Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Edwin Shaw

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, Edwin Shaw (CCRH Edwin Shaw or "the hospital") to identify significant community health needs and to inform development of an Implementation Strategy to address current needs.

Edwin Shaw is a 60-bed rehabilitation hospital, 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 health care 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 health care 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.

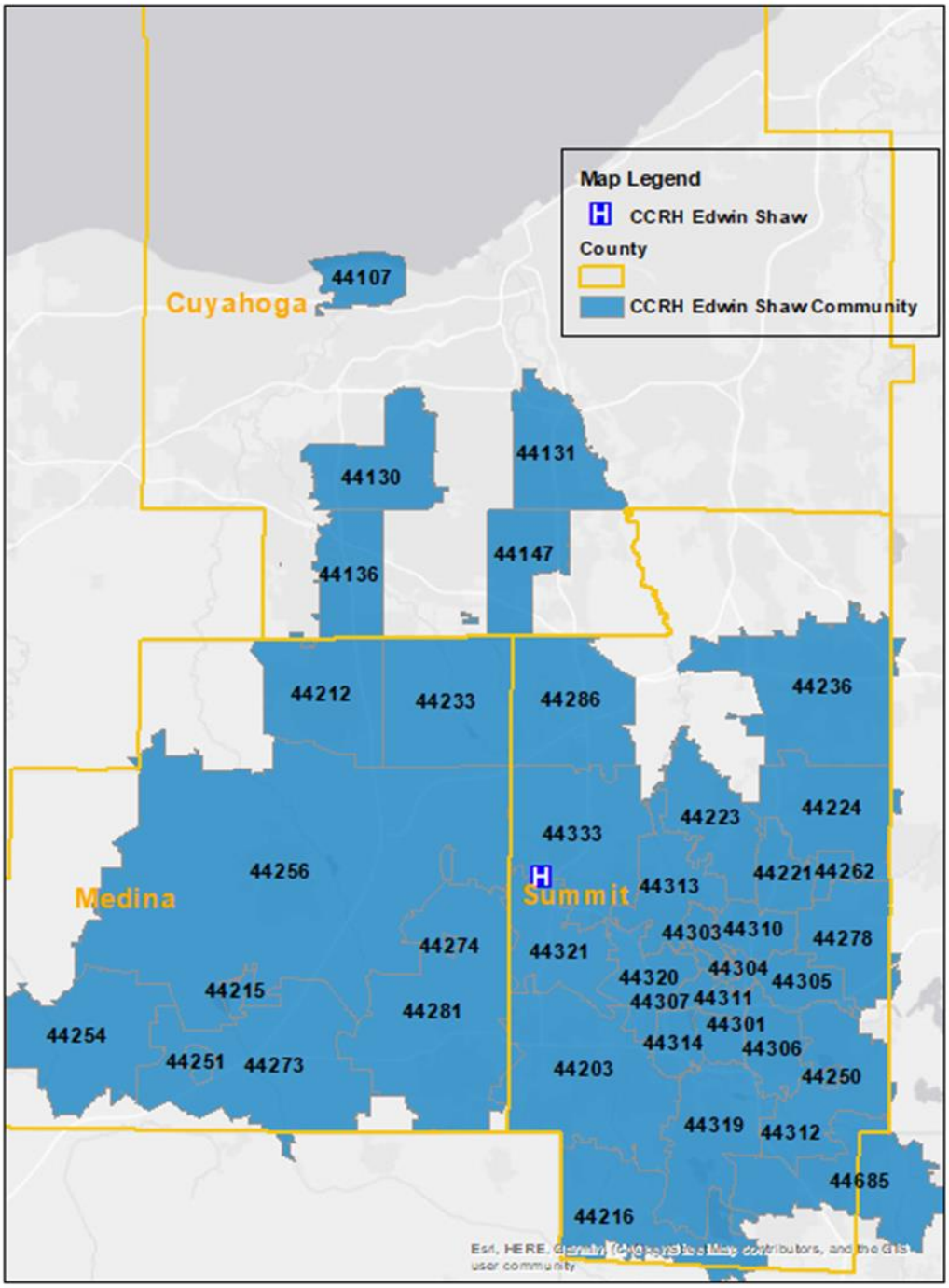
These assessments are conducted using widely accepted methodologies to identify the significant health needs of a specific community. The assessments also are conducted to comply with federal and state laws and regulations including IRS requirements for 501(c)(3) Hospitals under the Affordable Care Act.[1]

Community Definition

The community definition describes the zip codes where approximately 75% of CCRH Edwin Shaw patients reside. Figure 1 shows the service area for the CCRH Edwin Shaw 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 Edwin Shaw 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 Edwin Shaw Community Definition—an aggregate of the 42 zip codes described in the Community Definition.
- Cuyahoga, Medina and Summit Counties—the three counties comprising the CCRH Edwin Shaw 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 33).

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 Edwin Shaw Community in both the Disparities and Health Equity section (page 24) of the report as well as in the Synthesis and Prioritization section (page 33). Special consideration will be given to addressing prioritized health needs through a health equity lens in the CCRH Edwin Shaw 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 Edwin Shaw 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 Edwin Shaw Community Definition.

