Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Avon

Community Health Needs Assessment

2022

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Executive Summary

Introduction

This Community Health Needs Assessment (CHNA) was conducted by Cleveland Clinic Rehabilitation Hospital, Avon (CCRH Avon or "the hospital") to identify significant community health needs and to inform development of an Implementation Strategy to address current needs.

Avon Rehabilitation is a 60-bed rehabilitation facility offering sophisticated technology and advanced medical care within an intimate and friendly environment. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/rehabilitation-hospital.

The hospital is a joint venture between Cleveland Clinic health system and Select Medical. 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 a number of other facilities and services across Ohio, Florida, and Nevada. Additional information about Cleveland Clinic is available at: https://my.clevelandclinic.org/.

Select Medical is one of the largest providers of post-acute care, operating 100 critical illness recovery hospitals in 28 states, 33 rehabilitation hospitals in 12 states and 1,695 outpatient rehabilitation clinics in 37 states and the District of Columbia. Additionally, Select Medical's joint venture subsidiary Concentra operates 526 occupational health centers in 41 states. Concentra also provides contract services at employer worksites and Department of Veterans Affairs community-based outpatient clinics. Select Medical provides post-acute care encompassing four areas of expertise: critical illness recovery, inpatient medical rehabilitation, outpatient physical therapy and occupational medicine, all of which are delivered and supported by more than 46,000 talented healthcare professionals across the U.S. Additional information about Select Medical is available at: https://www.selectmedical.com/.

Each Cleveland Clinic hospital supports a tripartite mission of patient care, research, and education. Research is conducted at and in collaboration with all Cleveland Clinic hospitals. Through research, Cleveland Clinic has advanced knowledge and improved community health for all its communities, from local to national, and across the world. This allows patients to access the latest techniques and to enroll in research trials no matter where they access care in the health system. Through education, Cleveland Clinic helps to train health professionals who are needed and who provide access to healthcare across Ohio and the United States.

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

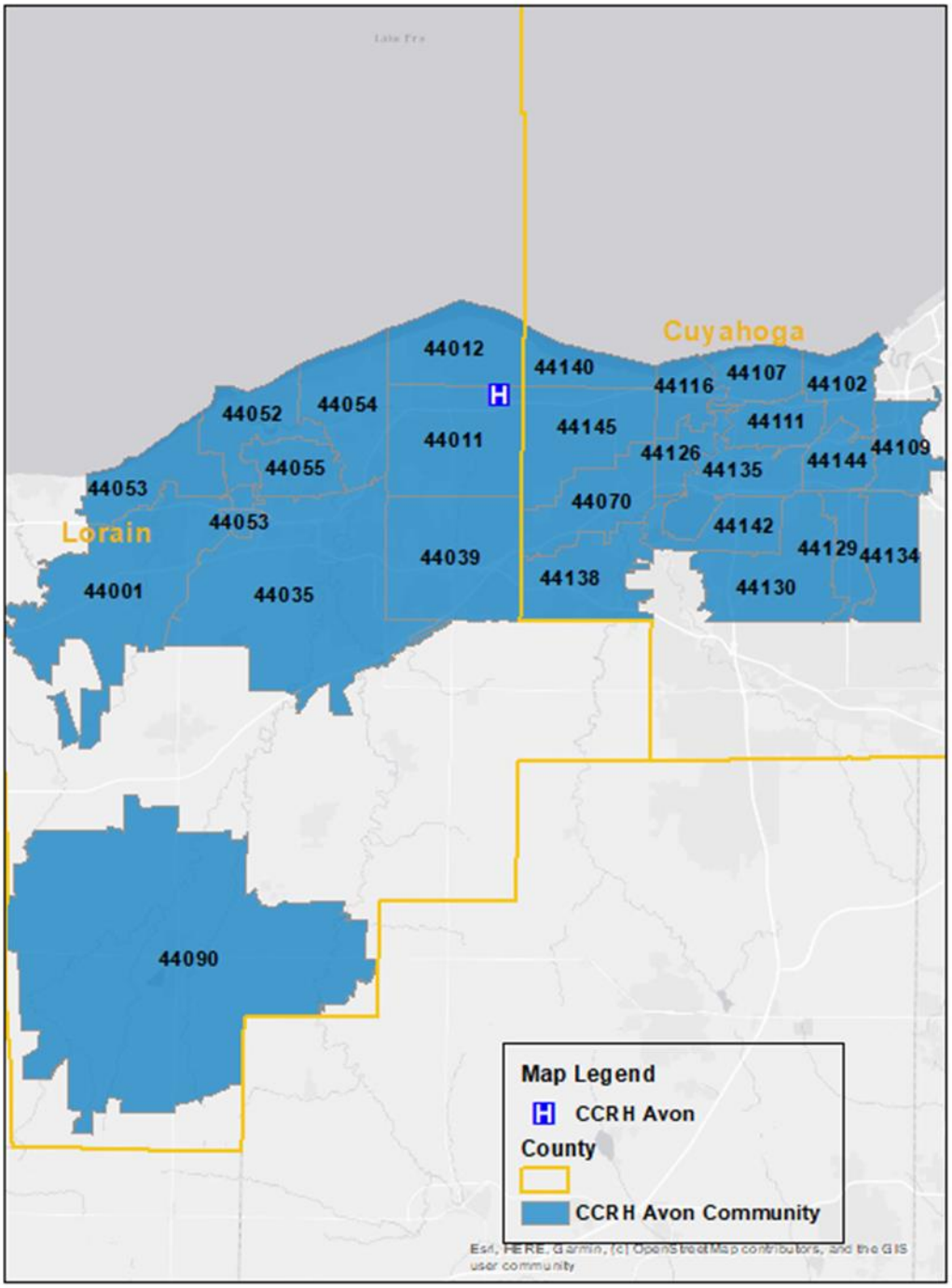
These assessments are conducted using widely accepted methodologies to identify the significant health needs of a specific community. The assessments also are conducted to comply with federal and state laws and regulations including IRS requirements for 501(c)(3) Hospitals under the Affordable Care Act.[1]

Community Definition

The community definition describes the zip codes where approximately 75% of CCRH Avon patients reside. Figure 1 shows the service area for the CCRH Avon Community. A table with zip codes and the associated postal names that comprise the community definition is located in Appendix C.

[1] 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 1: CCRH Avon 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 CCRH Avon Community Definition—an aggregate of the 26 zip codes described in the Community Definition.
- Cuyahoga and Lorain Counties—the two counties comprising the CCRH Avon Community Definition

Primary Data Summary

Qualitative data collected from community members through key stakeholder interviews 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.

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
- Adult Health
- Community Safety

Access to Healthcare

Access to Healthcare secondary data analysis results describe community needs related to consumer expenditures for health insurance, medical expenses, medicines and other supplies. Primary data collection found themes around limitations to accessing healthcare described in terms of transportation challenges, resource limitations and availability of primary care and other prevention services in local neighborhoods.

Adult Health

This health topic encompasses several subtopics where information is available including Older Adult Health; Other Conditions; and Chronic Disease Prevention and Management including Nutrition and Healthy Eating. By addressing these issues in concert, the Cleveland Clinic Foundation hopes to impact concerns for older adult mental health from

isolation, chronic conditions and access to healthy food as described in the Synthesis and Prioritization section of this report (page 34).

Community Safety

Community Safety issues, though related to social determinants of health (SDOH) stands apart as a health topic intended to describe community health needs related to the following subtopics: Prevention & Safety and Alcohol & Drug Use.

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.[2] 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 CCRH Avon Community in both the Disparities and Health Equity section (page 25) 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 CCRH Avon implementation strategy report.

[2] 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

Demographics of the CCRH Avon Community

The demographics of a community significantly impact its health profile.[3] 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 CCRH Avon Community Definition.

Geography and Data Sources

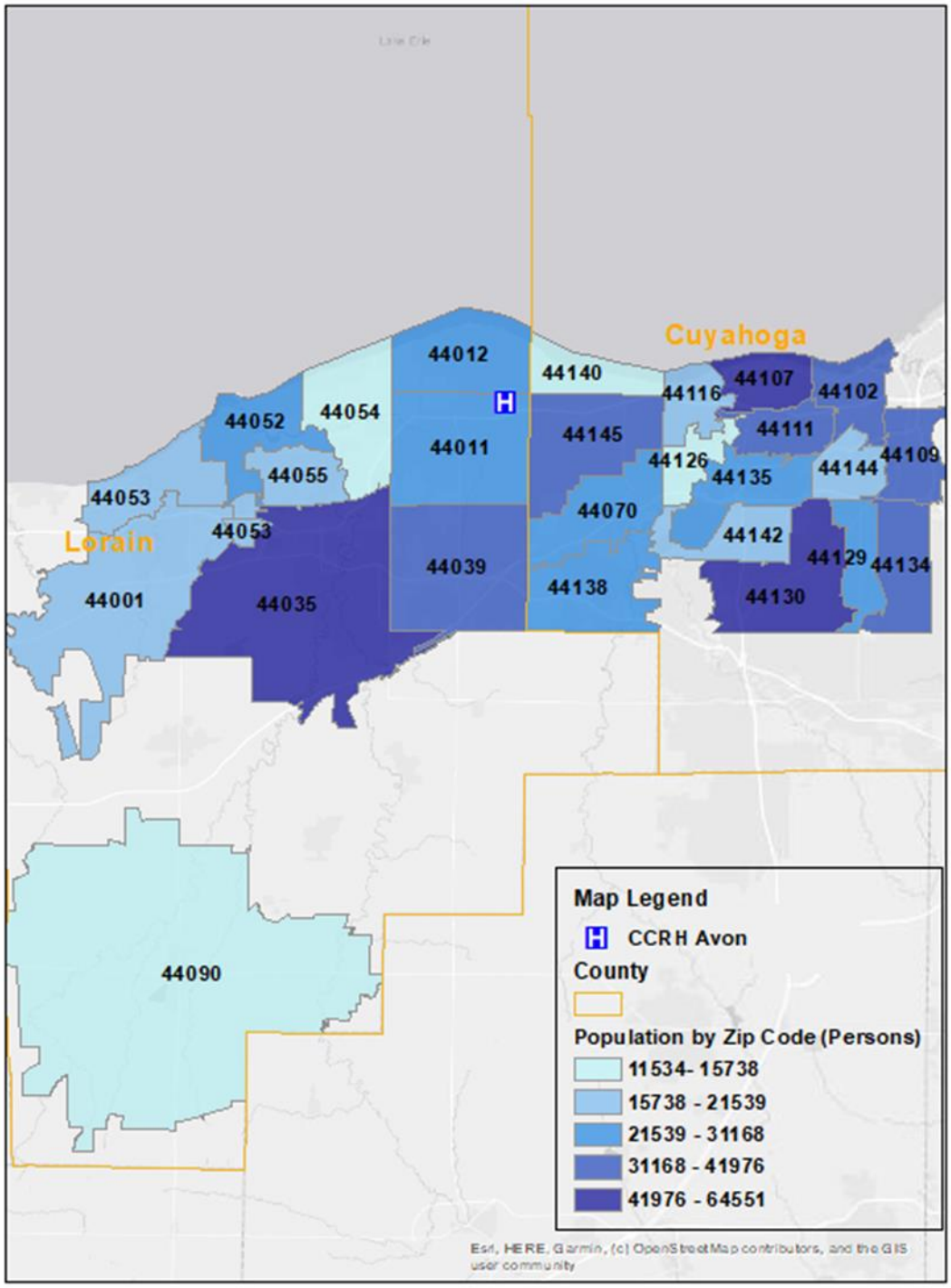
Data are presented in this section at the geographic level of the Community Definition. Comparisons to the county, state, and national values are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey[4] one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Population

According to the 2022 Claritas Pop-Facts® population estimates, the CCRH Avon community has an estimated population of 746,753 persons. Figure 2 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 CCRH Avon Community is zip code 44035 (Lorain) with a population of 64,551.

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

Figure 2: Population by Zip Code

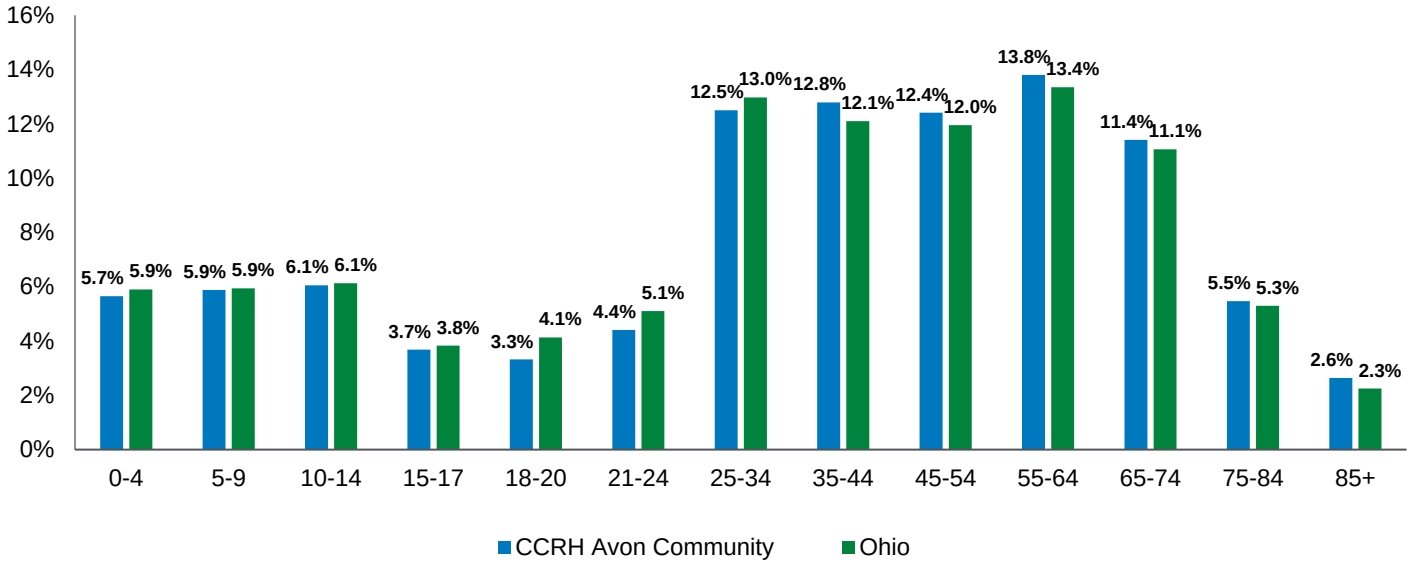


County values· Claritas Pop-Facts® (2022 population estimates)

Age

Children (Ages 0-17) comprised 21.3% of the population in the CCRH Avon Community which is slightly less when compared to the state of Ohio (21.8%). The CCRH Avon Community has a higher proportion of residents aged 65+ (19.5%) when compared with the state of Ohio at 18.6%. Figure 3 shows further breakdown of age categories.

Figure 3: Population by Age: Hospital and State Comparisons

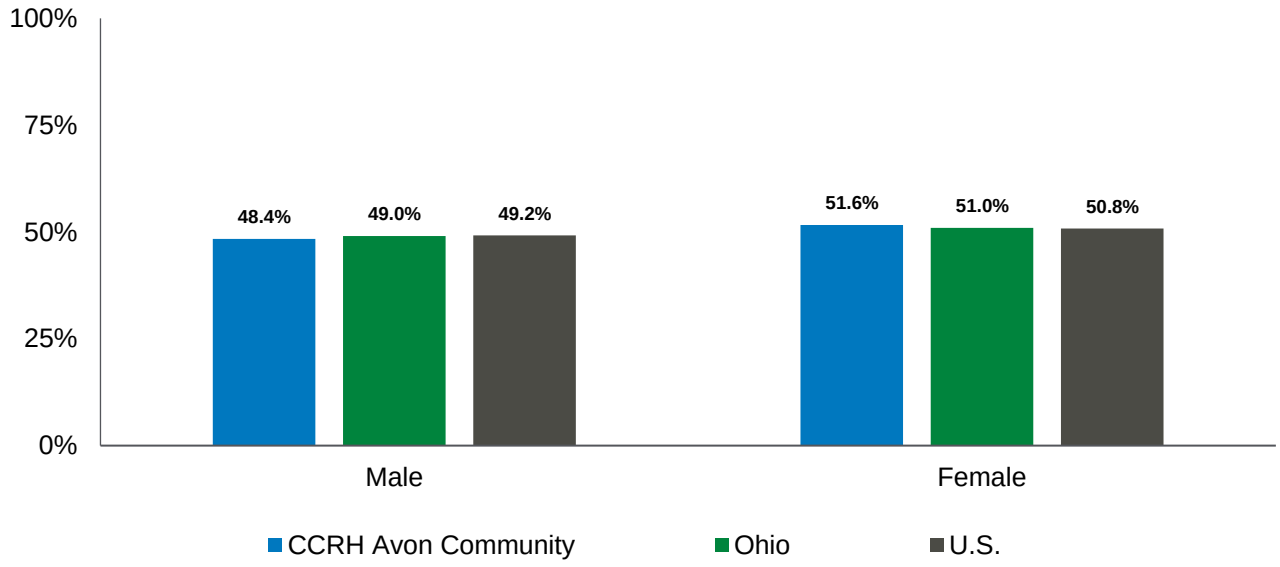


County and state values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 4 shows the population of the CCRH Avon Community by sex. Males comprise 48.4% of the population, which is less than both the Ohio (49.0%) and U.S. (49.2%) values. Whereas females comprise 51.6% of the population in the CCRH Avon Community which is greater than Ohio (51.0%) and the U.S. (50.8%) values.

Figure 4: Population by Sex: Hospital, State, and U.S. Comparisons



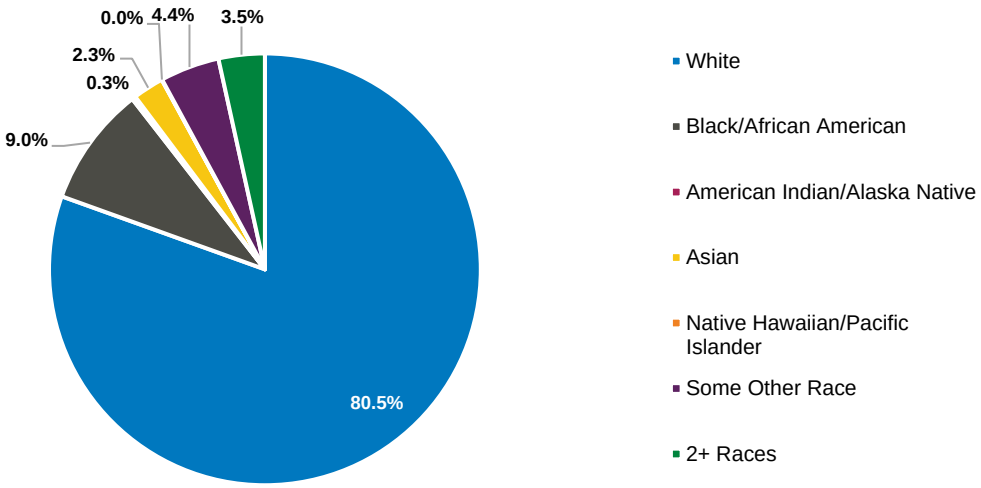
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2016-2020) estimates

Race and Ethnicity

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

The racial makeup of CCRH Avon area shows 80.5% of the population identifying as White, as indicated in Figure 5. The proportion of Black/African American community members is the second largest of all races in the CCRH Avon Community at 9.0%.

