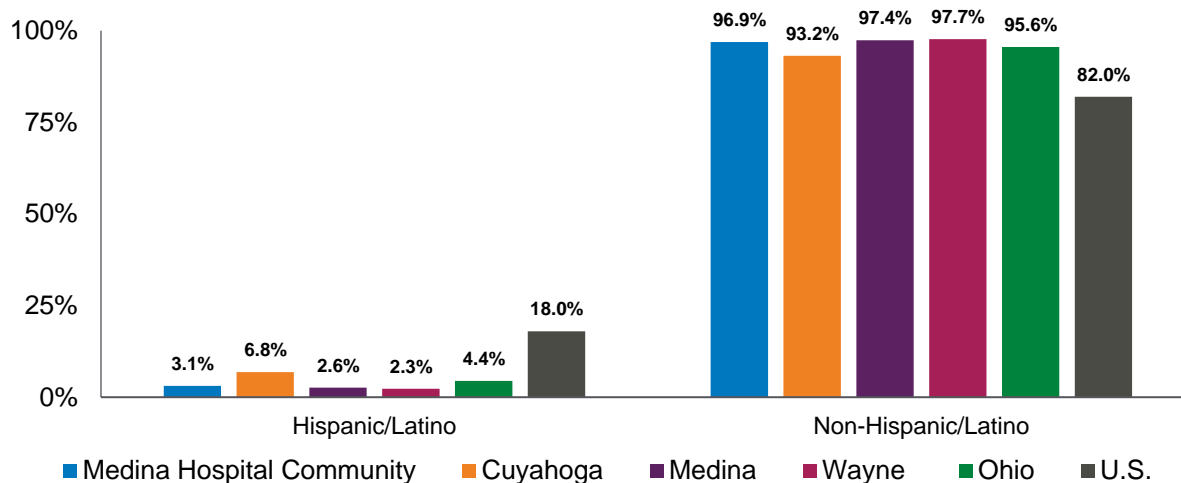
Figure 7: Population by Race: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

As shown in Figure 8, 3.1% of the population in the Medina Hospital Community identify as Hispanic/Latino. This is a smaller proportion of the population when compared to both Ohio (4.4%) and the U.S. (18.0%). Cuyahoga County has the largest percentage of community members who identify as Hispanic/Latino (6.8%).

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



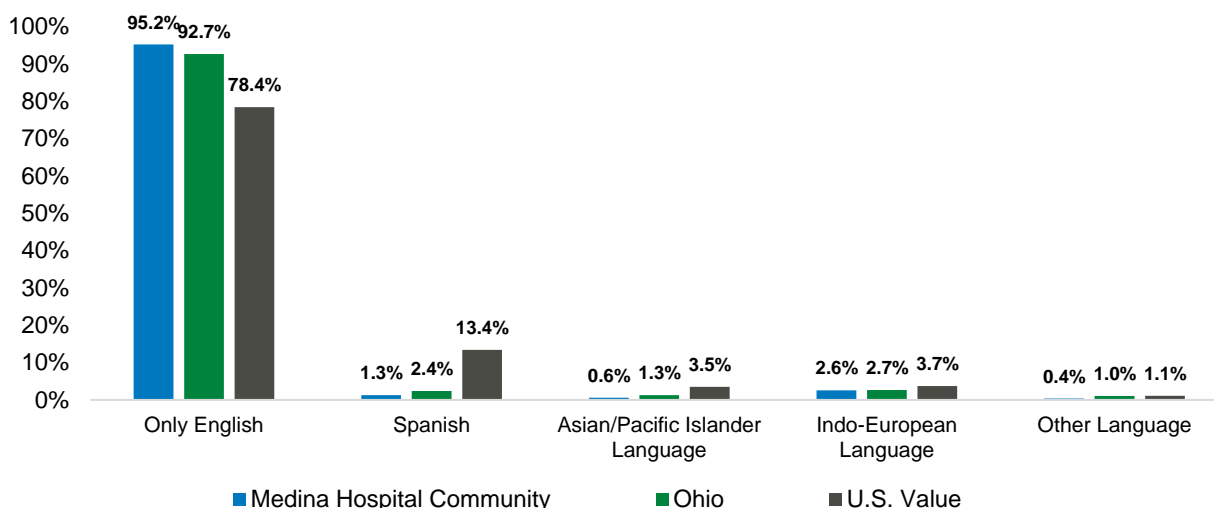
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

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 Medina Hospital Community, 95.2% of the population age five and older speak only English at home, which is greater than the state value of 92.7% and the national value of 78.4% (Figure 9). This data indicates that 1.3% of the population in the Medina Hospital Community speak Spanish, 0.6% speak an Asian/Pacific Islander language, 2.6% speak an Indo-European Language, and 0.4% 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 (2015-2019) estimates

Highlighted Demographics: Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Medina 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 systems¹¹. The Social Determinants of Health (SDOH) can be grouped into five domains. Figure 10 shows the Healthy People 2030 Social Determinants of Health domains¹².

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.

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>

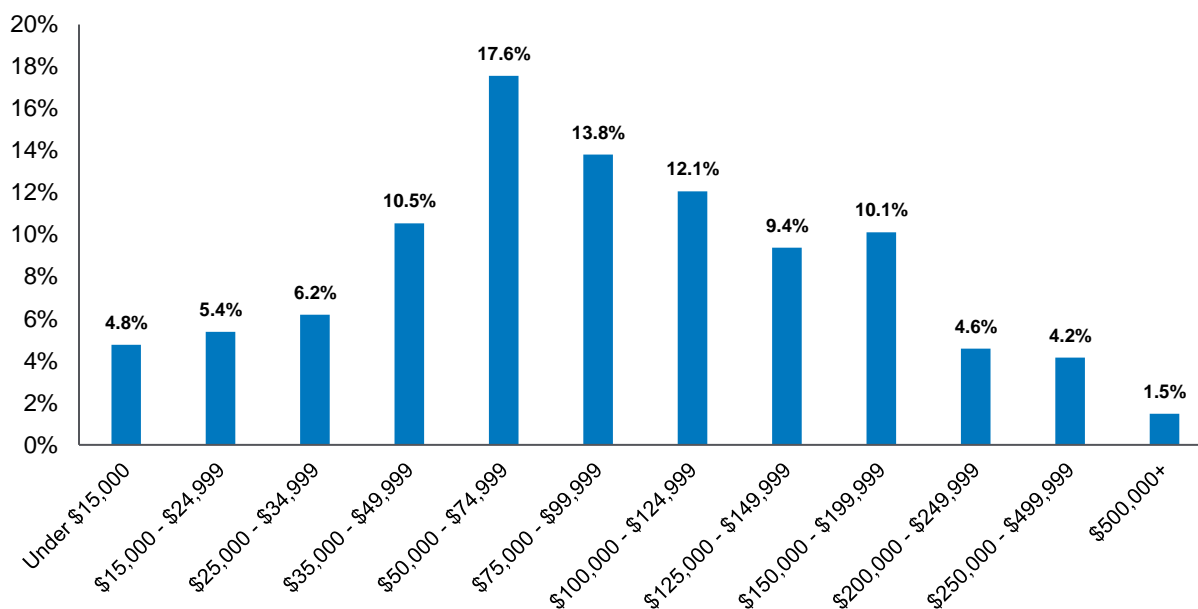
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

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 Medina Hospital Community Definition. A household income of \$50,000 - \$74,999 is shared by the largest proportion of households in the Medina Hospital Community (17.6%). Households with an income of less than \$15,000 make up 4.8% of households in the Medina Hospital Community.

Figure 11: Households by Income: The Medina Hospital Community

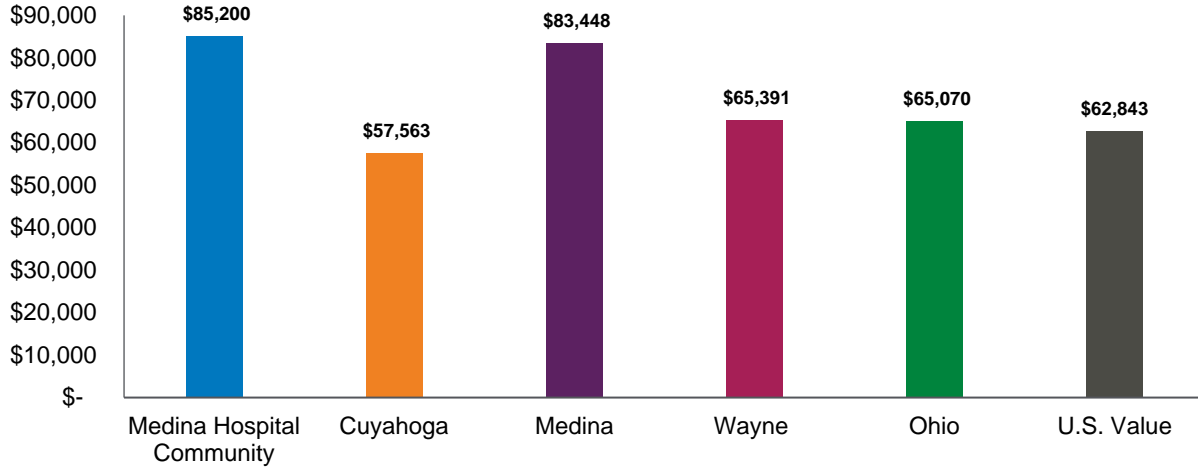


County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for the Medina Hospital Community is \$85,200, which is higher than the state value of \$65,070 and national value of \$62,843 (Figure 12).

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>

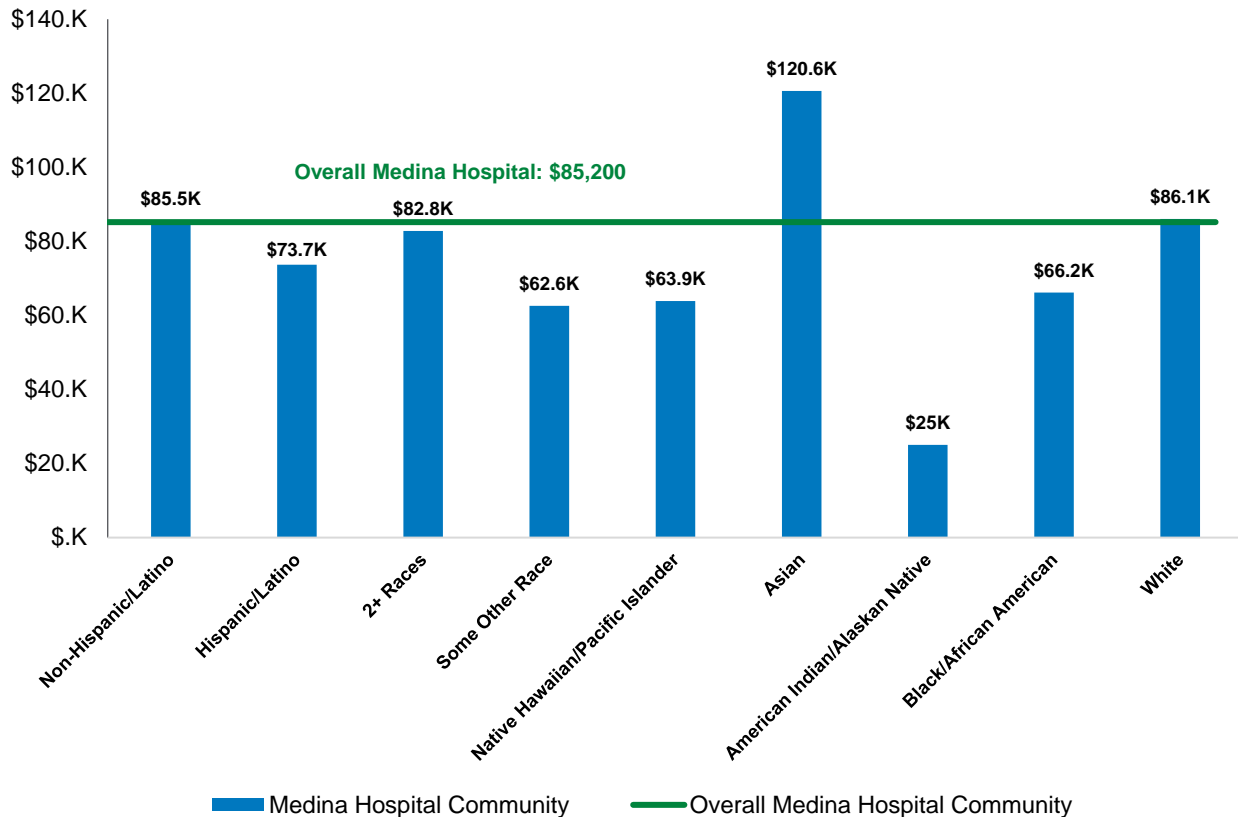
Figure 12: Household Income by: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) 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 American Indian/Alaskan Native population having the lowest median household income at \$25,044.

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



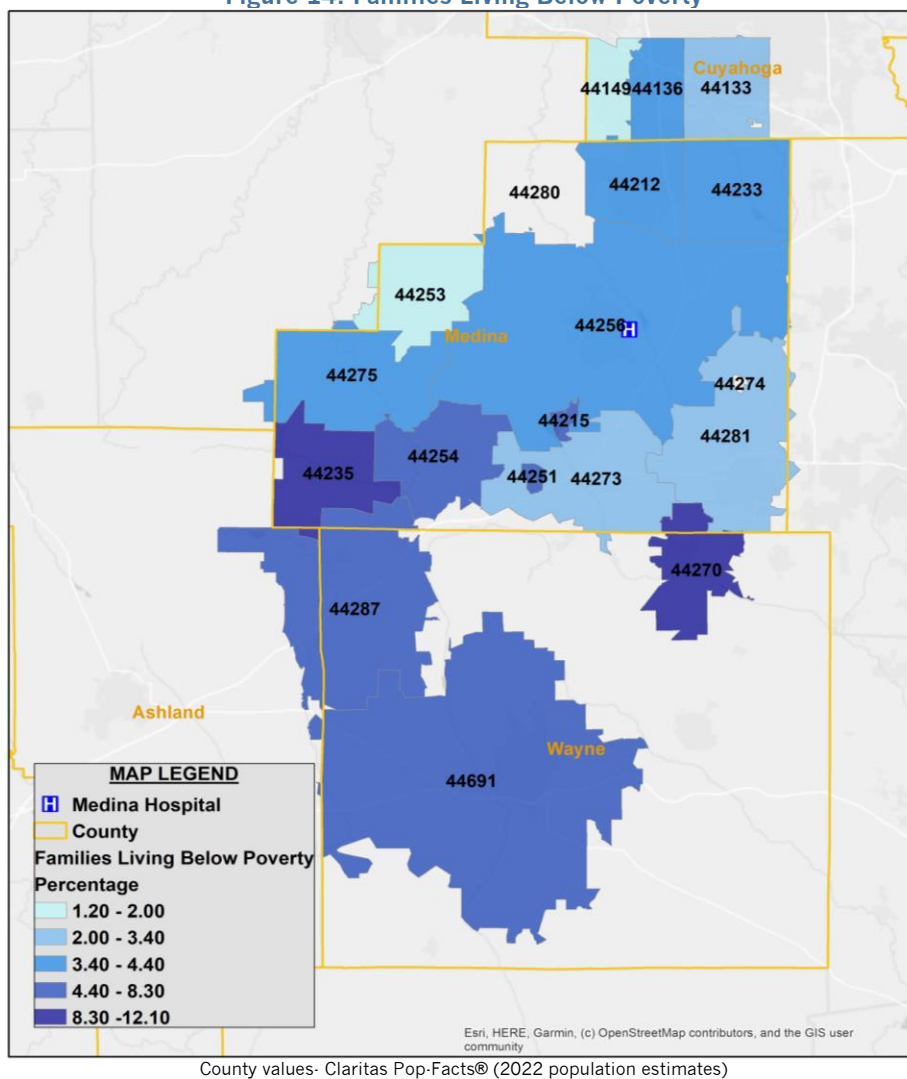
County values- Claritas Pop-Facts® (2022 population estimates)

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 44235 (Homerville) and 44270 (Rittman) having the highest percentages at 12.10% and 11.40%, respectively. Overall, 4.2% of families in the Medina 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 Medina Hospital Community is provided in Appendix C.

Figure 14: Families Living Below Poverty



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

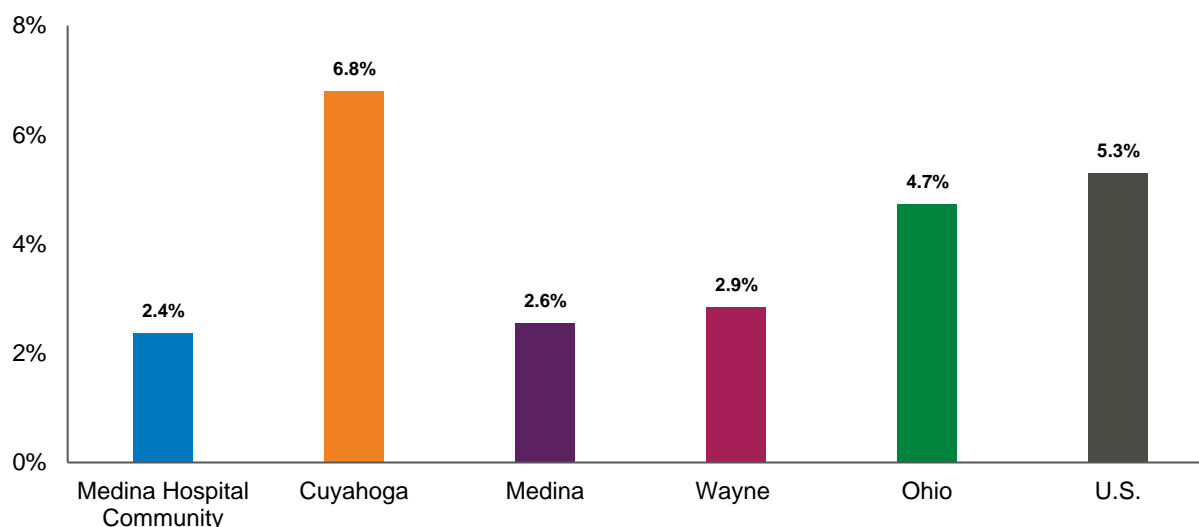
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, 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 Medina Hospital Community is 2.4%, which is lower than 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 (2015-2019) estimates

Education

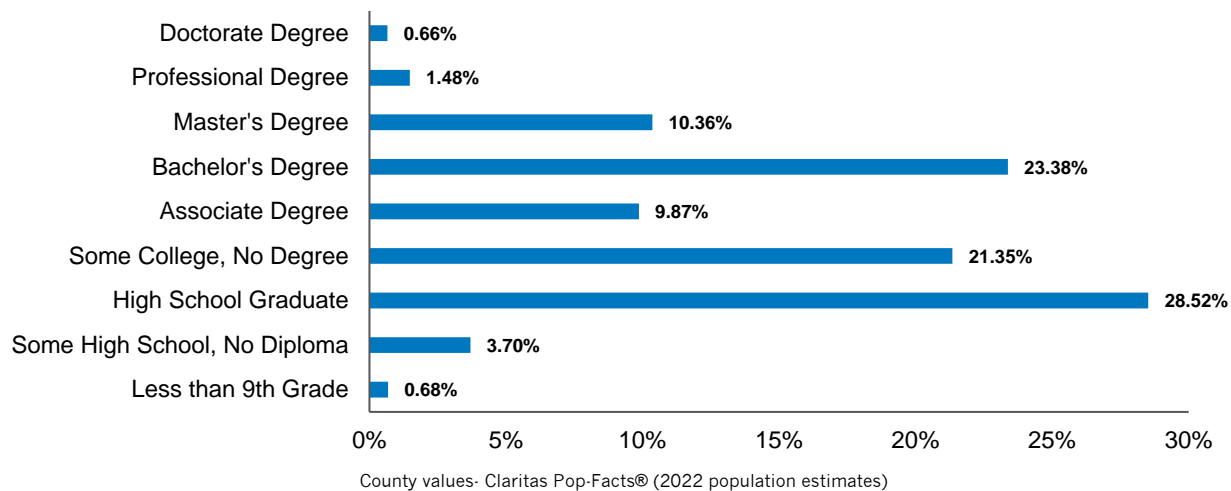
Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely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

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.