Geography and Data Sources

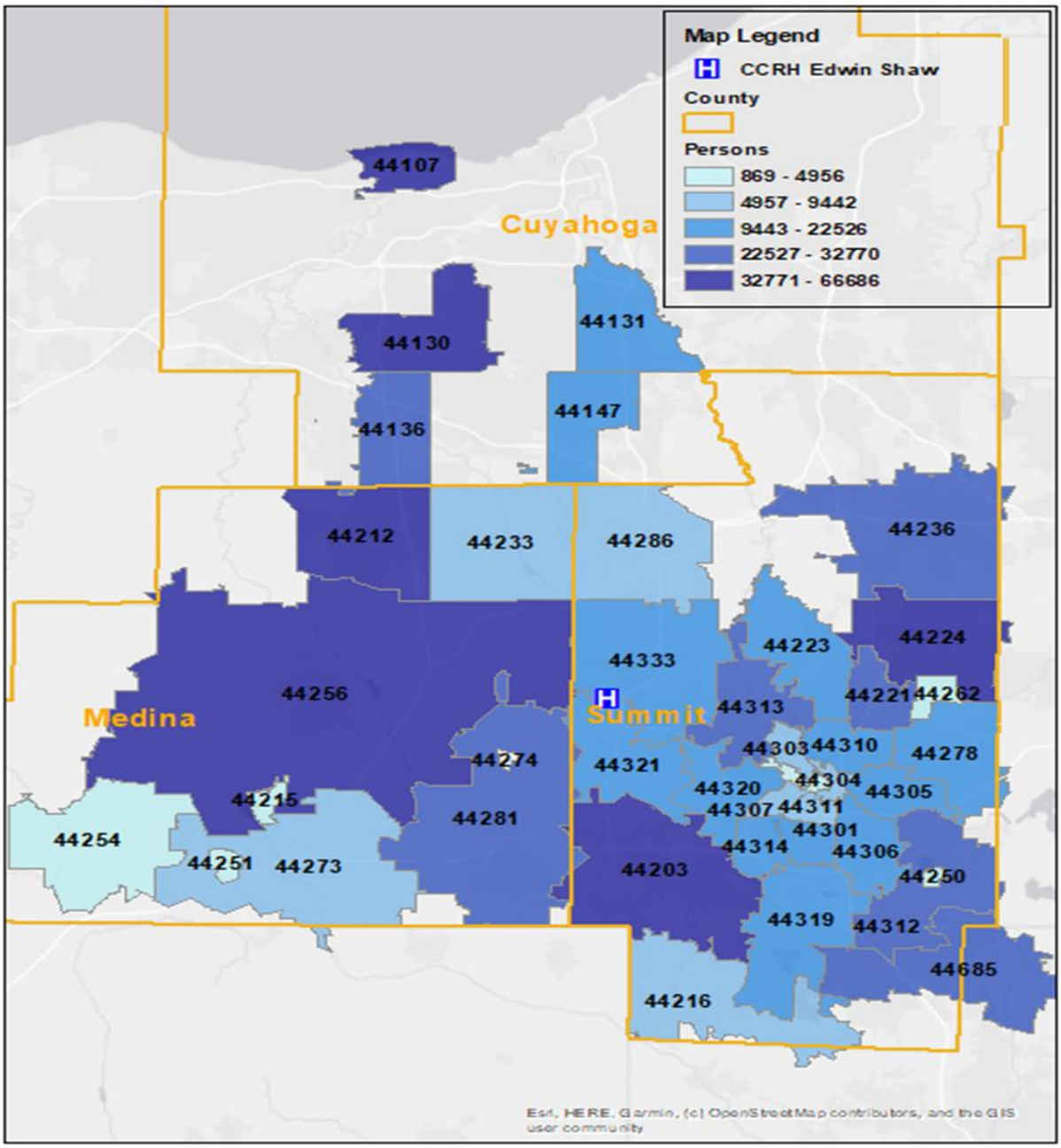
Data are presented in this section at the geographic level of the Community Definition. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey[4] one-year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

Population

According to the 2022 Claritas Pop-Facts® population estimates, the CCRH Edwin Shaw community has an estimated population of 821,254 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 Edwin Shaw Community is zip code 44256 (Medina) with a population of 66,686.