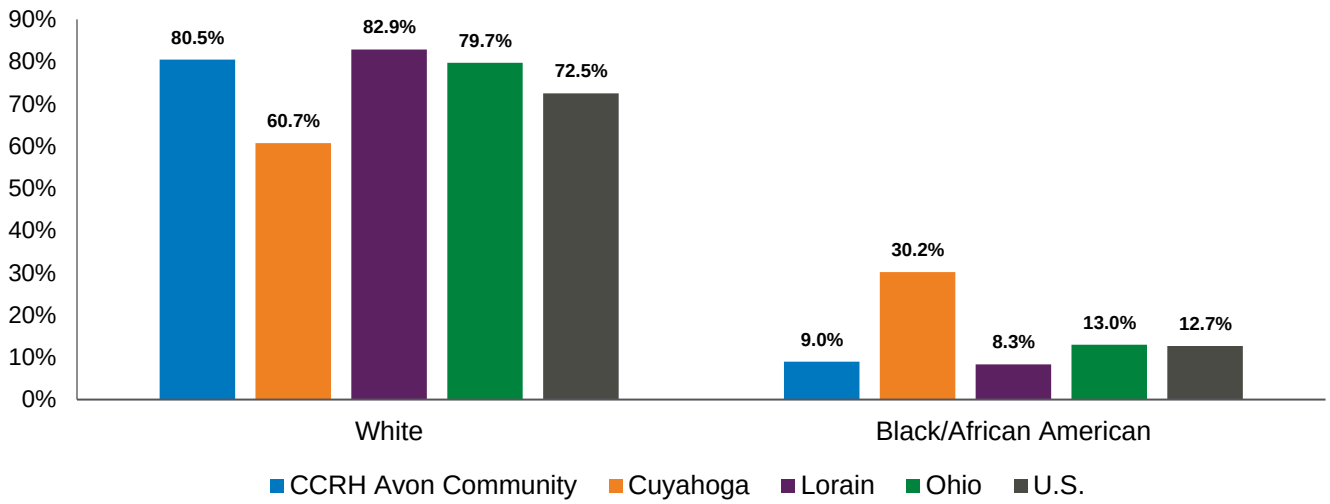
Figure 5: Population by Race: The CCRH Avon Community



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

Community members who identify as White represent a higher proportion of the population in the CCRH Avon Community (80.5%) compared to Ohio (79.7%) and the U.S. (72.5%). Black/African American community members represent a lower proportion of the population in the CCRH Avon Community (9.0%) 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 CCRH Avon Community Definition. (Figure 6)

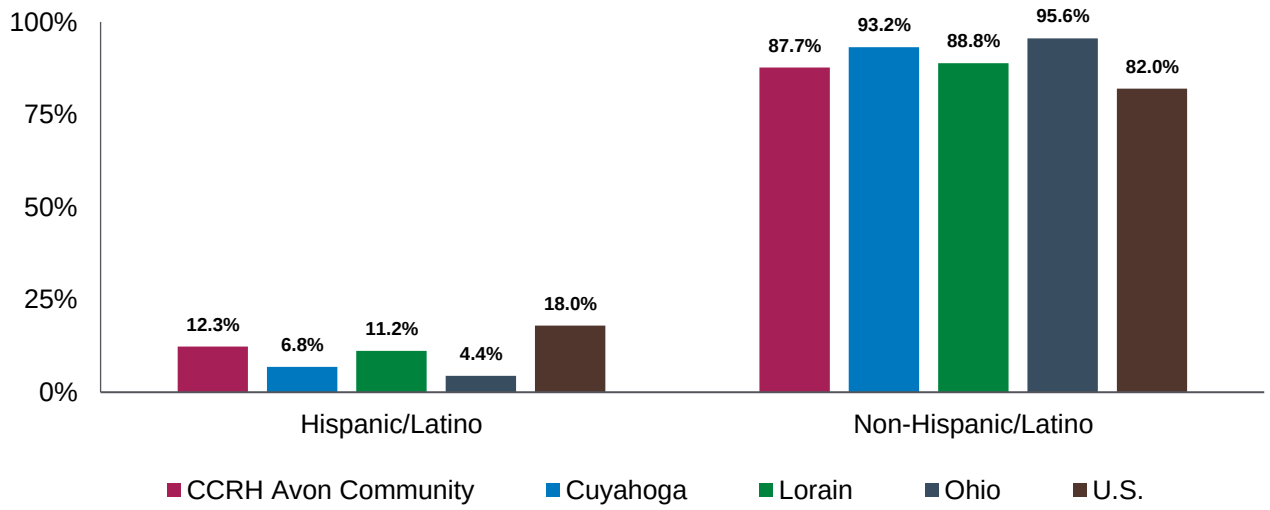
Figure 6: Population by Race: Hospital, County, State, and U.S. Comparisons



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

As shown in Figure 7, 12.3% of the population in the CCRH Avon Community identify as Hispanic/Latino. This is a larger proportion of the population when compared to Ohio (4.4%) but smaller when compared to the U.S. (18.0%). Lorain County has the largest percentage of community members who identify as Hispanic/Latino (11.2%).

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



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

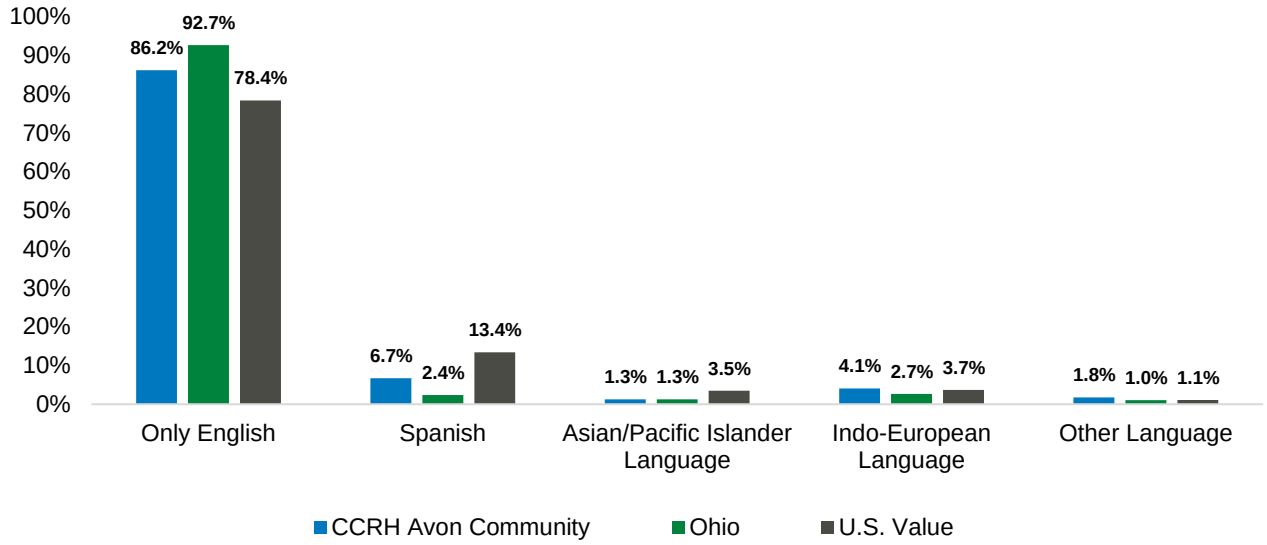
Language and Immigration

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

In the CCRH Avon Community, 86.2% of the population age five and older speak only English at home, which is lower than the state value of 92.7% but higher than the national value of 78.4% (Figure 8). This data indicates that 6.7% of the population in the CCRH

Avon Community speak Spanish, 1.3% speak an Asian/Pacific Islander language,[5] 4.1% speak an Indo-European Language, and 1.8% speak Other Languages at home.

Figure 8: Population 5+ by Language Spoken at Home: Hospital, State and U.S. Comparisons



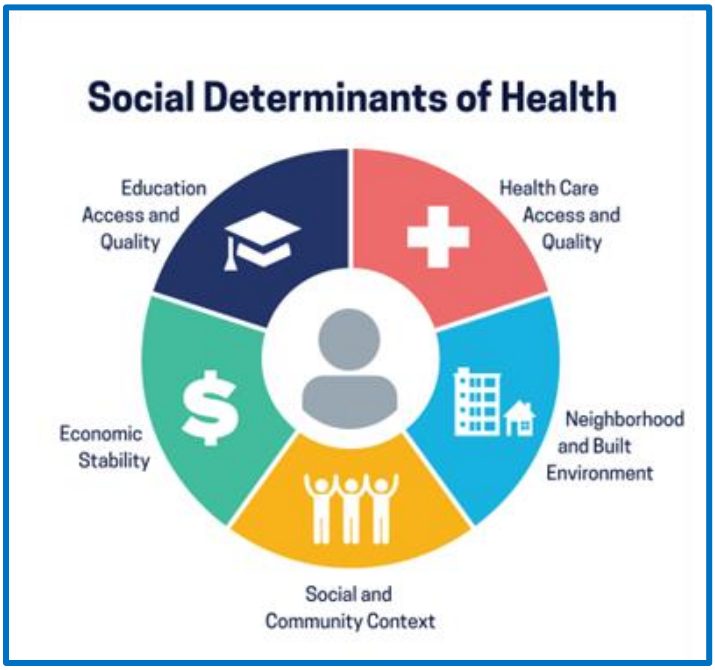
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

[5] United States Census Bureau. https://www.census.gov/topics/population/language-use/about.html

Highlighted Demographics: Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health (SDOH) impacting the CCRH Beachwood Community. The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.[6] Figure 9 shows the Healthy People 2030 grouping of Social Determinants of Health domains into five key domains.[7]

Figure 9: Healthy People 2030 Social Determinants of Health Domains



Geography and Data Sources

Data in this section are presented at various geographic levels (e.g., 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.

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

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

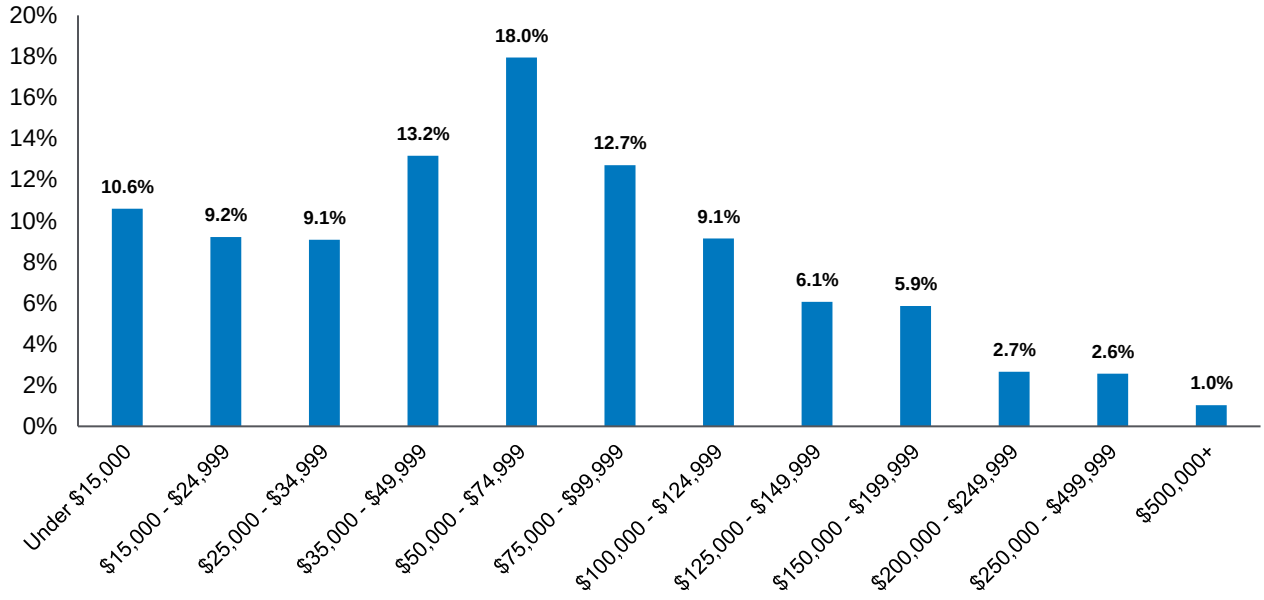
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2016-2020) estimates unless otherwise indicated.

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.[8]

Figure 10 provides a breakdown of households by income in the CCRH Avon Community Definition. A household income of $50,000 - $74,999 is shared by the largest proportion of households in the CCRH Avon Community (18.0%). Households with an income of less than $15,000 make up 10.6% of households in the CCRH Avon Community.

Figure 10: Households by Income: CCRH Avon Community

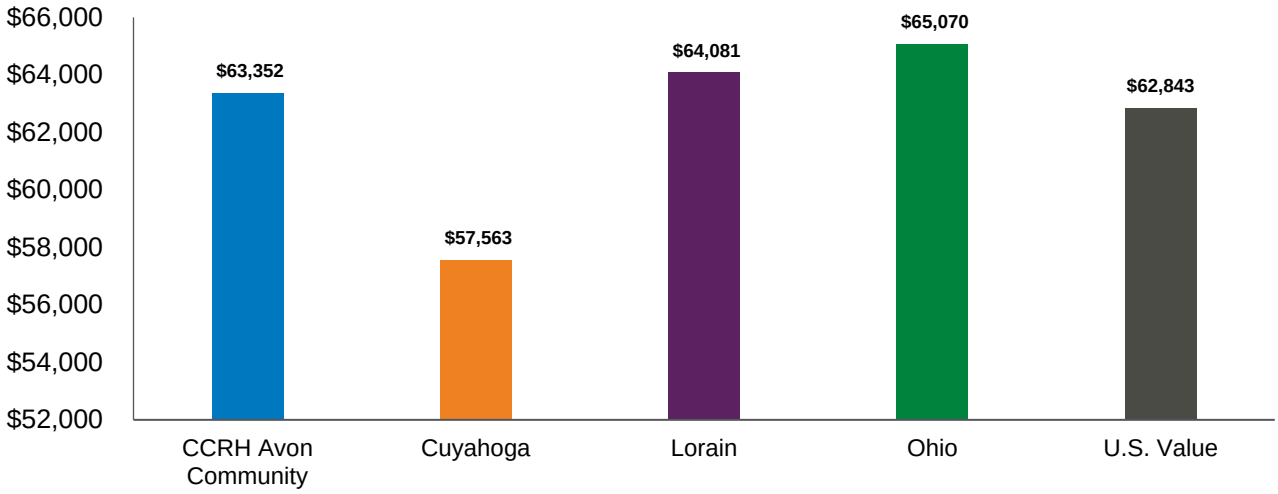


County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for the CCRH Avon Community is $63,352, which is lower than the state value of $65,070 but higher than the national value of $62,843 (Figure 11).

[8] 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

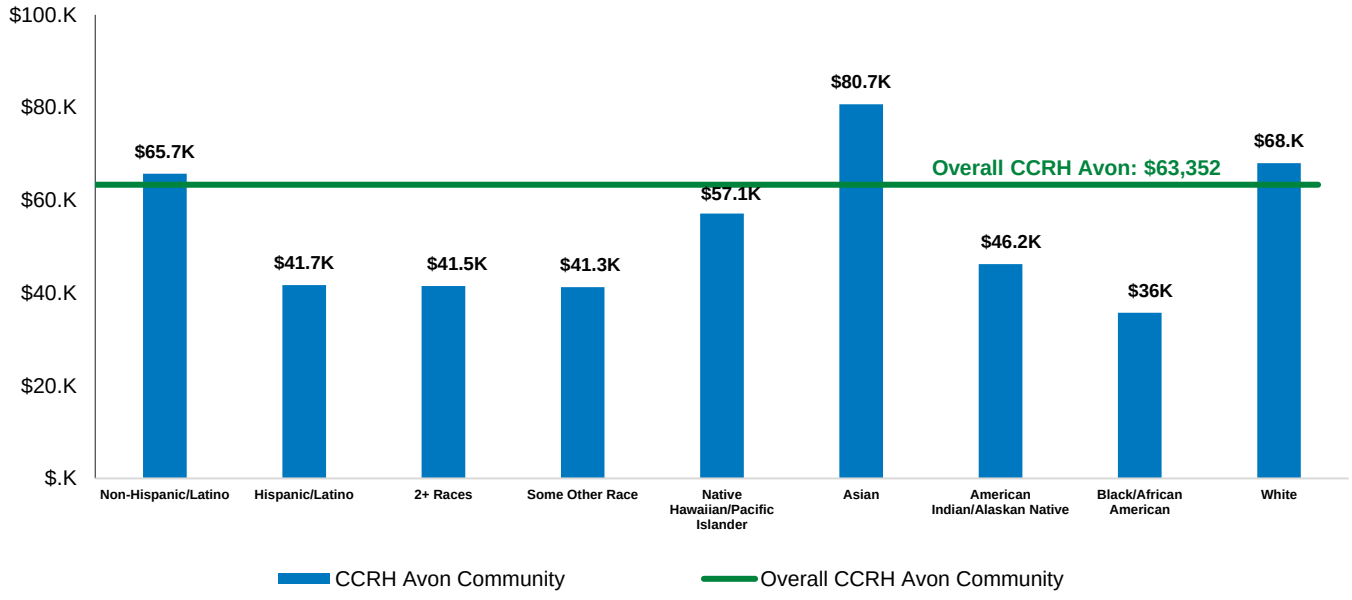
Figure 11: Household Income by: Hospital, County, State, and U.S. Comparisons



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

Figure 12 shows the median household income by race and ethnicity. Three racial/ethnic groups – White (Hispanic and Non-Hispanic), Asian (Hispanic and Non-Hispanic), and Non-Hispanic/Latino– have median household incomes above the overall median value. All other races have incomes below the overall value, with the Black/African American population having the lowest median household income at $35,762.

Figure 12: Median Household Income by Race/Ethnicity: CCRH Avon Community



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

Poverty

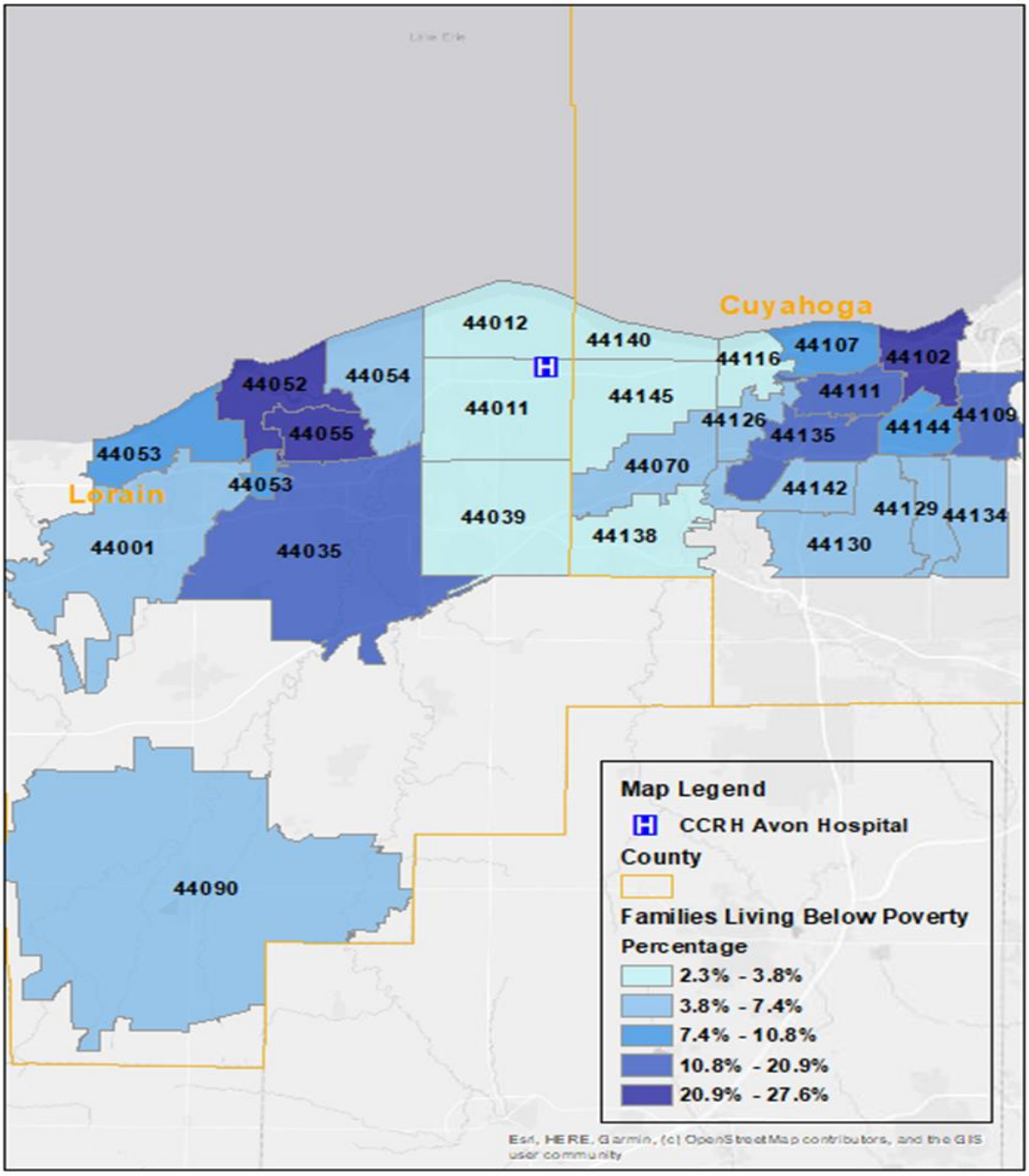
Federal poverty thresholds are set every year by the U.S. Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity.

These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[9]

Figure 13 shows the percentage of families living below the poverty level by zip code. The darker blue colors represent a higher percentage of families living below the poverty level, with zip codes 44052 (Lorain) and 44102 (Cleveland) having the highest percentages at 27.6% and 27.3%, respectively. Overall, 10.7% of families in the CCRH Avon Community live below the poverty level, which is higher 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 CCRH Avon Community is provided in Appendix C.

[9] 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

Figure 13: Families Living Below Poverty



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

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

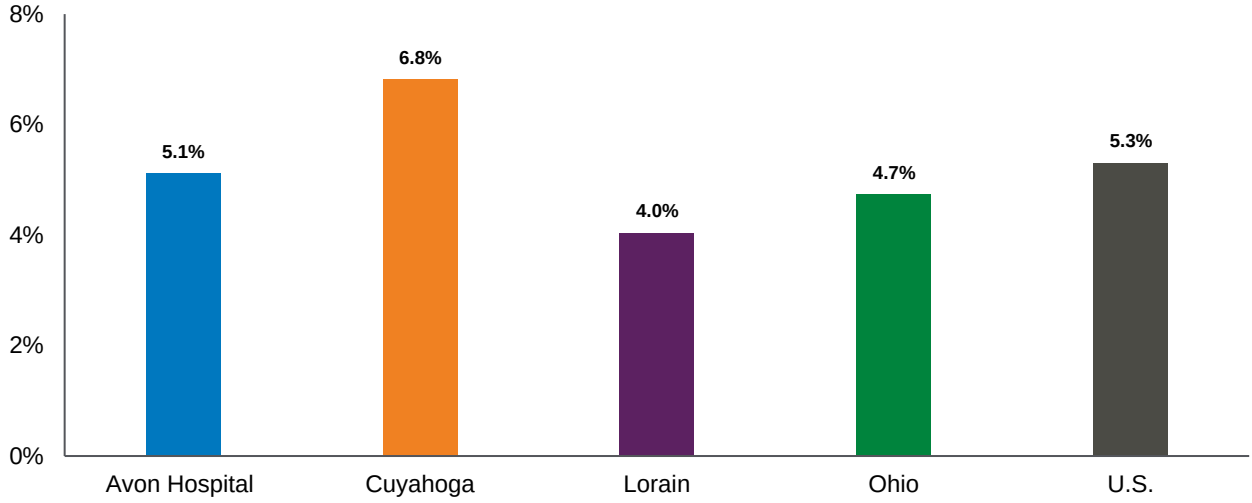
conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[10]

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.[10]

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.[10]

Figure 14 shows the population aged 16 and over who are unemployed. The unemployment rate for the CCRH Avon Community is 5.1%, which is greater than the state value of 4.7% but lower than the national value of 5.3%.