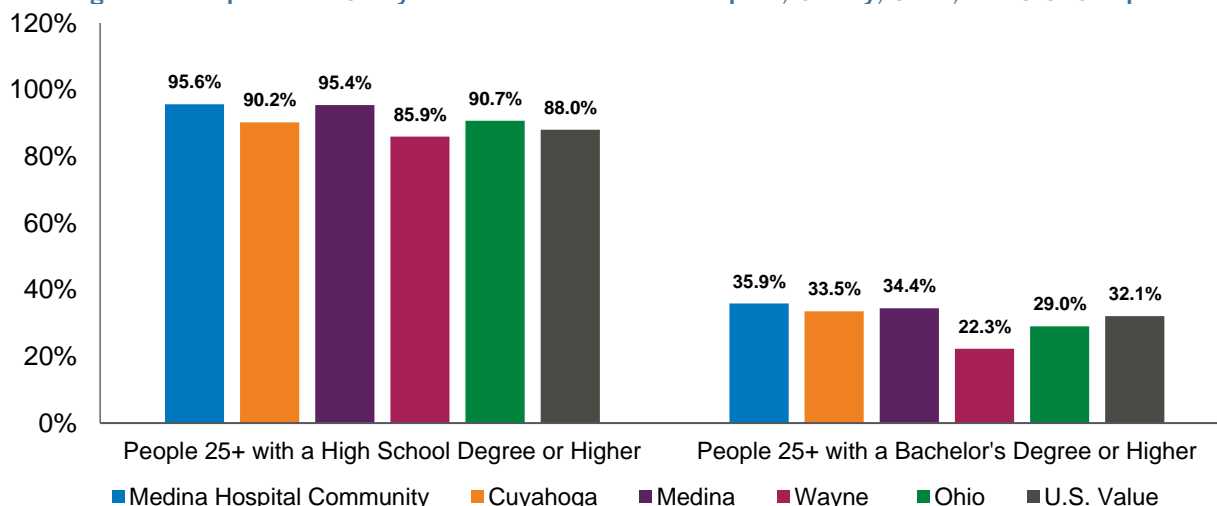
Figure 16: Population 25+ by Education Attainment: The Medina Hospital Community



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 Medina Hospital Community has a higher percentage of residents with a high school degree or higher (95.6%) and bachelor's degree or higher (35.9%) 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 (2015-2019) estimates

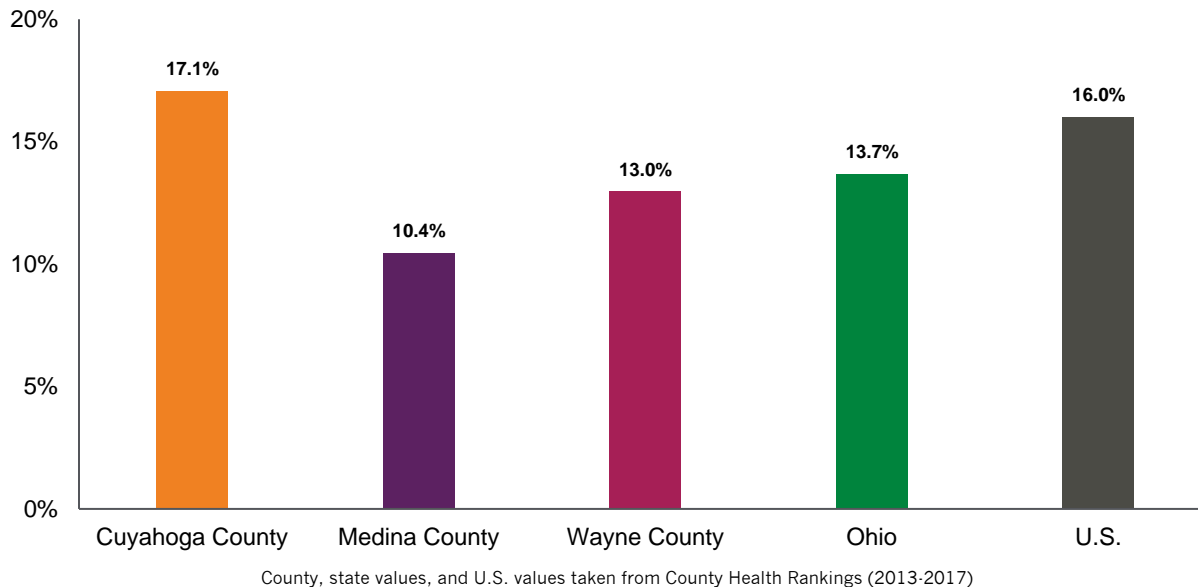
¹⁷ U.S. Department of Health and Human Services, Healthy People 2030. <https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation>

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



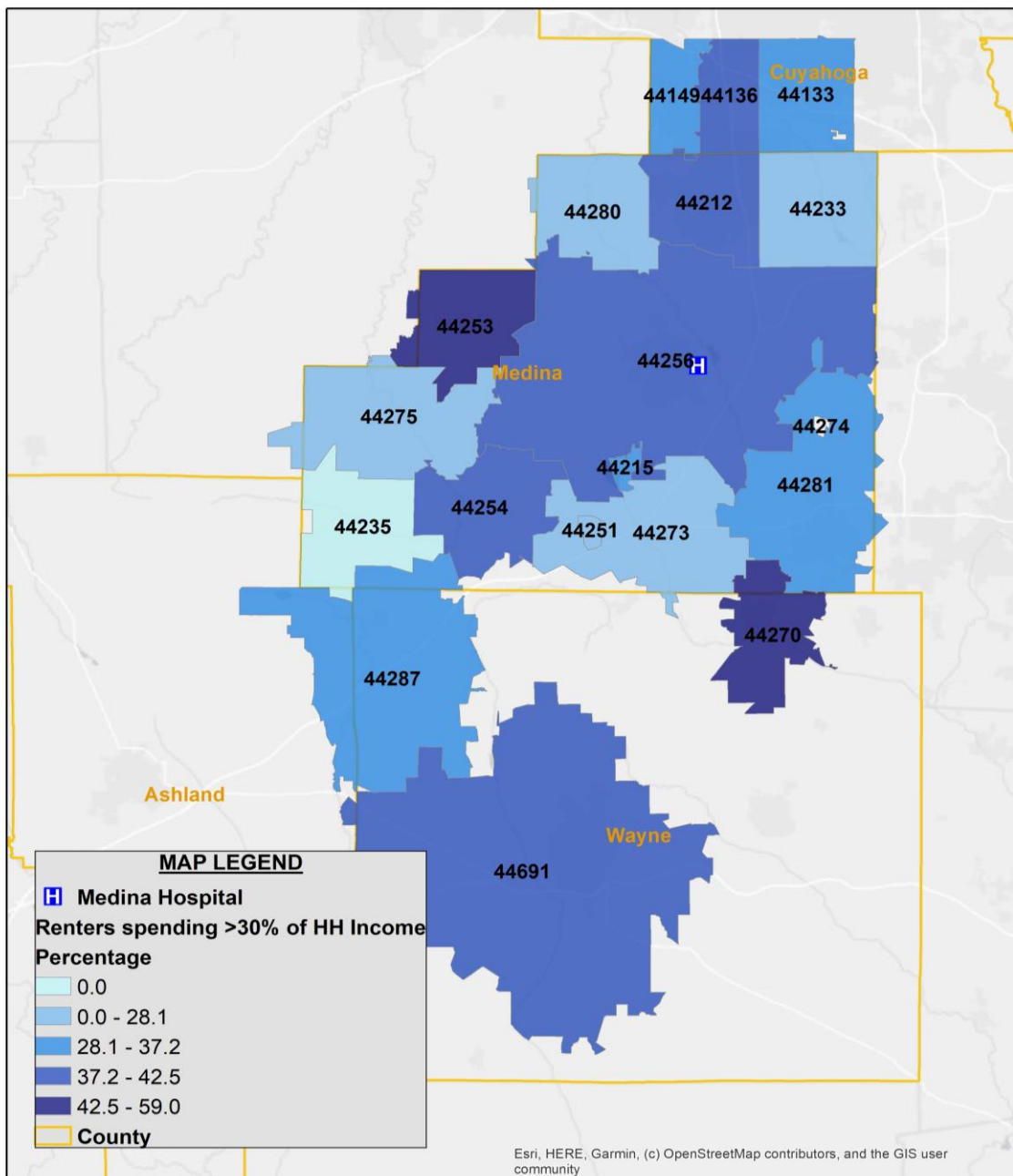
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.¹⁹

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

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

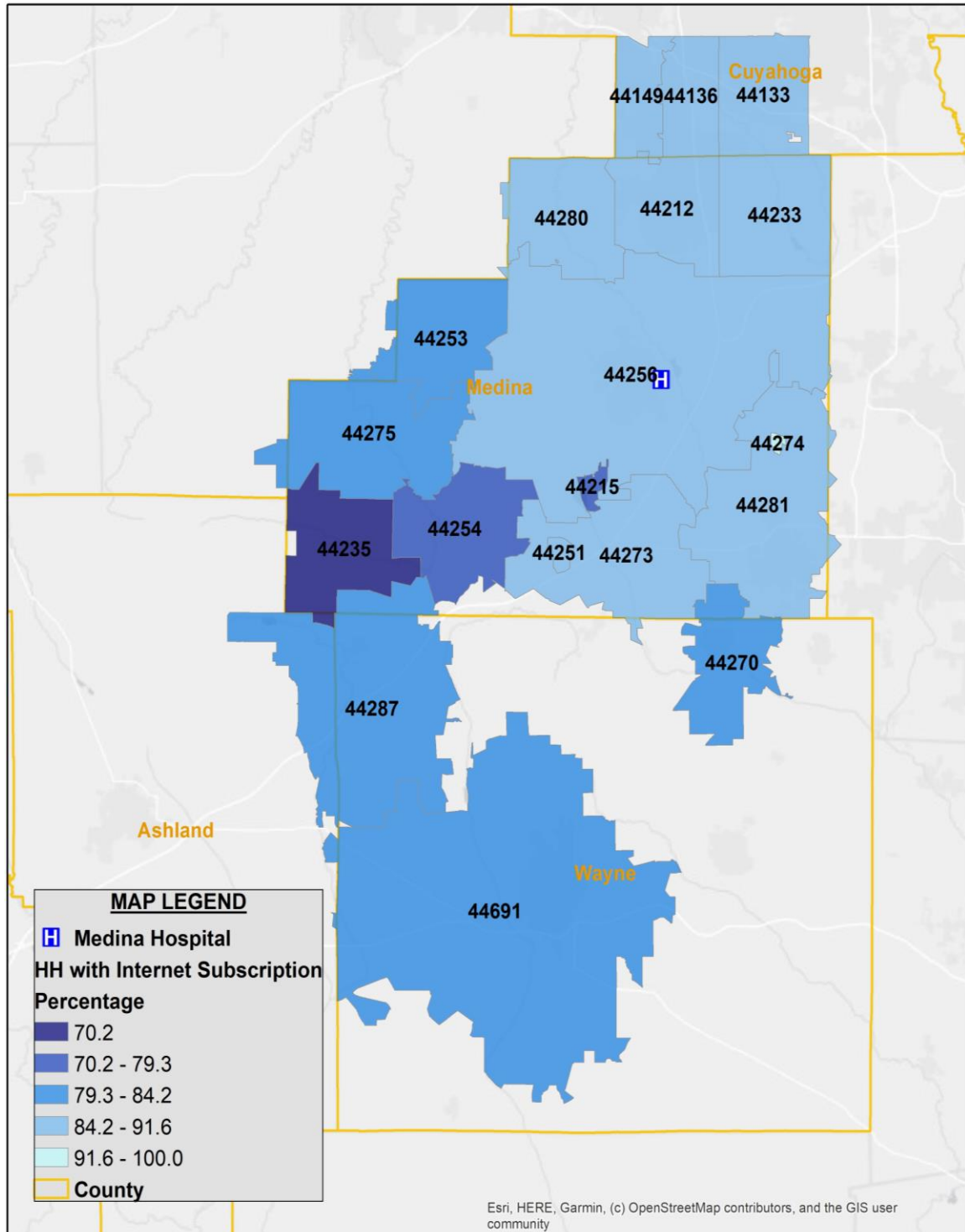
Neighborhood and Built Environment

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

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>

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. 44235 (Homerville) has the least percentage of households with internet connection, represented by darkest shade of blue on the map.

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 Disparity²³ 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 Medina Hospital Community, based on the Index of Disparity.

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

Table 1: Indicators with Significant Race or Ethnic Disparities

Health Indicator	Group(s) Negatively Impacted
Babies with Very Low Birth Weight	Black/African American
Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Other Race
Families Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race
HIV/AIDS Prevalence Rate	Black/African American, Hispanic/Latino
People 65+ Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino
People Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, Two or More Races
Persons without Health Insurance	Hispanic/Latino, Other Race
Workers Commuting by Public Transportation	American Indian/Alaska Native, White (Non-Hispanic)
Workers who Walk to Work	Other Race, American Indian/Alaska Native
Young Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Native Hawaiian/Pacific Islander, Other Race

The Index of Disparity analysis for Cuyahoga, Medina, and Wayne counties reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, 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 HIV/AIDS Prevalence Rate while Black/African American populations experience higher rates of Babies with Very Low Birth Weight. Hispanic/Latino and Other Race groups also have the highest rates of Persons without Health Insurance, compared to other races/ethnicities in the region.

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

Geographic Disparities

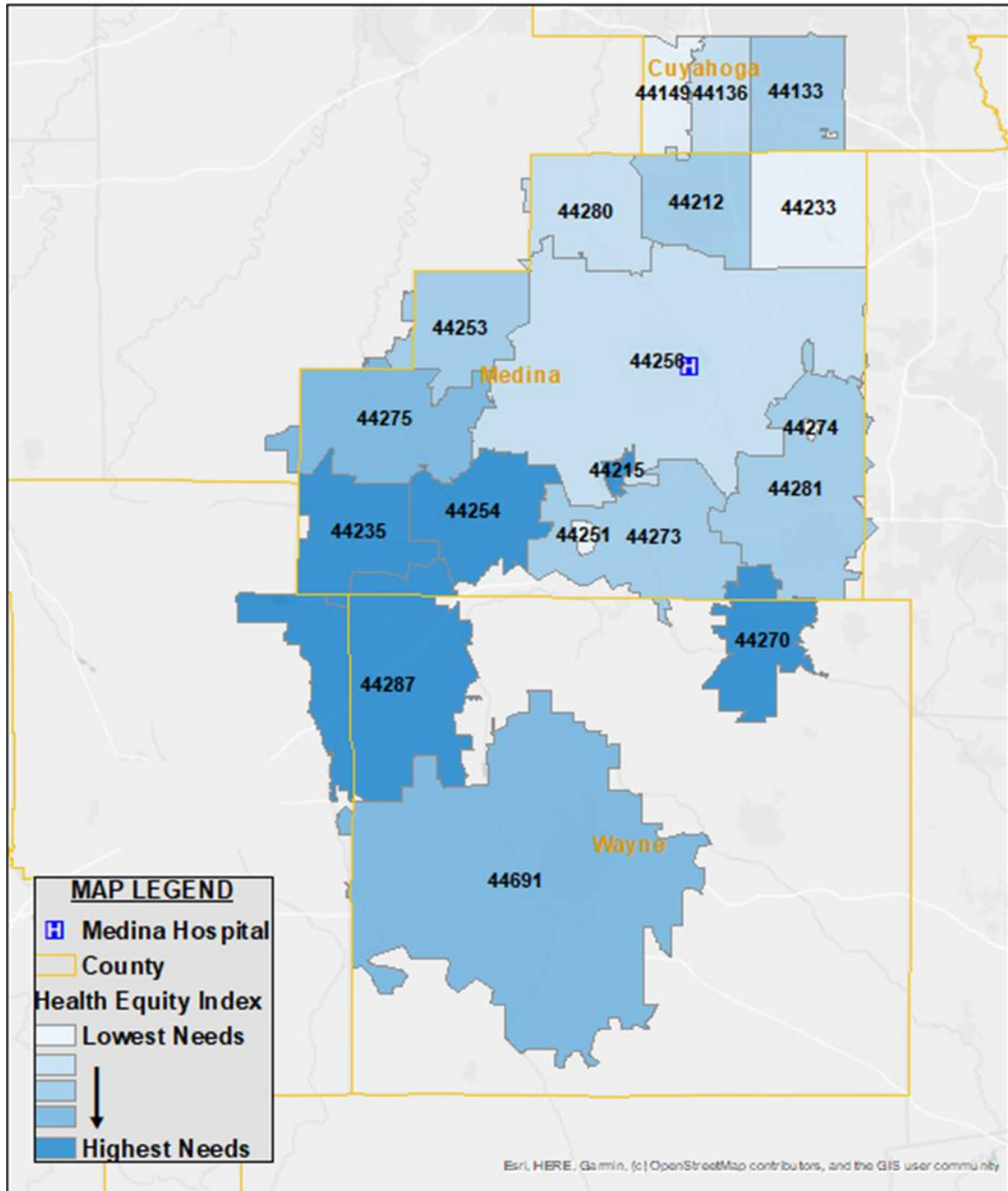
In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific zip codes/municipalities with differences in outcomes related to health

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 Medina Hospital Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44235, 44254, 44215 in Medina County, 44287, and 44270 in Wayne County. Appendix A provides the index values for each zip code.

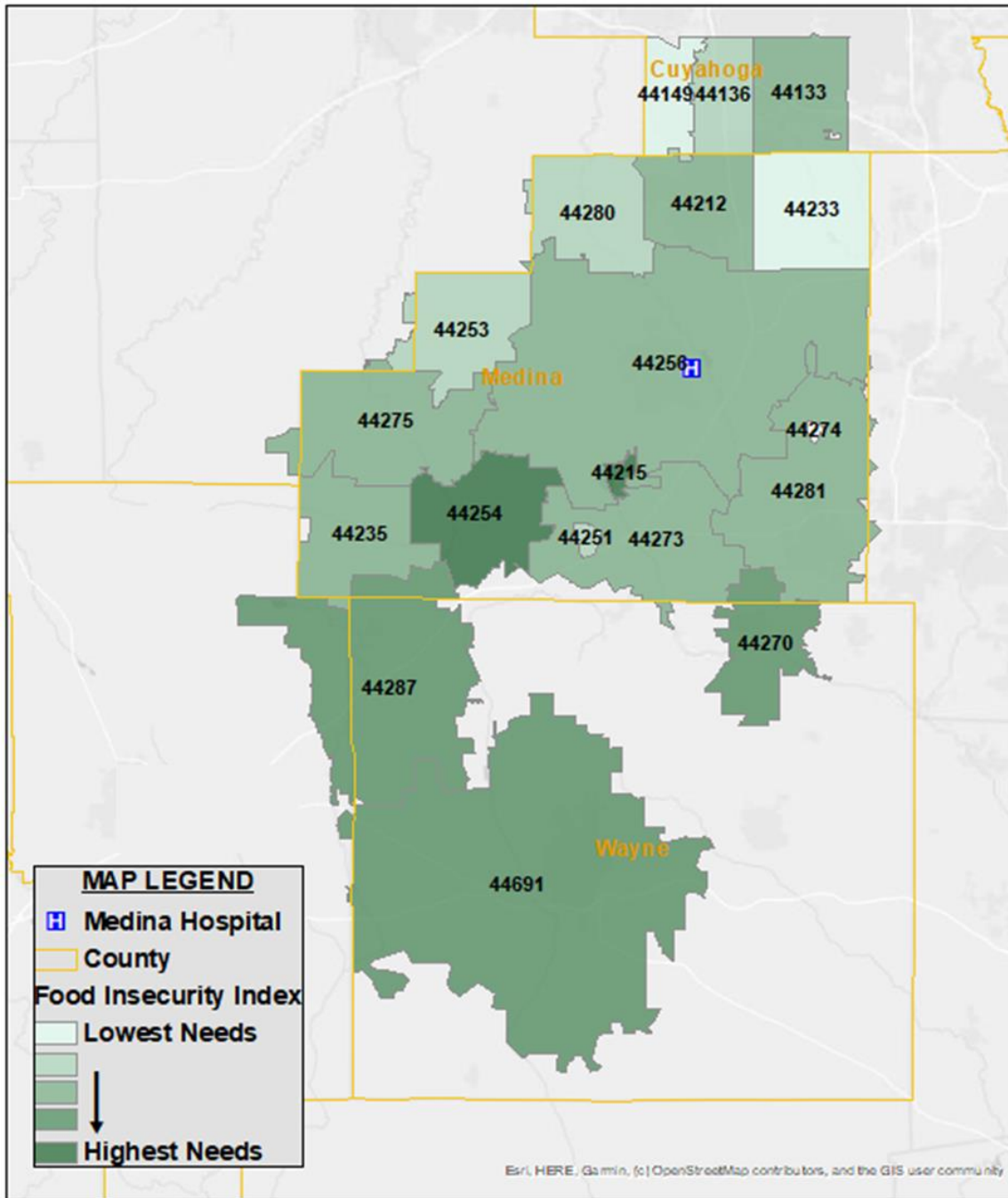
Figure 21: Health Equity Index



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): 44254 and 44215 in Medina County. Appendix A provides the index values for each zip code.

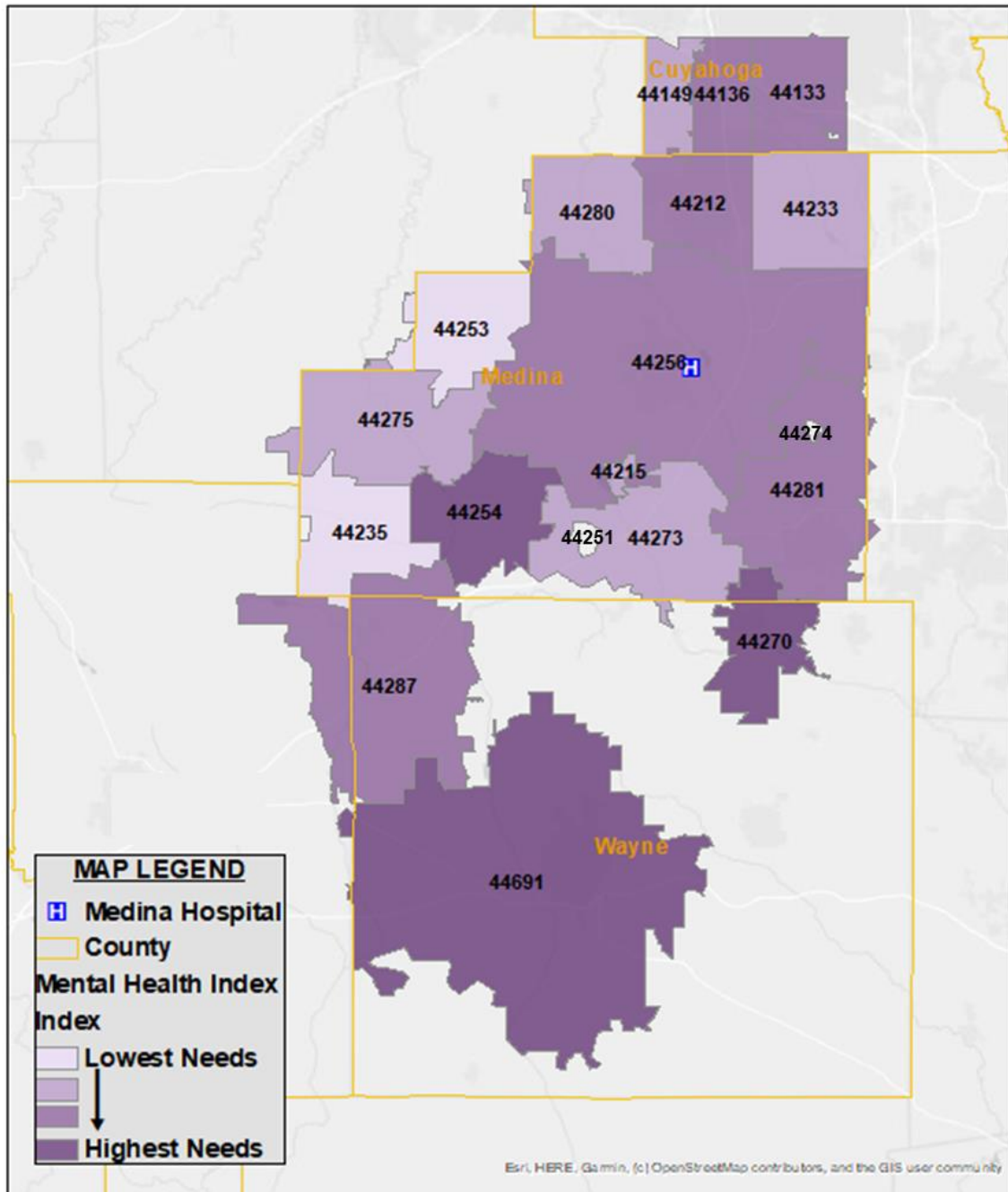
Figure 22: Food Insecurity Index



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): 44254 in Medina County and 44691 and 44270 in Wayne County. Appendix A provides the index values for all zip codes within the Medina 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 Medina 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.

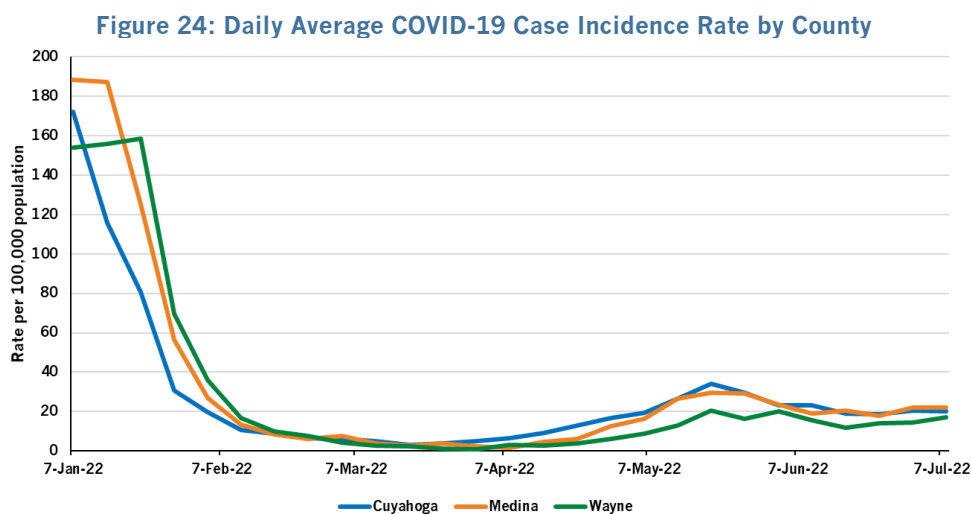
COVID-19 Pandemic

Community Input

Key stakeholder interviews and the Medina 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. Widespread workforce attrition during the pandemic placed additional burdens on those who continued to work—placing them both at greater risk for disease and higher stress levels. Furthermore, inflation and other economic forces increased food insecurity among low-income populations and exacerbated existing challenges with finding safe and affordable housing.