[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

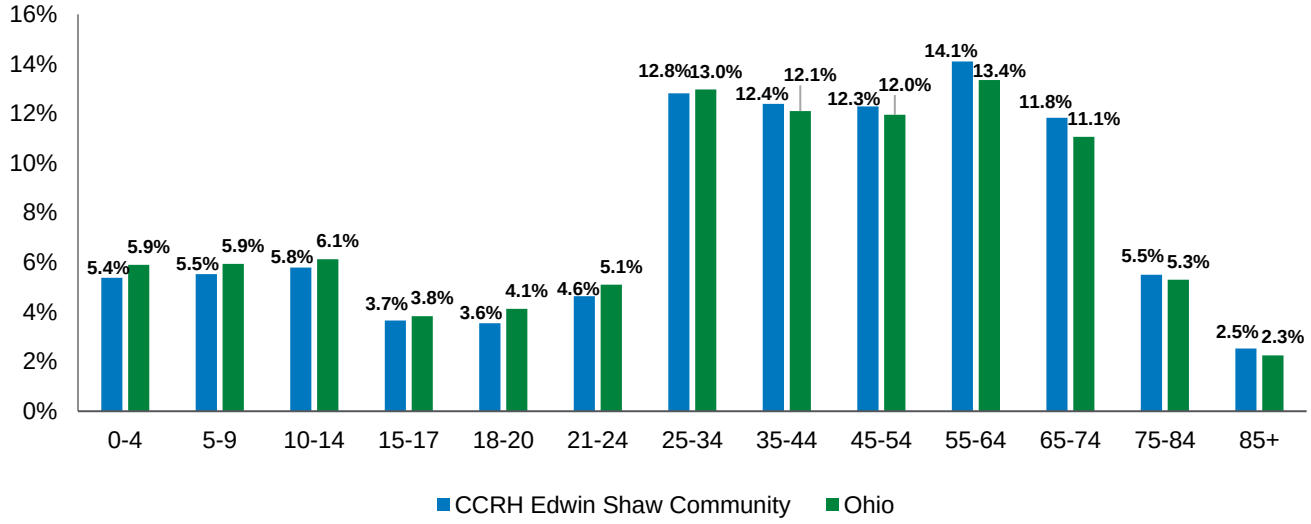


County values- Claritas Pop-Facts® (2022 population estimates)

Age

Children (Ages 0-17) comprised 20.4% of the population in the CCRH Edwin Shaw Community which is less when compared to the state of Ohio (21.8%). The CCRH Edwin Shaw Community has a higher proportion of residents aged 65+ (19.9%) 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

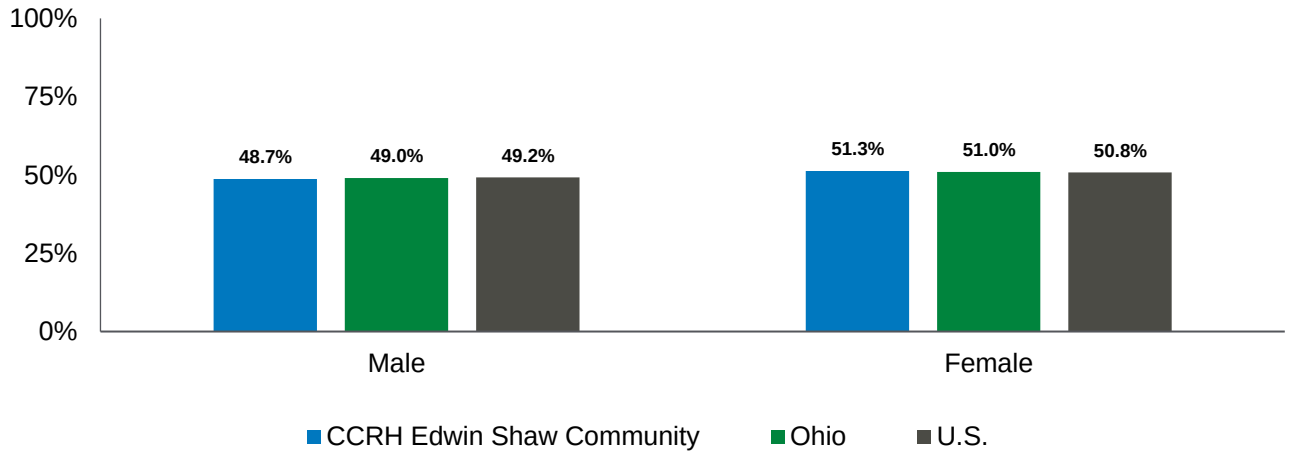


County and state values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 4 shows the population of the CCRH Edwin Shaw Community by sex. Males comprise 48.7% of the population in the CCRH Edwin Shaw Community, which is less than both the Ohio (49.0%) and U.S. (49.2%) values. Whereas females comprise 51.3% of the population in the CCRH Edwin Shaw Community which is slightly greater than Ohio (51.0%) and the U.S. (50.8%) values.