Figure 14: Population 16+ Unemployed: CCRH Avon Community



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

Education

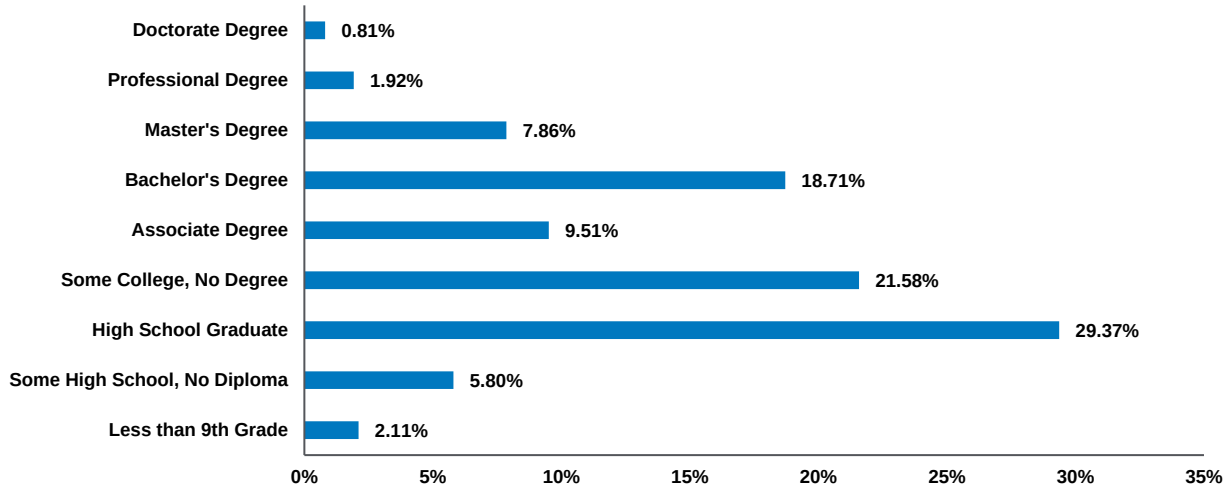
Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[11]

Figure 15 shows the percentage of the population 25 years or older by educational attainment.

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

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

Figure 15: Population 25+ by Education Attainment: CCRH Avon Community

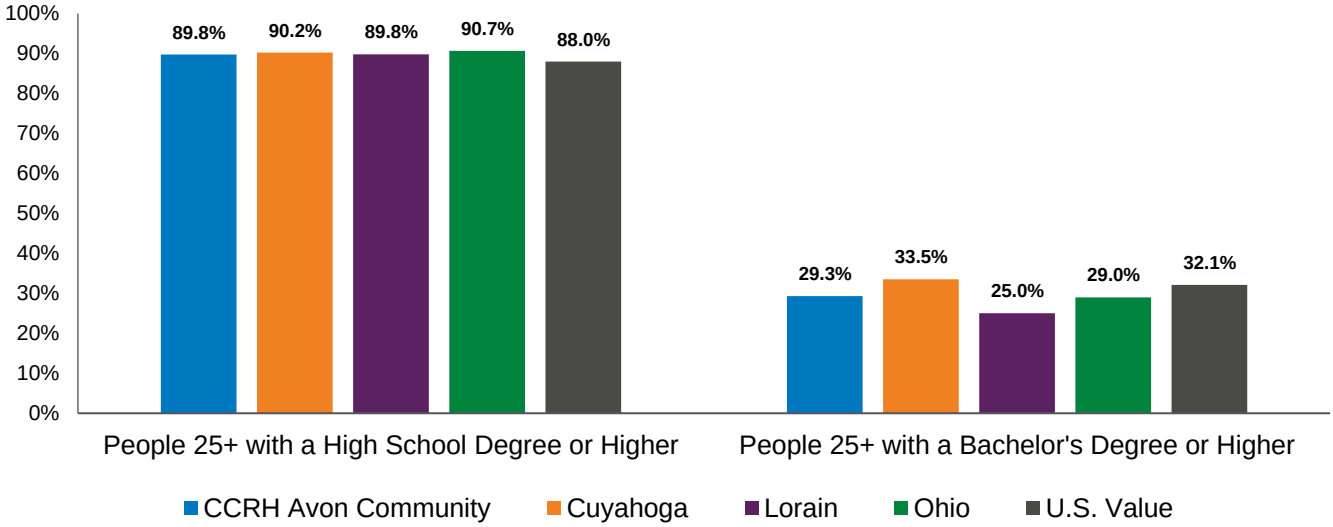


County values· Claritas Pop-Facts® (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[12]

Figure 16 shows that the CCRH Avon Community has a smaller percentage of residents with a high school degree or higher (89.8%) when compared to the state of Ohio value (90.7%) and a higher percentage when compared to the U.S. value (88.0%). Furthermore, the CCRH Avon Community has a slightly higher percentage of residents with a bachelor's degree or higher (29.3%) when compared to the state of Ohio value (29.0%) but has smaller percentage when compared to the U.S. value (32.1%).

Figure 16: Population 25+ by Education Attainment: Hospital, County, State, and U.S. Comparisons



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

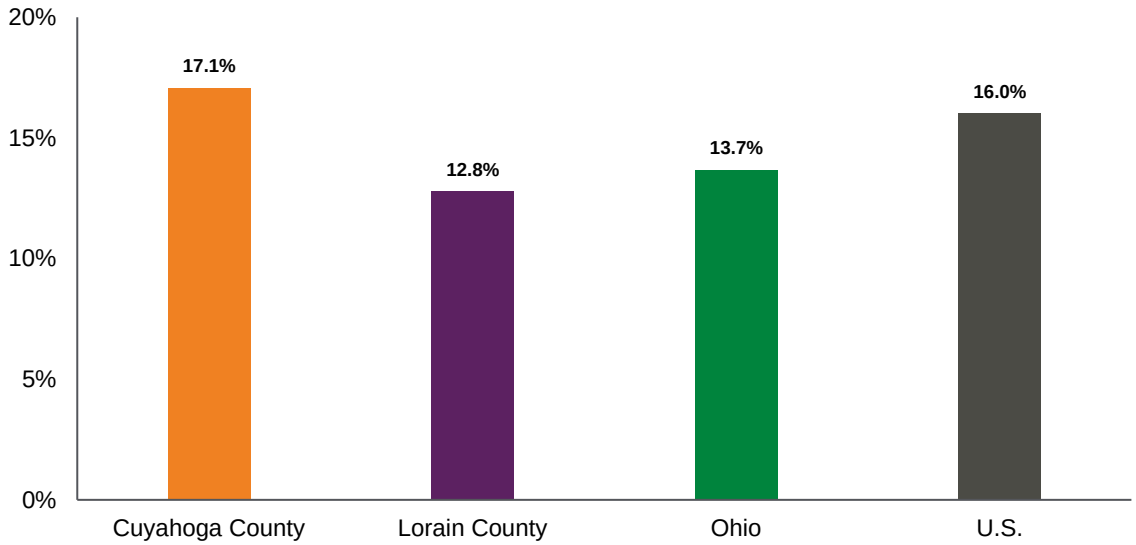
[12] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

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.[13]

Figure 17 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following housing 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 17: Severe Housing Problems: County, State, And U.S. Comparisons



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

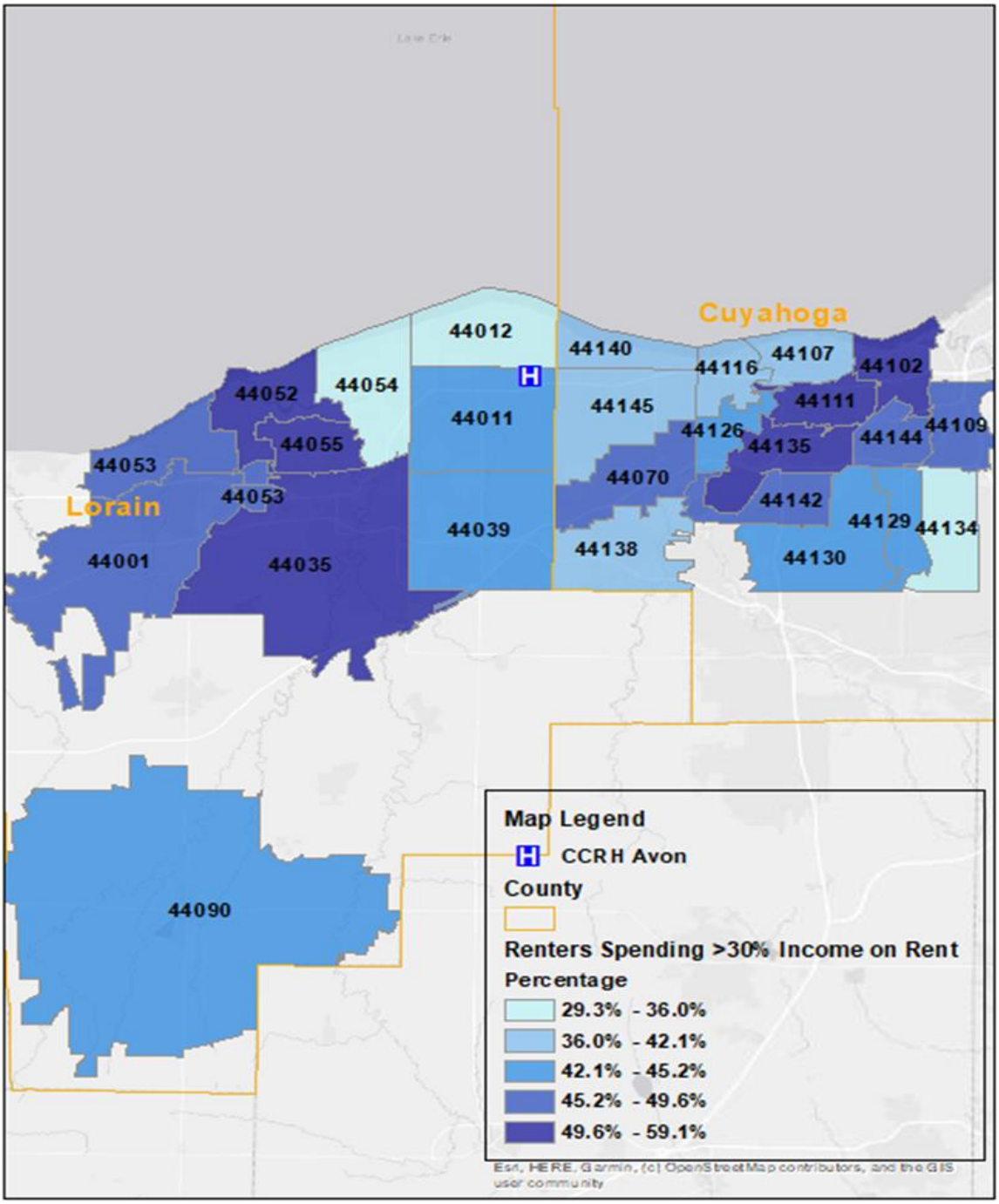
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.[14]

Figure 18 shows the percentage of renters who are spending 30% or more of their household income on rent.

[13] 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

[14] 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 18: Renters Spending 30% Or More Of Household Income on Rent



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

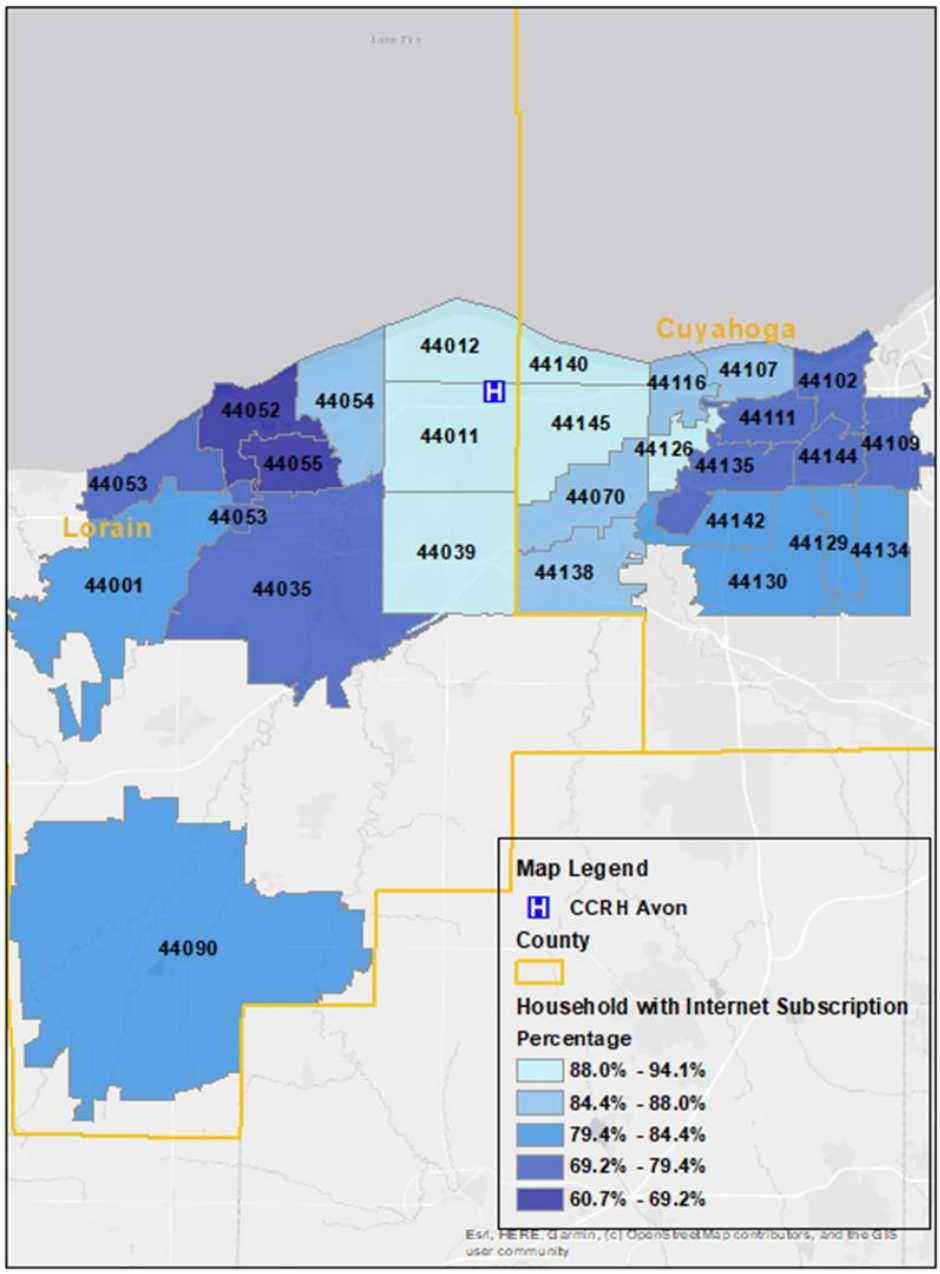
Neighborhood and Built Environment

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.[15] Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[15]

Figure 19 shows the percentage of households that have an internet subscription. Zip code 44055 (Cleveland) has the lowest percentage of households with internet connection, represented by darkest shade of blue on the map.

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

Figure 19: 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.[16] 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.[17]

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 have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[18] 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 CCRH Avon Community, based on the Index of Disparity.

[16] 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

[17] 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/

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

Table 1: Indictors with Significant Race or Ethnic Disparities

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

The Index of Disparity analysis for Cuyahoga and Lorain counties reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Two or More Races, Native Hawaiian/Pacific Islander, 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 by HIV/AIDS Prevalence Rate and Babies with Very Low Birth Weight. Black/African American populations also experience inequities in education, including 4th Grade Students Proficient in Math. Additionally, Black/African American populations

experience a heavier burden related to chronic diseases, such as diabetes and kidney disease.

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

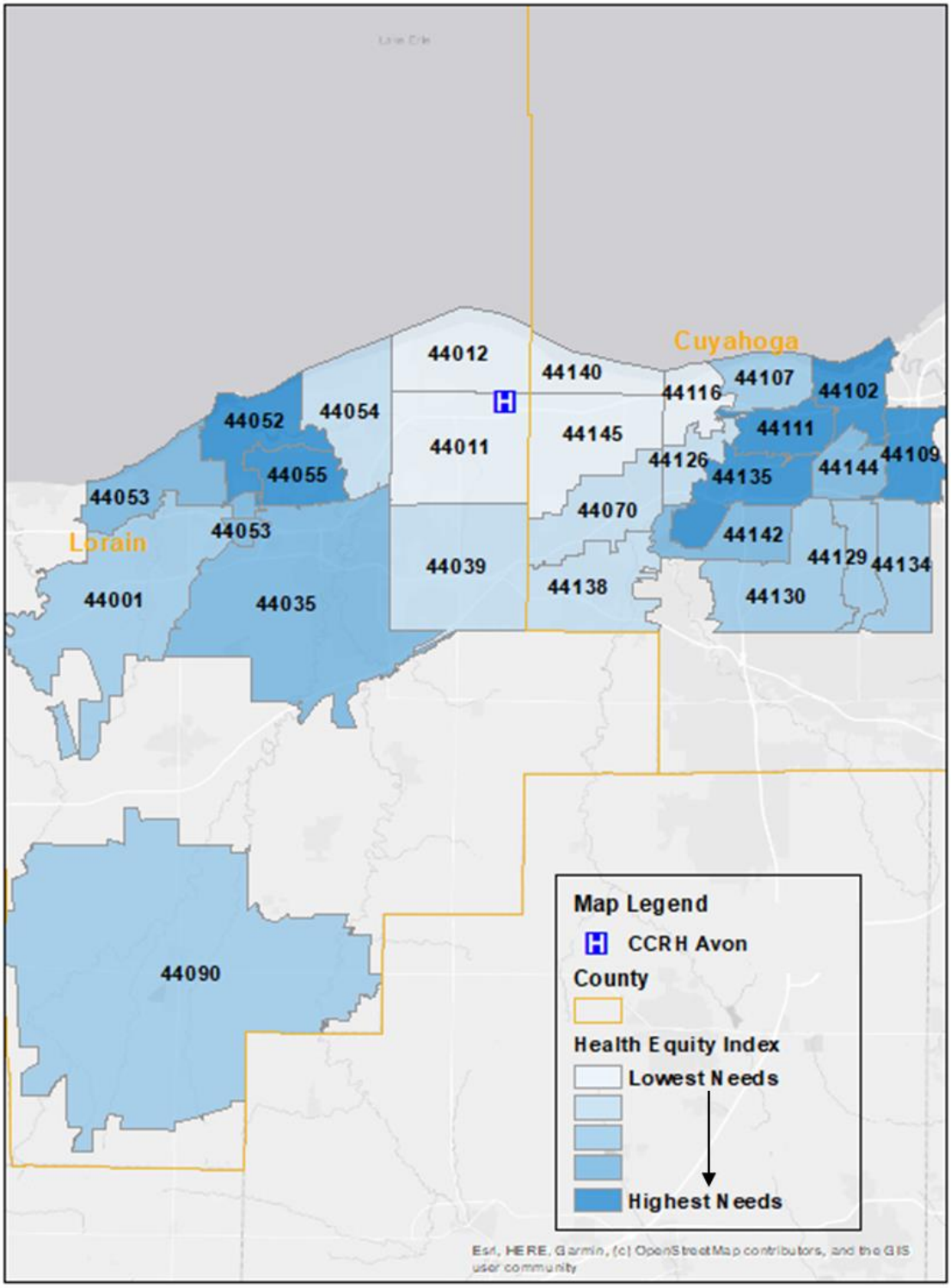
Geographic Disparities

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

Health Equity Index

Conduent's Health Equity Index (HEI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 20. The following zip codes in the CCRH Avon Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44052 and 44055 in Lorain County; 44102, 44111, 44135, and 44109 in Cuyahoga County. Appendix A provides the index values for each zip code.