The COVID-19 Daily Average Case Incidence Rate by County

Figure 24 shows the daily average COVID-19 case incidence rate for Cuyahoga, Medina, and Wayne 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.



County values- Centers for Disease Control and Prevention (2022)

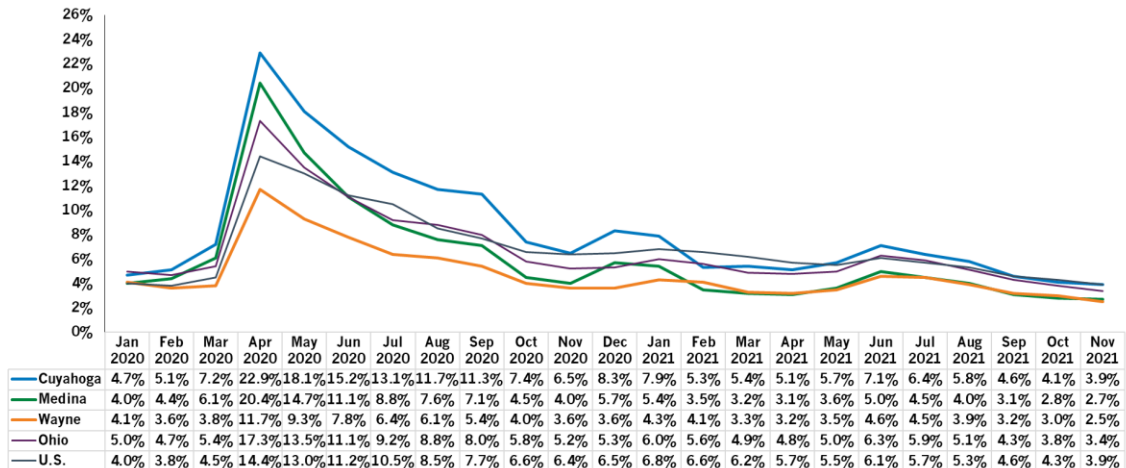
Vaccination Rates

As of June 2022, at least 46% of the population residing in counties within the Medina Hospital Community Definition are fully vaccinated against COVID-19. Cuyahoga County has the highest vaccination rates (65.5%), followed by Medina County (64.6%) and Wayne County (46.1%).

Unemployment Rates

Unemployment rates rose between March and April 2020 for Cuyahoga Medina, and Wayne 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



County, State, and National Values- Bureau of Labor Statistics (2020-2021)

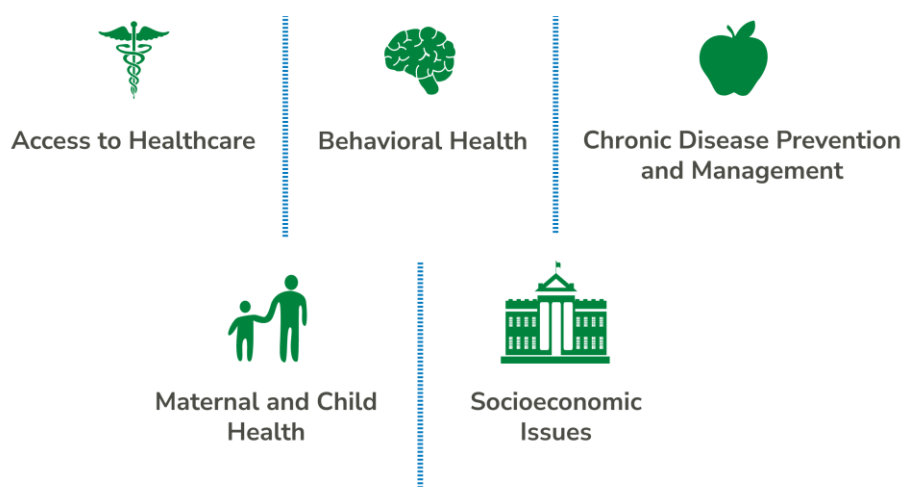
Synthesis and Prioritization

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 Medina 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. Four 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, Medina and Wayne 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



Prioritized Health Topic #1: Access to Healthcare

Access to Healthcare

Secondary
Data Score: **1.43**



Key Themes from Community Input



- Barriers: transportation, hours of operation and health illiteracy (not knowing what insurance covers/what parts to pay, making appointments at Cleveland Clinic is difficult)
- Cultural beliefs within Amish communities effects health behaviors and outcomes
- 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
- Dentists accepting Medicaid is large need (Wayne County)
- Issues of discrimination/bias create mistrust in healthcare solutions:
 - doctors that look like the people they're serving
 - building 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



- Children with Health Insurance
- 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

Access to Health Care was described as a top health need by the Medina Hospital Community Advisory Council members participating in the Community Engagement Session. Access, and access-related topics including transportation, affordability of care and health disparities were described as among the top barriers to improving health. Affordable prescriptions and coverage for hospice or other high-cost medical services were discussed as barriers to improving health in the community.



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

Racial, economic, geographic, educational, and environmental inequities can all impact access to care and disproportionately affect communities of color. Three key themes surfaced from community discussions with key informants, including systemic inequities in healthcare, the need to focus on preventative care, and barriers to healthcare. Key stakeholders noted a lack of investment in prevention practices, including accessibility of primary services at a local level. Finally, there was discussion surrounding the need for Dentists to accept Medicaid in Wayne County, specifically, for adults.

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 who 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 a fragmented healthcare system, ability to pay for services/insurance (lack of insurance, high co-pays/deductibles), and communication challenges between providers and patients.

Secondary Data

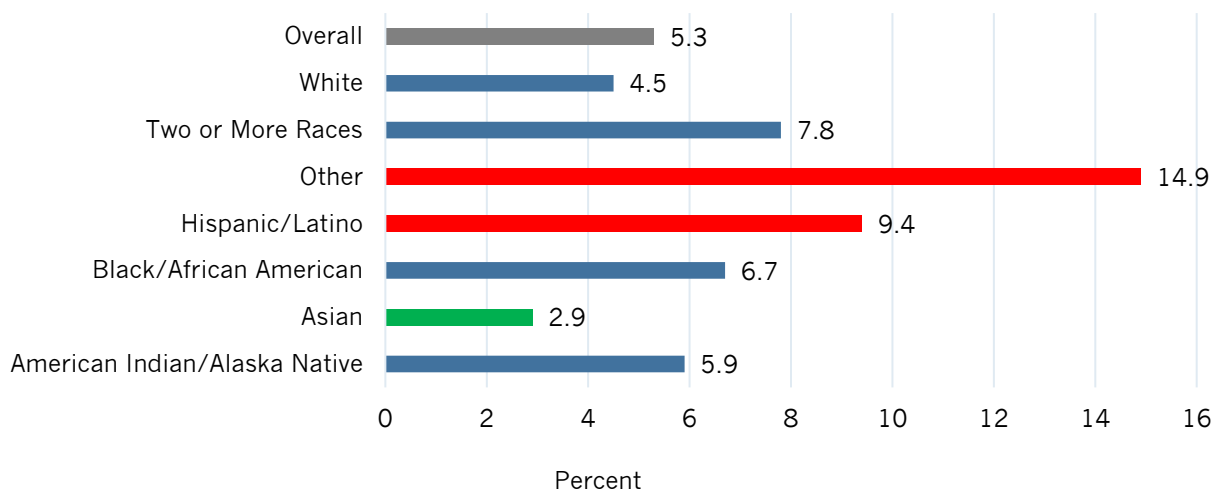
From the secondary data scoring results, Health Care Access & Quality ranked as the 11th highest scoring health need, with a score of 1.43. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized 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 Medina County is \$5,410.80, which is higher than the average dollar amount spent on health insurance in the state of Ohio, where that amount is \$4,371.7 dollars per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. For this indicator, Medina County 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

Consumer Expenditures: Medical Services also ranked poorly in all three counties: Cuyahoga, Medina and Wayne. This indicator measures the average dollar amount spent on medical services per consumer unit. This includes expenditures on eye care, dental care, physician care, non-physician care (e.g., chiropractors, naturopaths, psychologists, midwives), lab and blood tests, x-rays, hospital rooms and related services, nursing homes/convalescent care, and other medical services. In 2021, Medina County residents spent \$1,419.1 per consumer unit on medical services

The rising costs of medical care and lack of insurance affects all races and ethnicities. However, in Cuyahoga County, people identifying as Hispanic/Latino and Some Other Race are disproportionately affected (see red in Figure 27 below). Conversely, Asian residents of Cuyahoga County have the lowest rate of persons without health insurance (see green below).

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



Source: American Community Survey, 2019

²⁴ Kaiser Family Foundation, 2020 and 2015

²⁵ The Commonwealth Fund, 2019

Prioritized Health Topic #2: Behavioral Health

Behavioral Health: Mental Health

Secondary
Data Score: **1.51**



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 meaningful investment in true community health programming
- Lack of providers to meet the increasing mental health/behavioral health needs
- 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
- Reported as increasing in both teachers and school-aged children as a result of COVID-19 isolation
- 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



- Adults Ever Diagnosed with Depression
- 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 Medina Hospital Community Advisory Council, representing a range of organizations within the community, who attended the Community Engagement session described 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 use and abuse alcohol, illicit drugs and prescription drugs as a form of self-medication to cope with stress. Notable stressors included inflation impacts on low-income populations and work-related stressors resulting from workforce attrition during the COVID-19 pandemic. Further, attendees reported an increase in mental health concerns and the difficulty of finding mental health providers to meet the rising demand for services.

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 resulting from differences in investment in education and resources for different communities. Furthermore, key informants shared that member of the LGBTQ community experience disproportionate mental health issues and are at a higher risk of suicide, particularly among those identifying as transgender. Participants also shared that the LGBTQ+ community has increased experiences with discrimination, bigotry and

isolation. These were thought to contribute to increased mental health risks. Stakeholders recommended an increase in meaningful investment in community health programming.

Secondary Data: Mental Health

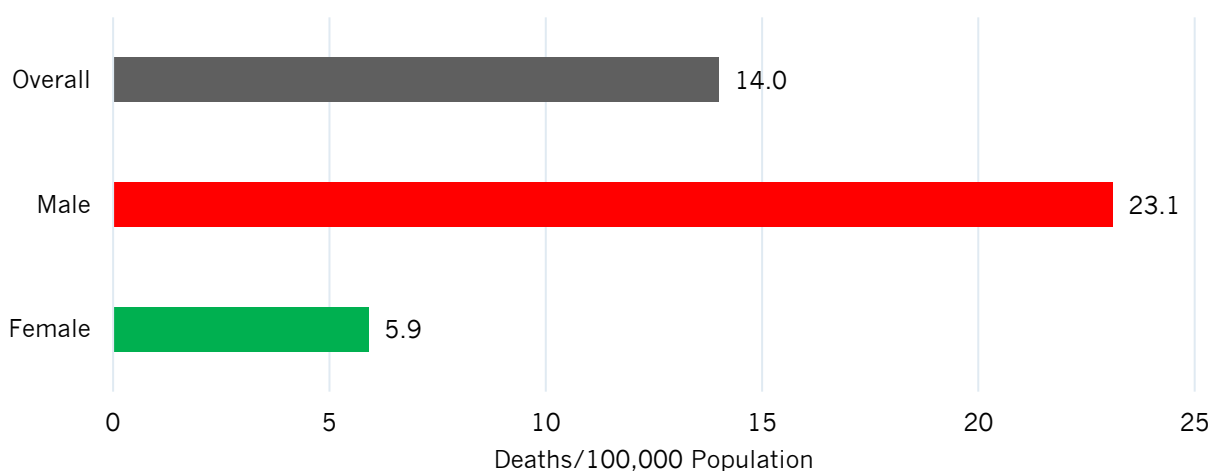
From the secondary data scoring results, Mental Health & Mental Disorders had the third highest data score of all topic areas, with a score of 1.53. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) 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 Alzheimer’s Disease is ranked poorly in Wayne County where the death rate is 38.1 per 100,000 population. Additionally, the Age-Adjusted Death Rate due to Suicide is a top area of concern in Wayne County. Wayne County has a rate of 16.7 deaths per 100,000 population and the trend over the last four years is increasing for both indicators.

Age-Adjusted Death Rate due to Suicide is also an area of concern in Medina County with a data value of 15.7 deaths due to suicide per 100,000 population. Depression in the Medicare Population is also of concern with 19% of Medicare beneficiaries in Medina County treated for depression. Both indicators are increasing significantly.

Disparities within the mental health topic area were also found for Medina Hospital community. As seen in Figure 28, in Cuyahoga County, the age-adjusted death rate due to suicide for males is 23.1 deaths per 100,000 population (see red below), compared to 5.9 deaths per 100,000 for females (see green below).

Figure 28. Age-Adjusted Death Rate due to Suicide by Gender in Cuyahoga County



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

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:

1.46



Key Themes from Community Input



- Access to healthy food limited by transportation, minimal grocery stores nearby, built environment, affordability
- Conditions such as hypertension asthma, diabetes, COPD, coronary heart disease, all related to the quality of food one has access to
- COVID-19 impacted the need for food and levels of food insecurity: i.e. homebound individuals, children reliant on school breakfast/lunch
- Effects of redlining are still seen—these are the neighborhoods that do not always have grocery stores in a close mile radius
- Food banks are seeing employees from medical institutions that are food insecure: institutions have really impactful voices and need to start advocating for things that affect so many of their employees and their patients i.e. paying employees wages & having benefits that allow them to be healthy/eat healthy
- 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
- More focus on expanding access to federal SNAP benefits as money is available but can't always get income eligible people as a community approved for benefits and get a SNAP card into their hands to use to access healthy food at the supermarket, also affects supermarket's ability to operate in a low income neighborhood

Warning Indicators



- Consumer Expenditures: Fast Food Restaurants
- Consumer Expenditures: High Sugar Beverages
- Consumer Expenditures: High Sugar Foods

Participants in the Medina Hospital Community Engagement Session described rates of food insecurity in the community that increased proportionately with unemployment rates during the pandemic. Participants mentioned that low-income community members were the population most impacted by inflation and housing prices. Shifting economic forces impacting the ability to purchase healthy foods, stigmas associated with accessing food assistance and unstable employment were described as the top barriers to improving health.

Key stakeholders revealed that access to healthy food was often limited by a lack of either public or private transportation. Participants shared that there were few or no grocery stores in some neighborhoods and existing stores were not within walking distance for some community members. Some key informants who were interviewed shared concerns that a lasting effect of redlining policies was limited access to grocery stores. Furthermore, key informants shared concerns about seeing an increase in employees from local healthcare systems receiving services at food banks and experiencing food insecurity. Participants expressed hope that healthcare institutions could help to address food insecurity within the walls of their hospital. Stakeholders perceived that COVID-19 greatly impacted food insecurity in the region as seen by elevated levels of need at food banks.

“ 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

Secondary Data

Nutrition & Healthy Eating had the sixth highest data score of all topic areas with a score of 1.46. 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: Fruits and Vegetables ranked highly in Cuyahoga and Wayne counties. In Wayne County, the average dollar amount per consumer unit spent on fruits and vegetables is \$818.0, which is lower than the Ohio state value of \$864.6 and the United States value of \$1,002.1.

In Medina County, consumer expenditures related to fast food restaurants and high sugar foods were identified as areas of concern. The average dollar spent per consumer unit on high sugar foods (cookies, ice cream, candy, gum, jams/jelly, etc.) in Medina County is \$627.0. This is higher than the Ohio value (\$519) and U.S. value (\$530.2). In addition, the average dollar amount spent per consumer unit on fast food restaurants is \$1,814.2 (compared to \$1,461 in Ohio and \$1,638.9 in the U.S.).

Prioritized Health Topic #4: Socioeconomic Issues

Prevention and Safety

Secondary Data Score: **1.50**



Key Themes from Community Input



- Affordable, accessible housing is a resource issue as there's not enough appropriate housing
 - home modifications to make it easier for people to stay in home i.e. ramp installations, walk-in shower instead of bathtubs
 - reduces fall risk, increases accessibility
- 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
- Urgent need for SANE nurses in Medina County for victims and survivors of sexual assault

Warning Indicators



- Age-Adjusted Death Rate due to Falls
- Adults with Current Asthma
- Age-Adjusted Death Rate due to Unintentional Poisonings
- Asthma: Medicare Population
- Children with Low Access to a Grocery Store
- Fast Food Restaurant Density
- Grocery Store Density
- Number of Extreme Precipitation Days
- People 65+ with Low Access to a Grocery Store
- Physical Environment Ranking
- SNAP Certified Stores
- WIC Certified Stores

Primary Data: Key Stakeholder Interviews and Community Engagement Session

The Prevention and Safety health topic includes a variety of subtopics namely affordable housing, violence, unintentional injuries and falls. During the Medina Hospital Community Engagement Session affordable housing was a key concern for participants. Low-income persons—particularly those living in southern Medina County, subsidized housing or mobile housing parks were described as among the most underserved populations in the community. Further, some of the ways to improve health in the community that participants suggested included addressing social determinants of health; stigmatizations surrounding mental health, substance abuse and unemployment; focusing on disease prevention in the community; improving housing and healthcare affordability; and collaborating with underserved populations to identify solutions.

Key stakeholders couched discussions around specific health needs in the context of intergenerational experiences of poverty, poor housing conditions and historical redlining. They shared that there is generally a lack of resources for individuals and communities to create healthy conditions for people to live, work and play. Some participants also shared their concerns that transgender patients were experiencing higher rates of violence.



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

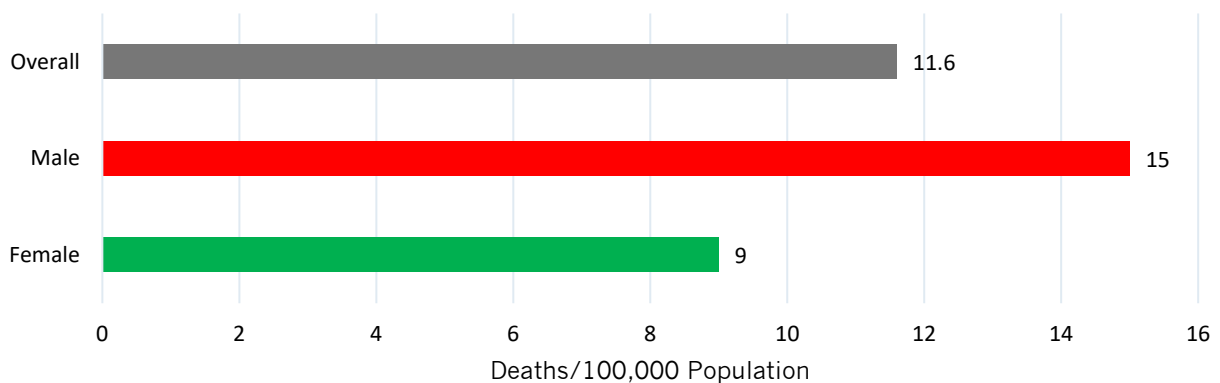
Prevention & Safety ranked fourth among all health topics with a score of 1.50. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix 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 is an area of concern in the prevention & safety topic area for Wayne County where the death rate is 16 per 100,000 population.

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.

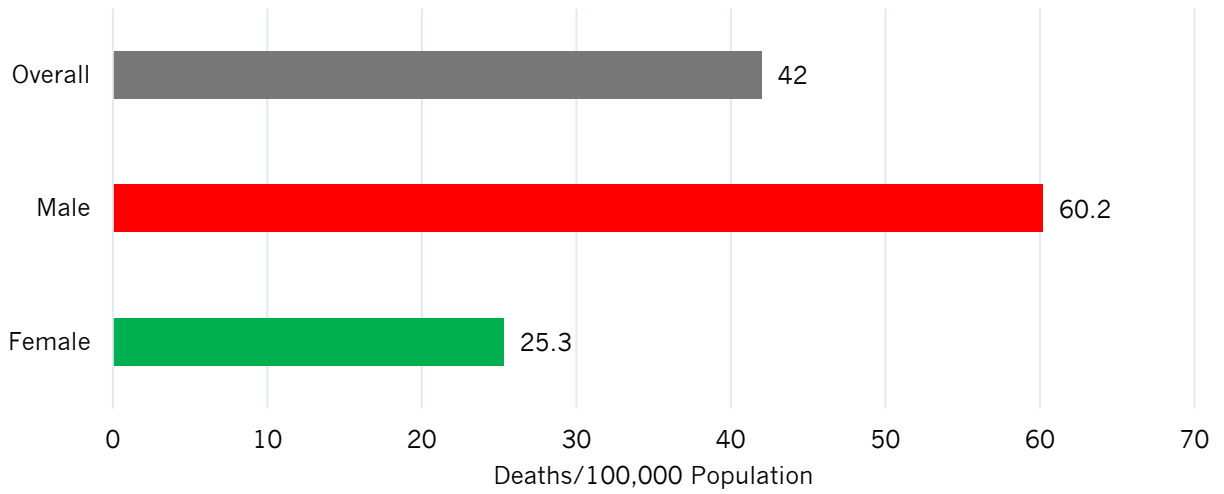
In Cuyahoga County, disparities exist for males in the following indicators: Age-Adjusted Death Rate due to Falls, Age-Adjusted Death Rate due to Unintentional Poisonings, and Age-Adjusted Death Rate due to Unintentional Injuries as seen in Figures 29, 30 and 31.