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



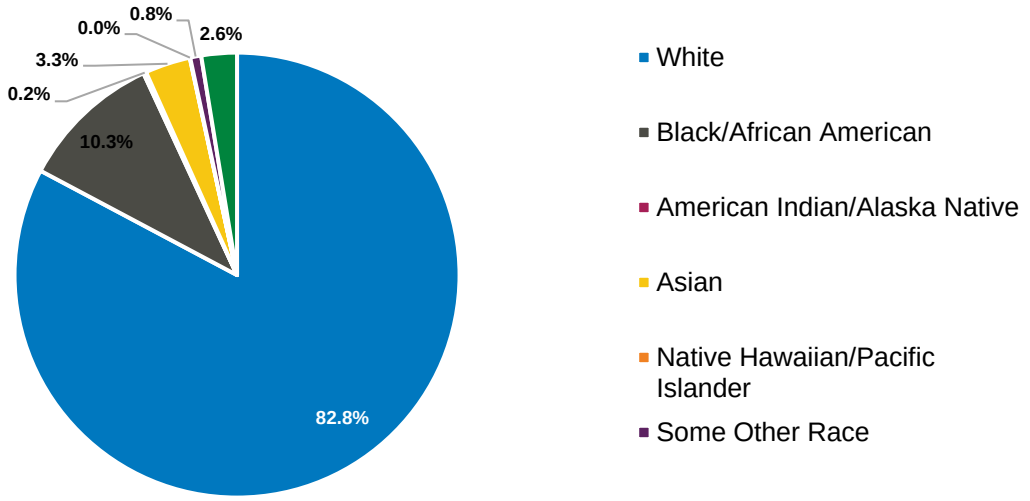
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2016-2020) estimates

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 Edwin Shaw area shows 82.8% 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 Edwin Shaw Community at 10.3%.

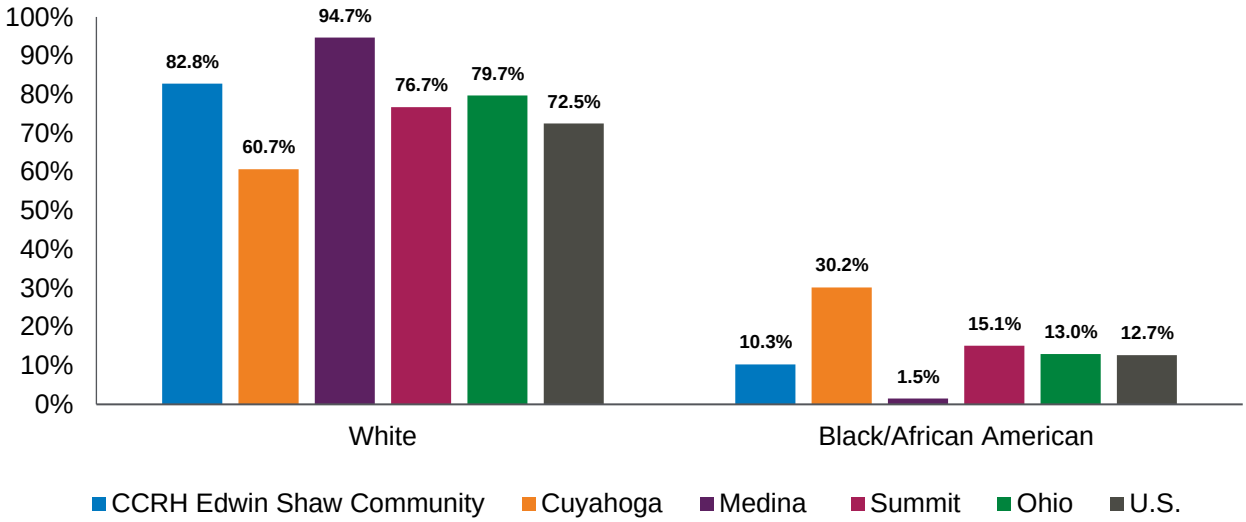
Figure 5: Population by Race: The CCRH Edwin Shaw Community



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

Community members who identify as White represent a higher proportion of the population in the CCRH Edwin Shaw Community (82.8%) 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 Edwin Shaw Community (10.3%) 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 Edwin Shaw Community Definition. (Figure 6)

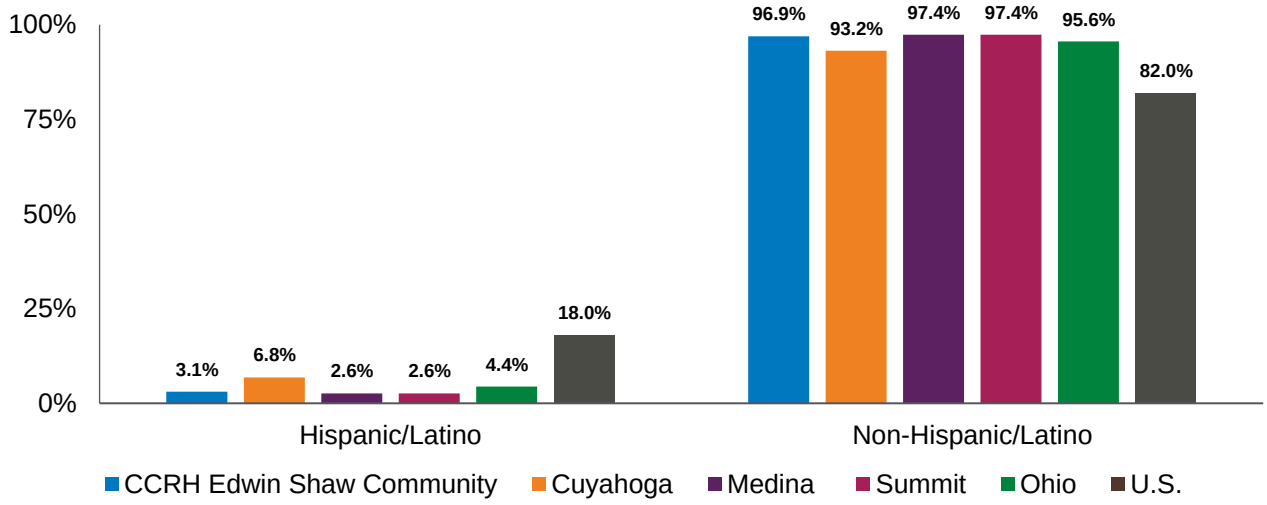
Figure 6: Population by Race: County, State, and U.S. Comparisons