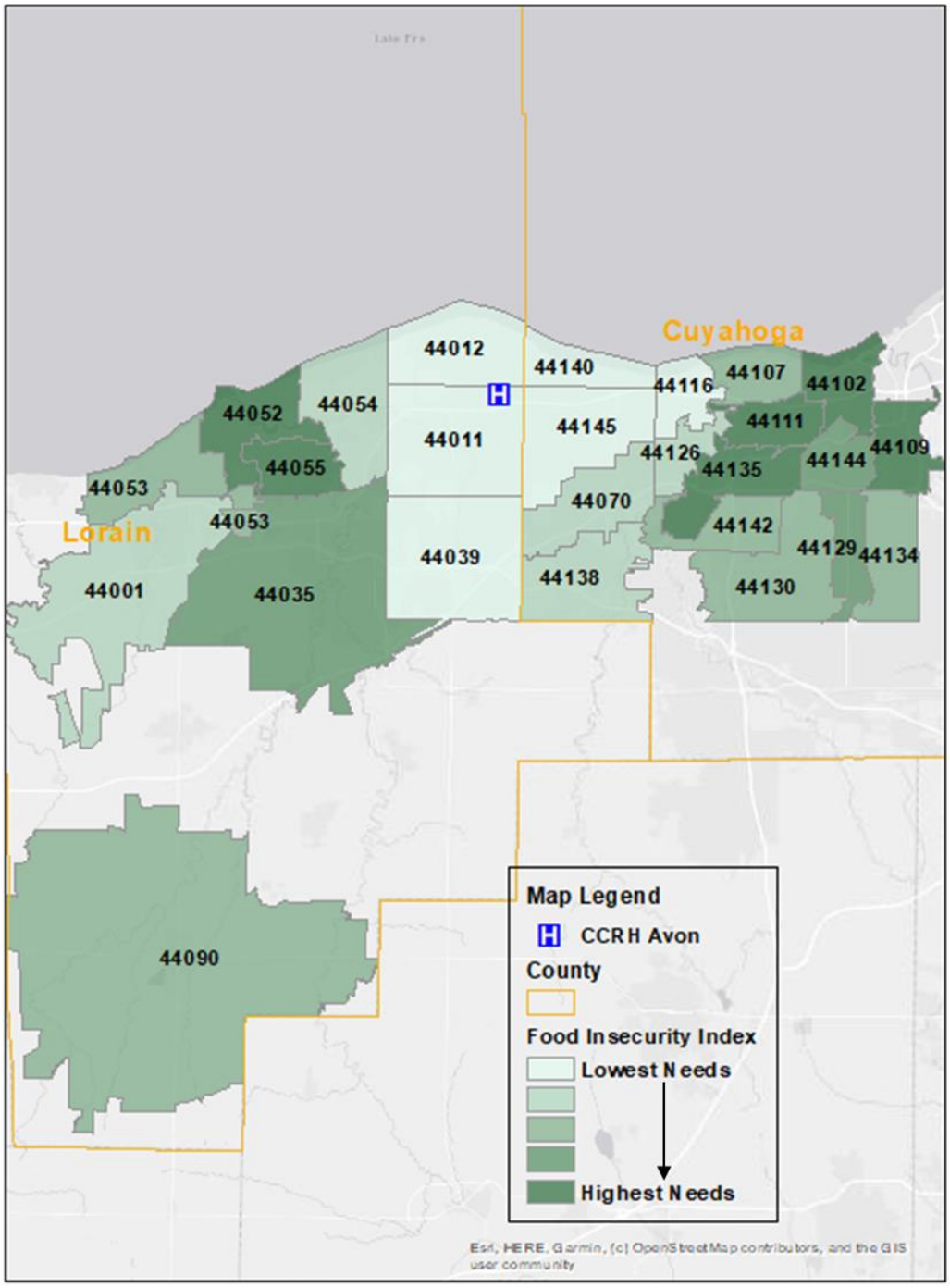
Figure 20: Health Equity Index



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 21. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 44052 and 44055 in Lorain County; 44102, 44111, 44135, and 44109 in Cuyahoga County. Appendix A provides the index values for each zip code.

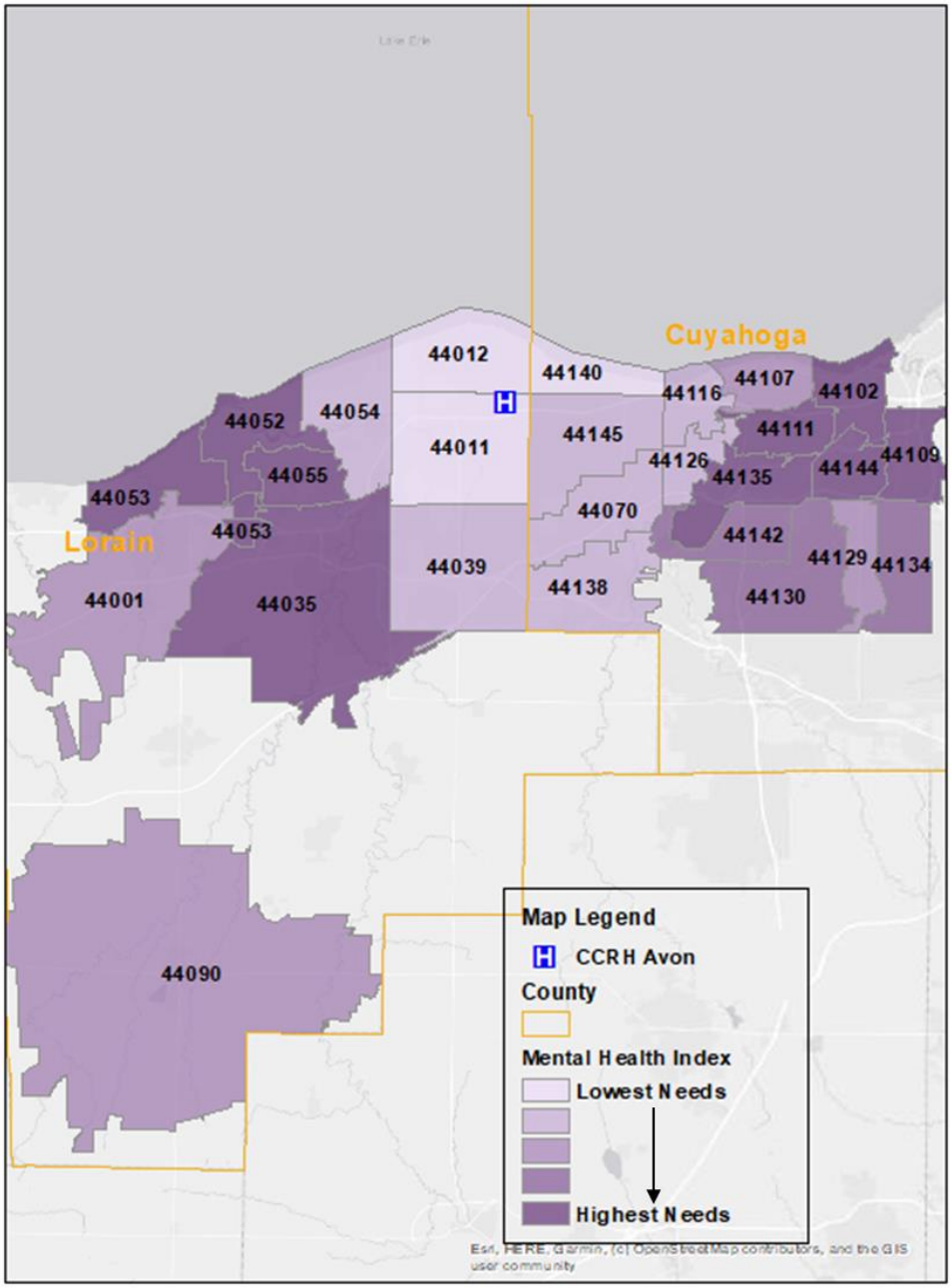
Figure 21: Food Insecurity Index



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 22. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 44052, 44053, 44055, and 44035 in Lorain County; 44135, 44111, 44144, 44109, and 44102 in Cuyahoga County. Appendix A provides the index values for all zip codes within the CCRH Avon Community.

Figure 22: 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 CCRH Avon 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

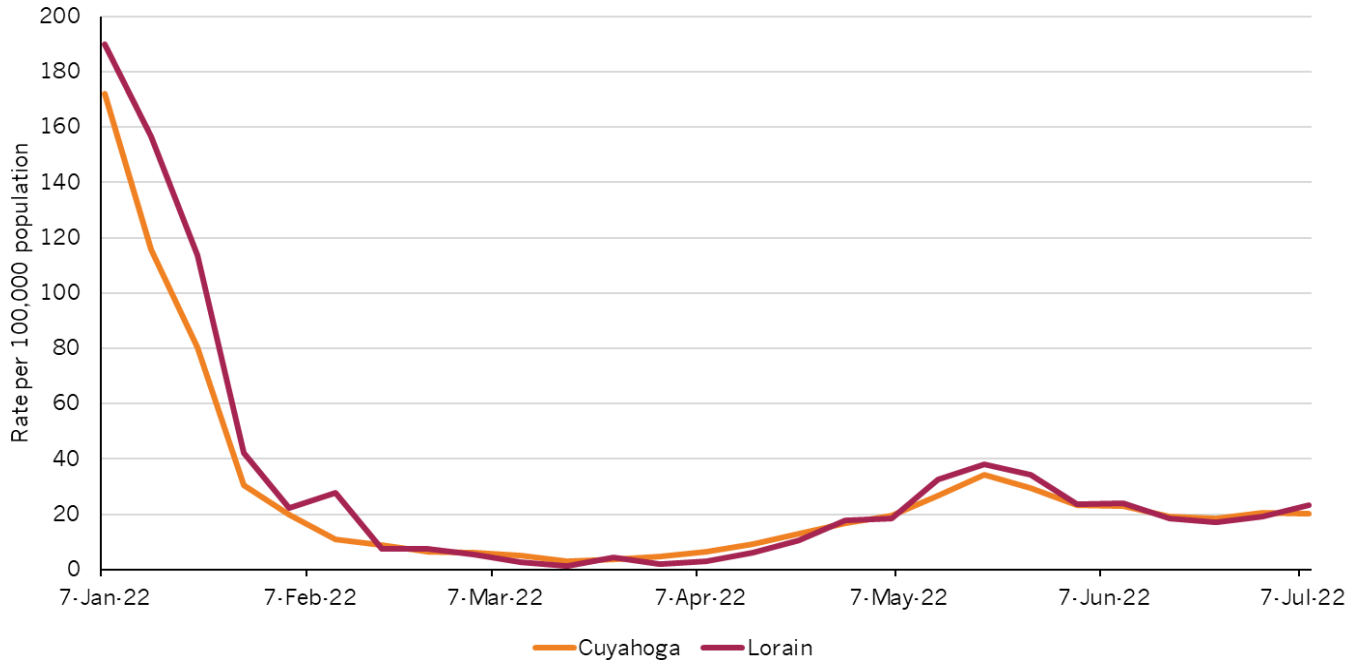
Community Input

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

The COVID-19 Daily Average Case Incidence Rate by County

Figure 23 shows the daily average COVID-19 case incidence rate for Cuyahoga and Lorain, counties from January 2022 through early July 2022. As shown, the incidence rate has declined since the beginning of 2022, although some small increases in incidence rates have occurred.

Figure 23: Daily Average COVID-19 Case Incidence Rate by County



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

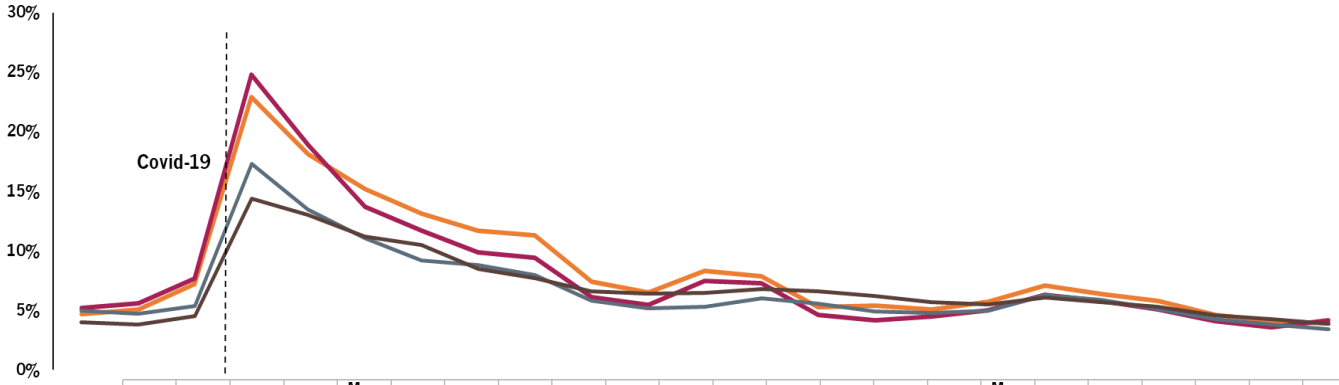
Vaccination Rates

As of June 2022, at least 64% of the population residing in counties within the CCRH Avon Community Definition are fully vaccinated against COVID-19. Cuyahoga County has the highest vaccination rates (65.5%), followed by Lorain County (64.5%).

Unemployment Rates

Unemployment rates rose between March and April 2020 for Cuyahoga and Lorain counties when stay-at-home orders were first announced. Illustrated in Figure 24 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 24: Unemployment Rate After the Start of the COVID-19 Pandemic



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Cuyahoga	4.7%	5.1%	7.2%	22.9%	18.1%	15.2%	13.1%	11.7%	11.3%	7.4%	6.5%	8.3%	7.9%	5.3%	5.4%	5.1%	5.7%	7.1%	6.4%	5.8%	4.6%	4.1%	3.9%
Lorain	5.2%	5.6%	7.7%	24.8%	18.9%	13.7%	11.7%	9.9%	9.4%	6.1%	5.5%	7.5%	7.3%	4.6%	4.2%	4.5%	5.0%	6.3%	5.8%	5.1%	4.1%	3.6%	4.2%
Ohio	5.0%	4.7%	5.4%	17.3%	13.5%	11.1%	9.2%	8.8%	8.0%	5.8%	5.2%	5.3%	6.0%	5.6%	4.9%	4.8%	5.0%	6.3%	5.9%	5.1%	4.3%	3.8%	3.4%
U.S.	4.0%	3.8%	4.5%	14.4%	13.0%	11.2%	10.5%	8.5%	7.7%	6.6%	6.4%	6.5%	6.8%	6.6%	6.2%	5.7%	5.5%	6.1%	5.7%	5.3%	4.6%	4.3%	3.9%

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

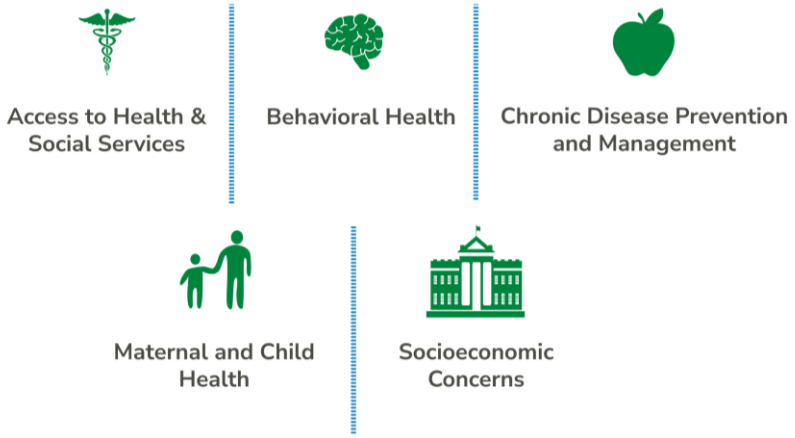
Synthesis and Prioritization

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, and key stakeholders as possible. A full list of contributors can be found in the Primary Data Collection and Analysis description in Appendix A.

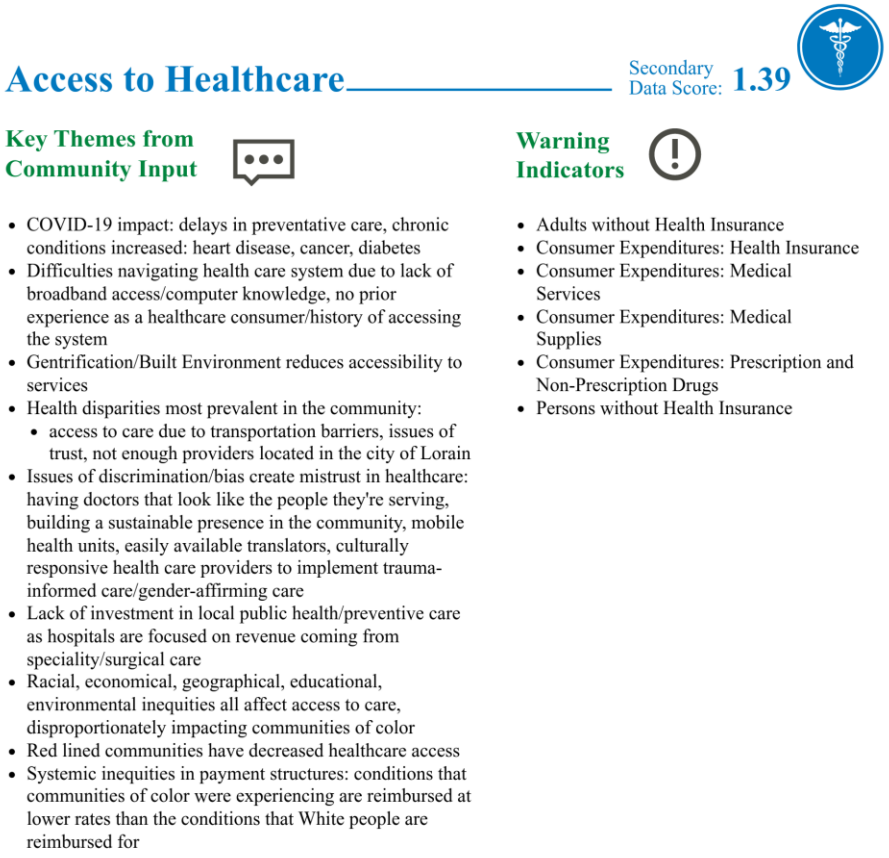
To gain a comprehensive understanding of the significant health needs for the CCRH Avon Community, the findings from both data sets were compared and studied simultaneously. The secondary data scores and key stakeholder responses were considered equally important in understanding the health issues of the community. The top health needs identified from each of these data sources were analyzed for areas of overlap. Three health issues were identified as significant health needs across both 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 and Lorain County Community Health Improvement Plans (CHIP) most recent findings. The prioritization process distilled the significant needs into five categories.

The five prioritized health needs are summarized in Figure 25. Each prioritized health topic includes the key findings from secondary data and key stakeholder interviews.

Figure 25: 2022 Prioritized Health Needs



Prioritized Health Topic #1: Access to Healthcare



Access to Healthcare — Secondary Data Score: 1.39

Key Themes from Community Input

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

Warning Indicators

- Adults without 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

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

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

Concerns about preventative care included the use of emergency departments for minor health issues due to lack of primary care physician, and the need to strengthen the public health infrastructure. Furthermore, COVID-19 allowed for the expansion of telehealth which increased access to healthcare for many. However, it also exposed the inequities in broadband support due to infrastructure issues leaving residents unable to access telehealth.

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

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

Secondary Data

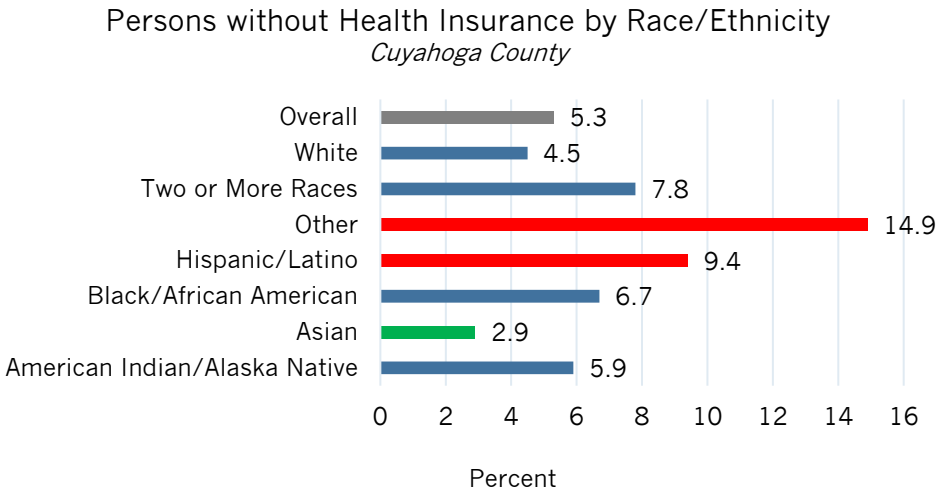
From the secondary data scoring results, Health Care Access & Quality ranked as the 15th highest scoring health need, with a score of 1.39. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

The average dollar amount per consumer unit for health insurance in Lorain County is $4,676.2, 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, Lorain 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.[19] Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.[20]

The rising costs of medical care and lack of insurance affects all races and ethnicities. However, although not identified as a high disparity in the CCRH Avon community, people identifying as Hispanic/Latino and Some Other Race in Cuyahoga County are disproportionately affected (see red in figure below). Conversely, Asian residents of Cuyahoga County have the lowest rate of persons without health insurance (see green below).

[19] Kaiser Family Foundation, 2020 and 2015
[20] The Commonwealth Fund, 2019

Figure 26. Persons without Health Insurance by Race/Ethnicity in Cuyahoga County



Source: American Community Survey, 2019

Consumer Expenditures: Medical Services ranked poorly in both Cuyahoga and Lorain counties. 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, Lorain County residents spent $1,181.4 on medical services per consumer unit, which is higher than the Ohio state value ($1,098.6) and U.S. value ($1,047.4).

Prioritized Health Topic #2: Adult Health

Adult Health includes secondary data from three health topics – Nutrition and Healthy Eating, Chronic Diseases, Older Adult Health and Other Conditions. An overview of each of these subtopics is provided below.