Figure 29. Age-Adjusted Death Rate due to Falls by Gender In Cuyahoga County



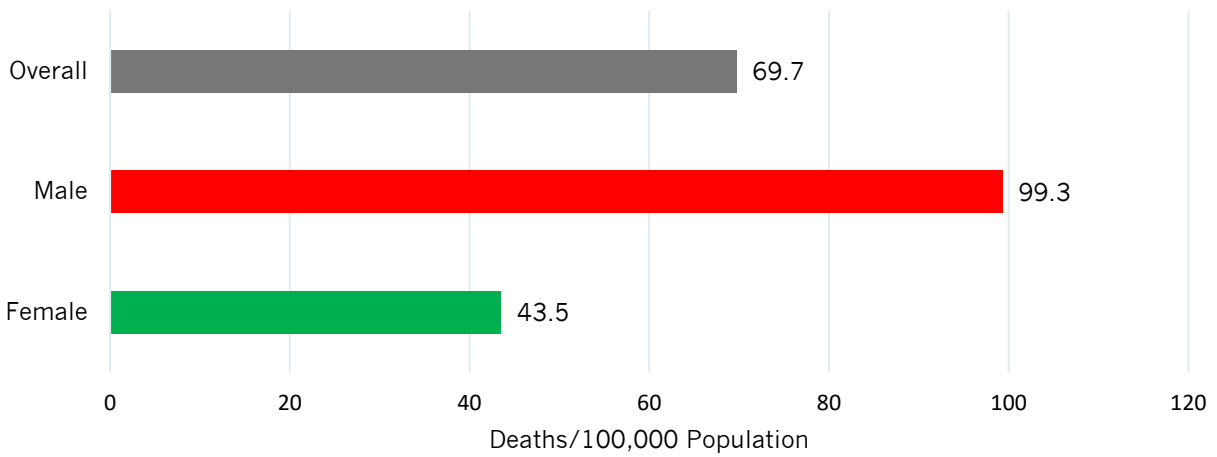
Source: Centers for Disease Control and Prevention, 2017-2019

Figure 30. Age-Adjusted Death Rate due to Unintentional Poisonings by Gender in Cuyahoga County



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

Figure 31. Age-Adjusted Death Rate due to Unintentional Injuries by Gender in Cuyahoga County



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

2022 Medina Hospital CHNA Alignment

The final prioritized health needs from this 2022 Medina Hospital CHNA are in alignment with some of 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 Medina CHNA priority areas. The check mark icon in Figure 32 indicates areas of alignment.

Figure 32. Medina Hospital CHNA Alignment

2019 Ohio SHA/SHIP	2019 Medina Hospital CHNA	2022 Medina Hospital CHNA
<p>Top Health Priorities:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> • Mental Health & Addiction <input checked="" type="checkbox"/> • Chronic Disease <input checked="" type="checkbox"/> • Maternal and Infant Health <p>Top Priority Factors Influencing Health Outcomes:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> • Community Conditions <input checked="" type="checkbox"/> • Health Behaviors <input checked="" type="checkbox"/> • Access to Care 	<p>Priority Health Areas:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> • Access to Affordable Healthcare <input checked="" type="checkbox"/> • Addiction and Mental Health <input checked="" type="checkbox"/> • Chronic Disease Prevention and Management <input checked="" type="checkbox"/> • Infant Mortality <input checked="" type="checkbox"/> • Socioeconomic Concerns • Medical Research and Health Professions Education 	<p>Prioritized Health Needs:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> • Access to Healthcare <input checked="" type="checkbox"/> • Behavioral health (Mental health and Substance Use Disorder) <input checked="" type="checkbox"/> • Chronic disease prevention and management <input checked="" type="checkbox"/> • 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, Medina, and Wayne 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 Medina 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 Medina 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

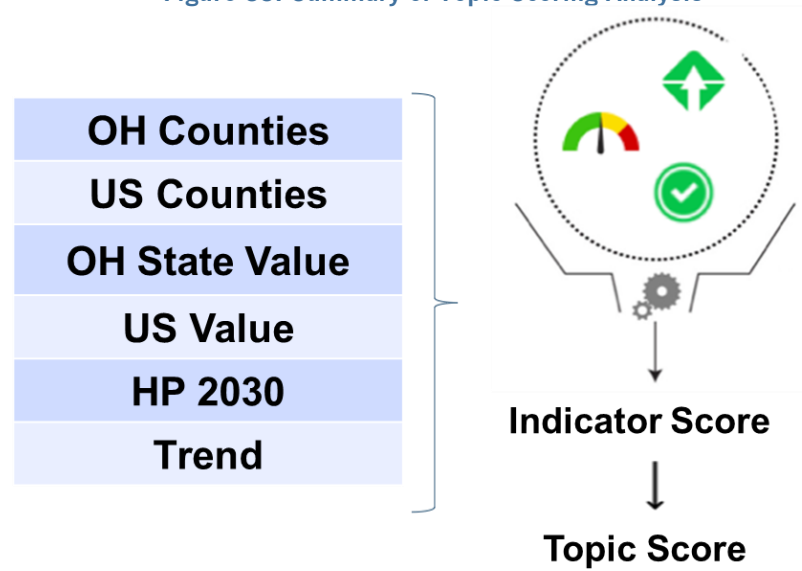
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food Environment Atlas
- U.S. Environmental Protection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

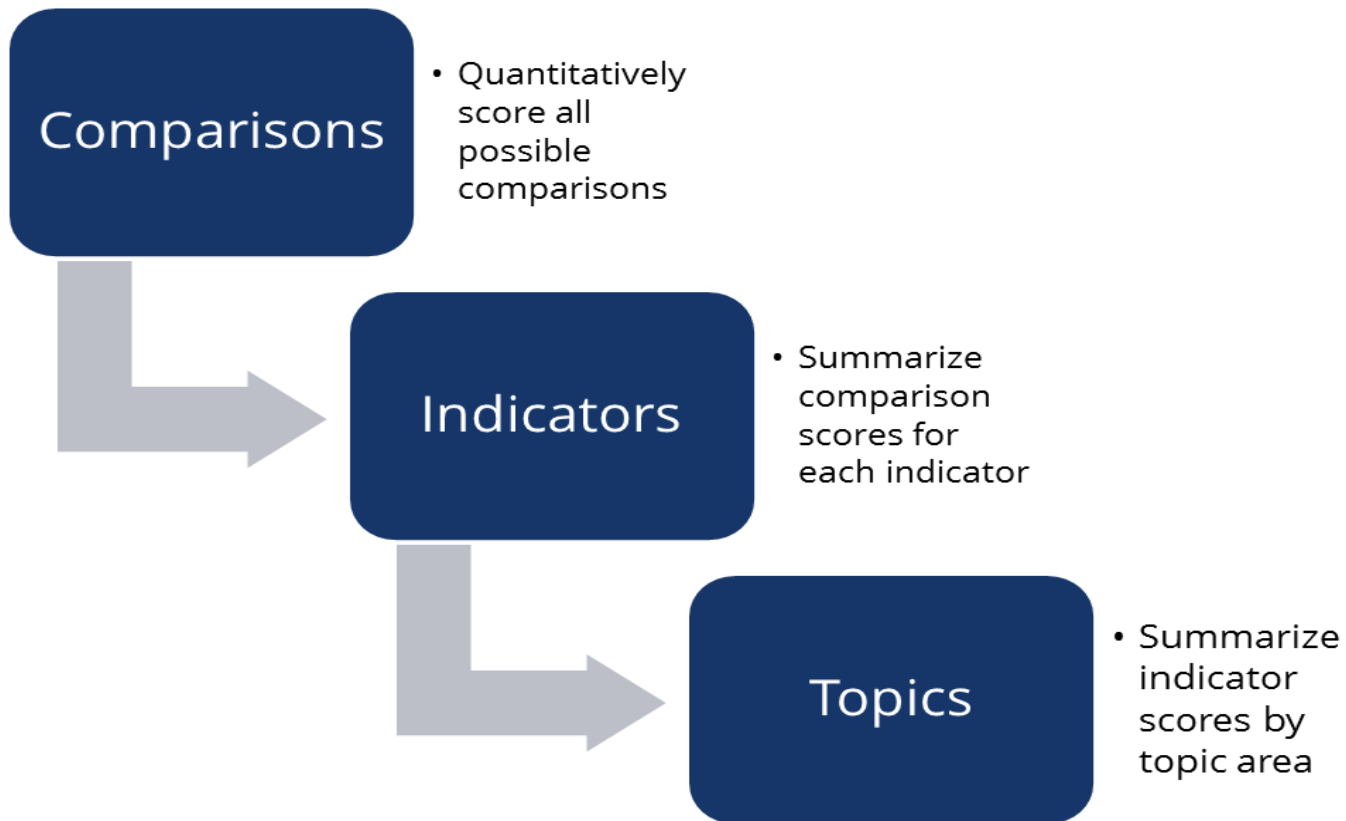
HCI's Data Scoring Tool (Figure 33) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national 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 33: 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 Medina Hospital Community: Cuyahoga, Medina, and Wayne 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 Medina 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 Medina Hospital Community, ranked in order of highest need. Medications & Prescriptions scored as the poorest performing topic area with a score of 2.00, followed by Other Conditions with a score of 1.55. Topics that received a score of 1.50 or higher were considered a significant health need. Three 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
Medications & Prescriptions
Other Conditions
Mental Health & Mental Disorders
Prevention & Safety

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 Medina Hospital Community and their respective HEI, FII, and MHI values.

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

Zip Code	HEI Value	FII Value	MHI Value
44133	14.5	20.6	49.9
44136	10.7	12.2	55.7
44149	6.1	5.4	31.4
44212	16.9	26.6	42.6
44215	48.6	62.5	29
44233	5.8	2.6	29.9
44235	48.1	20.5	12.8
44251	6.7	7.4	N/A
44253	19.6	9.1	4
44254	58.2	63.1	76.4
44256	11.7	19.9	43.3
44270	60.2	50.6	66
44273	20	28.6	27.4
44274	N/A	N/A	N/A
44275	29	26.3	28
44280	9.9	8.3	24.2
44281	14.6	24.3	40
44287	59.9	49.9	54.4
44691	42.8	42.6	75.4

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

Medina Hospital invited members of the hospital Community Advisory Council (CAC) to participate in a community engagement session. The session was held virtually on June 23, 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 34 shows the results from analysis of inputs collected from these tools.

Figure 34: Community Engagement Session Findings

Top health issues	Barriers/Social Determinants of Health	Populations most impacted
<ul style="list-style-type: none"> • Mental Health • Access to Affordable Healthcare • Food Insecurity • Housing • Substance Use 	<ul style="list-style-type: none"> • Income insufficiency • Affordable prescriptions and insurance coverage • Stigma associated with needing help (food, health care navigation) • Transportation • Workforce stability/staffing issues 	<ul style="list-style-type: none"> • LGBTQIA+ • Low income • Southern Medina County • Subsidized and mobile housing residents • Children/Adolescents

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.

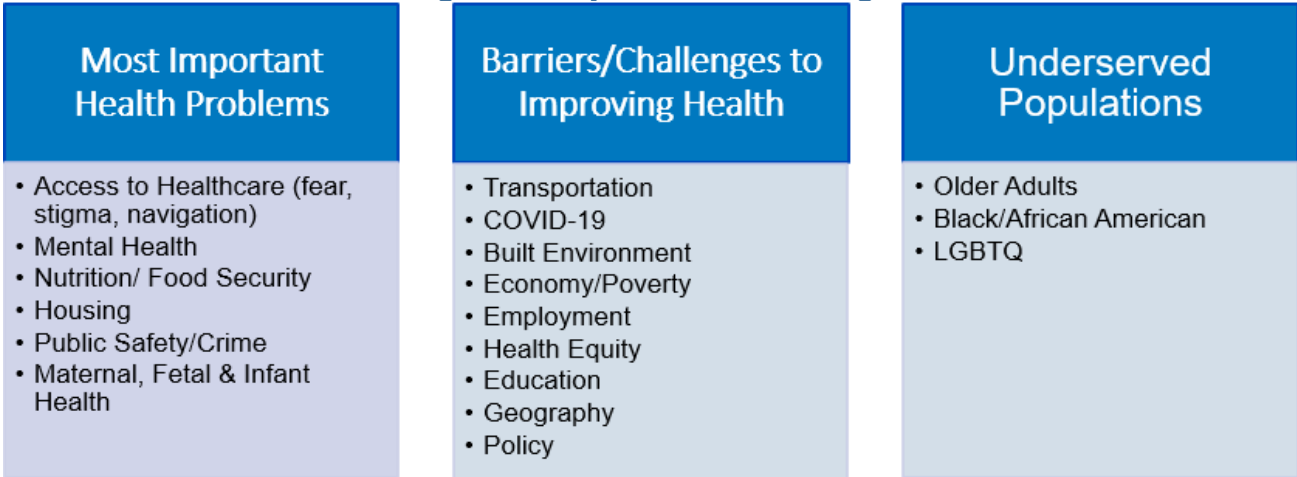
Table 4: Medina Hospital Key Stakeholder Organizations

Key Stakeholder and Community Organizations	
<ul style="list-style-type: none"> • City of Cleveland Department of Public Health • Cuyahoga County Board of Health • Medina County Health Department • Wayne County Health Department 	<ul style="list-style-type: none"> • Neighborhood Family Practice • Birthing Beautiful Communities • Lead Safe Cleveland Coalition • Better Health Partnerships • NAMI Greater Cleveland

<ul style="list-style-type: none"> • Medina Hospital Community Advisory Council 	<ul style="list-style-type: none"> • 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
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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 35 shows key findings from community stakeholder interviews specific to the Medina Hospital Community.

Figure 35: Key Stakeholder Findings



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 Medina 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

Medina 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, 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. In addition to direct patient care, Cleveland Clinic's Opioid Awareness Center, provides intervention and treatment for substance abuse disorders to Cleveland Clinic caregivers and their family members.
 - 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, Cleveland Clinic participates in the Northeast Ohio Hospital Opioid Consortium and Medina's Opiate Task Forces, and community-based classes and presentations. Cleveland Clinic continues to provide preventative education and share evidence-based practices
 - Medina Hospital strengthened relationships with community partners in regard to opiate outreach, including representation on the Medina County Overdose Fatality Review Committee which offers providers educational opportunities to learn more about language usage with those in recovery or active addiction.
 - Medina Hospital continues to provide training and supplies of the prescription drug Narcan (naloxone) nasal spray to our county law enforcement colleagues who are often first on the scene of opioid overdoses.
 - Funding was provided to Cathy's House, a recovery housing site, amounting to three weeks of rental assistance for sixty residents.
 - Partnered with Alternative Paths to provide 24/7 crisis intervention and referral services for patients who present to the emergency department with psychiatric symptoms and substance use disorders.
- c. Cleveland Clinic has developed suicide risk and self-harm policies, procedures and screening tools for patients in a variety of care settings.
 - Medina Hospital continues to partner with Alternative Paths and expand involvement in county-wide initiatives for those experiencing mental health crisis, including imbedding a clinician in the emergency department to address behavioral health issues.
 - Medina Hospital has representation on the Medina County Local Outreach to Suicide Survivors (LOSS) Team which provides trainings throughout the community to raise suicide awareness and help identify potential victims.

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 COVID 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. Through the Healthy Medina initiative, provided health and wellness programs related to nutrition and physical activity to community members. The Healthy Medina workplace wellness program offered health education and activity tracking to thirteen workplaces throughout the county.
- c. Implemented health promotion messaging, health education, and outreach programs related to reducing behavioral risk factors, including *Healthy Strides*, community health education sessions and school-based education on heart disease and stroke
- d. Through the Healthy Communities Initiative (HCI), partnered 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.
- e. Provided free health screenings for the surrounding communities at the Medina Community Recreation Center, Cloverleaf Recreation Center, local schools, and other community-based locations.
- f. Partnered with Red Cross 'Stop the Bleed' program to educate the community on issues regarding victims of trauma.

- g. Partnered with the Medina County Health Department as a member of the *Living Well Medina* County workgroups related to chronic disease, obesity, heart health, vaping, and diabetes. Although COVID impacted this action, we collaborated with Medina County Health Commissioner, coordinating community COVID-19 educational outreach efforts to schools, county leadership and faith-based organizations. Additional educational efforts were reinstated in spring 2022 including chronic disease, heart health and mental health.

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. Partnered with Medina Police Activities League in youth engagement strategies and support the Medina County Career Center by providing volunteer work experience for students with developmental disabilities.
- d. Provided emergency preparedness training including Rescue Task Force training, role-play scenarios for first responders, and Code Silver event training.
- e. Provided safety training in collaboration with the City of Medina.
- f. Provided 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. Efforts paused by COVID are currently being explored. Connected Career Rounds provided 4,233 middle and high school students from 76 schools across 7 states including Ohio.
 - In 2021, Cleveland Clinic, an anchor institution in the Cleveland Innovation District, collaborated with the state of Ohio to launch in 2021 an initiative to advance healthcare and digital technology, attract and create new businesses, and train the workforce of the future. The state of Ohio and Cleveland Clinic pledged to contribute a combined \$565 million for the district — the largest research investment in our history.

- g. Sponsored the Medina Farmer’s Market, including a collaborative Juneteenth Celebration with Medina Diversity Project, Sister’s Circle, Second Baptist Church, City of Medina, and the Medina Farmer’s Market.
- h. Sponsored the Medina Community Recreation Center, which provides adult wellness programs, exercise classes, youth programming, and recovery programs. Programs were provided virtually throughout the pandemic.

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. Provided walk-in care at Express Care Clinics and offer evening and weekend hours.
- c. Utilizing medically secure online and mobile platforms, connected 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, advanced 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

Community Health Needs Assessment reports from 2019 were published on the Medina 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: Medina Hospital Community Definition

Zip code	Postal Name
44133	North Royalton
44136	Strongsville
44149	Strongsville
44212	Brunswick
44215	Chippewa Lake
44233	Medina County
44235	Homerville
44251	Westfield Center
44253	Litchfield
44254	Lodi
44256	Medina
44270	Rittman
44273	Seville
44274	Sharon Center
44275	Spencer
44280	Valley City
44281	Wadsworth
44287	West Salem
44691	Wooster

Table 6: Population Estimates for Each Zip Code

Zip code	City	Population
44133	North Royalton	31,201
44136	Strongsville	25,115
44149	Strongsville	20,163
44212	Brunswick	45,649
44215	Chippewa Lake	2,191
44233	Medina County	8,228

44235	Homerville	1,722
44251	Westfield Center	869
44253	Litchfield	3,497
44254	Lodi	4,683
44256	Medina	66,686
44270	Rittman	8,766
44273	Seville	6,815
44274	Sharon Center	#N/A
44275	Spencer	3,413
44280	Valley City	5,768
44281	Wadsworth	32,770
44287	West Salem	7,968
44691	Wooster	44,601

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

Zip Code	City	Families Below Poverty Level (%)
44133	North Royalton	3.00%
44136	Strongsville	3.70%
44149	Strongsville	2.00%
44212	Brunswick	3.90%
44215	Chippewa Lake	6.80%
44233	Medina County	4.20%
44235	Homerville	12.10%
44251	Westfield Center	6.40%
44253	Litchfield	1.20%
44254	Lodi	7.60%
44256	Medina	4.40%
44270	Rittman	11.40%
44273	Seville	2.50%
44274	Sharon Center	N/A

44275	Spencer	4.00%
44280	Valley City	N/A
44281	Wadsworth	3.40%
44287	West Salem	8.30%
44691	Wooster	7.40%

Table 8: Secondary Data Results by Health Topic— Cuyahoga, Medina and Wayne Counties







HEALTH TOPICS	CUYAHOGA	MEDINA	WAYNE	AVG
Alcohol & Drug Use	1.73	1.47	1.12	1.42
Cancer	1.71	1.34	1.31	1.49
Children's Health	1.72	1.34	1.24	1.45
Diabetes	1.17	0.89	1.45	1.27
Health Care Access & Quality	1.21	1.54	1.53	1.43
Heart Disease & Stroke	1.35	1.19	1.42	1.42
Immunizations & Infectious Diseases	1.20	0.82	1.30	1.16
Maternal, Fetal & Infant Health	1.56	1.03	1.32	1.32
Medications & Prescriptions	1.72	2.50	1.78	1.85
Mental Health & Mental Disorders	1.39	1.34	1.81	1.55
Nutrition & Healthy Eating	1.31	1.64	1.44	1.42
Older Adults	1.65	1.35	1.45	1.51
Oral Health	1.14	1.11	1.19	1.21
Other Conditions	1.83	1.53	1.28	1.51
Physical Activity	1.39	1.36	1.48	1.38
Prevention & Safety	2.21	1.00	1.29	1.35
Respiratory Diseases	1.23	0.96	1.33	1.29
Tobacco Use	1.19	1.11	1.86	1.49

Wellness & Lifestyle	1.49	1.10	1.53	1.40
Women's Health	1.46	1.22	1.67	1.42
QUALITY OF LIFE TOPIC	SCORE			
Community	1.66	1.09	1.28	1.35
Economy	1.68	0.74	1.05	1.18
Education	1.55	1.22	1.24	1.30
Environmental Health	1.53	1.19	1.43	1.40











Secondary Data Scoring Indicators of Concern

From the secondary data scoring results, Health Care Access & Quality ranked as the 8th highest scoring health need, with a score of 1.43. 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 36) 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 (Table 8).

Figure 36: Prioritized Health Needs

	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% (or best half) 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 trending up and this is not the ideal direction.
	The indicator is trending down, significantly, 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 Medina 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.

Medina County

SCORE	HEALTH CARE ACCESS & QUALITY	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
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2.50	Consumer Expenditures: Health Insurance	5410.8		4371.7	4321.1			...
2.50	Consumer Expenditures: Medical Services	1419.1		1098.6	1047.4			...
2.50	Consumer Expenditures: Medical Supplies	259.4		204.8	194.9			...
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	781.2		638.9	609.6			...
1.72	Primary Care Provider Rate	60.3		76.7				
1.50	Non-Physician Primary Care Provider Rate	63.4		108.9				

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.

Wayne County

SCORE	HEALTH CARE ACCESS & QUALITY	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Children with Health Insurance	75.8		95.2	94.3	...	...	...
1.89	Persons without Health Insurance	15.7		6.6		2019		














1.83	Consumer Expenditures: Medical Services	1064.3		1098.6	1047.4			...
1.83	Consumer Expenditures: Medical Supplies	196.3		204.8	194.9			...
1.72	Primary Care Provider Rate	51.7		76.7				
1.67	Adults with Health Insurance	84.3		90.9	87.1	...	...	...
1.67	Consumer Expenditures: Health Insurance	4333.6		4371.7	4321.1			...
1.67	Consumer Expenditures: Prescription and Non-Prescription Drugs	633.6		638.9	609.6			...
1.58	Clinical Care Ranking	52					...	...
1.50	Adults who Visited a Dentist	51.4		51.6	52.9			...
1.50	Non-Physician Primary Care Provider Rate	53.6		108.9				

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









From the secondary data scoring results, Mental Health & Mental Disorders had the third highest data score of all topic areas, with a score of 1.51. 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.

Medina County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.92	Depression: Medicare Population	19		20.4	18.4			
1.89	Age-Adjusted Death Rate due to Suicide	15.7	12.8	15.1	14.1			
1.58	Adults Ever Diagnosed with Depression	21.2			18.8			...

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.

Wayne County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	38.1		34	30.5			
2.50	Age-Adjusted Death Rate due to Suicide	16.7	12.8	15.1	14.1			
2.17	Poor Mental Health: Average Number of Days	5.2		4.8	4.1			...

1.92	Alzheimer's Disease or Dementia: Medicare Population	10.4		10.4	10.8			
1.92	Poor Mental Health: 14+ Days	16.9			13.6			...
1.75	Adults Ever Diagnosed with Depression	21.9			18.8			...
1.64	Depression: Medicare Population	19.2		20.4	18.4			
1.50	Self-Reported General Health Assessment: Good or Better	84.7		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: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #3: Chronic Disease Prevention & Management

Nutrition & Healthy Eating had the sixth highest data score of all topic areas with a score of 1.46. 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 11.

Cuyahoga County

SCORE	NUTRITION & HEALTHY EATING	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
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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.