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, 3.1% of the population in the CCRH Edwin Shaw Community identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Ohio (4.4%) and the U.S. (18.0%). Cuyahoga County has the largest percentage of community members who identify as Hispanic/Latino (6.8%).

Figure 7: Population by Ethnicity: The CCRH Edwin Shaw Community, County, State, and U.S. Comparisons

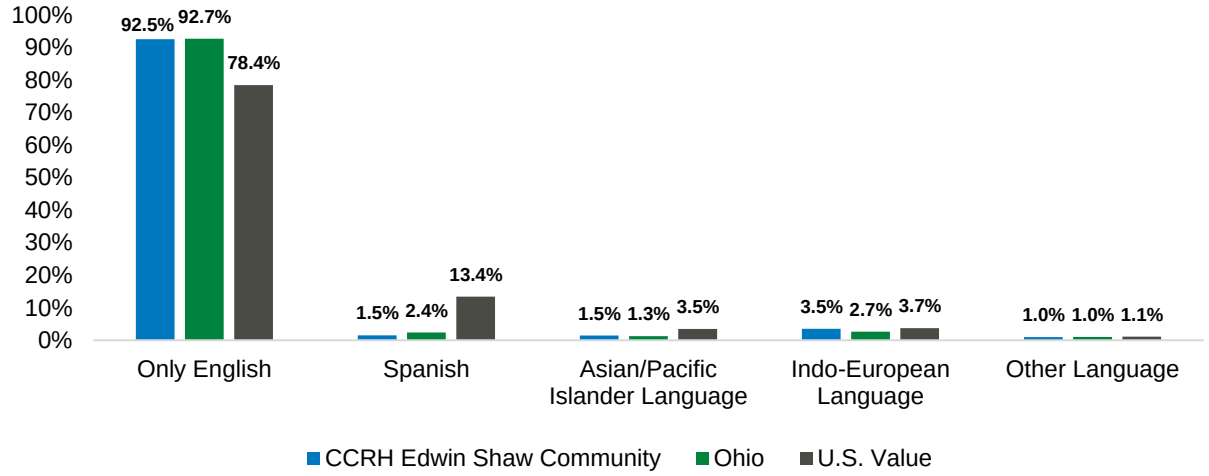


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

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 Edwin Shaw Community, 92.5% of the population age five and older speak only English at home, which is slightly lower than the state value of 92.7% but higher than the national value of 78.4% (Figure 8). This data indicates that 1.5% of the population in the CCRH Edwin Shaw Community speak Spanish, 1.5% speak an Asian/Pacific Islander language, 3.5% speak an Indo-European Language, and 1.0% speak Other Languages at home.

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

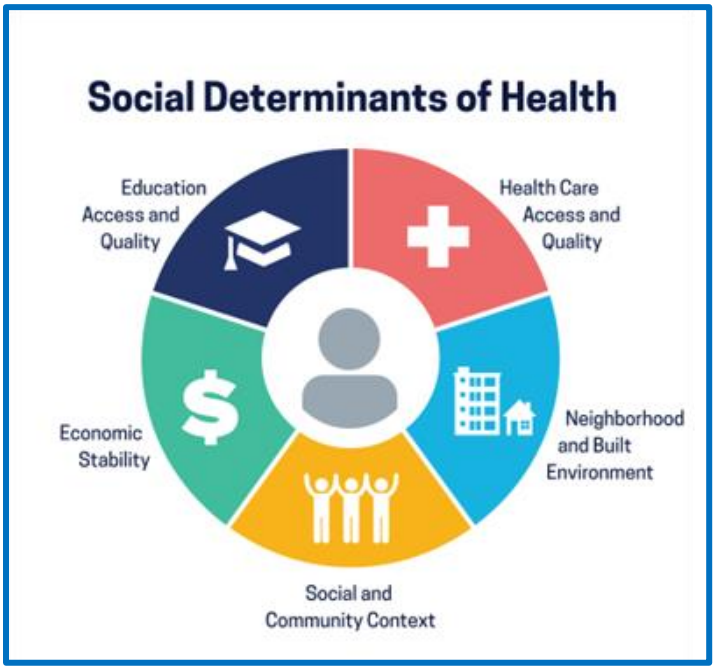


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Highlighted Demographics: Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health (SDOH) impacting the CCRH Edwin Shaw 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.[5] Figure 9 shows the Healthy People 2030 grouping of Social Determinants of Health domains into five key domains.[6]

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.