OLDER ADULT HEALTH & OTHER CONDITIONS

Older Adult Health & Other Conditions

Secondary Data Score: 1.71 (Older Adults) 2.00 (Other Conditions)

Key Themes from Community Input

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

Warning Indicators

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

Primary Data: Key Stakeholder Interviews

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

Key stakeholders revealed that access to healthy food was often limited by a lack of either public or private transportation, disproportionately affected lower income older adults. There are only a few grocery stores in the community and few community members can access those by walking. The effects of redlining are evident as these neighborhoods do not always have grocery stores and therefore are limited to corner stores which often do not have fresh fruits and vegetables. COVID-19 greatly impacted the need for food as seen by elevated levels of food insecurity throughout the community. Conditions such as

hypertension, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease are all related to the quality of food community members have access to.[21]

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

Secondary Data

From the secondary data scoring results, Nutrition and Healthy Eating had the 13th highest data score at 1.45. While the Older Adults topic area had the fifth highest at a score of 1.71 and Other Conditions had the third highest topic score at 2.00. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

The Age-Adjusted Death Rate due to Prostate Cancer is the worst performing indicator in Cuyahoga County with a score of 2.72. Not surprisingly, the county also has a high incidence rate of prostate cancer, with Cuyahoga County performing in the worst 25% of counties in the state and nation.

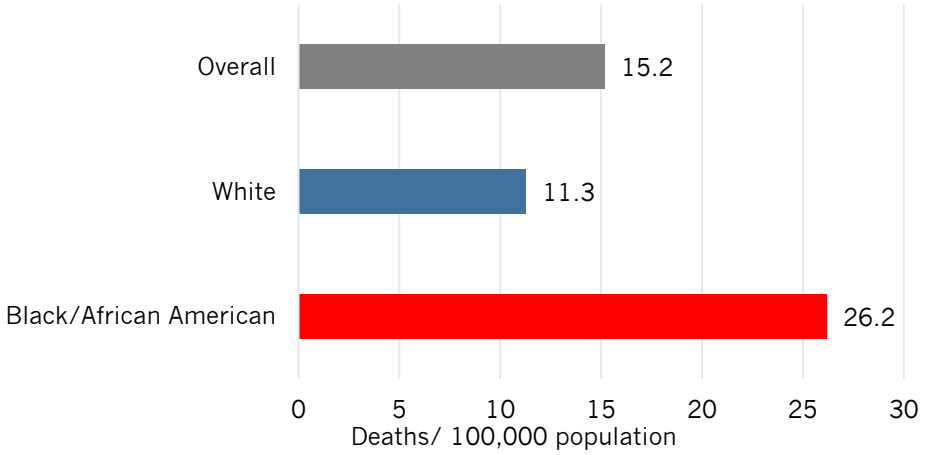
In Lorain County, the Age-Adjusted Death Rate due to Falls and Rheumatoid Arthritis or Osteoarthritis: Medicare Population are the worst performing indicators, both scoring a 2.75 out of a possible 3.00.

Black/African American residents of both Cuyahoga and Lorain County experience worse rates of Age-Adjusted Death Rate due to Kidney Disease than their White peers (see red in figures below). Figure 27 shows Black/African Americans in Cuyahoga County have a death rate due to Kidney Disease of 26.2 deaths per 100,000 population compared to the overall rate of 15.2. Similarly, Figure 28 shows Black/African Americans in Lorain County have a

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

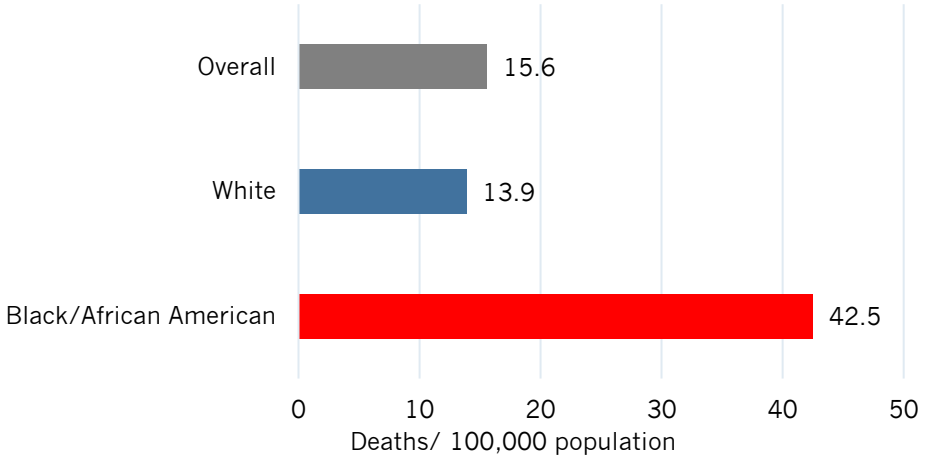
Kidney Disease death rate of 42.5 deaths per 100,000 compared to the overall value of 15.6.

Figure 27. Age-Adjusted Death Rate due to Kidney Disease by Race/Ethnicity in Cuyahoga County



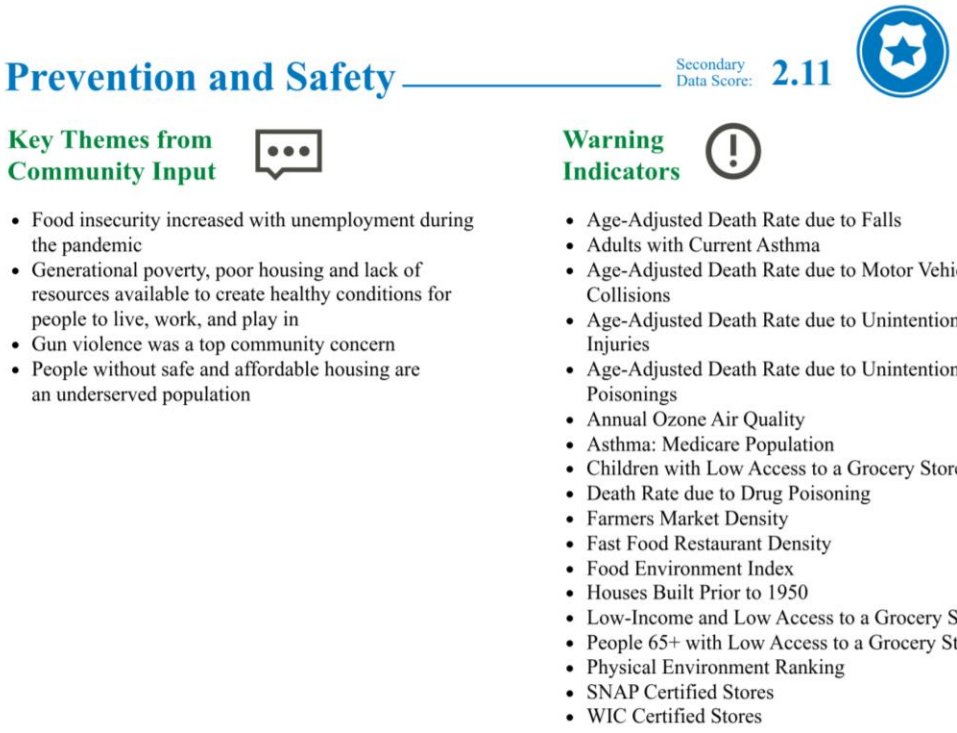
Source: Centers for Disease Control and Prevention, 2017-2019

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



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

Prioritized Health Topic #3: Community Safety



Prevention and Safety — Secondary Data Score: **2.11**

Key Themes from Community Input

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

Warning Indicators

- Age-Adjusted Death Rate due to Falls
- Adults with Current Asthma
- Age-Adjusted Death Rate due to Motor Vehicle Collisions
- Age-Adjusted Death Rate due to Unintentional Injuries
- Age-Adjusted Death Rate due to Unintentional Poisonings
- Annual Ozone Air Quality
- Asthma: Medicare Population
- Children with Low Access to a Grocery Store
- Death Rate due to Drug Poisoning
- Farmers Market Density
- Fast Food Restaurant Density
- Food Environment Index
- Houses Built Prior to 1950
- Low-Income and Low Access to a Grocery Store
- People 65+ with Low Access to a Grocery Store
- Physical Environment Ranking
- SNAP Certified Stores
- WIC Certified Stores

Primary Data: Key Stakeholder Interviews

Key stakeholders couched discussions around specific health needs in the context of intergenerational experiences of poverty, poor housing conditions, and historical red lining. Stakeholders expressed that they felt there were generally lack of resources individually and as a community to create healthy conditions for people to live, work and play. Gun violence was also a recurring theme throughout key stakeholder interviews. Community violence was mentioned as a barrier to physical activity, specifically, children playing outside in unsafe communities.

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

Secondary Data

Prevention & Safety ranked first among all health topics with a score of 2.11. Further analysis was done to identify specific indicators of concern. Those indicators with high

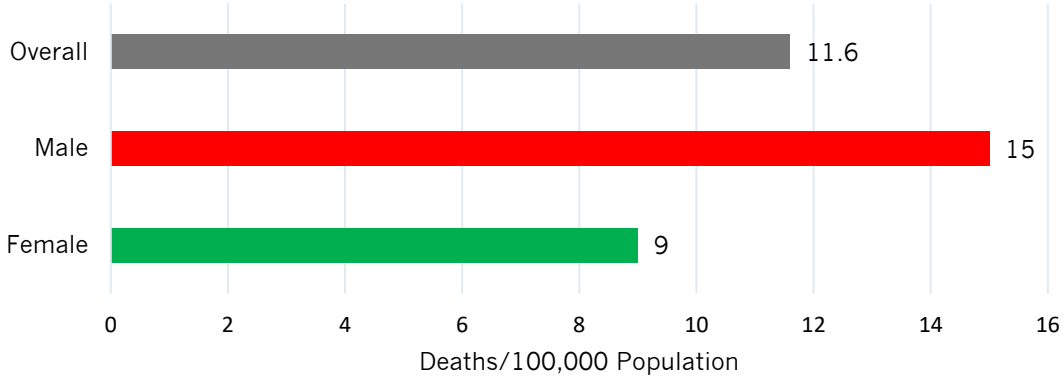
data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

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

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

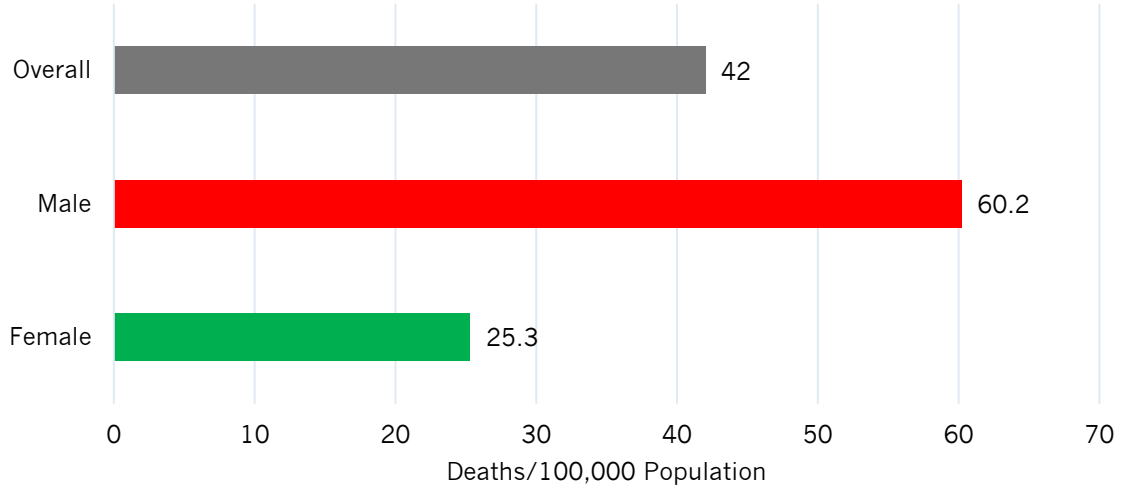
In Cuyahoga County, disparities exist for males in the following indicators: Age-Adjusted Death Rate due to Falls, Age-Adjusted Death Rate due to Unintentional Poisonings, and Age-Adjusted Death Rate due to Unintentional Injuries as seen in Figures 29, 30 and 31.

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



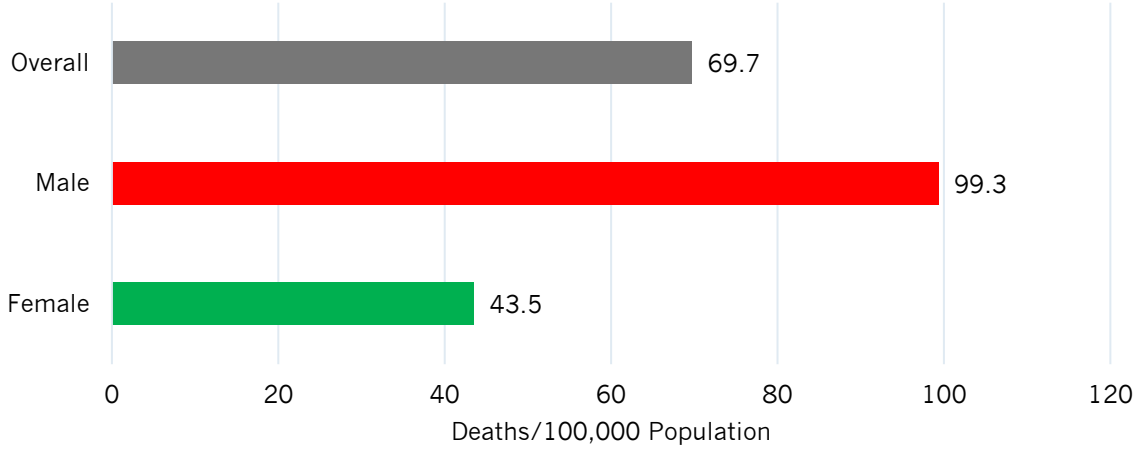
Source: Centers for Disease Control and Prevention, 2017-2019

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

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:

- 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 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 and Lorain counties. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of health needs in the CCRH Avon 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 CCRH Avon Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention (CDC)
- 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

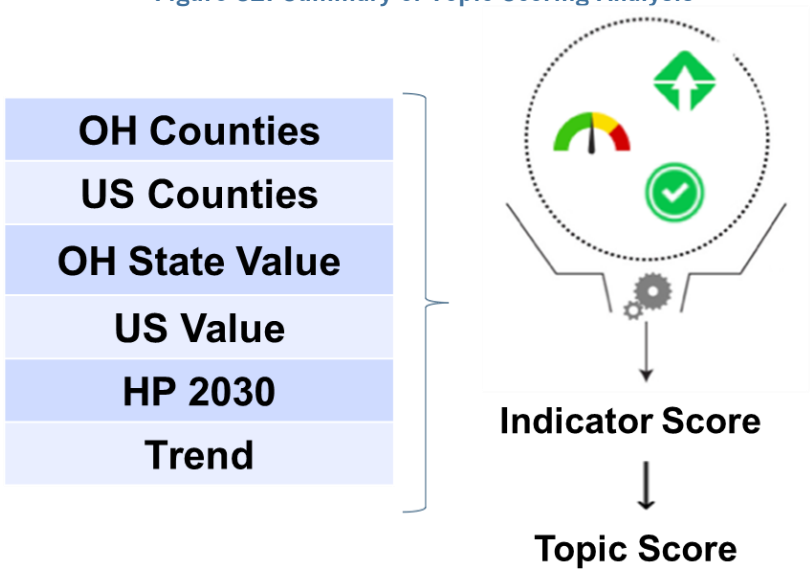
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food Environment Atlas
- U.S. Environmental Protection Agency
- United For ALICE

Secondary data used for this assessment were collected and analyzed from Conduent Healthy Communities Institute'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

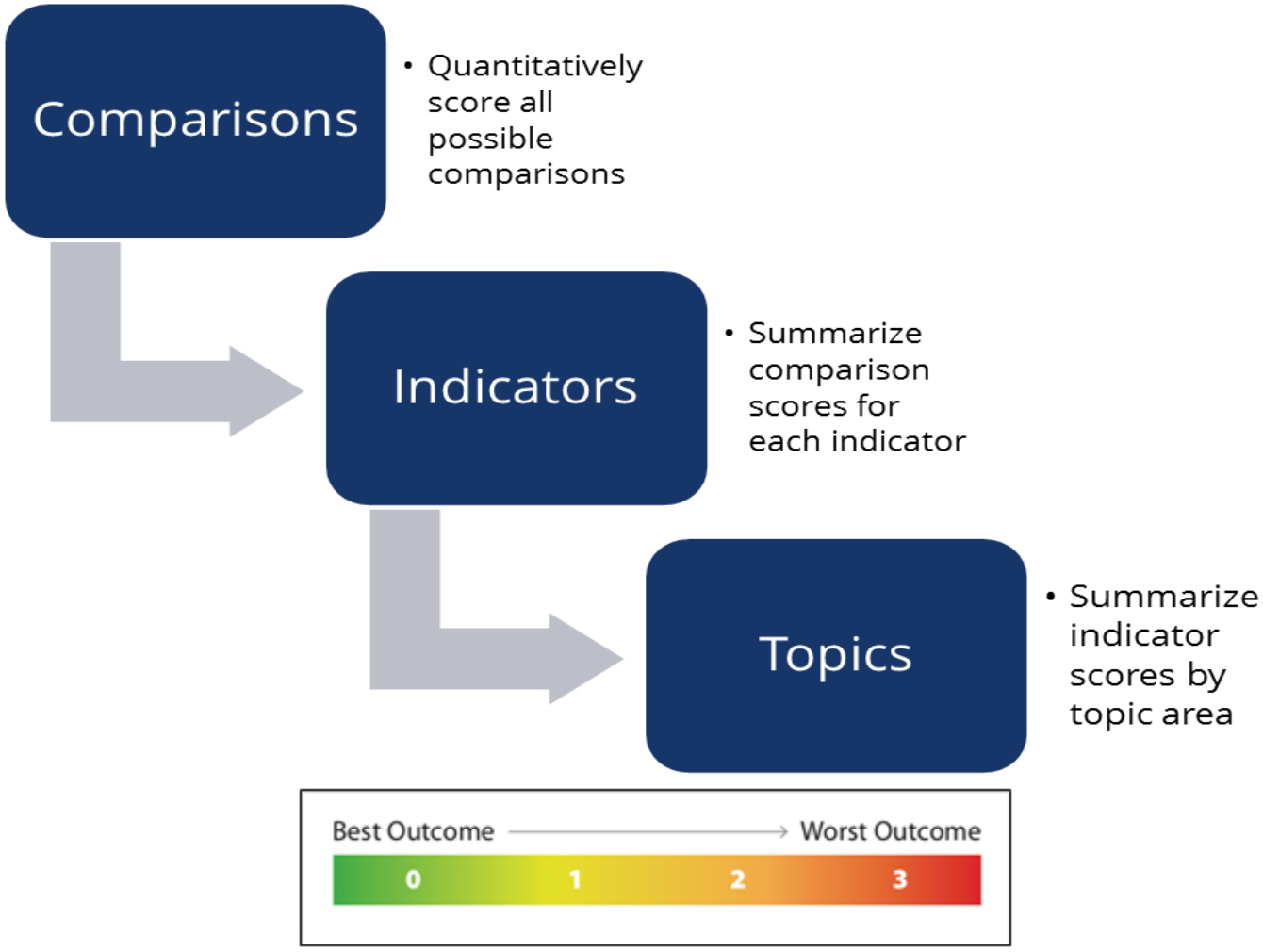
HCI's Data Scoring Tool (Figure 32) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national 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 32: 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 CCRH Avon Community: Cuyahoga and Lorain counties. To calculate the overall highest needs topic area scores, an average was taken for each topic area across the two counties. Each county's values were weighted the same. More details about topics scores and the average score for the CCRH Avon 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 CCRH Avon Community, ranked in order of highest need. Prevention & Safety scored as the poorest performing topic area with a score of 2.11, followed by Medications & Prescriptions with a score of 2.03. Topics that received a score of 1.50 or higher were considered a significant health need. Thirteen topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 2: Top Secondary Data Health Needs

Top Secondary Data Health Needs
Prevention & Safety
Medications & Prescriptions
Other Conditions
Alcohol & Drug Use
Older Adults
Cancer
Women's Health
Maternal, Fetal & Infant Health
Education
Children’s Health
Community
Heart Disease & Stroke
Economy

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 CCRH Avon Community and their respective HEI, FII, and MHI values.

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

Zip Code	HEI Value	FII Value	MHI Value
44001	29.9	28.5	67.6
44011	4.4	7.8	21
44012	5	12.9	30
44035	75.4	74	93.9
44039	15.6	15.8	49.1
44052	94.4	93.8	95.6
44053	59.4	61	91.3
44054	20.7	29.4	65.3

44055	97.2	94.7	96.5
44070	25	25.1	64.7
44090	42.6	42.7	72.4
44102	96.7	96.6	98.3
44107	35.3	50.8	77
44109	95.6	95.7	97.4
44111	85.6	88.1	95.6
44116	6.4	15.2	61.1
44126	20.8	26.2	62
44129	42.8	72.2	77.4
44130	36.6	45.8	81.6
44134	45.6	57.3	81.7
44135	92.7	91.1	97.4
44138	13.3	24.4	51.6
44140	2.6	3.7	29.4
44142	54	43	85.1
44144	71	79.5	91.8
44145	7.8	10.8	62.8

Data Considerations

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

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

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

Primary Data Collection & Analysis

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

Key Stakeholder Interviews Methodology and Results

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

Table 4: CCRH Avon Key Stakeholder Organizations

Key Stakeholder and Community Organizations	
• City of Cleveland Department of Public Health • Cuyahoga County Board of Health • Lorain County Public Health	• Neighborhood Family Practice • Birthing Beautiful Communities • Lead Safe Cleveland Coalition • Better Health Partnerships

• Select Specialty Hospital-Cleveland Fairhill • Cleveland Clinic Avon Hospital	• NAMI Greater Cleveland • Asian Services in Action (ASIA) • Cleveland Clinic LGBTQ+ Care • Benjamin Rose Institute on Aging • Greater Cleveland Food Bank • The Gathering Place • Cuyahoga Metropolitan Housing Authority • Esperanza • The Centers for Families and Children

The transcripts were analyzed using the qualitative analysis program Dedoose 2®. Text was coded using a pre-designed codebook-organized by themes and analyzed for significant observations. Figure 33 shows key findings from community stakeholder interviews specific to the CCRH Avon Community.