Medina County

SCORE	NUTRITION & HEALTHY EATING	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Consumer Expenditures: Fast Food Restaurants	1814.2		1461	1638.9			...
2.50	Consumer Expenditures: High Sugar Foods	627		519	530.2			...
2.33	Consumer Expenditures: High Sugar Beverages	370		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.

Wayne County

SCORE	NUTRITION & HEALTHY EATING	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
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1.83	Consumer Expenditures: Fruits and Vegetables	818		864.6	1002.1			...
1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	82		80.9	80.4			...
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	41.4		41.5	41.2			...

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 12: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #4: Socioeconomic Issues

Prevention & Safety ranked fourth among all health topics with a score of 1.50. 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 12 below. Medina County did not have any indicators of concern. 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.

Wayne County

SCORE	PREVENTION & SAFETY	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Age-Adjusted Death Rate due to Falls	16		10.5	9.5			
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.8		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 13: Secondary Data Scoring Results by Health Topic for The Medina Hospital Community in Rank Order by Topic Score

HEALTH TOPICS	AVG
Medications & Prescriptions	2.00
Other Conditions	1.55
Mental Health & Mental Disorders	1.51
Prevention & Safety	1.50
Older Adults	1.48
Nutrition & Healthy Eating	1.46
Cancer	1.45
Women's Health	1.45
Alcohol & Drug Use	1.44
Children's Health	1.43
Health Care Access & Quality	1.43
Physical Activity	1.41
Tobacco Use	1.39
Wellness & Lifestyle	1.37
Heart Disease & Stroke	1.32
Maternal, Fetal & Infant Health	1.30
Respiratory Diseases	1.17
Diabetes	1.17
Oral Health	1.15
Immunizations & Infectious Diseases	1.11
QUALITY OF LIFE TOPIC	SCORE
Environmental Health	1.38
Community	1.34
Education	1.34
Economy	1.16

SCORE	ALCOHOL & DRUG USE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	42.6		38.1	21	2017-2019	9
2.44	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	41.4	28.3	32.2	27	2015-2019	9
2.00	Adults who Drink Excessively	<i>percent</i>	19.6		18.5	19	2018	9
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	<i>Deaths per 100,000 population</i>	43.8		42	22.8	2017-2019	5
1.67	Consumer Expenditures: Alcoholic Beverages	<i>average dollar amount per consumer unit</i>	637.1		651.5	701.9	2021	7
1.42	Health Behaviors Ranking	<i>ranking</i>	31				2021	9
1.31	Liquor Store Density	<i>stores/ 100,000 population</i>	6.4		5.6	10.5	2019	22
1.25	Adults who Binge Drink	<i>percent</i>	16			16.7	2019	4
0.92	Mothers who Smoked During Pregnancy	<i>percent</i>	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	<i>deaths/ 100,000 males</i>	23.8	16.9	19.4	18.9	2015-2019	12
2.58	Breast Cancer Incidence Rate	<i>cases/ 100,000 females</i>	134.8		129.6	126.8	2014-2018	12
2.36	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	128		107.2	106.2	2014-2018	12
2.31	Cancer: Medicare Population	<i>percent</i>	9		8.4	8.4	2018	6
2.28	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	23.6	15.3	21.6	19.9	2015-2019	12
2.25	All Cancer Incidence Rate	<i>cases/ 100,000 population</i>	479.7		467.5	448.6	2014-2018	12
2.14	Colorectal Cancer Incidence Rate	<i>cases/ 100,000 population</i>	44.2		41.3	38	2014-2018	12
1.78	Age-Adjusted Death Rate due to Cancer	<i>deaths/ 100,000 population</i>	171	122.7	169.4	152.4	2015-2019	12
1.67	Colon Cancer Screening	<i>percent</i>	63.7	74.4		66.4	2018	4
1.44	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	42.9	25.1	45	36.7	2015-2019	12
1.36	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	63.7		67.3	57.3	2014-2018	12
1.28	Age-Adjusted Death Rate due to Colorectal Cancer	<i>deaths/ 100,000 population</i>	14.5	8.9	14.8	13.4	2015-2019	12

1.25	Adults with Cancer	<i>percent</i>	7.5			7.1	2019	4
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	11.5		12.2	11.9	2014-2018	12
0.94	Mammogram in Past 2 Years: 50-74	<i>percent</i>	75.2	77.1		74.8	2018	4
0.89	Cervical Cancer Screening: 21-65	<i>Percent</i>	85.3	84.3		84.7	2018	4
0.61	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	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	<i>percent</i>	20.7		17.4	14.6	2019	10
2.08	Projected Child Food Insecurity Rate	<i>percent</i>	23.4		18.5		2021	10
1.94	Substantiated Child Abuse Rate	<i>cases/ 1,000 children</i>	10	8.7	6.8		2020	3
1.86	Blood Lead Levels in Children (≥ 10 micrograms per deciliter)	<i>percent</i>	1.7		0.5		2020	19
1.58	Blood Lead Levels in Children (≥ 5 micrograms per deciliter)	<i>percent</i>	5.8		1.9		2020	19

1.50	Children with Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.33	Children with Health Insurance	<i>percent</i>	97.1		95.2	94.3	2019	1
1.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	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	<i>percent</i>	34.8		28.8	26.1	2015-2019	1
2.50	Single-Parent Households	<i>percent</i>	37.6		27.1	25.5	2015-2019	1
2.47	Homeownership	<i>percent</i>	50.9		59.4	56.2	2015-2019	1
2.44	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	41.4	28.3	32.2	27	2015-2019	9
2.39	Violent Crime Rate	<i>crimes/ 100,000 population</i>	637		303.5	394	2017	18
2.31	Social Associations	<i>membership associations/ 10,000 population</i>	9.2		11	9.3	2018	9
2.14	Linguistic Isolation	<i>percent</i>	2.9		1.4	4.4	2015-2019	1
2.08	Households without a Vehicle	<i>percent</i>	12.8		7.9	8.6	2015-2019	1

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

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

0.69	Workers who Walk to Work	<i>percent</i>	2.7		2.2	2.7	2015-2019	1
0.58	Per Capita Income	<i>dollars</i>	33114		31552	34103	2015-2019	1
0.25	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	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	<i>percent</i>	9				2019	5
1.14	Diabetes: Medicare Population	<i>percent</i>	25.3		27.2	27	2018	6
0.86	Age-Adjusted Death Rate due to Diabetes	<i>deaths/ 100,000 population</i>	22.4		25.3	21.5	2017-2019	5
SCORE	ECONOMY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.47	Homeownership	<i>percent</i>	50.9		59.4	56.2	2015-2019	1
2.47	People 65+ Living Below Poverty Level	<i>percent</i>	10.9		8.1	9.3	2015-2019	1
2.17	Child Food Insecurity Rate	<i>percent</i>	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)	<i>percent</i>	33.9		29.5	26.1	2015-2019	1

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

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

1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	<i>percent</i>	23.5		24.5		2018	25
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.31	Overcrowded Households	<i>percent of households</i>	1.2		1.4		2015-2019	1
1.25	Unemployed Workers in Civilian Labor Force	<i>percent</i>	4.6		4.3	4.6	Sep-21	21
1.17	Consumer Expenditures: Home Rental Expenses	<i>average dollar amount per consumer unit</i>	3928.7		3798.7	5460.2	2021	7
1.00	Mortgaged Owners Spending 30% or More of Household Income on Housing	<i>percent</i>	22.7		19.7	26.5	2019	1
0.58	Per Capita Income	<i>dollars</i>	33114		31552	34103	2015-2019	1
0.58	Students Eligible for the Free Lunch Program	<i>percent</i>	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	<i>percent</i>	46.6		63.3		2018-2019	15
1.86	4th Grade Students Proficient in Math	<i>percent</i>	52.5		74.3		2018-2019	15
1.86	8th Grade Students Proficient in English/Language Arts	<i>percent</i>	43.1		58.3		2018-2019	15
1.86	8th Grade Students Proficient in Math	<i>percent</i>	39.5		57.3		2018-2019	15
1.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	272.1		301.6	368.2	2021	7
1.67	Consumer Expenditures: Education	<i>average dollar amount per consumer unit</i>	1196.7		1200.4	1492.4	2021	7
1.44	High School Graduation	<i>percent</i>	89.5	90.7	92		2019-2020	15
0.25	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	32.5		28.3	32.1	2015-2019	1
1.81	Student-to-Teacher Ratio	<i>students/ teacher</i>	16.5				2019-2020	13
SCORE	ENVIRONMENTAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

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

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

1.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	1.3				2015	23
1.00	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016	23
0.50	Access to Exercise Opportunities	<i>percent</i>	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+	<i>percent</i>	89.8		90.2	90.6	2021	8
1.83	Consumer Expenditures: Medical Services	<i>average dollar amount per consumer unit</i>	1057.6		1098.6	1047.4	2021	7
1.83	Consumer Expenditures: Medical Supplies	<i>average dollar amount per consumer unit</i>	199.2		204.8	194.9	2021	7
1.50	Adults who Visited a Dentist	<i>percent</i>	51.3		51.6	52.9	2021	8
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	<i>average dollar amount per consumer unit</i>	627.2		638.9	609.6	2021	7
1.42	Adults without Health Insurance	<i>percent</i>	13			13	2019	4
1.39	Persons without Health Insurance	<i>percent</i>	5.3		6.6		2019	1

1.33	Adults with Health Insurance	<i>percent</i>	92.2		90.9	87.1	2019	1
1.33	Children with Health Insurance	<i>percent</i>	97.1		95.2	94.3	2019	1
1.33	Consumer Expenditures: Health Insurance	<i>average dollar amount per consumer unit</i>	4238.3		4371.7	4321.1	2021	7
1.25	Adults who have had a Routine Checkup	<i>percent</i>	78.2			76.6	2019	4
1.25	Clinical Care Ranking		10				2021	9
0.61	Primary Care Provider Rate	<i>providers/ 100,000 population</i>	112.7		76.7		2018	9
0.33	Dentist Rate	<i>dentists/ 100,000 population</i>	109.6		64.2		2019	9
0.33	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	401.4		261.3		2020	9
0.33	Non-Physician Primary Care Provider Rate	<i>providers/ 100,000 population</i>	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	<i>percent</i>	9		9	8.4	2018	6

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

1.25	Cholesterol Test History	<i>percent</i>	86.3			87.6	2019	4
1.00	Hyperlipidemia: Medicare Population	<i>percent</i>	45.2		49.4	47.7	2018	6
1.00	Ischemic Heart Disease: Medicare Population	<i>percent</i>	25.8		27.5	26.8	2018	6
0.92	High Cholesterol Prevalence: Adults 18+	<i>percent</i>	32.2			33.6	2019	4
0.58	Age-Adjusted Death Rate due to Heart Attack	<i>deaths/ 100,000 population 35+ years</i>	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	<i>cases/ 100,000 population</i>	949.5		561.9	551	2019	16
2.39	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	432.9		224	187.8	2019	16
1.61	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	1.2	1.4	1.1		2020	16
1.53	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0		0	0.5	28-Jan-22	11
1.31	Overcrowded Households	<i>percent of households</i>	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	<i>cases/ 100,000 population</i>	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	<i>deaths/ 100,000 population</i>	11.1		14.4	13.8	2017-2019	5
0.08	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	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	<i>average dollar amount per consumer unit</i>	272.1		301.6	368.2	2021	7
1.78	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	8.6	5	6.9		2019	17

1.00	Mothers who Received Early Prenatal Care	<i>percent</i>	72.4		68.9	76.1	2020	17
0.92	Mothers who Smoked During Pregnancy	<i>percent</i>	6.1	4.3	11.5	5.5	2020	17
1.67	Preterm Births	<i>percent</i>	11.4	9.4	10.3		2020	17
1.53	Teen Birth Rate: 15-17	<i>live births/ 1,000 females aged 15-17</i>	7.2		6.8		2020	17
1.58	Teen Pregnancy Rate	<i>pregnancies/ 1,000 females aged 15-17</i>	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	<i>average dollar amount per consumer unit</i>	1057.6		1098.6	1047.4	2021	7
1.83	Consumer Expenditures: Medical Supplies	<i>average dollar amount per consumer unit</i>	199.2		204.8	194.9	2021	7
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	<i>average dollar amount per consumer unit</i>	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	<i>percent</i>	20.9			18.8	2019	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	21		34	30.5	2017-2019	5
1.61	Age-Adjusted Death Rate due to Suicide	<i>deaths/ 100,000 population</i>	14	12.8	15.1	14.1	2017-2019	5
2.17	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	11.4		10.4	10.8	2018	6
1.75	Depression: Medicare Population	<i>percent</i>	18.5		20.4	18.4	2018	6
0.33	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	401.4		261.3		2020	9
1.75	Poor Mental Health: 14+ Days	<i>percent</i>	16			13.6	2019	4
1.83	Poor Mental Health: Average Number of Days	<i>days</i>	5		4.8	4.1	2018	9
1.00	Self-Reported General Health Assessment: Good or Better	<i>percent</i>	85.8		85.6	86.5	2021	8
SCORE	NUTRITION & HEALTHY EATING	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

1.67	Consumer Expenditures: Fruits and Vegetables	<i>average dollar amount per consumer unit</i>	838.8		864.6	1002.1	2021	7
1.50	Consumer Expenditures: High Sugar Foods	<i>average dollar amount per consumer unit</i>	502.1		519	530.2	2021	7
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	<i>Percent</i>	41.1		41.5	41.2	2021	8
1.33	Consumer Expenditures: Fast Food Restaurants	<i>average dollar amount per consumer unit</i>	1415.1		1461	1638.9	2021	7
1.17	Consumer Expenditures: High Sugar Beverages	<i>average dollar amount per consumer unit</i>	310.6		319.7	357	2021	7
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	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	<i>percent</i>	34.8		28.8	26.1	2015-2019	1
2.47	People 65+ Living Below Poverty Level	<i>percent</i>	10.9		8.1	9.3	2015-2019	1

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

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

1.00	Ischemic Heart Disease: Medicare Population	<i>percent</i>	25.8		27.5	26.8	2018	6
0.97	COPD: Medicare Population	<i>percent</i>	11.2		13.2	11.5	2018	6
0.92	Adults 65+ who Received Recommended Preventive Services: Males	<i>percent</i>	34.5			32.4	2018	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	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	<i>percent</i>	15.5			13.5	2018	4
1.50	Adults who Visited a Dentist	<i>percent</i>	51.3		51.6	52.9	2021	8
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	11.5		12.2	11.9	2014-2018	12
0.33	Dentist Rate	<i>dentists/ 100,000 population</i>	109.6		64.2		2019	9
SCORE	OTHER CONDITIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.08	Osteoporosis: Medicare Population	<i>percent</i>	6.3		6.2	6.6	2018	6
1.92	Adults with Kidney Disease	<i>Percent of adults</i>	3.6			3.1	2019	4
1.92	Chronic Kidney Disease: Medicare Population	<i>percent</i>	25.2		25.3	24.5	2018	6
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	35.4		36.1	33.5	2018	6
1.69	Age-Adjusted Death Rate due to Kidney Disease	<i>deaths/ 100,000 population</i>	15.2		14.5	12.9	2017-2019	5
1.42	Adults with Arthritis	<i>percent</i>	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	<i>percent</i>	34.2	36			2019	5
2.14	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.9				2016	23
1.67	Farmers Market Density	<i>markets/ 1,000 population</i>	0				2018	23
1.67	People 65+ with Low Access to a Grocery Store	<i>percent</i>	3.4				2015	23

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

0.69	Workers who Walk to Work	<i>percent</i>	2.7		2.2	2.7	2015-2019	1
0.50	Access to Exercise Opportunities	<i>percent</i>	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	<i>deaths/ 100,000 population</i>	11.6		10.5	9.5	2017-2019	5
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	<i>deaths/ 100,000 population</i>	3.6		2.8	2.5	2015-2019	5
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	<i>deaths/ 100,000 population</i>	69.7	43.2	68.8	48.9	2017-2019	5
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	<i>deaths/ 100,000 population</i>	42		40.2	21.4	2017-2019	5
2.64	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	42.6		38.1	21	2017-2019	9
1.75	Severe Housing Problems	<i>percent</i>	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	<i>percent</i>	11			8.9	2019	4

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

0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	1.2		2.2	2	2021	8
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	11.1		14.4	13.8	2017-2019	5
0.08	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	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	<i>average dollar amount per consumer unit</i>	485.5		487.9	422.4	2021	7
1.42	Adults who Smoke	<i>percent</i>	20.9	5	21.4	17	2018	9
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	<i>percent</i>	4		4.3	4.1	2021	8
0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	1.2		2.2	2	2021	8
SCORE	WELLNESS & LIFESTYLE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Insufficient Sleep	<i>percent</i>	44.9	31.4	40.6	35	2018	9

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

0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	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	<i>cases/ 100,000 females</i>	134.8		129.6	126.8	2014-2018	12
2.28	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	23.6	15.3	21.6	19.9	2015-2019	12
0.94	Mammogram in Past 2 Years: 50-74	<i>percent</i>	75.2	77.1		74.8	2018	4
0.89	Cervical Cancer Screening: 21-65	<i>Percent</i>	85.3	84.3		84.7	2018	4
0.61	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	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 Ohio Department of Public Safety, Office of Criminal Justice
18	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	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Liquor Store Density	<i>stores/ 100,000 population</i>	11.2		5.6	10.5	2019	21
1.92	Adults who Binge Drink	<i>percent</i>	17.9			16.7	2019	3
1.33	Consumer Expenditures: Alcoholic Beverages	<i>average dollar amount per consumer unit</i>	596.4		651.5	701.9	2021	6
1.25	Health Behaviors Ranking		8				2021	8
1.19	Mothers who Smoked During Pregnancy	<i>percent</i>	10.3	4.3	11.5	5.5	2020	16
0.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	<i>Deaths per 100,000 population</i>	21.5		42	22.8	2017-2019	4
0.53	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	17.8		38.1	21	2017-2019	8
0.50	Adults who Drink Excessively	<i>percent</i>	16.5		18.5	19	2018	8
0.44	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	23.2	28.3	32.2	27	2015-2019	8
SCORE	CANCER	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.56	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	22.7	16.9	19.4	18.9	2015-2019	11
2.22	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	22.9	15.3	21.6	19.9	2015-2019	11
1.78	Mammogram in Past 2 Years: 50-74	<i>percent</i>	71	77.1		74.8	2018	3
1.75	Adults with Cancer	<i>percent</i>	8.2			7.1	2019	3
1.75	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	101.5		107.2	106.2	2014-2018	11

1.64	Breast Cancer Incidence Rate	<i>cases/ 100,000 females</i>	123.1		129.6	126.8	2014-2018	11
1.61	Cervical Cancer Screening: 21-65	<i>Percent</i>	83.3	84.3		84.7	2018	3
1.47	Cancer: Medicare Population	<i>percent</i>	7.6		8.4	8.4	2018	5
1.33	Colon Cancer Screening	<i>percent</i>	66.2	74.4		66.4	2018	3
1.14	All Cancer Incidence Rate	<i>cases/ 100,000 population</i>	432.2		467.5	448.6	2014-2018	11
1.11	Age-Adjusted Death Rate due to Cancer	<i>deaths/ 100,000 population</i>	155.4	122.7	169.4	152.4	2015-2019	11
1.08	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	7		7.9	7.7	2014-2018	11
0.86	Colorectal Cancer Incidence Rate	<i>cases/ 100,000 population</i>	38		41.3	38	2014-2018	11
0.69	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	55.4		67.3	57.3	2014-2018	11
0.61	Age-Adjusted Death Rate due to Colorectal Cancer	<i>deaths/ 100,000 population</i>	12.5	8.9	14.8	13.4	2015-2019	11
0.61	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	35.6	25.1	45	36.7	2015-2019	11
0.08	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	9.6		12.2	11.9	2014-2018	11
SCORE	CHILDREN'S HEALTH	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Children with Health Insurance	<i>percent</i>	75.8		95.2	94.3	2019	1
1.61	Substantiated Child Abuse Rate	<i>cases/ 1,000 children</i>	7.6	8.7	6.8		2020	2
1.33	Children with Low Access to a Grocery Store	<i>percent</i>	3.6				2015	22

1.17	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	234.9		301.6	368.2	2021	6
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	<i>percent</i>	1.1		1.9		2020	18
1.00	Child Food Insecurity Rate	<i>percent</i>	14.7		17.4	14.6	2019	9
0.92	Projected Child Food Insecurity Rate	<i>percent</i>	15.5		18.5		2021	9
0.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	<i>percent</i>	0.2		0.5		2020	18
SCORE	COMMUNITY	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.47	Households without a Vehicle	<i>percent</i>	9.4		7.9	8.6	2015-2019	1
2.42	Workers Commuting by Public Transportation	<i>percent</i>	0.2	5.3	1.6	5	2015-2019	1
2.14	Linguistic Isolation	<i>percent</i>	2.3		1.4	4.4	2015-2019	1
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	<i>deaths/ 100,000 population</i>	3.8		2.8	2.5	2015-2019	4
2.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	5.3				2015	22
1.83	Households with One or More Types of Computing Devices	<i>percent</i>	85		89.1	90.3	2015-2019	1
1.83	Persons with an Internet Subscription	<i>percent</i>	80.9		86.2	86.2	2015-2019	1
1.69	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	22.2		28.3	32.1	2015-2019	1

1.64	People 65+ Living Alone	<i>percent</i>	27		28.8	26.1	2015-2019	1
1.61	Substantiated Child Abuse Rate	<i>cases/ 1,000 children</i>	7.6	8.7	6.8		2020	2
1.53	Voter Turnout: Presidential Election	<i>percent</i>	73.7		74		2020	19
1.53	Youth not in School or Working	<i>percent</i>	1.9		1.8	1.9	2015-2019	1
1.50	Adults with Internet Access	<i>percent</i>	94.1		94.5	95	2021	7
1.50	Households with a Computer	<i>percent</i>	84.9		85.2	86.3	2021	7
1.50	Households with a Smartphone	<i>percent</i>	78.9		80.5	81.9	2021	7
1.50	Households with an Internet Subscription	<i>percent</i>	80		82.4	83	2015-2019	1
1.50	Households with Wireless Phone Service	<i>percent</i>	96.1		96.8	97	2020	7
1.50	Violent Crime Rate	<i>crimes/ 100,000 population</i>	180.9		303.5	394	2017	17
1.42	Per Capita Income	<i>dollars</i>	27884		31552	34103	2015-2019	1
1.25	Social and Economic Factors Ranking	<i>ranking</i>	22				2021	8
1.03	Workers who Drive Alone to Work	<i>percent</i>	78.5		82.9	76.3	2015-2019	1
0.92	Median Household Income	<i>dollars</i>	58300		56602	62843	2015-2019	1
0.83	Consumer Expenditures: Local Public Transportation	<i>average dollar amount per consumer unit</i>	106.8		121.7	148.8	2021	6
0.78	People Living Below Poverty Level	<i>percent</i>	11.3	8	14	13.4	2015-2019	1
0.69	Children Living Below Poverty Level	<i>percent</i>	16.4		19.9	18.5	2015-2019	1