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

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

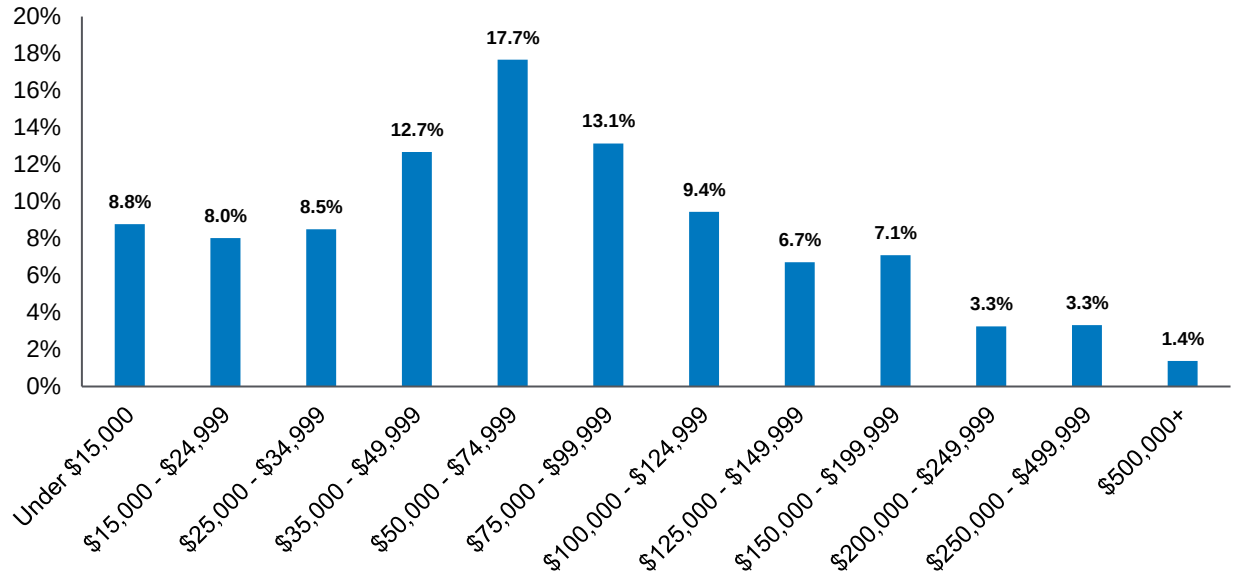
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2016-2020) estimates unless otherwise indicated.

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.[7]

Figure 10 provides a breakdown of households by income in the CCRH Edwin Shaw Community Definition. A household income of $50,000 - $74,999 is shared by the largest proportion of households in the CCRH Edwin Shaw Community (17.7%). Households with an income of less than $15,000 make up 8.8% of households in the CCRH Edwin Shaw Community.

Figure 10: Households by Income: CCRH Edwin Shaw Community

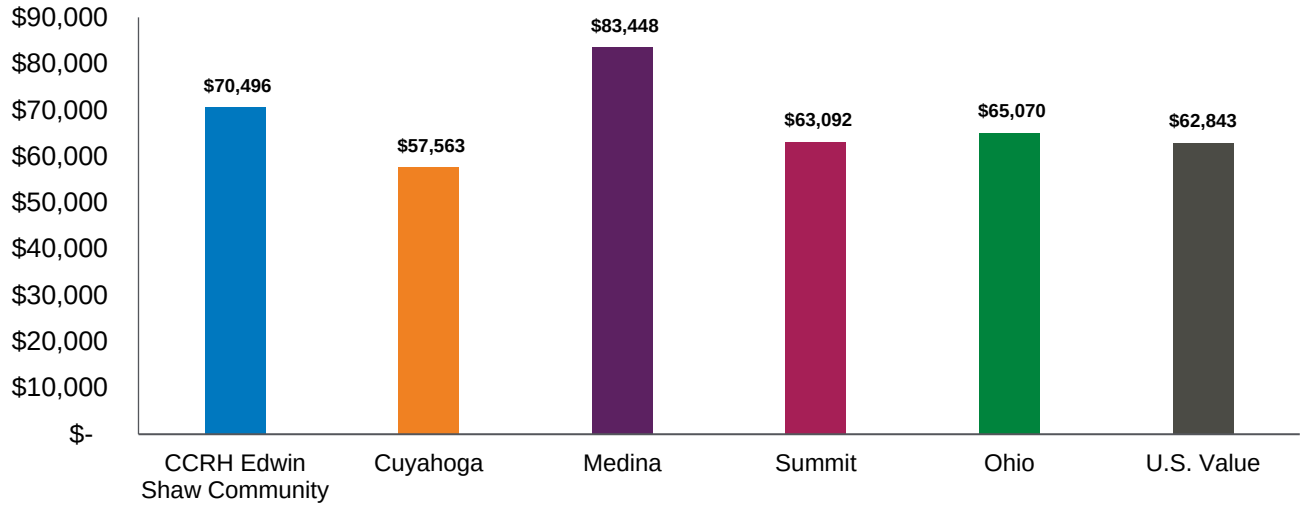


County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for the CCRH Edwin Shaw Community is $70,496, which is higher than the state value of $65,070 and national value of $62,843 (Figure 11).