Figure 33: Key Stakeholder Findings

**Feedback specific to Select Hospital key stakeholders*

Findings from the key stakeholder interview 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 CCRH Avon Community from the 2019 CHNA were:

- Access to Affordable Healthcare
- Chronic Disease Prevention and Management
- Socioeconomic Concerns

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

Cleveland Clinic Avon Rehabilitation's previous Implementation Strategy outlined a plan for addressing the following priorities identified in the 2019 CHNA. Access to affordable healthcare and chronic disease prevention and the management of chronic disease were identified as needs within the 2019 CHNA for Avon Rehabilitation. The table below describes the strategies completed and modifications made to the action plans for each health priority area.

Access to Affordable Healthcare

Actions:

- Access to affordable healthcare was identified as a significant need in the 2019 CHNA for Avon Rehabilitation. Access barriers include cost, poverty, inadequate transportation, a lack of awareness regarding available services, and an undersupply of providers.

Highlighted Impacts:

- Financial Assistance - Avon Rehabilitation provided medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. Financial assistance was also provided to patients on a case-by-case basis under certain medical circumstances.
- Awareness – the hospital developed educational materials with patients, families, and providers to broaden community awareness and improve patients' ability to choose the most appropriate care setting.
- How to Access Care - Clinical staff serving the Brain Injury and Stroke Program teams at Avon Rehabilitation developed support groups and educational sessions for families and community residents.

Chronic Disease Prevention and Management

Actions:

- Chronic disease prevention and the management of chronic disease were identified as needs within the 2019 CHNA for Avon Rehabilitation. Chronic diseases, including addiction and mental health, heart disease, hypertension, obesity, diabetes, COPD.

Highlighted Impacts:

- Physicians educated patients on overall healthcare and on potential risk factors that may affect recovery. They also educated patients on their past medical history and how their existing conditions may be impacted by their new injury.
- Physical and functional impairments may be exacerbated by obesity. To encourage weight loss, the clinical team provided education and training to patients to increase mobility and activity. Discussions regarding healthy eating and interpretation of food labels were included as part of the therapy care plan.
- Depression and emotional changes, common following illness or injury, were addressed by a variety of modes of treatment and professionals including: therapists, nursing staff, psychologists, psychiatrists, non-pharmacological techniques, pharmacological treatment and recreation therapy.
- The hospital formalized an internal opioid management process for reviewing healthcare prescribing, data collection, and the use of non-pharmacologic treatment for pain.
- Appropriate referrals to community programs, such as AA, NA, or mental health resources were delivered by case management and psychology staff.
- Avon Rehabilitation developed a large network of clinical liaisons throughout the community to assist elderly consumers in understanding their post-acute care options.
- Avon Rehabilitation developed evidence-based falls prevention education for internal and external stakeholders including information on environmental modifications, balance exercises, and home safety assessments
- Smoking cessation aligned with Avon Rehabilitation's goals for our patients. The hospital is a smoke free campus. A formalized smoking cessation program was developed including resources and education that were provided to patients during an inpatient rehabilitation stay. Patients were also connected with organizations in the community for ongoing follow up and support.

Community Feedback

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

Zip code	Postal Name
44001	Cleveland Metro Area
44011	Avon
44012	Cleveland Metro Area
44035	Lorain
44039	North Ridgeville
44052	Lorain
44053	Lorain
44054	Cleveland Metro Area
44055	Lorain
44070	Cleveland Metro Area
44090	Wellington
44102	Cleveland
44107	Lakewood
44109	Cleveland
44111	Cleveland Metro Area
44116	Rocky River
44126	Cleveland
44129	Cleveland
44130	Cleveland Metro Area
44134	Cleveland Metro Area
44135	Cleveland
44138	Cleveland Metro Area
44140	Bay Village
44142	Cleveland Metro Area
44144	Cleveland
44145	Westlake

Table 6: Population Estimates for Each Zip Code

Zip code	City	Population
44001	Cleveland Metro Area	21,539
44011	Avon	25,407
44012	Cleveland Metro Area	25,634
44035	Lorain	64,551
44039	North Ridgeville	35,503
44052	Lorain	28,119
44053	Lorain	20,084
44054	Cleveland Metro Area	12,915
44055	Lorain	19,113
44070	Cleveland Metro Area	31,168
44090	Wellington	11,534
44102	Cleveland	41,976
44107	Lakewood	50,128
44109	Cleveland	37,153
44111	Cleveland Metro Area	37,302
44116	Rocky River	19,724
44126	Cleveland	15,738
44129	Cleveland	27,621
44130	Cleveland Metro Area	48,243
44134	Cleveland Metro Area	37,062
44135	Cleveland	25,852
44138	Cleveland Metro Area	23,771
44140	Bay Village	14,895
44142	Cleveland Metro Area	17,862
44144	Cleveland	20,393
44145	Westlake	33,466

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

Zip Code	City	Families Below Poverty Level (%)
44001	Cleveland Metro Area	5.6%
44011	Avon	2.4%
44012	Cleveland Metro Area	2.6%
44035	Lorain	17.6%
44039	North Ridgeville	3.6%
44052	Lorain	27.6%
44053	Lorain	10.3%
44054	Cleveland Metro Area	4.5%
44055	Lorain	26.4%
44070	Cleveland Metro Area	6.4%
44090	Wellington	4.3%
44102	Cleveland	27.3%
44107	Lakewood	9.6%
44109	Cleveland	20.7%
44111	Cleveland Metro Area	15.9%
44116	Rocky River	2.4%
44126	Cleveland	4.4%
44129	Cleveland	6.8%
44130	Cleveland Metro Area	6.4%
44134	Cleveland Metro Area	5.9%
44135	Cleveland	20.9%
44138	Cleveland Metro Area	2.3%
44140	Bay Village	2.8%
44142	Cleveland Metro Area	7.4%
44144	Cleveland	10.8%
44145	Westlake	3.8%

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

HEALTH TOPICS	CUYAHOGA	LORAIN	AVG
Alcohol & Drug Use	1.73	1.70	1.72
Cancer	1.71	1.57	1.64
Children's Health	1.72	1.48	1.60
Diabetes	1.17	1.33	1.25
Health Care Access & Quality	1.21	1.57	1.39
Heart Disease & Stroke	1.35	1.70	1.53
Immunizations & Infectious Diseases	1.20	1.20	1.20
Maternal, Fetal & Infant Health	1.56	1.69	1.63
Medications & Prescriptions	1.72	2.33	2.03
Mental Health & Mental Disorders	1.39	1.48	1.44
Nutrition & Healthy Eating	1.31	1.58	1.45
Older Adults	1.65	1.77	1.71
Oral Health	1.14	1.14	1.14
Other Conditions	1.83	2.17	2.00
Physical Activity	1.39	1.56	1.48
Prevention & Safety	2.21	2.00	2.11
Respiratory Diseases	1.23	1.39	1.31
Tobacco Use	1.19	1.23	1.21
Wellness & Lifestyle	1.49	1.43	1.46
Women's Health	1.46	1.82	1.64
QUALITY OF LIFE TOPIC			
Community	1.66	1.5	1.58
Economy	1.68	1.34	1.51
Education	1.55	1.71	1.63
Environmental Health	1.53	1.39	1.46

Secondary Data Scoring Indicators of Concern

From the secondary data scoring results, Health Care Access & Quality ranked as the 15th highest scoring health need, with a score of 1.39. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 9 below. For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. The legend (Figure 34) 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 34: 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% of counties in the state or nation.
	The indicator is trending down, significantly, and this is not the ideal direction.
	The indicator is trending down and this is not the ideal direction.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trendng up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction .
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.

Table 9. Data Scoring Results for Healthcare Access & Quality for the CCRH Avon Community
Cuyahoga County

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

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

Lorain County

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

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

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

Table 10: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #2: Adult Health

From the secondary data scoring results, Nutrition and Healthy Eating had the 13th highest data score at 1.45. While the Older Adults topic area had the fifth highest at a score of 1.71 and Other Conditions had the third highest topic score at 2.00. 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	ADULT HEALTH	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.72	Age-Adjusted Death Rate due to Prostate Cancer	23.8	16.9	19.4	18.9			
2.64	People 65+ Living Alone	34.8		28.8	26.1			
2.58	Breast Cancer Incidence Rate	134.8		129.6	126.8			
2.47	People 65+ Living Below Poverty Level	10.9		8.1	9.3			
2.36	Prostate Cancer Incidence Rate	128		107.2	106.2			
2.31	Cancer: Medicare Population	9		8.4	8.4			
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			
2.28	Age-Adjusted Death Rate due to Breast Cancer	23.6	15.3	21.6	19.9			

2.25	All Cancer Incidence Rate	479.7		467.5	448.6			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4		10.4	10.8			
2.14	Colorectal Cancer Incidence Rate	44.2		41.3	38			
2.14	Atrial Fibrillation: Medicare Population	9		9	8.4			
2.08	Osteoporosis: Medicare Population	6.3		6.2	6.6			...
2.03	Asthma: Medicare Population	5.2		4.8	5			
1.92	Chronic Kidney Disease: Medicare Population	25.2		25.3	24.5			
1.92	Adults with Kidney Disease	3.6			3.1			...
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	35.4		36.1	33.5			

1.78	Age-Adjusted Death Rate due to Cancer	171	122.7	169.4	152.4			
1.75	Adults 65+ who Received Recommended Preventive Services: Females	28.6			28.4			...
1.75	Depression: Medicare Population	18.5		20.4	18.4			
1.69	Heart Failure: Medicare Population	15.3		14.7	14			
1.69	Age-Adjusted Death Rate due to Kidney Disease	15.2		14.5	12.9			
1.67	People 65+ with Low Access to a Grocery Store	3.4						...
1.67	Colon Cancer Screening	63.7	74.4		66.4			...
1.67	Consumer Expenditures: Fruits and Vegetables	838.8		864.6	1002.1			...
1.58	Adults 65+ with Total Tooth Loss	15.5			13.5			...

1.50	Consumer Expenditures: High Sugar Foods	502.1		519	530.2			...

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

Lorain County

SCORE	ADULT HEALTH	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.31	Breast Cancer Incidence Rate	134.8		129.6	126.8			
2.31	Cancer: Medicare Population	8.9		8.4	8.4			
2.25	All Cancer Incidence Rate	475.8		467.5	448.6			
2.22	Age-Adjusted Death Rate due to Breast Cancer	22.2	15.3	21.6	19.9			
2.22	Cervical Cancer Incidence Rate	9.2		7.9	7.7	...		
2.00	Prostate Cancer Incidence Rate	115.9		107.2	106.2			

1.78	Age-Adjusted Death Rate due to Lung Cancer	45.4	25.1	45	36.7			
1.61	Age-Adjusted Death Rate due to Cancer	167.8	122.7	169.4	152.4			
1.50	Colon Cancer Screening	64.5	74.4		66.4			...
2.17	Consumer Expenditures: High Sugar Foods	548.3		519	530.2			...
2.00	Consumer Expenditures: Fast Food Restaurants	1521.4		1461	1638.9			...
1.83	Consumer Expenditures: High Sugar Beverages	330.4		319.7	357			...
2.75	Age-Adjusted Death Rate due to Falls	14.5		10.5	9.5			
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	38.4		36.1	33.5			
2.64	Atrial Fibrillation: Medicare Population	10.2		9	8.4			

2.64	Stroke: Medicare Population	4.7		3.8	3.8			
2.58	Osteoporosis: Medicare Population	6.8		6.2	6.6			
2.47	Hyperlipidemia: Medicare Population	53.1		49.4	47.7			...
2.25	Chronic Kidney Disease: Medicare Population	25.8		25.3	24.5			
2.19	Ischemic Heart Disease: Medicare Population	30.6		27.5	26.8			
2.00	COPD: Medicare Population	14.5		13.2	11.5			
1.97	Hypertension: Medicare Population	61.2		59.5	57.2			
1.92	Depression: Medicare Population	19.9		20.4	18.4			
1.83	People 65+ with Low Access to a Grocery Store	4						...

1.81	People 65+ Living Alone	27.5		28.8	26.1			
1.75	Adults with Arthritis	31.1			25.1			...
1.75	Heart Failure: Medicare Population	14.2		14.7	14			
1.64	Alzheimer's Disease or Dementia: Medicare Population	10.4		10.4	10.8			
2.25	Age-Adjusted Death Rate due to Kidney Disease	15.6		14.5	12.9			
1.75	Adults with Arthritis	31.1			25.1			...

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

Table 11: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #4: Socioeconomic Issues

Prevention & Safety ranked first among all health topics with a score of 2.11. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 11 below. 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

2.64	Death Rate due to Drug Poisoning	42.6		38.1	21			
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	42		40.2	21.4			
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	69.7	43.2	68.8	48.9			
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.6		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.

Lorain County

SCORE	PREVENTION & SAFETY	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.75	Age-Adjusted Death Rate due to Falls	14.5		10.5	9.5			
2.39	Age-Adjusted Death Rate due to Unintentional Injuries	71.1	43.2	68.8	48.9			

2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	41.2		40.2	21.4			
2.31	Death Rate due to Drug Poisoning	38.4		38.1	21			
1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	2.7		2.8	2.5	...	...	...

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

Table 12: Secondary Data Scoring Results by Health Topic for The CCRH Avon Community in Rank Order by Topic Score

HEALTH TOPICS	AVG
Prevention & Safety	2.11
Medications & Prescriptions	2.03
Other Conditions	2.00
Alcohol & Drug Use	1.72
Older Adults	1.71
Cancer	1.64
Women's Health	1.64
Maternal, Fetal & Infant Health	1.63
Children's Health	1.60
Heart Disease & Stroke	1.53
Physical Activity	1.48
Wellness & Lifestyle	1.46
Nutrition & Healthy Eating	1.45
Mental Health & Mental Disorders	1.44
Health Care Access & Quality	1.39
Respiratory Diseases	1.31
Diabetes	1.25
Tobacco Use	1.21
Immunizations & Infectious Diseases	1.20
Oral Health	1.14
QUALITY OF LIFE TOPIC	**SCORE**
Education	1.63
Community	1.58
Economy	1.51

Environmental Health	1.46

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

0.92	Mothers who Smoked During Pregnancy	*percent*	6.1	4.3	11.5	5.5	*2020*	17

SCORE	CANCER	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.72	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	23.8	16.9	19.4	18.9	*2015-2019*	12
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.8		129.6	126.8	*2014-2018*	12
2.36	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	128		107.2	106.2	*2014-2018*	12
2.31	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.6	15.3	21.6	19.9	*2015-2019*	12
2.25	All Cancer Incidence Rate	*cases/ 100,000 population*	479.7		467.5	448.6	*2014-2018*	12
2.14	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	44.2		41.3	38	*2014-2018*	12
1.78	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	171	122.7	169.4	152.4	*2015-2019*	12
1.67	Colon Cancer Screening	*percent*	63.7	74.4		66.4	*2018*	4

1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	42.9	25.1	45	36.7	*2015-2019*	12
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		67.3	57.3	*2014-2018*	12
1.28	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.5	8.9	14.8	13.4	*2015-2019*	12
1.25	Adults with Cancer	*percent*	7.5			7.1	*2019*	4
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.2	11.9	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	75.2	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.3	84.3		84.7	*2018*	4
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.4		7.9	7.7	*2014-2018*	12

SCORE	**CHILDREN'S HEALTH**	**UNITS**	**CUYAHOGA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.17	Child Food Insecurity Rate	*percent*	20.7		17.4	14.6	*2019*	10
2.08	Projected Child Food Insecurity Rate	*percent*	23.4		18.5		*2021*	10
1.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10	8.7	6.8		*2020*	3

1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.7		0.5		*2020*	19
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.8		1.9		*2020*	19
1.50	Children with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.33	Children with Health Insurance	*percent*	97.1		95.2	94.3	*2019*	1
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7

SCORE	COMMUNITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	*percent*	34.8		28.8	26.1	*2015-2019*	1
2.50	Single-Parent Households	*percent*	37.6		27.1	25.5	*2015-2019*	1
2.47	Homeownership	*percent*	50.9		59.4	56.2	*2015-2019*	1
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	41.4	28.3	32.2	27	*2015-2019*	9

2.39	Violent Crime Rate	*crimes/ 100,000 population*	637		303.5	394	*2017*	18
2.31	Social Associations	*membership associations/ 10,000 population*	9.2		11	9.3	*2018*	9
2.14	Linguistic Isolation	*percent*	2.9		1.4	4.4	*2015-2019*	1
2.08	Households without a Vehicle	*percent*	12.8		7.9	8.6	*2015-2019*	1
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.6		2.8	2.5	*2015-2019*	5
2.00	People Living Below Poverty Level	*percent*	17.5	8	14	13.4	*2015-2019*	1
1.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10	8.7	6.8		*2020*	3
1.92	Children Living Below Poverty Level	*percent*	25.5		19.9	18.5	*2015-2019*	1
1.75	Median Household Income	*dollars*	50366		56602	62843	*2015-2019*	1
1.75	Social and Economic Factors Ranking	*ranking*	72				*2021*	9
1.75	Young Children Living Below Poverty Level	*percent*	27.3		23	20.3	*2015-2019*	1
1.75	Youth not in School or Working	*percent*	2.3		1.8	1.9	*2015-2019*	1

1.69	Voter Turnout: Presidential Election	*percent*	71	74		*2020*	20
1.67	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	122.3	121.7	148.8	*2021*	7
1.67	Households with an Internet Subscription	*percent*	79.1	82.4	83	*2015-2019*	1
1.67	Households with One or More Types of Computing Devices	*percent*	87.4	89.1	90.3	*2015-2019*	1
1.53	Mean Travel Time to Work	*minutes*	24.3	23.7	26.9	*2015-2019*	1
1.50	Adults with Internet Access	*percent*	94.3	94.5	95	*2021*	8
1.50	Households with a Computer	*percent*	84.2	85.2	86.3	*2021*	8
1.50	Persons with an Internet Subscription	*percent*	84	86.2	86.2	*2015-2019*	1
1.36	Solo Drivers with a Long Commute	*percent*	32.3	31.1	37	*2015-2019*	9
1.33	Households with a Smartphone	*percent*	80.3	80.5	81.9	*2021*	8

1.06	Workers Commuting by Public Transportation	*percent*	4.6	5.3	1.6	5	*2015-2019*	1
1.03	Workers who Drive Alone to Work	*percent*	79.3		82.9	76.3	*2015-2019*	1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
0.83	Households with Wireless Phone Service	*percent*	97.2		96.8	97	*2020*	8
0.69	Workers who Walk to Work	*percent*	2.7		2.2	2.7	*2015-2019*	1
0.58	Per Capita Income	*dollars*	33114		31552	34103	*2015-2019*	1
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1

SCORE	**DIABETES**	**UNITS**	**CUYAHOGA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.50	Adults 20+ with Diabetes	*percent*	9				*2019*	5
1.14	Diabetes: Medicare Population	*percent*	25.3		27.2	27	*2018*	6

0.86	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	22.4		25.3	21.5	*2017-2019*	5

SCORE	ECONOMY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.47	Homeownership	*percent*	50.9		59.4	56.2	*2015-2019*	1
2.47	People 65+ Living Below Poverty Level	*percent*	10.9		8.1	9.3	*2015-2019*	1
2.17	Child Food Insecurity Rate	*percent*	20.7		17.4	14.6	*2019*	10
2.17	Income Inequality		0.5		0.5	0.5	*2015-2019*	1
2.08	Persons with Disability Living in Poverty (5-year)	*percent*	33.9		29.5	26.1	*2015-2019*	1
2.08	Projected Child Food Insecurity Rate	*percent*	23.4		18.5		*2021*	10
2.00	Adults who Feel Overwhelmed by Financial Burdens	*percent*	15.1		14.6	14.4	*2021*	8
2.00	Food Insecurity Rate	*percent*	13.9		13.2	10.9	*2019*	10
2.00	Households that are Below the Federal Poverty Level	*percent*	17.7		13.8		*2018*	25

2.00	People Living Below Poverty Level	*percent*	17.5	8	14	13.4	*2015-2019*	1
1.92	Children Living Below Poverty Level	*percent*	25.5		19.9	18.5	*2015-2019*	1
1.92	Families Living Below Poverty Level	*percent*	13		9.9	9.5	*2015-2019*	1
1.92	Projected Food Insecurity Rate	*percent*	15.6		14.1		*2021*	10
1.83	Renters Spending 30% or More of Household Income on Rent	*percent*	48.4		44.9	49.6	*2015-2019*	1
1.75	Households with Cash Public Assistance Income	*percent*	3.1		2.9	2.4	*2015-2019*	1
1.75	Median Household Income	*dollars*	50366		56602	62843	*2015-2019*	1
1.75	Severe Housing Problems	*percent*	17.1		13.7	18	*2013-2017*	9
1.75	Social and Economic Factors Ranking	*ranking*	72				*2021*	9
1.75	Young Children Living Below Poverty Level	*percent*	27.3		23	20.3	*2015-2019*	1
1.75	Youth not in School or Working	*percent*	2.3		1.8	1.9	*2015-2019*	1