0.69	Young Children Living Below Poverty Level	percent	17.2		23	20.3	2015-2019	1
0.64	Workers who Walk to Work	percent	4		2.2	2.7	2015-2019	1
0.53	Mean Travel Time to Work	minutes	20.5		23.7	26.9	2015-2019	1
0.53	Social Associations	membership associations/ 10,000 population	14.1		11	9.3	2018	8
0.44	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	23.2	28.3	32.2	27	2015-2019	8
0.36	Homeownership	percent	68.5		59.4	56.2	2015-2019	1
0.25	Solo Drivers with a Long Commute	percent	23.6		31.1	37	2015-2019	8
0.08	Single-Parent Households	percent	15.9		27.1	25.5	2015-2019	1
SCORE	DIABETES	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	31.6		25.3	21.5	2017-2019	4
1.03	Adults 20+ with Diabetes	percent	8.2				2019	4
1.00	Diabetes: Medicare Population	percent	25.4		27.2	27	2018	5
SCORE	ECONOMY	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.86	Overcrowded Households	percent of households	1.9		1.4		2015-2019	1
1.86	SNAP Certified Stores	stores/ 1,000 population	0.5				2017	22
1.67	Households that are Asset Limited, Income Constrained, Employed (ALICE)	percent	26.3		24.5		2018	24

1.53	Youth not in School or Working	<i>percent</i>	1.9		1.8	1.9	2015-2019	1
1.50	Food Insecurity Rate	<i>percent</i>	12		13.2	10.9	2019	9
1.50	Households with a Savings Account	<i>percent</i>	68.3		68.8	70.2	2021	7
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016	22
1.47	Persons with Disability Living in Poverty (5-year)	<i>percent</i>	26.6		29.5	26.1	2015-2019	1
1.42	Per Capita Income	<i>dollars</i>	27884		31552	34103	2015-2019	1
1.36	Size of Labor Force	<i>persons</i>	59579				Oct-21	20
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	5				2015	22
1.25	Projected Food Insecurity Rate	<i>percent</i>	12.7		14.1		2021	9
1.25	Social and Economic Factors Ranking	<i>ranking</i>	22				2021	8
1.17	Consumer Expenditures: Homeowner Expenses	<i>average dollar amount per consumer unit</i>	7433.7		7828	8900.1	2021	6
1.17	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	<i>percent</i>	66.2		61.6		2018	24
1.00	Child Food Insecurity Rate	<i>percent</i>	14.7		17.4	14.6	2019	9
1.00	Households that are Below the Federal Poverty Level	<i>percent</i>	7.6		13.8		2018	24
1.00	Income Inequality		0.4		0.5	0.5	2015-2019	1
0.97	People 65+ Living Below Poverty Level	<i>percent</i>	7.2		8.1	9.3	2015-2019	1
0.92	Median Household Income	<i>dollars</i>	58300		56602	62843	2015-2019	1

0.92	Projected Child Food Insecurity Rate	<i>percent</i>	15.5		18.5		2021	9
0.92	Students Eligible for the Free Lunch Program	<i>percent</i>	28				2019-2020	12
0.86	Households with Cash Public Assistance Income	<i>percent</i>	2.1		2.9	2.4	2015-2019	1
0.83	Adults who Feel Overwhelmed by Financial Burdens	<i>percent</i>	14		14.6	14.4	2021	7
0.83	Consumer Expenditures: Home Rental Expenses	<i>average dollar amount per consumer unit</i>	3627.5		3798.7	5460.2	2021	6
0.78	People Living Below Poverty Level	<i>percent</i>	11.3	8	14	13.4	2015-2019	1
0.75	People Living 200% Above Poverty Level	<i>percent</i>	69.7		68.8	69.1	2015-2019	1
0.75	Severe Housing Problems	<i>percent</i>	13		13.7	18	2013-2017	8
0.69	Children Living Below Poverty Level	<i>percent</i>	16.4		19.9	18.5	2015-2019	1
0.69	Renters Spending 30% or More of Household Income on Rent	<i>percent</i>	38.4		44.9	49.6	2015-2019	1
0.69	Young Children Living Below Poverty Level	<i>percent</i>	17.2		23	20.3	2015-2019	1
0.42	Families Living Below Poverty Level	<i>percent</i>	7.5		9.9	9.5	2015-2019	1
0.36	Homeownership	<i>percent</i>	68.5		59.4	56.2	2015-2019	1
0.33	Mortgaged Owners Spending 30% or More of Household Income on Housing	<i>percent</i>	17.5		19.7	26.5	2019	1
0.25	Unemployed Workers in Civilian Labor Force	<i>percent</i>	3		3.8	4.3	Oct-21	20

SCORE	EDUCATION	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.69	People 25+ with a Bachelor's Degree or Higher	percent	22.2		28.3	32.1	2015-2019	1
1.53	Student-to-Teacher Ratio	students/ teacher	16.2				2019-2020	12
1.42	8th Grade Students Proficient in Math	percent	60		42.6		2020-2021	14
1.17	4th Grade Students Proficient in Math	percent	74		59.4		2020-2021	14
1.17	Consumer Expenditures: Childcare	average dollar amount per consumer unit	234.9		301.6	368.2	2021	6
1.17	Consumer Expenditures: Education	average dollar amount per consumer unit	968.6		1200.4	1492.4	2021	6
1.00	4th Grade Students Proficient in English/Language Arts	percent	68.1		56		2020-2021	14
1.00	8th Grade Students Proficient in English/Language Arts	percent	65.6		52.7		2020-2021	14
1.00	High School Graduation	percent	95.8	90.7	92		2019-2020	14
SCORE	ENVIRONMENTAL HEALTH	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Access to Exercise Opportunities	percent	66.7		83.9	84	2020	8
2.00	Households with No Car and Low Access to a Grocery Store	percent	5.3				2015	22
2.00	Liquor Store Density	stores/ 100,000 population	11.2		5.6	10.5	2019	21
1.86	Overcrowded Households	percent of households	1.9		1.4		2015-2019	1

1.86	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.5				2017	22
1.67	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.9				2015	22
1.64	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.7				2016	22
1.58	Adults with Current Asthma	<i>percent</i>	9.9			8.9	2019	3
1.50	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016	22
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016	22
1.42	Physical Environment Ranking	<i>ranking</i>	33				2021	8
1.36	Asthma: Medicare Population	<i>percent</i>	4.7		4.8	5	2018	5
1.36	Number of Extreme Heat Days	<i>days</i>	14				2019	13
1.36	Number of Extreme Precipitation Days	<i>days</i>	32				2019	13
1.36	PBT Released	<i>pounds</i>	2117.7				2020	23
1.36	Recognized Carcinogens Released into Air	<i>pounds</i>	3237.3				2020	23
1.36	Weeks of Moderate Drought or Worse	<i>weeks per year</i>	5				2020	13
1.33	Children with Low Access to a Grocery Store	<i>percent</i>	3.6				2015	22
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	5				2015	22
1.17	Farmers Market Density	<i>markets/ 1,000 population</i>	0.1				2018	22
1.17	Grocery Store Density	<i>stores/ 1,000 population</i>	0.2				2016	22
1.14	Food Environment Index	<i>index</i>	8		6.8	7.8	2021	8
1.08	Houses Built Prior to 1950	<i>percent</i>	23.2		26.2	17.5	2015-2019	1

1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	<i>percent</i>	1.1		1.9		2020	18
0.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	<i>percent</i>	0.2		0.5		2020	18
0.75	Severe Housing Problems	<i>percent</i>	13		13.7	18	2013-2017	8
SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Children with Health Insurance	<i>percent</i>	75.8		95.2	94.3	2019	1
1.89	Persons without Health Insurance	<i>percent</i>	15.7		6.6		2019	1
1.83	Consumer Expenditures: Medical Services	<i>average dollar amount per consumer unit</i>	1064.3		1098.6	1047.4	2021	6
1.83	Consumer Expenditures: Medical Supplies	<i>average dollar amount per consumer unit</i>	196.3		204.8	194.9	2021	6
1.72	Primary Care Provider Rate	<i>providers/ 100,000 population</i>	51.7		76.7		2018	8
1.67	Adults with Health Insurance	<i>percent</i>	84.3		90.9	87.1	2019	1
1.67	Consumer Expenditures: Health Insurance	<i>average dollar amount per consumer unit</i>	4333.6		4371.7	4321.1	2021	6
1.67	Consumer Expenditures: Prescription and Non-Prescription Drugs	<i>average dollar amount per consumer unit</i>	633.6		638.9	609.6	2021	6
1.58	Clinical Care Ranking	<i>ranking</i>	52				2021	8
1.50	Adults who Visited a Dentist	<i>percent</i>	51.4		51.6	52.9	2021	7
1.50	Non-Physician Primary Care Provider Rate	<i>providers/ 100,000 population</i>	53.6		108.9		2020	8

1.44	Dentist Rate	<i>dentists/ 100,000 population</i>	43.2		64.2		2019	8
1.42	Adults who have had a Routine Checkup	<i>percent</i>	77.9			76.6	2019	3
1.33	Adults with Health Insurance: 18+	<i>percent</i>	90.3		90.2	90.6	2021	7
1.08	Adults without Health Insurance	<i>percent</i>	12.2			13	2019	3
0.33	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	342.2		261.3		2020	8
SCORE	HEART DISEASE & STROKE	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.39	Age-Adjusted Death Rate due to Coronary Heart Disease	<i>deaths/ 100,000 population</i>	113.8	71.1	101.4	90.5	2017-2019	4
2.31	Atrial Fibrillation: Medicare Population	<i>percent</i>	9.6		9	8.4	2018	5
1.75	Cholesterol Test History	<i>percent</i>	84.2			87.6	2019	3
1.64	Hyperlipidemia: Medicare Population	<i>percent</i>	48.7		49.4	47.7	2018	5
1.64	Ischemic Heart Disease: Medicare Population	<i>percent</i>	27.4		27.5	26.8	2018	5
1.58	Adults who Experienced a Stroke	<i>percent</i>	3.8			3.4	2019	3
1.58	Adults who Experienced Coronary Heart Disease	<i>percent</i>	7.8			6.2	2019	3
1.58	Adults who Have Taken Medications for High Blood Pressure	<i>percent</i>	77.7			76.2	2019	3
1.33	Age-Adjusted Death Rate due to Heart Attack	<i>deaths/ 100,000 population 35+ years</i>	55		55.4		2019	13

1.33	High Blood Pressure Prevalence	<i>percent</i>	34.7	27.7		32.6	2019	3
1.31	Hypertension: Medicare Population	<i>percent</i>	57.2		59.5	57.2	2018	5
1.25	High Cholesterol Prevalence: Adults 18+	<i>percent</i>	33.2			33.6	2019	3
0.69	Heart Failure: Medicare Population	<i>percent</i>	12.6		14.7	14	2018	5
0.53	Stroke: Medicare Population	<i>percent</i>	3.1		3.8	3.8	2018	5
0.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	<i>deaths/ 100,000 population</i>	35.6	33.4	42.5	37.2	2017-2019	4
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.92	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	17.3	11.1	13.7		2019	15
1.86	Overcrowded Households	<i>percent of households</i>	1.9		1.4		2015-2019	1
1.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	14.4		14.4	13.8	2017-2019	4
1.53	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0.7		0.3	1.6	4-Feb-22	10
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	<i>Percent</i>	48.2		48.6	49.4	2021	7
1.25	Persons Fully Vaccinated Against COVID-19	<i>percent</i>	44.6				4-Feb-22	4
1.17	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	56.2		262.6		2020	15
1.00	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	201.4		504.8		2020	15

0.92	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	0	1.4	1.1		2020	15
0.08	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	16.6		36.7	67.6	4-Feb-22	10
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	9	5	6.9		2019	16
2.39	Mothers who Received Early Prenatal Care	<i>percent</i>	57.2		68.9	76.1	2020	16
1.31	Teen Birth Rate: 15-17	<i>live births/ 1,000 females aged 15-17</i>	4.3		6.8		2020	16
1.19	Mothers who Smoked During Pregnancy	<i>percent</i>	10.3	4.3	11.5	5.5	2020	16
1.17	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	234.9		301.6	368.2	2021	6
1.06	Babies with Low Birth Weight	<i>percent</i>	7		8.5	8.2	2020	16
0.86	Teen Pregnancy Rate	<i>pregnancies/ 1,000 females aged 15-17</i>	12.2		19.5		2016	16
0.78	Preterm Births	<i>percent</i>	7.6	9.4	10.3		2020	16
0.61	Babies with Very Low Birth Weight	<i>percent</i>	0.7		1.4	1.3	2020	16
SCORE	MEDICATIONS & PRESCRIPTIONS	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Consumer Expenditures: Medical Services	<i>average dollar amount per consumer unit</i>	1064.3		1098.6	1047.4	2021	6
1.83	Consumer Expenditures: Medical Supplies	<i>average dollar amount per consumer unit</i>	196.3		204.8	194.9	2021	6

1.67	Consumer Expenditures: Prescription and Non-Prescription Drugs	<i>average dollar amount per consumer unit</i>	633.6		638.9	609.6	2021	6
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	38.1		34	30.5	2017-2019	4
2.50	Age-Adjusted Death Rate due to Suicide	<i>deaths/ 100,000 population</i>	16.7	12.8	15.1	14.1	2017-2019	4
2.17	Poor Mental Health: Average Number of Days	<i>days</i>	5.2		4.8	4.1	2018	8
1.92	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	10.4		10.4	10.8	2018	5
1.92	Poor Mental Health: 14+ Days	<i>percent</i>	16.9			13.6	2019	3
1.75	Adults Ever Diagnosed with Depression	<i>percent</i>	21.9			18.8	2019	3
1.64	Depression: Medicare Population	<i>percent</i>	19.2		20.4	18.4	2018	5
1.50	Self-Reported General Health Assessment: Good or Better	<i>percent</i>	84.7		85.6	86.5	2021	7
0.33	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	342.2		261.3		2020	8
SCORE	NUTRITION & HEALTHY EATING	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Consumer Expenditures: Fruits and Vegetables	<i>average dollar amount per consumer unit</i>	818		864.6	1002.1	2021	6

1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	82		80.9	80.4	2021	7
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	<i>Percent</i>	41.4		41.5	41.2	2021	7
1.33	Consumer Expenditures: Fast Food Restaurants	<i>average dollar amount per consumer unit</i>	1360.5		1461	1638.9	2021	6
1.33	Consumer Expenditures: High Sugar Foods	<i>average dollar amount per consumer unit</i>	497.4		519	530.2	2021	6
1.00	Consumer Expenditures: High Sugar Beverages	<i>average dollar amount per consumer unit</i>	304		319.7	357	2021	6
SCORE	OLDER ADULTS	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	38.1		34	30.5	2017-2019	4
2.50	Age-Adjusted Death Rate due to Falls	<i>deaths/ 100,000 population</i>	16		10.5	9.5	2017-2019	4
2.31	Atrial Fibrillation: Medicare Population	<i>percent</i>	9.6		9	8.4	2018	5
1.92	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	10.4		10.4	10.8	2018	5
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	34.3		36.1	33.5	2018	5
1.75	Adults 65+ with Total Tooth Loss	<i>percent</i>	16.7			13.5	2018	3
1.75	Adults with Arthritis	<i>percent</i>	31.6			25.1	2019	3
1.67	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.9				2015	22

1.64	Depression: Medicare Population	<i>percent</i>	19.2		20.4	18.4	2018	5
1.64	Hyperlipidemia: Medicare Population	<i>percent</i>	48.7		49.4	47.7	2018	5
1.64	Ischemic Heart Disease: Medicare Population	<i>percent</i>	27.4		27.5	26.8	2018	5
1.64	People 65+ Living Alone	<i>percent</i>	27		28.8	26.1	2015-2019	1
1.47	Cancer: Medicare Population	<i>percent</i>	7.6		8.4	8.4	2018	5
1.42	Chronic Kidney Disease: Medicare Population	<i>percent</i>	23.1		25.3	24.5	2018	5
1.36	Asthma: Medicare Population	<i>percent</i>	4.7		4.8	5	2018	5
1.33	Colon Cancer Screening	<i>percent</i>	66.2	74.4		66.4	2018	3
1.31	Hypertension: Medicare Population	<i>percent</i>	57.2		59.5	57.2	2018	5
1.14	COPD: Medicare Population	<i>percent</i>	11.8		13.2	11.5	2018	5
1.08	Adults 65+ who Received Recommended Preventive Services: Females	<i>percent</i>	32			28.4	2018	3
1.00	Diabetes: Medicare Population	<i>percent</i>	25.4		27.2	27	2018	5
0.97	People 65+ Living Below Poverty Level	<i>percent</i>	7.2		8.1	9.3	2015-2019	1
0.92	Adults 65+ who Received Recommended Preventive Services: Males	<i>percent</i>	34.1			32.4	2018	3
0.83	Consumer Expenditures: Eldercare	<i>average dollar amount per consumer unit</i>	20.1		20.5	34.3	2021	6
0.81	Osteoporosis: Medicare Population	<i>percent</i>	4.9		6.2	6.6	2018	5

0.69	Heart Failure: Medicare Population	<i>percent</i>	12.6		14.7	14	2018	5
0.53	Stroke: Medicare Population	<i>percent</i>	3.1		3.8	3.8	2018	5
SCORE	ORAL HEALTH	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.75	Adults 65+ with Total Tooth Loss	<i>percent</i>	16.7			13.5	2018	3
1.50	Adults who Visited a Dentist	<i>percent</i>	51.4		51.6	52.9	2021	7
1.44	Dentist Rate	<i>dentists/ 100,000 population</i>	43.2		64.2		2019	8
0.08	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	9.6		12.2	11.9	2014-2018	11
SCORE	OTHER CONDITIONS	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	34.3		36.1	33.5	2018	5
1.75	Adults with Arthritis	<i>percent</i>	31.6			25.1	2019	3
1.42	Adults with Kidney Disease	<i>Percent of adults</i>	3.2			3.1	2019	3
1.42	Chronic Kidney Disease: Medicare Population	<i>percent</i>	23.1		25.3	24.5	2018	5
0.81	Osteoporosis: Medicare Population	<i>percent</i>	4.9		6.2	6.6	2018	5
0.36	Age-Adjusted Death Rate due to Kidney Disease	<i>deaths/ 100,000 population</i>	8.9		14.5	12.9	2017-2019	4
SCORE	PHYSICAL ACTIVITY	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.17	Adults 20+ who are Obese	<i>percent</i>	36.3	36			2019	4
2.00	Access to Exercise Opportunities	<i>percent</i>	66.7		83.9	84	2020	8
2.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	5.3				2015	22
1.86	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.5				2017	22
1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	82		80.9	80.4	2021	7
1.67	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.9				2015	22
1.64	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.7				2016	22
1.50	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016	22
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016	22
1.33	Children with Low Access to a Grocery Store	<i>percent</i>	3.6				2015	22
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	5				2015	22
1.25	Health Behaviors Ranking	<i>ranking</i>	8				2021	8
1.19	Adults 20+ who are Sedentary	<i>percent</i>	22.7				2019	4
1.17	Farmers Market Density	<i>markets/ 1,000 population</i>	0.1				2018	22
1.17	Grocery Store Density	<i>stores/ 1,000 population</i>	0.2				2016	22
1.14	Food Environment Index	<i>index</i>	8		6.8	7.8	2021	8
0.64	Workers who Walk to Work	<i>percent</i>	4		2.2	2.7	2015-2019	1

SCORE	PREVENTION & SAFETY	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Age-Adjusted Death Rate due to Falls	<i>deaths/ 100,000 population</i>	16		10.5	9.5	2017-2019	4
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	<i>deaths/ 100,000 population</i>	3.8		2.8	2.5	2015-2019	4
1.11	Age-Adjusted Death Rate due to Unintentional Injuries	<i>deaths/ 100,000 population</i>	57.4	43.2	68.8	48.9	2017-2019	4
0.83	Age-Adjusted Death Rate due to Unintentional Poisonings	<i>deaths/ 100,000 population</i>	20.4		40.2	21.4	2017-2019	4
0.75	Severe Housing Problems	<i>percent</i>	13		13.7	18	2013-2017	8
0.53	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	17.8		38.1	21	2017-2019	8
SCORE	RESPIRATORY DISEASES	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Adults Who Used Electronic Cigarettes: Past 30 Days	<i>percent</i>	4.7		4.3	4.1	2021	7
1.92	Adults who Smoke	<i>percent</i>	22.8	5	21.4	17	2018	8
1.83	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	3.1		2.2	2	2021	7
1.75	Adults with COPD	<i>Percent of adults</i>	9.8			6.6	2019	3
1.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	14.4		14.4	13.8	2017-2019	4
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	<i>average dollar amount per consumer unit</i>	470.6		487.9	422.4	2021	6

1.58	Adults with Current Asthma	<i>percent</i>	9.9			8.9	2019	3
1.53	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0.7		0.3	1.6	4-Feb-22	10
1.36	Asthma: Medicare Population	<i>percent</i>	4.7		4.8	5	2018	5
1.14	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	<i>deaths/ 100,000 population</i>	42.3		47.8	39.6	2017-2019	4
1.14	COPD: Medicare Population	<i>percent</i>	11.8		13.2	11.5	2018	5
0.92	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	0	1.4	1.1		2020	15
0.69	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	55.4		67.3	57.3	2014-2018	11
0.61	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	35.6	25.1	45	36.7	2015-2019	11
0.08	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	16.6		36.7	67.6	4-Feb-22	10
SCORE	TOBACCO USE	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Adults Who Used Electronic Cigarettes: Past 30 Days	<i>percent</i>	4.7		4.3	4.1	2021	7
1.92	Adults who Smoke	<i>percent</i>	22.8	5	21.4	17	2018	8
1.83	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	3.1		2.2	2	2021	7
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	<i>average dollar amount per consumer unit</i>	470.6		487.9	422.4	2021	6

SCORE	WELLNESS & LIFESTYLE	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Poor Physical Health: Average Number of Days	days	4.5		4.1	3.7	2018	8
1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	percent	82		80.9	80.4	2021	7
1.58	Insufficient Sleep	percent	38.6	31.4	40.6	35	2018	8
1.58	Poor Physical Health: 14+ Days	percent	14.6			12.5	2019	3
1.58	Self-Reported General Health Assessment: Poor or Fair	percent	21.2			18.6	2019	3
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	Percent	48.2		48.6	49.4	2021	7
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	Percent	41.4		41.5	41.2	2021	7
1.50	Self-Reported General Health Assessment: Good or Better	percent	84.7		85.6	86.5	2021	7
1.42	Morbidity Ranking	ranking	23				2021	8
1.33	Consumer Expenditures: Fast Food Restaurants	average dollar amount per consumer unit	1360.5		1461	1638.9	2021	6
1.33	High Blood Pressure Prevalence	percent	34.7	27.7		32.6	2019	3
1.17	Life Expectancy	years	78		77	79.2	2017-2019	8
SCORE	WOMEN'S HEALTH	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.22	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	22.9	15.3	21.6	19.9	2015-2019	11
1.78	Mammogram in Past 2 Years: 50-74	<i>percent</i>	71	77.1		74.8	2018	3
1.64	Breast Cancer Incidence Rate	<i>cases/ 100,000 females</i>	123.1		129.6	126.8	2014-2018	11
1.61	Cervical Cancer Screening: 21-65	<i>Percent</i>	83.3	84.3		84.7	2018	3
1.08	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	7		7.9	7.7	2014-2018	11