[7] 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

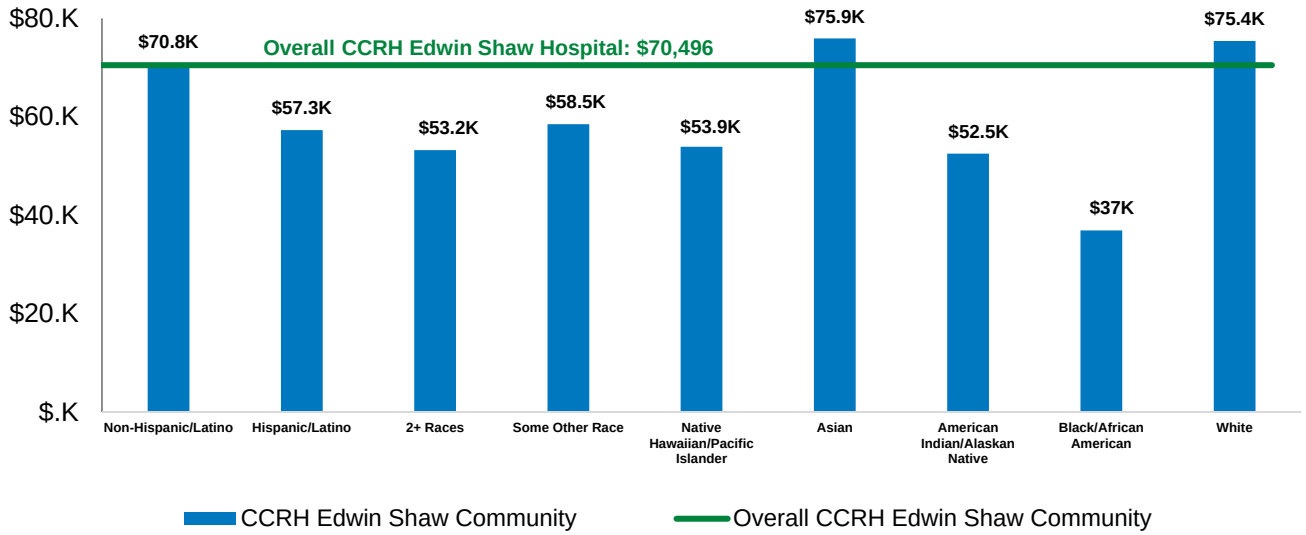
Figure 11: Household Income by: Community, County, State, and U.S. Comparisons



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 $36,911.

Figure 12: Median Household Income by Race/Ethnicity, CCRH Edwin Shaw Community



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

Poverty

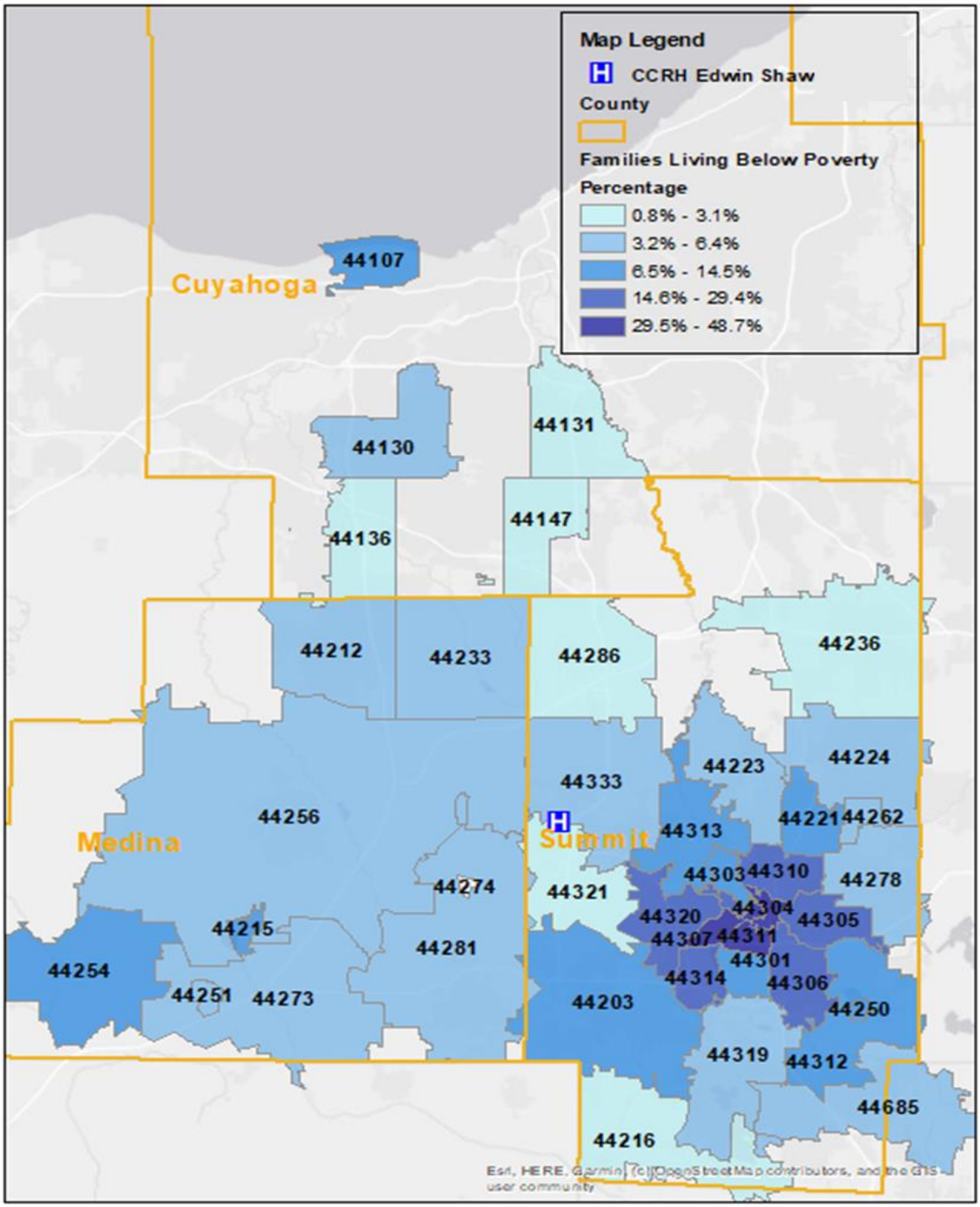
Federal poverty thresholds are set every year by the U.S. Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity.