1.67	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	58.8	61.6		*2018*	25
1.64	Size of Labor Force	*persons*	582791			*44440*	21
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9			*2017*	23
1.50	Households with a Savings Account	*percent*	67.7	68.8	70.2	*2021*	8
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.42	People Living 200% Above Poverty Level	*percent*	64.7	68.8	69.1	*2015-2019*	1
1.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7600	7828	8900.1	*2021*	7
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	23.5	24.5		*2018*	25
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3			*2015*	23

1.31	Overcrowded Households	*percent of households*	1.2		1.4		*2015-2019*	1
1.25	Unemployed Workers in Civilian Labor Force	*percent*	4.6		4.3	4.6	*Sep-21*	21
1.17	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3928.7		3798.7	5460.2	*2021*	7
1.00	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	22.7		19.7	26.5	*2019*	1
0.58	Per Capita Income	*dollars*	33114		31552	34103	*2015-2019*	1
0.58	Students Eligible for the Free Lunch Program	*percent*	12.9				*2019-2020*	13

SCORE	EDUCATION	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.86	4th Grade Students Proficient in English/Language Arts	*percent*	46.6		63.3		*2018-2019*	15
1.86	4th Grade Students Proficient in Math	*percent*	52.5		74.3		*2018-2019*	15

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

SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**CUYAHOGA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.25	Adults with Current Asthma	*percent*	11			8.9	*2019*	4
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
2.08	Houses Built Prior to 1950	*percent*	39.2		26.2	17.5	*2015-2019*	1

2.03	Asthma: Medicare Population	*percent*	5.2	4.8	5	*2018*	6
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.7	0.5		*2020*	19
1.75	Annual Ozone Air Quality		F			*2017-2019*	2
1.75	Physical Environment Ranking	*ranking*	88			*2021*	9
1.75	Severe Housing Problems	*percent*	17.1	13.7	18	*2013-2017*	9
1.67	Farmers Market Density	*markets/ 1,000 population*	0			*2018*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4			*2015*	23
1.64	Number of Extreme Precipitation Days	*days*	34			*2019*	14
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9			*2017*	23
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.8	1.9		*2020*	19
1.53	Food Environment Index	*index*	7.3	6.8	7.8	*2021*	9

1.50	Children with Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.44	Annual Particle Pollution		B			*2017-2019*	2
1.36	Number of Extreme Heat Days	*days*	12			*2019*	14
1.36	Number of Extreme Heat Events	*events*	6			*2019*	14
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	0			*2020*	14
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.31	Grocery Store Density	*stores/ 1,000 population*	0.2			*2016*	23
1.31	Liquor Store Density	*stores/ 100,000 population*	6.4	5.6	10.5	*2019*	22
1.31	Overcrowded Households	*percent of households*	1.2	1.4		*2015-2019*	1
1.08	PBT Released	*pounds*	234591.7			*2020*	24
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3			*2015*	23

1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.50	Access to Exercise Opportunities	*percent*	97.5		83.9	84	*2020*	9

SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**CUYAHOGA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Adults with Health Insurance: 18+	*percent*	89.8		90.2	90.6	*2021*	8
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1057.6		1098.6	1047.4	*2021*	7
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	199.2		204.8	194.9	*2021*	7
1.50	Adults who Visited a Dentist	*percent*	51.3		51.6	52.9	*2021*	8
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	627.2		638.9	609.6	*2021*	7
1.42	Adults without Health Insurance	*percent*	13			13	*2019*	4
1.39	Persons without Health Insurance	*percent*	5.3		6.6		*2019*	1
1.33	Adults with Health Insurance	*percent*	92.2		90.9	87.1	*2019*	1

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

SCORE	HEART DISEASE & STROKE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.14	Atrial Fibrillation: Medicare Population	*percent*	9		9	8.4	*2018*	6
1.92	Adults who Experienced a Stroke	*percent*	4.2			3.4	*2019*	4

1.69	Heart Failure: Medicare Population	*percent*	15.3		14.7	14	*2018*	6
1.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	107.8	71.1	101.4	90.5	*2017-2019*	5
1.50	High Blood Pressure Prevalence	*percent*	35.4	27.7		32.6	*2019*	4
1.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	36.6	33.4	42.5	37.2	*2017-2019*	5
1.42	Adults who Experienced Coronary Heart Disease	*percent*	7.4			6.2	*2019*	4
1.36	Stroke: Medicare Population	*percent*	3.8		3.8	3.8	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	57.2		59.5	57.2	*2018*	6
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.7			76.2	*2019*	4
1.25	Cholesterol Test History	*percent*	86.3			87.6	*2019*	4

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

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

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

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

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

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

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.42	Adults Ever Diagnosed with Depression	*percent*	20.9			18.8	*2019*	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21		34	30.5	*2017-2019*	5
1.61	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	14	12.8	15.1	14.1	*2017-2019*	5
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.4		10.4	10.8	*2018*	6
1.75	Depression: Medicare Population	*percent*	18.5		20.4	18.4	*2018*	6
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	401.4		261.3		*2020*	9
1.75	Poor Mental Health: 14+ Days	*percent*	16			13.6	*2019*	4
1.83	Poor Mental Health: Average Number of Days	*days*	5		4.8	4.1	*2018*	9

1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8

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

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

SCORE	OLDER ADULT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	*percent*	34.8		28.8	26.1	*2015-2019*	1
2.47	People 65+ Living Below Poverty Level	*percent*	10.9		8.1	9.3	*2015-2019*	1
2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.6		10.5	9.5	*2017-2019*	5
2.31	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.4		10.4	10.8	*2018*	6
2.14	Atrial Fibrillation: Medicare Population	*percent*	9		9	8.4	*2018*	6
2.08	Osteoporosis: Medicare Population	*percent*	6.3		6.2	6.6	*2018*	6

2.03	Asthma: Medicare Population	*percent*	5.2		4.8	5	*2018*	6
1.92	Chronic Kidney Disease: Medicare Population	*percent*	25.2		25.3	24.5	*2018*	6
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4		36.1	33.5	*2018*	6
1.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	28.6			28.4	*2018*	4
1.75	Depression: Medicare Population	*percent*	18.5		20.4	18.4	*2018*	6
1.69	Heart Failure: Medicare Population	*percent*	15.3		14.7	14	*2018*	6
1.67	Colon Cancer Screening	*percent*	63.7	74.4		66.4	*2018*	4
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4				*2015*	23
1.58	Adults 65+ with Total Tooth Loss	*percent*	15.5			13.5	*2018*	4

1.42	Adults with Arthritis	*percent*	29.3		25.1	*2019*	4
1.36	Stroke: Medicare Population	*percent*	3.8	3.8	3.8	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	57.2	59.5	57.2	*2018*	6
1.14	Diabetes: Medicare Population	*percent*	25.3	27.2	27	*2018*	6
1.00	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	20.8	20.5	34.3	*2021*	7
1.00	Hyperlipidemia: Medicare Population	*percent*	45.2	49.4	47.7	*2018*	6
1.00	Ischemic Heart Disease: Medicare Population	*percent*	25.8	27.5	26.8	*2018*	6
0.97	COPD: Medicare Population	*percent*	11.2	13.2	11.5	*2018*	6
0.92	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	34.5		32.4	*2018*	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21	34	30.5	*2017-2019*	5

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

SCORE	OTHER CONDITIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.08	Osteoporosis: Medicare Population	*percent*	6.3		6.2	6.6	*2018*	6
1.92	Adults with Kidney Disease	*Percent of adults*	3.6			3.1	*2019*	4
1.92	Chronic Kidney Disease: Medicare Population	*percent*	25.2		25.3	24.5	*2018*	6
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4		36.1	33.5	*2018*	6

1.69	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	15.2		14.5	12.9	*2017-2019*	5
1.42	Adults with Arthritis	*percent*	29.3			25.1	*2019*	4

SCORE	PHYSICAL ACTIVITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.22	Adults 20+ who are Obese	*percent*	34.2	36			*2019*	5
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
1.67	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4				*2015*	23
1.64	Adults 20+ who are Sedentary	*percent*	25.1				*2019*	5
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*	23
1.53	Food Environment Index	*index*	7.3		6.8	7.8	*2021*	9
1.50	Children with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23

1.42	Health Behaviors Ranking	*ranking*	31				*2021*	9
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.31	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6		80.9	80.4	*2021*	8
0.69	Workers who Walk to Work	*percent*	2.7		2.2	2.7	*2015-2019*	1
0.50	Access to Exercise Opportunities	*percent*	97.5		83.9	84	*2020*	9

SCORE	PREVENTION & SAFETY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.6		10.5	9.5	*2017-2019*	5

2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.6		2.8	2.5	*2015-2019*	5
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.7	43.2	68.8	48.9	*2017-2019*	5
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42		40.2	21.4	*2017-2019*	5
2.64	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.6		38.1	21	*2017-2019*	9
1.75	Severe Housing Problems	*percent*	17.1		13.7	18	*2013-2017*	9

SCORE	RESPIRATORY DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.25	Adults with Current Asthma	*percent*	11			8.9	*2019*	4
2.03	Asthma: Medicare Population	*percent*	5.2		4.8	5	*2018*	6
2.00	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	485.5		487.9	422.4	*2021*	7
1.61	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.2	1.4	1.1		*2020*	16

1.58	Adults with COPD	*Percent of adults*	8.6			6.6	*2019*	4
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-22*	11
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	42.9	25.1	45	36.7	*2015-2019*	12
1.42	Adults who Smoke	*percent*	20.9	5	21.4	17	*2018*	9
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		67.3	57.3	*2014-2018*	12
0.97	COPD: Medicare Population	*percent*	11.2		13.2	11.5	*2018*	6
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4		4.3	4.1	*2021*	8
0.81	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	38.4		47.8	39.6	*2017-2019*	5
0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.2		2.2	2	*2021*	8
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	11.1		14.4	13.8	*2017-2019*	5

0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.6		128.4	177.3	*28-Jan-22*	11

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

SCORE	WELLNESS & LIFESTYLE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Insufficient Sleep	*percent*	44.9	31.4	40.6	35	*2018*	9
1.75	Morbidity Ranking	*ranking*	76				*2021*	9
1.67	Poor Physical Health: Average Number of Days	*days*	4.2		4.1	3.7	*2018*	9
1.58	Poor Physical Health: 14+ Days	*percent*	14.3			12.5	*2019*	4

1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.1			18.6	*2019*	4
1.50	High Blood Pressure Prevalence	*percent*	35.4	27.7		32.6	*2019*	4
1.50	Life Expectancy	*years*	77		77	79.2	*2017-2019*	9
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.1		41.5	41.2	*2021*	8
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1415.1		1461	1638.9	*2021*	7
1.17	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.6		48.6	49.4	*2021*	8
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6		80.9	80.4	*2021*	8

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

Cuyahoga Data Sources

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

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

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

1.17	Adults who Drink Excessively	*percent*	18		18.5	19	*2018*	9

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

1.50	Colon Cancer Screening	*percent*	64.5	74.4		66.4	*2018*	4
1.39	Cervical Cancer Screening: 21-65	*Percent*	84.3	84.3		84.7	*2018*	4
1.25	Adults with Cancer	*percent*	7.7			7.1	*2019*	4
1.11	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	13.8	8.9	14.8	13.4	*2015-2019*	12
1.08	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	65.8		67.3	57.3	*2014-2018*	12
1.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	17.5	16.9	19.4	18.9	*2015-2019*	12
0.97	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.2		12.2	11.9	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.9	77.1		74.8	*2018*	4
0.75	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	39.1		41.3	38	*2014-2018*	12

SCORE	CHILDREN'S HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per*	336.9		301.6	368.2	*2021*	7

		consumer unit						
1.83	Children with Low Access to a Grocery Store	*percent*	6.7				*2015*	23
1.56	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.1	8.7	6.8		*2020*	3
1.50	Child Food Insecurity Rate	*percent*	17.1		17.4	14.6	*2019*	10
1.42	Projected Child Food Insecurity Rate	*percent*	18.7		18.5		*2021*	10
1.33	Children with Health Insurance	*percent*	96.1		95.2	94.3	*2019*	1
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.4		1.9		*2020*	19

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

2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	39.7	28.3	32.2	27	*2015-2019*	9
2.25	Social Associations	*membership associations/ 10,000 population*	9.5		11	9.3	*2018*	9
2.19	Single-Parent Households	*percent*	29.4		27.1	25.5	*2015-2019*	1
2.19	Youth not in School or Working	*percent*	2.6		1.8	1.9	*2015-2019*	1
2.17	Young Children Living Below Poverty Level	*percent*	27.6		23	20.3	*2015-2019*	1
1.97	Workers who Walk to Work	*percent*	2		2.2	2.7	*2015-2019*	1
1.81	Mean Travel Time to Work	*minutes*	24.6		23.7	26.9	*2015-2019*	1
1.81	People 65+ Living Alone	*percent*	27.5		28.8	26.1	*2015-2019*	1
1.69	Solo Drivers with a Long Commute	*percent*	35.6		31.1	37	*2015-2019*	9
1.69	Voter Turnout: Presidential Election	*percent*	72.6		74		*2020*	20

1.58	Children Living Below Poverty Level	*percent*	20.6		19.9	18.5	*2015-2019*	1
1.58	Social and Economic Factors Ranking	*ranking*	49				*2021*	9
1.56	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.1	8.7	6.8		*2020*	3
1.53	Linguistic Isolation	*percent*	1.5		1.4	4.4	*2015-2019*	1
1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.7		2.8	2.5	*2015-2019*	5
1.50	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	121.5		121.7	148.8	*2021*	7
1.50	Households with a Smartphone	*percent*	80.1		80.5	81.9	*2021*	8
1.50	Households with an Internet Subscription	*percent*	80.8		82.4	83	*2015-2019*	1
1.50	Persons with an Internet Subscription	*percent*	84.5		86.2	86.2	*2015-2019*	1

1.44	People Living Below Poverty Level	*percent*	13.5	8	14	13.4	*2015-2019*	1
1.44	Workers Commuting by Public Transportation	*percent*	0.7	5.3	1.6	5	*2015-2019*	1
1.39	Violent Crime Rate	*crimes/ 100,000 population*	242		303.5	394	*2017*	18
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.1				*2015*	23
1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	24.9		28.3	32.1	*2015-2019*	1
1.25	Workers who Drive Alone to Work	*percent*	83.3		82.9	76.3	*2015-2019*	1
1.17	Adults with Internet Access	*percent*	94.5		94.5	95	*2021*	8
1.17	Households with a Computer	*percent*	85.5		85.2	86.3	*2021*	8
1.17	Households with Wireless Phone Service	*percent*	96.6		96.8	97	*2020*	8
1.08	Per Capita Income	*dollars*	30928		31552	34103	*2015-2019*	1

0.92	Median Household Income	*dollars*	58427		56602	62843	*2015-2019*	1
0.83	Households with One or More Types of Computing Devices	*percent*	90.4		89.1	90.3	*2015-2019*	1
0.75	Households without a Vehicle	*percent*	6.8		7.9	8.6	*2015-2019*	1
0.25	Homeownership	*percent*	66.3		59.4	56.2	*2015-2019*	1

SCORE	DIABETES	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Adults 20+ with Diabetes	*percent*	11.5				*2019*	5
1.14	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	21.6		25.3	21.5	*2017-2019*	5
0.86	Diabetes: Medicare Population	*percent*	26.3		27.2	27	*2018*	6

SCORE	ECONOMY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Households with Cash Public Assistance Income	*percent*	3.2		2.9	2.4	*2015-2019*	1

2.33	Renters Spending 30% or More of Household Income on Rent	*percent*	49.9	44.9	49.6	*2015-2019*	1
2.19	Youth not in School or Working	*percent*	2.6	1.8	1.9	*2015-2019*	1
2.17	Young Children Living Below Poverty Level	*percent*	27.6	23	20.3	*2015-2019*	1
2.00	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	8253.1	7828	8900.1	*2021*	7
1.69	Families Living Below Poverty Level	*percent*	10	9.9	9.5	*2015-2019*	1
1.67	Households that are Below the Federal Poverty Level	*percent*	14.2	13.8		*2018*	25
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.9			*2015*	23
1.64	Income Inequality		0.5	0.5	0.5	*2015-2019*	1
1.64	Size of Labor Force	*persons*	148191			*44470*	21

1.58	Children Living Below Poverty Level	*percent*	20.6		19.9	18.5	*2015-2019*	1
1.58	Social and Economic Factors Ranking	*ranking*	49				*2021*	9
1.53	Persons with Disability Living in Poverty (5-year)	*percent*	28.2		29.5	26.1	*2015-2019*	1
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.50	Child Food Insecurity Rate	*percent*	17.1		17.4	14.6	*2019*	10
1.50	Food Insecurity Rate	*percent*	12.4		13.2	10.9	*2019*	10
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.44	People Living Below Poverty Level	*percent*	13.5	8	14	13.4	*2015-2019*	1
1.42	Projected Child Food Insecurity Rate	*percent*	18.7		18.5		*2021*	10

1.33	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	63.7	61.6		*2018*	25
1.25	Projected Food Insecurity Rate	*percent*	13.5	14.1		*2021*	10
1.17	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.1	14.6	14.4	*2021*	8
1.17	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	22.1	24.5		*2018*	25
1.08	Per Capita Income	*dollars*	30928	31552	34103	*2015-2019*	1
1.00	Households with a Savings Account	*percent*	69.6	68.8	70.2	*2021*	8
0.92	Median Household Income	*dollars*	58427	56602	62843	*2015-2019*	1
0.86	Overcrowded Households	*percent of households*	0.9	1.4		*2015-2019*	1
0.75	People Living 200% Above Poverty Level	*percent*	71.2	68.8	69.1	*2015-2019*	1

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

SCORE	**EDUCATION**	**UNITS**	**LORAIN COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.17	Consumer Expenditures: Childcare	*average dollar amount per*	336.9		301.6	368.2	*2021*	7

		consumer unit						
1.97	4th Grade Students Proficient in Math	*percent*	55.6		59.4		*2020-2021*	15
1.83	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1217.2		1200.4	1492.4	*2021*	7
1.81	4th Grade Students Proficient in English/Language Arts	*percent*	55.3		56		*2020-2021*	15
1.69	Student-to-Teacher Ratio	*students/ teacher*	17.1				*2019-2020*	13
1.67	8th Grade Students Proficient in Math	*percent*	39.8		42.6		*2020-2021*	15
1.50	8th Grade Students Proficient in English/Language Arts	*percent*	53.5		52.7		*2020-2021*	15
1.50	High School Graduation	*percent*	91.5	90.7	92		*2019-2020*	15

1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	24.9		28.3	32.1	*2015-2019*	1

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

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

1.25	Annual Particle Pollution		A			*2017-2019*	2
1.25	Physical Environment Ranking	*ranking*	3			*2021*	9
1.19	Asthma: Medicare Population	*percent*	4.7	4.8	5	*2018*	6
1.19	Houses Built Prior to 1950	*percent*	21.7	26.2	17.5	*2015-2019*	1
1.19	Liquor Store Density	*stores/ 100,000 population*	7.1	5.6	10.5	*2019*	22
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3	0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.4	1.9		*2020*	19
0.86	Overcrowded Households	*percent of households*	0.9	1.4		*2015-2019*	1
0.83	Access to Exercise Opportunities	*percent*	90.9	83.9	84	*2020*	9
0.75	Severe Housing Problems	*percent*	12.8	13.7	18	*2013-2017*	9

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1181.4		1098.6	1047.4	*2021*	7
2.33	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	217.8		204.8	194.9	*2021*	7
2.33	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	687.1		638.9	609.6	*2021*	7
2.17	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4676.2		4371.7	4321.1	*2021*	7
1.75	Adults without Health Insurance	*percent*	13.7			13	*2019*	4
1.72	Primary Care Provider Rate	*providers/ 100,000 population*	54.6		76.7		*2018*	9
1.56	Persons without Health Insurance	*percent*	6.1		6.6		*2019*	1

1.42	Clinical Care Ranking	*ranking*	40				*2021*	9
1.33	Adults with Health Insurance	*percent*	91		90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	96.1		95.2	94.3	*2019*	1
1.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	66.2		108.9		*2020*	9
1.25	Adults who have had a Routine Checkup	*percent*	78.4			76.6	*2019*	4
1.17	Dentist Rate	*dentists/ 100,000 population*	51		64.2		*2019*	9
1.17	Mental Health Provider Rate	*providers/ 100,000 population*	177.8		261.3		*2020*	9
1.00	Adults who Visited a Dentist	*percent*	52.9		51.6	52.9	*2021*	8
1.00	Adults with Health Insurance: 18+	*percent*	90.9		90.2	90.6	*2021*	8

SCORE	HEART DISEASE & STROKE	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Atrial Fibrillation: Medicare Population	*percent*	10.2		9	8.4	*2018*	6

2.64	Stroke: Medicare Population	*percent*	4.7		3.8	3.8	*2018*	6
2.47	Hyperlipidemia: Medicare Population	*percent*	53.1		49.4	47.7	*2018*	6
2.19	Ischemic Heart Disease: Medicare Population	*percent*	30.6		27.5	26.8	*2018*	6
2.00	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40	33.4	42.5	37.2	*2017-2019*	5
1.97	Hypertension: Medicare Population	*percent*	61.2		59.5	57.2	*2018*	6
1.75	Heart Failure: Medicare Population	*percent*	14.2		14.7	14	*2018*	6
1.58	Adults who Experienced a Stroke	*percent*	3.8			3.4	*2019*	4
1.58	Adults who Experienced Coronary Heart Disease	*percent*	7.6			6.2	*2019*	4