Wayne 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	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	40.7	28.3	32.2	27	2015-2019	9
2.50	Consumer Expenditures: Alcoholic Beverages	<i>average dollar amount per consumer unit</i>	821.2		651.5	701.9	2021	7
1.92	Adults who Binge Drink	<i>percent</i>	17.6			16.7	2019	4
1.33	Adults who Drink Excessively	<i>percent</i>	18.5		18.5	19	2018	9
1.25	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	<i>Deaths per 100,000 population</i>	25.1		42	22.8	2017-2019	5
1.25	Health Behaviors Ranking		4				2021	9
1.19	Mothers who Smoked During Pregnancy	<i>percent</i>	6.9	4.3	11.5	5.5	2020	17
1.14	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	20.1		38.1	21	2017-2019	9
0.08	Liquor Store Density	<i>stores/ 100,000 population</i>	1.7		5.9	10.6	2018	22
SCORE	CANCER	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	135.8		107.2	106.2	2014-2018	12

2.58	Breast Cancer Incidence Rate	<i>cases/ 100,000 females</i>	134.7		129.6	126.8	2014-2018	12
2.58	Cancer: Medicare Population	<i>percent</i>	9		8.4	8.4	2018	6
2.25	All Cancer Incidence Rate	<i>cases/ 100,000 population</i>	486.3		467.5	448.6	2014-2018	12
1.92	Adults with Cancer	<i>percent</i>	8.3			7.1	2019	4
1.42	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	11.4		12.2	11.9	2014-2018	12
1.25	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	18.6	16.9	19.4	18.9	2015-2019	12
1.03	Colorectal Cancer Incidence Rate	<i>cases/ 100,000 population</i>	38.8		41.3	38	2014-2018	12
0.94	Colon Cancer Screening	<i>percent</i>	68.2	74.4		66.4	2018	4
0.94	Mammogram in Past 2 Years: 50-74	<i>percent</i>	74.8	77.1		74.8	2018	4
0.89	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	5.1		7.9	7.7	2014-2018	12
0.89	Cervical Cancer Screening: 21-65	<i>Percent</i>	86.8	84.3		84.7	2018	4
0.86	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	57.4		67.3	57.3	2014-2018	12
0.78	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	18.2	15.3	21.6	19.9	2015-2019	12
0.78	Age-Adjusted Death Rate due to Cancer	<i>deaths/ 100,000 population</i>	149	122.7	169.4	152.4	2015-2019	12

0.61	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	36.5	25.1	45	36.7	2015-2019	12
0.44	Age-Adjusted Death Rate due to Colorectal Cancer	<i>deaths/ 100,000 population</i>	11.4	8.9	14.8	13.4	2015-2019	12
SCORE	CHILDREN'S HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	403.8		301.6	368.2	2021	7
1.83	Children with Low Access to a Grocery Store	<i>percent</i>	6.8				2015	23
1.72	Substantiated Child Abuse Rate	<i>cases/ 1,000 children</i>	7.4	8.7	6.8		2020	3
1.33	Children with Health Insurance	<i>percent</i>	95.4		95.2	94.3	2019	1
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	<i>percent</i>	0.2		0.5		2020	19
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	<i>percent</i>	0.6		1.9		2020	19
0.75	Projected Child Food Insecurity Rate	<i>percent</i>	11.7		18.5		2021	10
0.50	Child Food Insecurity Rate	<i>percent</i>	10.6		17.4	14.6	2019	10
SCORE	COMMUNITY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.64	Workers who Walk to Work	<i>percent</i>	0.9		2.2	2.7	2015-2019	1
2.58	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	40.7	28.3	32.2	27	2015-2019	9
2.36	Solo Drivers with a Long Commute	<i>percent</i>	43.4		31.1	37	2015-2019	9
2.22	Workers Commuting by Public Transportation	<i>percent</i>	0.3	5.3	1.6	5	2015-2019	1
2.19	Workers who Drive Alone to Work	<i>percent</i>	86.9		82.9	76.3	2015-2019	1
2.17	Consumer Expenditures: Local Public Transportation	<i>average dollar amount per consumer unit</i>	134.3		121.7	148.8	2021	7
2.14	Social Associations	<i>membership associations/ 10,000 population</i>	9.4		11	9.3	2018	9
2.03	Mean Travel Time to Work	<i>minutes</i>	27.3		23.7	26.9	2015-2019	1
1.72	Substantiated Child Abuse Rate	<i>cases/ 1,000 children</i>	7.4	8.7	6.8		2020	3
1.25	Social and Economic Factors Ranking	<i>ranking</i>	6				2021	9
1.19	People 65+ Living Alone	<i>percent</i>	26.3		28.8	26.1	2015-2019	1
1.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	1.3				2015	23
1.00	Households with Wireless Phone Service	<i>percent</i>	97		96.8	97	2020	8

0.97	Linguistic Isolation	<i>percent</i>	0.5		1.4	4.4	2015-2019	1
0.83	Adults with Internet Access	<i>percent</i>	95.8		94.5	95	2021	8
0.83	Households with a Computer	<i>percent</i>	88.7		85.2	86.3	2021	8
0.83	Households with a Smartphone	<i>percent</i>	82.9		80.5	81.9	2021	8
0.83	Households with an Internet Subscription	<i>percent</i>	87.6		82.4	83	2015-2019	1
0.83	Households with One or More Types of Computing Devices	<i>percent</i>	93.4		89.1	90.3	2015-2019	1
0.83	Persons with an Internet Subscription	<i>percent</i>	90.5		86.2	86.2	2015-2019	1
0.64	Young Children Living Below Poverty Level	<i>percent</i>	11.3		23	20.3	2015-2019	1
0.61	Violent Crime Rate	<i>crimes/ 100,000 population</i>	41.6		303.5	394	2017	18
0.58	Voter Turnout: Presidential Election	<i>percent</i>	82		74		2020	20
0.53	Youth not in School or Working	<i>percent</i>	0.6		1.8	1.9	2015-2019	1
0.36	Children Living Below Poverty Level	<i>percent</i>	8.1		19.9	18.5	2015-2019	1
0.36	Homeownership	<i>percent</i>	76.1		59.4	56.2	2015-2019	1
0.36	Households without a Vehicle	<i>percent</i>	4.1		7.9	8.6	2015-2019	1

0.36	Single-Parent Households	percent	16		27.1	25.5	2015-2019	1
0.28	People Living Below Poverty Level	percent	6	8	14	13.4	2015-2019	1
0.25	People 25+ with a Bachelor's Degree or Higher	percent	33.9		28.3	32.1	2015-2019	1
0.08	Median Household Income	dollars	76600		56602	62843	2015-2019	1
0.08	Per Capita Income	dollars	37788		31552	34103	2015-2019	1
SCORE	DIABETES	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.50	Adults 20+ with Diabetes	percent	9.2				2019	5
0.81	Diabetes: Medicare Population	percent	23.9		27.2	27	2018	6
0.36	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	18.8		25.3	21.5	2017-2019	5
SCORE	ECONOMY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Homeowner Expenses	average dollar amount per consumer unit	9561.5		7828	8900.1	2021	7
1.86	SNAP Certified Stores	stores/ 1,000 population	0.6				2017	23
1.64	Size of Labor Force	persons	93296				Sep-21	21
1.50	WIC Certified Stores	stores/ 1,000 population	0.1				2016	23

1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	4.2				2015	23
1.25	Social and Economic Factors Ranking	<i>ranking</i>	6				2021	9
1.03	Overcrowded Households	<i>percent of households</i>	1.1		1.4		2015-2019	1
1.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	<i>percent</i>	73.7		61.6		2018	25
1.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	<i>percent</i>	19.3		24.5		2018	25
1.00	Households that are Below the Federal Poverty Level	<i>percent</i>	7		13.8		2018	25
0.83	Adults who Feel Overwhelmed by Financial Burdens	<i>percent</i>	13.2		14.6	14.4	2021	8
0.83	Households with a Savings Account	<i>percent</i>	74.1		68.8	70.2	2021	8
0.83	Renters Spending 30% or More of Household Income on Rent	<i>percent</i>	39.1		44.9	49.6	2015-2019	1
0.75	Projected Child Food Insecurity Rate	<i>percent</i>	11.7		18.5		2021	10
0.75	Projected Food Insecurity Rate	<i>percent</i>	10.1		14.1		2021	10

0.67	Income Inequality		0.4		0.5	0.5	2015-2019	1
0.64	People 65+ Living Below Poverty Level	<i>percent</i>	5.2		8.1	9.3	2015-2019	1
0.64	Young Children Living Below Poverty Level	<i>percent</i>	11.3		23	20.3	2015-2019	1
0.58	Students Eligible for the Free Lunch Program	<i>percent</i>	15.8				2019-2020	13
0.53	Youth not in School or Working	<i>percent</i>	0.6		1.8	1.9	2015-2019	1
0.50	Child Food Insecurity Rate	<i>percent</i>	10.6		17.4	14.6	2019	10
0.50	Consumer Expenditures: Home Rental Expenses	<i>average dollar amount per consumer unit</i>	3057.8		3798.7	5460.2	2021	7
0.50	Food Insecurity Rate	<i>percent</i>	9.3		13.2	10.9	2019	10
0.50	Persons with Disability Living in Poverty (5-year)	<i>percent</i>	16.4		29.5	26.1	2015-2019	1
0.36	Children Living Below Poverty Level	<i>percent</i>	8.1		19.9	18.5	2015-2019	1
0.36	Families Living Below Poverty Level	<i>percent</i>	4.1		9.9	9.5	2015-2019	1
0.36	Homeownership	<i>percent</i>	76.1		59.4	56.2	2015-2019	1
0.36	Households with Cash Public Assistance Income	<i>percent</i>	1.2		2.9	2.4	2015-2019	1
0.33	Mortgaged Owners Spending 30% or More of Household Income on Housing	<i>percent</i>	16.4		19.7	26.5	2019	1

0.28	People Living Below Poverty Level	<i>percent</i>	6	8	14	13.4	2015-2019	1
0.25	Severe Housing Problems	<i>percent</i>	10.4		13.7	18	2013-2017	9
0.25	Unemployed Workers in Civilian Labor Force	<i>percent</i>	3.1		4.3	4.6	Sep-21	21
0.08	Median Household Income	<i>dollars</i>	76600		56602	62843	2015-2019	1
0.08	People Living 200% Above Poverty Level	<i>percent</i>	82.8		68.8	69.1	2015-2019	1
0.08	Per Capita Income	<i>dollars</i>	37788		31552	34103	2015-2019	1
SCORE	EDUCATION	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	403.8		301.6	368.2	2021	7
2.17	Consumer Expenditures: Education	<i>average dollar amount per consumer unit</i>	1490.7		1200.4	1492.4	2021	7
1.58	Student-to-Teacher Ratio	<i>students/ teacher</i>	18.3				2019-2020	13
1.50	8th Grade Students Proficient in Math	<i>percent</i>	62.1		57.3		2018-2019	15
1.00	4th Grade Students Proficient in Math	<i>percent</i>	86.3		74.3		2018-2019	15
0.86	4th Grade Students Proficient in English/Language Arts	<i>percent</i>	79		63.3		2018-2019	15
0.72	High School Graduation	<i>percent</i>	96.3	90.7	92		2019-2020	15

0.58	8th Grade Students Proficient in English/Language Arts	<i>percent</i>	74		58.3		2018-2019	15
0.25	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	33.9		28.3	32.1	2015-2019	1
SCORE	ENVIRONMENTAL HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Grocery Store Density	<i>stores/ 1,000 population</i>	0.1				2016	23
1.86	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.6				2017	23
1.83	Children with Low Access to a Grocery Store	<i>percent</i>	6.8				2015	23
1.81	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.7				2016	23
1.50	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.5				2015	23
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016	23
1.36	Number of Extreme Heat Days	<i>days</i>	14				2019	14
1.36	Number of Extreme Precipitation Days	<i>days</i>	28				2019	14
1.36	PBT Released	<i>pounds</i>	676.8				2020	24

1.36	Recognized Carcinogens Released into Air	<i>pounds</i>	447				2020	24
1.36	Weeks of Moderate Drought or Worse	<i>weeks per year</i>	1				2020	14
1.33	Farmers Market Density	<i>markets/ 1,000 population</i>	0				2018	23
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	4.2				2015	23
1.25	Adults with Current Asthma	<i>percent</i>	9.4			8.9	2019	4
1.25	Physical Environment Ranking	<i>ranking</i>	10				2021	9
1.19	Asthma: Medicare Population	<i>percent</i>	4.7		4.8	5	2018	6
1.14	Blood Lead Levels in Children (≥ 10 micrograms per deciliter)	<i>percent</i>	0.2		0.5		2020	19
1.14	Blood Lead Levels in Children (≥ 5 micrograms per deciliter)	<i>percent</i>	0.6		1.9		2020	19
1.11	Annual Ozone Air Quality		A				2017-2019	2
1.11	Annual Particle Pollution		A				2017-2019	2
1.03	Overcrowded Households	<i>percent of households</i>	1.1		1.4		2015-2019	1
1.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	1.3				2015	23

1.00	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016	23
0.83	Access to Exercise Opportunities	<i>percent</i>	92.1		83.9	84	2020	9
0.53	Houses Built Prior to 1950	<i>percent</i>	12.5		26.2	17.5	2015-2019	1
0.36	Food Environment Index	<i>index</i>	8.6		6.8	7.8	2021	9
0.25	Severe Housing Problems	<i>percent</i>	10.4		13.7	18	2013-2017	9
0.08	Liquor Store Density	<i>stores/ 100,000 population</i>	1.7		5.9	10.6	2018	22
SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Consumer Expenditures: Health Insurance	<i>average dollar amount per consumer unit</i>	5410.8		4371.7	4321.1	2021	7
2.50	Consumer Expenditures: Medical Services	<i>average dollar amount per consumer unit</i>	1419.1		1098.6	1047.4	2021	7
2.50	Consumer Expenditures: Medical Supplies	<i>average dollar amount per consumer unit</i>	259.4		204.8	194.9	2021	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	<i>average dollar amount per consumer unit</i>	781.2		638.9	609.6	2021	7
1.72	Primary Care Provider Rate	<i>providers/ 100,000 population</i>	60.3		76.7		2018	9
1.50	Non-Physician Primary Care Provider Rate	<i>providers/ 100,000 population</i>	63.4		108.9		2020	9
1.44	Dentist Rate	<i>dentists/ 100,000 population</i>	53.4		64.2		2019	9

1.39	Persons without Health Insurance	percent	4.3		6.6		2019	1
1.33	Adults with Health Insurance	percent	94.4		90.9	87.1	2019	1
1.33	Children with Health Insurance	percent	95.4		95.2	94.3	2019	1
1.33	Mental Health Provider Rate	providers/ 100,000 population	140.8		261.3		2020	9
1.25	Clinical Care Ranking	ranking	4				2021	9
0.92	Adults who have had a Routine Checkup	percent	79.5			76.6	2019	4
0.83	Adults who Visited a Dentist	percent	56.6		51.6	52.9	2021	8
0.83	Adults with Health Insurance: 18+	percent	92.4		90.2	90.6	2021	8
0.75	Adults without Health Insurance	percent	9.5			13	2019	4
SCORE	HEART DISEASE & STROKE	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Atrial Fibrillation: Medicare Population	percent	9.4		9	8.4	2018	6
1.81	Hyperlipidemia: Medicare Population	percent	50		49.4	47.7	2018	6
1.42	Adults who Have Taken Medications for High Blood Pressure	percent	78			76.2	2019	4

1.33	High Blood Pressure Prevalence	<i>percent</i>	33.7	27.7		32.6	2019	4
1.31	Hypertension: Medicare Population	<i>percent</i>	57.5		59.5	57.2	2018	6
1.28	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	<i>deaths/ 100,000 population</i>	34.1	33.4	42.5	37.2	2017-2019	5
1.25	Cholesterol Test History	<i>percent</i>	87.1			87.6	2019	4
1.08	Adults who Experienced Coronary Heart Disease	<i>percent</i>	6.6			6.2	2019	4
1.08	High Cholesterol Prevalence: Adults 18+	<i>percent</i>	32.8			33.6	2019	4
1.03	Stroke: Medicare Population	<i>percent</i>	3.5		3.8	3.8	2018	6
0.92	Adults who Experienced a Stroke	<i>percent</i>	3.2			3.4	2019	4
0.86	Age-Adjusted Death Rate due to Heart Attack	<i>deaths/ 100,000 population 35+ years</i>	45.4		55.4		2019	14
0.78	Age-Adjusted Death Rate due to Coronary Heart Disease	<i>deaths/ 100,000 population</i>	83.7	71.1	101.4	90.5	2017-2019	5
0.69	Heart Failure: Medicare Population	<i>percent</i>	12.9		14.7	14	2018	6
0.69	Ischemic Heart Disease: Medicare Population	<i>percent</i>	24.7		27.5	26.8	2018	6

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.92	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	16.2	11.1	12.9		2018	16
1.72	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	1.1	1.4	1.1		2020	16
1.03	Overcrowded Households	<i>percent of households</i>	1.1		1.4		2015-2019	1
0.89	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	43		224	187.8	2019	16
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	<i>Percent</i>	50.9		48.6	49.4	2021	8
0.75	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	216.8		561.9	551	2019	16
0.58	Persons Fully Vaccinated Against COVID-19	<i>percent</i>	62.5				28-Jan-22	5
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	8		14.4	13.8	2017-2019	5
0.08	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0		0	0.5	28-Jan-22	11
0.08	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	56.4		128.4	177.3	28-Jan-22	11
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	403.8		301.6	368.2	2021	7
1.19	Mothers who Smoked During Pregnancy	<i>percent</i>	6.9	4.3	11.5	5.5	2020	17
1.11	Mothers who Received Early Prenatal Care	<i>percent</i>	74.7		68.9	76.1	2020	17
0.86	Teen Birth Rate: 15-17	<i>live births/ 1,000 females aged 15-17</i>	1.6		6.8		2020	17
0.86	Teen Pregnancy Rate	<i>pregnancies/ 1,000 females aged 15-17</i>	13.4		19.5		2016	17
0.78	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	1.8	5	6.9		2019	17
0.78	Preterm Births	<i>percent</i>	7.6	9.4	10.3		2020	17
0.75	Babies with Low Birth Weight	<i>percent</i>	5.7		8.5	8.2	2020	17
0.61	Babies with Very Low Birth Weight	<i>percent</i>	0.6		1.4	1.3	2020	17
SCORE	MEDICATIONS & PRESCRIPTIONS	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Consumer Expenditures: Medical Services	<i>average dollar amount per consumer unit</i>	1419.1		1098.6	1047.4	2021	7
2.50	Consumer Expenditures: Medical Supplies	<i>average dollar amount per consumer unit</i>	259.4		204.8	194.9	2021	7
2.50	Consumer Expenditures: Prescription and Non- Prescription Drugs	<i>average dollar amount per consumer unit</i>	781.2		638.9	609.6	2021	7

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.92	Depression: Medicare Population	<i>percent</i>	19		20.4	18.4	2018	6
1.89	Age-Adjusted Death Rate due to Suicide	<i>deaths/ 100,000 population</i>	15.7	12.8	15.1	14.1	2017-2019	5
1.58	Adults Ever Diagnosed with Depression	<i>percent</i>	21.2			18.8	2019	4
1.33	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	140.8		261.3		2020	9
1.25	Poor Mental Health: 14+ Days	<i>percent</i>	14.3			13.6	2019	4
1.17	Poor Mental Health: Average Number of Days	<i>days</i>	4.4		4.8	4.1	2018	9
1.14	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	9.4		10.4	10.8	2018	6
0.97	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	28.8		34	30.5	2017-2019	5
0.83	Self-Reported General Health Assessment: Good or Better	<i>percent</i>	88.2		85.6	86.5	2021	8
SCORE	NUTRITION & HEALTHY EATING	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.50	Consumer Expenditures: Fast Food Restaurants	<i>average dollar amount per consumer unit</i>	1814.2		1461	1638.9	2021	7
2.50	Consumer Expenditures: High Sugar Foods	<i>average dollar amount per consumer unit</i>	627		519	530.2	2021	7
2.33	Consumer Expenditures: High Sugar Beverages	<i>average dollar amount per consumer unit</i>	370		319.7	357	2021	7
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	<i>Percent</i>	40.2		41.5	41.2	2021	8
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	80.2		80.9	80.4	2021	8
0.67	Consumer Expenditures: Fruits and Vegetables	<i>average dollar amount per consumer unit</i>	1043.8		864.6	1002.1	2021	7
SCORE	OLDER ADULT HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Cancer: Medicare Population	<i>percent</i>	9		8.4	8.4	2018	6
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	37.2		36.1	33.5	2018	6
2.31	Atrial Fibrillation: Medicare Population	<i>percent</i>	9.4		9	8.4	2018	6
2.14	Osteoporosis: Medicare Population	<i>percent</i>	6.6		6.2	6.6	2018	6

1.92	Depression: Medicare Population	<i>percent</i>	19		20.4	18.4	2018	6
1.81	Hyperlipidemia: Medicare Population	<i>percent</i>	50		49.4	47.7	2018	6
1.75	Adults with Arthritis	<i>percent</i>	30			25.1	2019	4
1.67	Consumer Expenditures: Eldercare	<i>average dollar amount per consumer unit</i>	24.4		20.5	34.3	2021	7
1.50	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.5				2015	23
1.47	Age-Adjusted Death Rate due to Falls	<i>deaths/ 100,000 population</i>	9.7		10.5	9.5	2017-2019	5
1.42	Chronic Kidney Disease: Medicare Population	<i>percent</i>	23		25.3	24.5	2018	6
1.31	Hypertension: Medicare Population	<i>percent</i>	57.5		59.5	57.2	2018	6
1.19	Asthma: Medicare Population	<i>percent</i>	4.7		4.8	5	2018	6
1.19	People 65+ Living Alone	<i>percent</i>	26.3		28.8	26.1	2015-2019	1
1.14	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	9.4		10.4	10.8	2018	6
1.03	Stroke: Medicare Population	<i>percent</i>	3.5		3.8	3.8	2018	6
0.97	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	28.8		34	30.5	2017-2019	5
0.97	COPD: Medicare Population	<i>percent</i>	10.8		13.2	11.5	2018	6

0.94	Colon Cancer Screening	percent	68.2	74.4		66.4	2018	4
0.81	Diabetes: Medicare Population	percent	23.9		27.2	27	2018	6
0.75	Adults 65+ who Received Recommended Preventive Services: Females	percent	36.5			28.4	2018	4
0.75	Adults 65+ who Received Recommended Preventive Services: Males	percent	38.5			32.4	2018	4
0.75	Adults 65+ with Total Tooth Loss	percent	11			13.5	2018	4
0.69	Heart Failure: Medicare Population	percent	12.9		14.7	14	2018	6
0.69	Ischemic Heart Disease: Medicare Population	percent	24.7		27.5	26.8	2018	6
0.64	People 65+ Living Below Poverty Level	percent	5.2		8.1	9.3	2015-2019	1
SCORE	ORAL HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.44	Dentist Rate	dentists/ 100,000 population	53.4		64.2		2019	9
1.42	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	11.4		12.2	11.9	2014-2018	12
0.83	Adults who Visited a Dentist	percent	56.6		51.6	52.9	2021	8

0.75	Adults 65+ with Total Tooth Loss	<i>percent</i>	11			13.5	2018	4
SCORE	OTHER CONDITIONS	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	37.2		36.1	33.5	2018	6
2.14	Osteoporosis: Medicare Population	<i>percent</i>	6.6		6.2	6.6	2018	6
1.75	Adults with Arthritis	<i>percent</i>	30			25.1	2019	4
1.42	Chronic Kidney Disease: Medicare Population	<i>percent</i>	23		25.3	24.5	2018	6
0.92	Adults with Kidney Disease	<i>Percent of adults</i>	2.8			3.1	2019	4
0.36	Age-Adjusted Death Rate due to Kidney Disease	<i>deaths/ 100,000 population</i>	8.7		14.5	12.9	2017-2019	5
SCORE	PHYSICAL ACTIVITY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Workers who Walk to Work	<i>percent</i>	0.9		2.2	2.7	2015-2019	1
2.00	Grocery Store Density	<i>stores/ 1,000 population</i>	0.1				2016	23
1.86	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.6				2017	23
1.83	Children with Low Access to a Grocery Store	<i>percent</i>	6.8				2015	23

1.81	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.7					2016	23
1.50	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.5					2015	23
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1					2016	23
1.33	Farmers Market Density	<i>markets/ 1,000 population</i>	0					2018	23
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	4.2					2015	23
1.25	Health Behaviors Ranking		4					2021	9
1.03	Adults 20+ who are Sedentary	<i>percent</i>	21.1					2019	5
1.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	1.3					2015	23
1.00	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1					2016	23
0.94	Adults 20+ who are Obese	<i>percent</i>	27.8	36				2019	5
0.83	Access to Exercise Opportunities	<i>percent</i>	92.1		83.9	84		2020	9
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	80.2		80.9	80.4		2021	8
0.36	Food Environment Index		8.6		6.8	7.8		2021	9

SCORE	PREVENTION & SAFETY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.47	Age-Adjusted Death Rate due to Falls	deaths/ 100,000 population	9.7		10.5	9.5	2017-2019	5
1.47	Age-Adjusted Death Rate due to Unintentional Poisonings	deaths/ 100,000 population	23.6		40.2	21.4	2017-2019	5
1.14	Death Rate due to Drug Poisoning	deaths/ 100,000 population	20.1		38.1	21	2017-2019	9
0.67	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	43.8	43.2	68.8	48.9	2017-2019	5
0.25	Severe Housing Problems	percent	10.4		13.7	18	2013-2017	9
SCORE	RESPIRATORY DISEASES	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.72	Tuberculosis Incidence Rate	cases/ 100,000 population	1.1	1.4	1.1		2020	16
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	average dollar amount per consumer unit	472.9		487.9	422.4	2021	7
1.47	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	deaths/ 100,000 population	43.7		47.8	39.6	2017-2019	5
1.42	Adults with COPD	Percent of adults	7.9			6.6	2019	4

1.33	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	2.3		2.2	2	2021	8
1.25	Adults with Current Asthma	<i>percent</i>	9.4			8.9	2019	4
1.19	Asthma: Medicare Population	<i>percent</i>	4.7		4.8	5	2018	6
0.97	COPD: Medicare Population	<i>percent</i>	10.8		13.2	11.5	2018	6
0.92	Adults who Smoke	<i>percent</i>	17.9	5	21.4	17	2018	9
0.86	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	57.4		67.3	57.3	2014-2018	12
0.61	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	36.5	25.1	45	36.7	2015-2019	12
0.50	Adults Who Used Electronic Cigarettes: Past 30 Days	<i>percent</i>	3.7		4.3	4.1	2021	8
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	8		14.4	13.8	2017-2019	5
0.08	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0		0	0.5	28-Jan-22	11
0.08	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	56.4		128.4	177.3	28-Jan-22	11
SCORE	TOBACCO USE	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

1.67	Consumer Expenditures: Tobacco and Legal Marijuana	<i>average dollar amount per consumer unit</i>	472.9		487.9	422.4	2021	7
1.33	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	2.3		2.2	2	2021	8
0.92	Adults who Smoke	<i>percent</i>	17.9	5	21.4	17	2018	9
0.50	Adults Who Used Electronic Cigarettes: Past 30 Days	<i>percent</i>	3.7		4.3	4.1	2021	8
SCORE	WELLNESS & LIFESTYLE	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Consumer Expenditures: Fast Food Restaurants	<i>average dollar amount per consumer unit</i>	1814.2		1461	1638.9	2021	7
1.42	Insufficient Sleep	<i>percent</i>	37.5	31.4	40.6	35	2018	9
1.33	High Blood Pressure Prevalence	<i>percent</i>	33.7	27.7		32.6	2019	4
1.25	Morbidity Ranking	<i>ranking</i>	4				2021	9
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	<i>Percent</i>	40.2		41.5	41.2	2021	8
0.92	Poor Physical Health: 14+ Days	<i>percent</i>	12.5			12.5	2019	4

0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	80.2		80.9	80.4	2021	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	<i>Percent</i>	50.9		48.6	49.4	2021	8
0.83	Life Expectancy	<i>years</i>	80.1		77	79.2	2017-2019	9
0.83	Self-Reported General Health Assessment: Good or Better	<i>percent</i>	88.2		85.6	86.5	2021	8
0.75	Self-Reported General Health Assessment: Poor or Fair	<i>percent</i>	16.5			18.6	2019	4
0.67	Poor Physical Health: Average Number of Days	<i>days</i>	3.6		4.1	3.7	2018	9
SCORE	WOMEN'S HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Breast Cancer Incidence Rate	<i>cases/ 100,000 females</i>	134.7		129.6	126.8	2014-2018	12
0.94	Mammogram in Past 2 Years: 50-74	<i>percent</i>	74.8	77.1		74.8	2018	4
0.89	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	5.1		7.9	7.7	2014-2018	12
0.89	Cervical Cancer Screening: 21-65	<i>Percent</i>	86.8	84.3		84.7	2018	4

0.78	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	18.2	15.3	21.6	19.9	<i>2015-2019</i>	12
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Medina 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 *{hospital name}* 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 Medina 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).²⁶ 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 Medina Hospital Community:

- Asian Services in Action, Inc.
- Care Alliance
- Health Source of Ohio
- Medina County Health Department
- MetroHealth Community Health Centers (MHCHC)
- Neighborhood Family Practice
- Northeast Ohio Neighborhood Health Services
- 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 Medina Hospital Community:

- Aultman Orrville Hospital

²⁶ Ohio Association of Community Health Centers, <https://www.ohiochc.org/page/178>

- Grace Hospital
- MetroHealth Medical Centers (Multiple Locations)
- St. Vincent Charity Medical Center
- Summa Health System – Barberton Campus
- University Hospitals (Multiple Locations)
- Wooster Community Hospital

Other Community Resources

A wide range of agencies, coalitions, and organizations that provide health and social services is available in the region served by Medina Hospital. 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

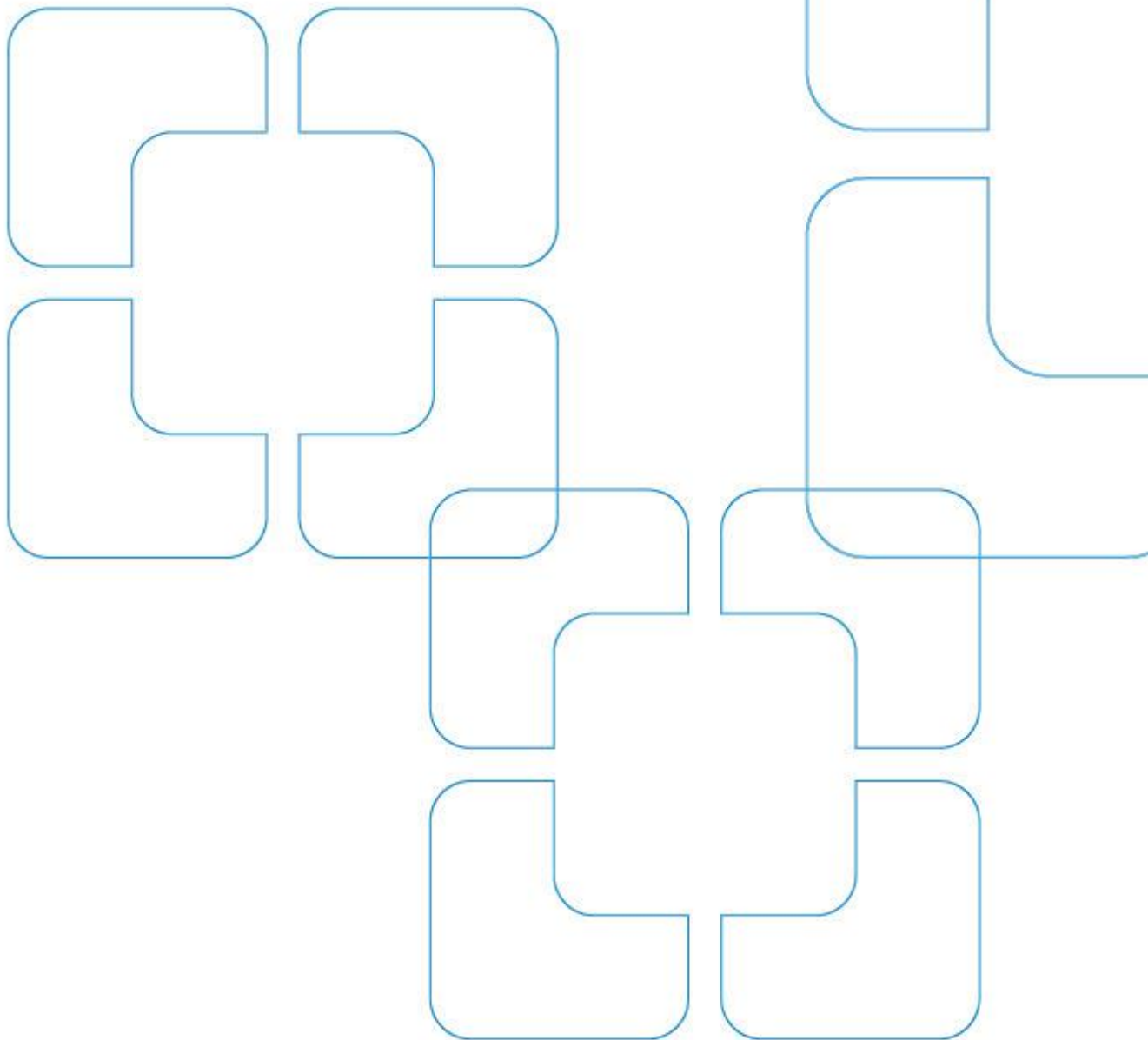
Conduent Healthy Communities Institute (HCI) supported report preparation. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance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

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Implementation Strategy Report

2022



MEDINA HOSPITAL 2022 IMPLEMENTATION STRATEGY REPORT
2022 Community Health Needs Assessment
Implementation Strategy Report for Years 2023 – 2025

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MEDINA HOSPITAL 2022 IMPLEMENTATION STRATEGY REPORT

I. INTRODUCTION AND PURPOSE

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 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

For over 75 years, Medina Hospital has remained dedicated to the surrounding community and its patients. Located on the corridor to the Medina community, Medina Hospital is a 148 staffed bed²⁷ acute care facility. In August 2009, the hospital affiliated with Cleveland Clinic becoming the ninth regional hospital in the health system. Medina Hospital is also introducing advanced clinical treatments and therapies, personal service enhancements for patients and visitors, and faster access to Cleveland Clinic's expertise and specialties. Medina Hospital's strong clinical Centers of Excellence include Emergency Department, Orthopedics and Surgery. Additional information on the hospital and its services is available at: <https://my.clevelandclinic.org/locations/medina-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.

Medina Hospital's mission is:

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

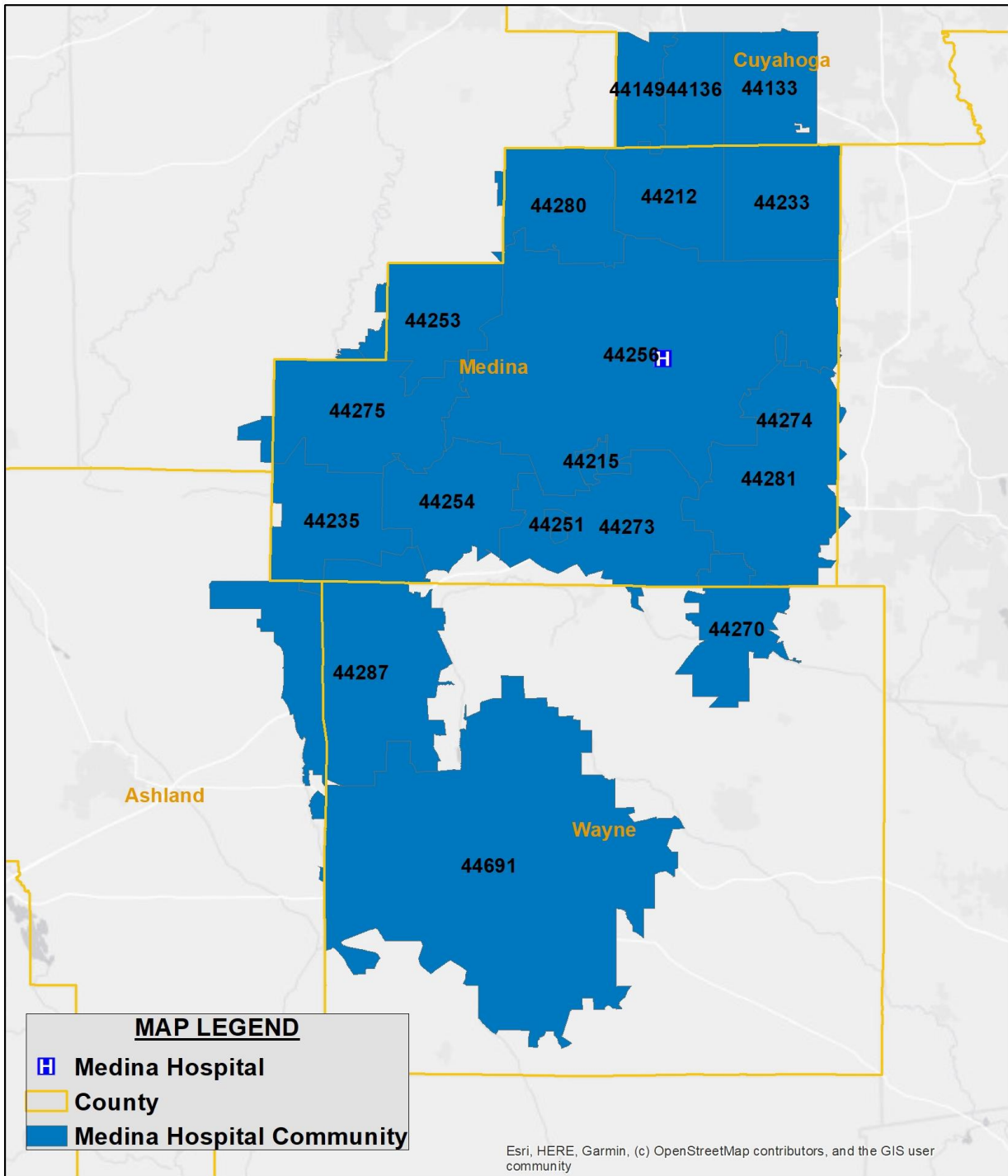
II. COMMUNITY DEFINITION

For purposes of this report, the Medina Hospital community definition is an aggregate of 19 zip codes in Cuyahoga, Medina, and Wayne Counties comprising approximately 75% of inpatient, outpatient and emergency department visits in 2021 (Figure 1).

Cleveland Clinic Medina Hospital is a significant healthcare resource, as noted on the map, for Medina County and, in varying amounts, four other surrounding counties. Most notably, a large portion of Wayne County to the south is utilizing Medina Hospital for their healthcare needs.

²⁷ 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: Medina Hospital Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of leadership at Medina 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 also considered. Leadership at Medina 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

Medina 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
- 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 worldwide, including Medina 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 Medina Hospital and other Cleveland Clinic CHNAs for more information:
www.clevelandclinic.org/CHNARports

V. NEEDS HOSPITAL WILL ADDRESS

Each Cleveland Clinic hospital provides numerous services and programs in efforts 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:

<i>Initiatives Including Collaborations and Resources Allocated</i>	<i>Anticipated Impacts</i>
<i>A</i> 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
<i>B</i> Address digital equity, utilize medically secure online and mobile platforms, and connect patients with Cleveland Clinic providers for telehealth and virtual visits	Overcome geographical and transportation barriers; Improve access to specialized care
<i>C</i> Expand Integrative Medicine services to outpatient population	Increase access to holistic and complimentary medicine care
<i>D</i> Provide Emergency Triage, Treat, and Transport (ET3) Model, a CMS pilot partner program, for community residents, expanding transport alternatives such primary care, doctor's office or urgent care clinic	Increase person centered care; Increase appropriate utilization of emergency medical services

Access to Healthcare (continued)

<i>Initiatives Including Collaborations and Resources Allocated</i>	<i>Anticipated Impacts</i>
<i>E</i> Sponsor Medina Hospital Health Fair	Increase healthcare access; Provide screenings and community education

B. Behavioral Health

Medina 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:

<i>Initiatives Including Collaborations and Resources Allocated</i>	<i>Anticipated Impacts</i>
<i>A</i> Continued collaboration in Northeast Ohio Hospital Opioid Consortium and Medina County Opioid Task Force in coordinated efforts to reduce the widespread effect of the heroin and opioid crisis	Improve access to treatment Services; Improve access to recovery support, and reduce rates of relapse
<i>B</i> Through the hospital pharmacy, provide free naloxone medication	Reduce opioid overdose rates
<i>C</i> Partner with Alternative Paths, LLC to provide 24/7 crisis intervention and referral services for patients who present to the emergency department with psychiatric symptoms	Improve access to inpatient and outpatient treatment services
<i>D</i> Expand behavioral health service provision via central intake access program	Improve access to regional inpatient treatment services
<i>E</i> Support Medina County Coalition for Suicide Prevention/Suicide Loss Prevention Team by providing caregiver time for community education services	Increase awareness of treatment; Reduce stigma; Improve early identification of behavioral health conditions
<i>F</i> Partner with Hope Recovery Community for patients in recovery from substance use disorder	Improve access, education and awareness of outpatient treatment modalities to better health outcomes
<i>G</i> Provide peer support for first responders.	Increase caregiver resilience

C. Chronic Disease Prevention & Management

Medina 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:

<i>Initiatives Including Collaborations and Resources Allocated</i>	<i>Anticipated Impacts</i>
<i>A</i> Through the <i>Healthy Medina</i> initiative, provide health and wellness programs related to nutrition and physical activity	Improve physical activity; Improve nutrition; Decrease obesity rates
<i>B</i> Implement health promotion messaging, health education, and outreach programs related to reducing behavioral risk factors, including <i>Healthy Strides</i> community health education sessions and school-based education on heart disease and stroke	Decrease smoking; Improve physical activity; Improve nutrition; Decrease stress levels
<i>C</i> Provide free health screenings for the surrounding communities at the Medina Community Recreation Center, Cloverleaf Recreation Center, local schools, and other community-based locations	Increase the number of individuals who receive a regular well-check; Improve vaccination rates
<i>D</i> Partner with the Medina County Health Department as a member of the <i>Living Well Medina County</i> workgroups related to chronic disease, obesity, heart health, vaping, and diabetes	Decrease obesity rates; Decrease smoking; Improve disease self-management

D. Socioeconomic Issues

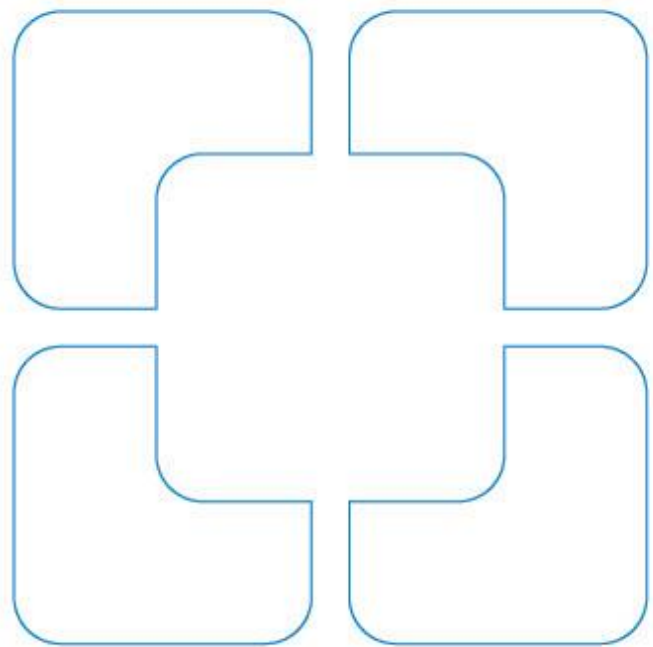
Medina Hospital’s 2022 CHNA demonstrated that health needs are multifaceted, involving medical as well as socioeconomic concerns. The assessment identified food security, affordable housing, employment, transportation, health literacy, structural racism, poverty, and environmental risk factors as significant 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 the prioritized socioeconomic issues described by primary and secondary data.

The Socioeconomic Initiatives highlighted for 2023 – 2025 include:

<i>Initiatives Including Collaborations and Resources Allocated</i>	<i>Anticipated Impacts</i>
<p><i>A</i> Continue a Cleveland Clinic common community referral data platform to coordinate services and ensure optimal communication</p>	<p>Improve active referrals to community-based organizations, non-profits, and other healthcare facilities; Track referral outcomes</p>
<p><i>B</i> Partner with Medina Police Activities League in youth engagement strategies and support the Medina County Career Center by providing volunteer work experience for students with developmental disabilities</p>	<p>Increase skills, knowledge, youths' self-esteem, and youth connectedness</p>
<p><i>C</i> Provide emergency preparedness training including Rescue Task Force training, role-play scenarios for first responders, and Code Silver event training</p>	<p>Decrease injuries and improve emergency response capacity</p>
<p>Provide safety training in collaboration with the City of Medina</p>	
<p><i>D</i> Provide workforce development and training opportunities for K-12 youth in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders</p>	<p>Increase diversity within the healthcare workforce; Improve trust in providers; Improve local provider shortages</p>
<p><i>E</i> Support the Medina Farmer's Market</p>	<p>Increase access to healthy foods</p>
<p><i>F</i> Sponsor the Medina Community Recreation Center, which provides adult wellness programs, exercise classes, youth programming, and recovery programs</p>	<p>Increase social connectedness; Improve physical activity; Improve nutrition; Increase skills, knowledge, and self-esteem for youth</p>

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, and Socioeconomic Issues, it does not reflect all the work being done by Medina Hospital to improve community health. Through this iterative process, opportunities are identified to grow and expand existing work in prioritized areas as well as implement additional programming in new areas. These ongoing strategic conversations will allow Medina 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/CHNARReports or contact CHNA@ccf.org.



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