1.58	Adults who Have Taken Medications for High Blood Pressure	*percent*	77.9			76.2	*2019*	4
1.50	High Blood Pressure Prevalence	*percent*	35.1	27.7		32.6	*2019*	4
1.42	Cholesterol Test History	*percent*	85.3			87.6	*2019*	4
1.08	High Cholesterol Prevalence: Adults 18+	*percent*	32.6			33.6	*2019*	4
0.58	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	41.8		55.4		*2019*	14
0.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	82.1	71.1	101.4	90.5	*2017-2019*	5

SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**LORAIN COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Gonorrhea Incidence Rate	*cases/ 100,000 population*	227.2		262.6		*2020*	16

1.92	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	17.4	11.1	13.7		*2019*	16
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.3		0.3	1.6	*4-Feb-22*	11
1.36	Chlamydia Incidence Rate	*cases/ 100,000 population*	437		504.8		*2020*	16
1.28	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.6	1.4	1.1		*2020*	16
1.03	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.5		14.4	13.8	*2017-2019*	5
1.00	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.2		48.6	49.4	*2021*	8
0.86	Overcrowded Households	*percent of households*	0.9		1.4		*2015-2019*	1
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	62.1				*4-Feb-22*	5
0.53	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	27.6		36.7	67.6	*4-Feb-22*	11

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	336.9		301.6	368.2	*2021*	7
2.06	Babies with Very Low Birth Weight	*percent*	1.5		1.4	1.3	*2020*	17
2.06	Mothers who Received Early Prenatal Care	*percent*	67		68.9	76.1	*2020*	17
1.89	Preterm Births	*percent*	10.5	9.4	10.3		*2020*	17
1.75	Babies with Low Birth Weight	*percent*	9		8.5	8.2	*2020*	17
1.53	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	6.9		6.8		*2020*	17
1.42	Mothers who Smoked During Pregnancy	*percent*	12.6	4.3	11.5	5.5	*2020*	17
1.25	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	19.9		19.5		*2016*	17

1.08	Infant Mortality Rate	*deaths/ 1,000 live births*	4.3	5	6.9		*2019*	17

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

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.67	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	17.5	12.8	15.1	14.1	*2017-2019*	5

1.92	Depression: Medicare Population	*percent*	19.9	20.4	18.4	*2018*	6
1.67	Poor Mental Health: Average Number of Days	*days*	4.8	4.8	4.1	*2018*	9
1.64	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.4	10.4	10.8	*2018*	6
1.58	Poor Mental Health: 14+ Days	*percent*	15.7		13.6	*2019*	4
1.25	Adults Ever Diagnosed with Depression	*percent*	20.3		18.8	*2019*	4
1.17	Mental Health Provider Rate	*providers/ 100,000 population*	177.8	261.3		*2020*	9
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8	85.6	86.5	*2021*	8
0.42	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	28.8	34	30.5	*2017-2019*	5

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

1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.7		80.9	80.4	*2021*	8

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

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

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

0.75	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	36			32.4	*2018*	4
0.53	People 65+ Living Below Poverty Level	*percent*	7		8.1	9.3	*2015-2019*	1
0.42	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	28.8		34	30.5	*2017-2019*	5

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

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

2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	38.4		36.1	33.5	*2018*	6
2.58	Osteoporosis: Medicare Population	*percent*	6.8		6.2	6.6	*2018*	6
2.25	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	15.6		14.5	12.9	*2017-2019*	5
2.25	Chronic Kidney Disease: Medicare Population	*percent*	25.8		25.3	24.5	*2018*	6
1.75	Adults with Arthritis	*percent*	31.1			25.1	*2019*	4
1.42	Adults with Kidney Disease	*Percent of adults*	3.3			3.1	*2019*	4

SCORE	PHYSICAL ACTIVITY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.03	Adults 20+ who are Obese	*percent*	36.6	36			*2019*	5
1.97	Workers who Walk to Work	*percent*	2		2.2	2.7	*2015-2019*	1

1.83	Children with Low Access to a Grocery Store	*percent*	6.7			*2015*	23
1.83	Farmers Market Density	*markets/ 1,000 population*	0			*2018*	23
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4			*2015*	23
1.69	Adults 20+ who are Sedentary	*percent*	25.7			*2019*	5
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.9			*2015*	23
1.64	Food Environment Index	*index*	7.5	6.8	7.8	*2021*	9
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.7			*2017*	23
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2			*2016*	23
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1			*2016*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.42	Health Behaviors Ranking		25			*2021*	9

1.36	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.6				*2016*	23
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.1				*2015*	23
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.7		80.9	80.4	*2021*	8
0.83	Access to Exercise Opportunities	*percent*	90.9		83.9	84	*2020*	9

SCORE	PREVENTION & SAFETY	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.5		10.5	9.5	*2017-2019*	5
2.39	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	71.1	43.2	68.8	48.9	*2017-2019*	5
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	41.2		40.2	21.4	*2017-2019*	5

2.31	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	38.4		38.1	21	*2017-2019*	9
1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.7		2.8	2.5	*2015-2019*	5
0.75	Severe Housing Problems	*percent*	12.8		13.7	18	*2013-2017*	9

SCORE	RESPIRATORY DISEASES	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.03	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	56.2		47.8	39.6	*2017-2019*	5
2.00	COPD: Medicare Population	*percent*	14.5		13.2	11.5	*2018*	6
1.78	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	45.4	25.1	45	36.7	*2015-2019*	12
1.75	Adults with COPD	*Percent of adults*	9.2			6.6	*2019*	4
1.75	Adults with Current Asthma	*percent*	10.2			8.9	*2019*	4

1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	474.5		487.9	422.4	*2021*	7
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.3		0.3	1.6	*4-Feb-22*	11
1.42	Adults who Smoke	*percent*	20.7	5	21.4	17	*2018*	9
1.28	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.6	1.4	1.1		*2020*	16
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
1.08	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	65.8		67.3	57.3	*2014-2018*	12
1.03	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.5		14.4	13.8	*2017-2019*	5
1.00	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.1		2.2	2	*2021*	8

0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.9		4.3	4.1	*2021*	8
0.53	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	27.6		36.7	67.6	*4-Feb-22*	11

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

SCORE	WELLNESS & LIFESTYLE	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1521.4		1461	1638.9	*2021*	7
1.75	Insufficient Sleep	*percent*	39.3	31.4	40.6	35	*2018*	9
1.67	Poor Physical Health: Average Number of Days	*days*	4.2		4.1	3.7	*2018*	9
1.58	Poor Physical Health: 14+ Days	*percent*	14.4			12.5	*2019*	4
1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.1			18.6	*2019*	4
1.50	High Blood Pressure Prevalence	*percent*	35.1	27.7		32.6	*2019*	4
1.42	Morbidity Ranking	*ranking*	40				*2021*	9
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.9		41.5	41.2	*2021*	8
1.33	Life Expectancy	*years*	77.7		77	79.2	*2017-2019*	9

1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.7		80.9	80.4	*2021*	8
1.00	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.2		48.6	49.4	*2021*	8
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8

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

0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.9	77.1		74.8	*2018*	4

Lorain County Data Sources

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

24 U.S. Environmental Protection Agency
25 United For ALICE

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 CCRH Avon 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).[22] 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 CCRH Avon Community:

- Asian Services in Action, Inc.
- Care Alliance
- Health Source of Ohio
- Lorain County Health and Dentistry
- 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 CCRH Avon Community:

- Grace Hospital
- Mercy Health (Multiple Locations)

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

- MetroHealth Medical Centers (Multiple Locations)
- St. Vincent Charity Medical Center
- University Hospitals (Multiple Locations)

Other Community Resources

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

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

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

Appendix F: Acknowledgements

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

HCI Authors for this report are listed below:

Sharri Morley, MPH, Public Health Consultant
Era Chaudry, MPH, MBA, Public Health Senior Analyst
Gautami Shikhare, MPH, Community Data Analyst II
Margaret Mysz, MPH, Community Data Analyst II
Dari Goldman, MPH, Public Health Analyst
Olivia Dunn, Community Data Analyst II
Garry Jacinto, Community Data Analyst

Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Avon

Implementation Strategy Report

2022

CEVELAND CLINIC REHABILITATION HOSPITAL, AVON
2022 IMPLEMENTATION STRATEGY REPORT
2022 Community Health Needs Assessment
Implementation Strategy Report for Years 2023 – 2025

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CEVELAND CLINIC REHABILITATION HOSPITAL, AVON
2022 IMPLEMENTATION STRATEGY REPORT

I. INTRODUCTION AND PURPOSE

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

A. Description of Hospital

Avon Rehabilitation is a 60-bed rehabilitation facility offering sophisticated technology and advanced medical care within an intimate and friendly environment. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/rehabilitation-hospital.

The hospital is a joint venture between Cleveland Clinic health system and Select Medical. 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 a number of other facilities and services across Ohio, Florida, and Nevada. Additional information about Cleveland Clinic is available at: https://my.clevelandclinic.org/.

Select Medical is one of the largest providers of post-acute care, operating 100 critical illness recovery hospitals in 28 states, 33 rehabilitation hospitals in 12 states, and 1,695 outpatient rehabilitation clinics in 37 states and the District of Columbia. Additionally, Select Medical's joint venture subsidiary Concentra operates 526 occupational health centers in 41 states. Concentra also provides contract services at employer worksites and Department of Veterans Affairs community-based outpatient clinics. Select Medical provides post-acute care encompassing four areas of expertise: critical illness recovery, inpatient medical rehabilitation, outpatient physical therapy, and occupational medicine, all of which are delivered and supported by more than 46,000 talented healthcare professionals across the U.S. Additional information about Select Medical is available at: https://www.selectmedical.com/.

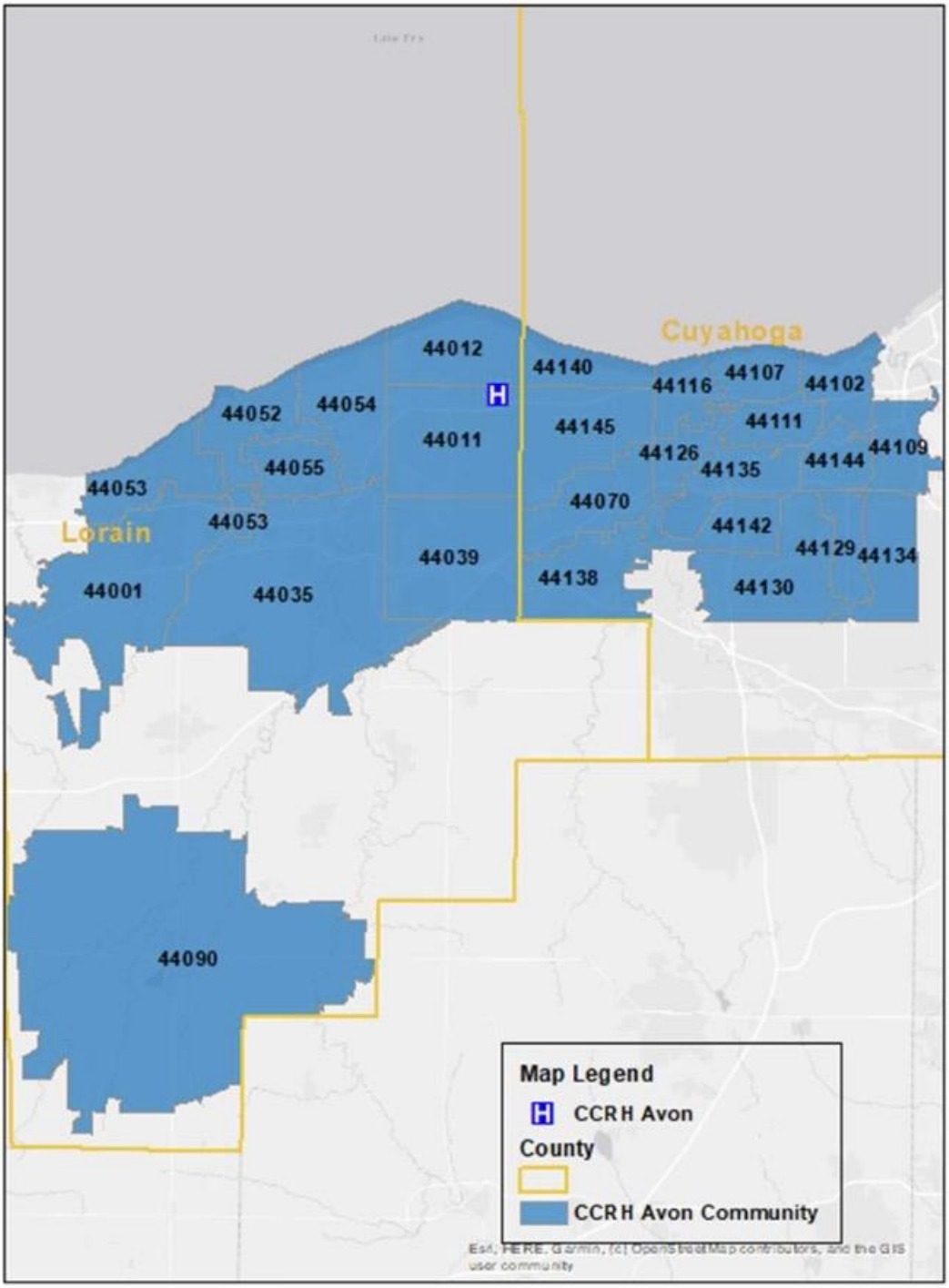
Avon Rehabilitation's mission is:

Cleveland Clinic Rehabilitation Hospital is committed to the provision of comprehensive physical medicine and rehabilitation programs and services to maximize the health, function, and quality of life to those we serve, ultimately returning those persons to their communities.

II. COMMUNITY DEFINITION

For purposes of this report, Avon Rehabilitation's community definition is an aggregate of 26 zip codes in Cuyahoga and Lorain Counties comprising approximately 75% of inpatient visits in 2021 (Figure 1).

Figure 1: Avon Rehabilitation Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of senior leadership at Avon Rehabilitation and Cleveland Clinic, representing several departments of these organizations. Alignment with county Community Health Assessments (CHA) and the State Health Assessment (SHA) was also considered. Leadership at Avon Rehabilitation will utilize this Implementation Strategy to determine whether changes should be made to better address the health needs of its communities.

IV. SUMMARY OF THE COMMUNITY HEALTH NEEDS IDENTIFIED

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

- Access to Healthcare
- Adult Health
- Community Safety

In addition to the prioritized community health needs, themes of healthy equity and social determinants of health are intertwined in all community health components and impact multiple areas of community health strategies and delivery.

COVID-19 Considerations

The COVID-19 global pandemic declared in early 2020 has caused extraordinary challenges for healthcare systems worldwide, including Avon Rehabilitation. 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 Cleveland Clinic CHNAs for more information:
www.clevelandclinic.org/CHNAReports

V. NEEDS HOSPITAL WILL ADDRESS

Each Cleveland Clinic hospital provides numerous services and programs in 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:

- Access to Healthcare
- Adult Health
- Community Safety

It should be noted that no one organization can address all the health needs identified in its community. Avon Rehabilitation is committed to serving the community by adhering to its mission, and using its skills, expertise, and resources to provide a range of community benefit programs to address post-acute rehabilitation services for adults.

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.

Access to Healthcare Initiatives for 2023-2025 include:

1. Avon Rehabilitation provides medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. Avon Rehabilitation has a financial assistance policy that provides free or discounted care based on financial need. Financial assistance may also be provided to patients on a case-by-case basis under certain medical circumstances. The financial assistance policy can be found here: Avon Rehabilitation Financial Assistance.
2. The term "rehabilitation" is widely used to describe many different levels of care, which contributes to confusion among stakeholders. The rehabilitation offered at Avon Rehabilitation is defined by licensure and regulatory requirements. For patients, confusion surrounding rehabilitation can be a barrier to accessing the right level of care at the right time. Avon Rehabilitation will develop and share educational materials with patients, families, and providers to broaden community awareness and improve patients' ability to choose the most appropriate care setting.
3. A key cornerstone of inpatient rehabilitation is the prevention of stroke and brain injury through patient and community education. Clinical staff serving the Brain Injury and Stroke Program teams at Avon Rehabilitation will develop support groups and educational sessions for families and community residents. As part of this education and outreach, the hospital will provide information on post-acute care settings, how to access different levels of care, and community based resources.

B. Adult Health

Adult Health encompasses several subtopics where information is available including Older Adult Health; Other Conditions; and Chronic Disease Prevention and Management including Nutrition and Healthy Eating. By addressing these issues in concert, Avon Rehabilitation hopes to impact concerns for older adult mental health from isolation, chronic conditions, and access to healthy food.

Adult Health Initiatives for 2023-2025 include:

1. Each patient is followed by a physician's service throughout their stay at the rehabilitation hospital. Physicians educate patients on their overall healthcare and on potential risk factors that may affect their recovery. They also educate patients on their past medical history and how their existing conditions may be impacted by their new injury. There are consulting physicians including but not limited to internal medicine, cardiologists, pulmonologists, and nephrologists that are available for consultation regarding secondary diagnoses or complications related to the new injury/illness. Additionally, through Avon Rehabilitation's linkage with Cleveland Clinic, patients have access to comprehensive diagnostic, medical, and surgical services.
2. Physical and functional impairments may be exacerbated by obesity. To encourage weight loss, the clinical team, which includes the attending physician, therapy, and nursing teams, provide education and training to patients to increase mobility and activity. Discussions regarding healthy eating and interpretation of food labels may be initiated as part of the therapy care plan.
3. Continuing education is routinely provided to nursing and pharmacy staff specific to diabetes medication and diabetic management.
4. Depression and emotional changes are common following illness or injury. These occur as primary effects of the illness, as in the case of stroke, or as secondary reactions to new disabilities that may have commonly pre-existed the event.
    a. Psychologists are capable of evaluation and psychotherapeutic treatment of a variety of disorders. They may recommend starting pharmacological intervention with antidepressant medications, mood stabilizers, and anxiolytics. It is important to use medications that can improve recovery and to avoid and/or discontinue those medications that have been shown or hypothesized to impede recovery.
    b. Therapists, case managers, and nursing staff also provide emotional support, encouragement, and hope. It is also essential to use non-pharmacological techniques to help with these psychological disorders.
    c. Recreational therapy is essential to help add some "downtime" to the rigors of the therapy schedule as well as to provide information on community resources, spiritual care, and participation in leisure activities.
5. The population in Avon Rehabilitation's community is expected to age. Providing an effective continuum of care, including rehabilitation services, for those over 65 years of age in the future will be challenging. Avon Rehabilitation will leverage relationships with providers across the continuum of post-acute care in order to cross-refer, provide patient education, and support self-advocacy. Recognizing the health literacy needs of the community and the wide array of post-acute care options available, Avon Rehabilitation has developed a large network of clinical liaisons throughout the community to assist elderly consumers in understanding their post-acute care options. The hospital offers facility tours and coordinates with our acute care case management partners.
6. As part of Avon Rehabilitation's inpatient care for individuals recovering from stroke, brain injury, spinal cord injury, limb loss, and other conditions, the Care Partner program is utilized to provide comprehensive caregiver/family training prior to the patient's discharge focusing on level of assistance and supervision needed to support a safe home discharge.
7. Avon Rehabilitation hosts an annual Stride On event. This event brings together current and former patients, their families, staff, and members of the community to celebrate stroke survivors and raise stroke prevention awareness.

8. Avon Rehabilitation is a member of the Avon Hospital Community Advisory Council. This group meets quarterly to provide updates and opportunities surrounding healthcare in Lorain County.

C. Community Safety

Community Safety issues, though related to social determinants of health (SDOH), stands apart as a health topic intended to describe community health needs related to the following subtopics: Prevention & Safety and Alcohol & Drug Use.

Community Safety Initiatives for 2023-2025 include:

1. Falls represent a particular concern for our elderly populations. Avon Rehabilitation has developed evidence-based fall prevention education for internal and external stakeholders including information on environmental modifications, balance exercises, and home safety assessments. In addition to focusing on fall prevention, the hospital also provides educational materials detailing how to reduce the likelihood of injury should a fall occur.
2. Tobacco use is a risk factor for several medical conditions commonly treated in the inpatient rehabilitation setting. Smoking can also increase the risk of disease recurrence and presents a significant barrier to healthy living. Smoking cessation aligns well with Avon Rehabilitation's goals for our patients. Since Avon Rehabilitation is a smoke free campus, inpatients have a head start on smoking cessation following discharge. A smoking cessation program is more than just nicotine replacement therapy (NRT). Though NRT addresses the physiological need for nicotine, the psychological need to smoke must also be of focus. Patients are more likely to succeed in quitting when they receive both pharmacologic therapy and counseling. A formalized smoking cessation program will be available including resources and education that can be provided to patients during an inpatient rehabilitation stay. Patients will also be connected with organizations in the community for ongoing follow up and support. Low-cost or free smoking cessation resources will also be investigated.
3. Avon Rehabilitation is committed to preventing deaths from opioid overdose by improving opioid prescribing practices, reducing exposure to opioids, and preventing misuse. The hospital has formalized an internal opioid management process for reviewing healthcare prescribing, data collection, and the use of non-pharmacological treatment for pain.
4. Healthcare providers screen all patients for pain on admission and develop a pain management plan based on the patient's input, history, and desired goals.
5. Appropriate referrals to community programs, such as Alcoholics Anonymous, Narcotics Anonymous, or mental health resources are provided by case management and psychology staff.

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

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

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