These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[8]

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 44308 (Akron) and 44307 (Akron) having the highest percentages at 48.7% and 42.5%, respectively. Overall, 8.0% of families in the CCRH Edwin Shaw Community live below the poverty level, which is lower than both the state value of 9.6% and the national value of 9.5%. The percentage of families living below poverty for each zip code in the CCRH Edwin Shaw Community is provided in Appendix C.

[8] 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

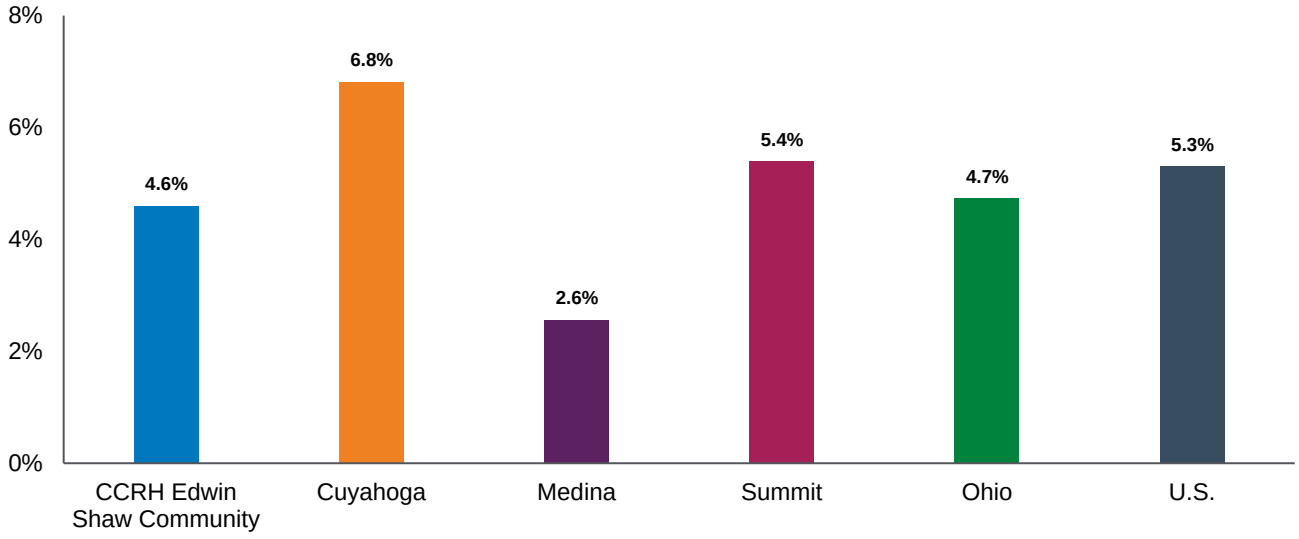
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[9]

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.[9]

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.[9]

Figure 14 shows the population aged 16 and over who are unemployed. The unemployment rate for the CCRH Edwin Shaw Community is 4.7%, which is same as the state value of 4.7% and lower than the national value of 5.3%.

Figure 14: Population 16+ Unemployed: CCRH Edwin Shaw 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

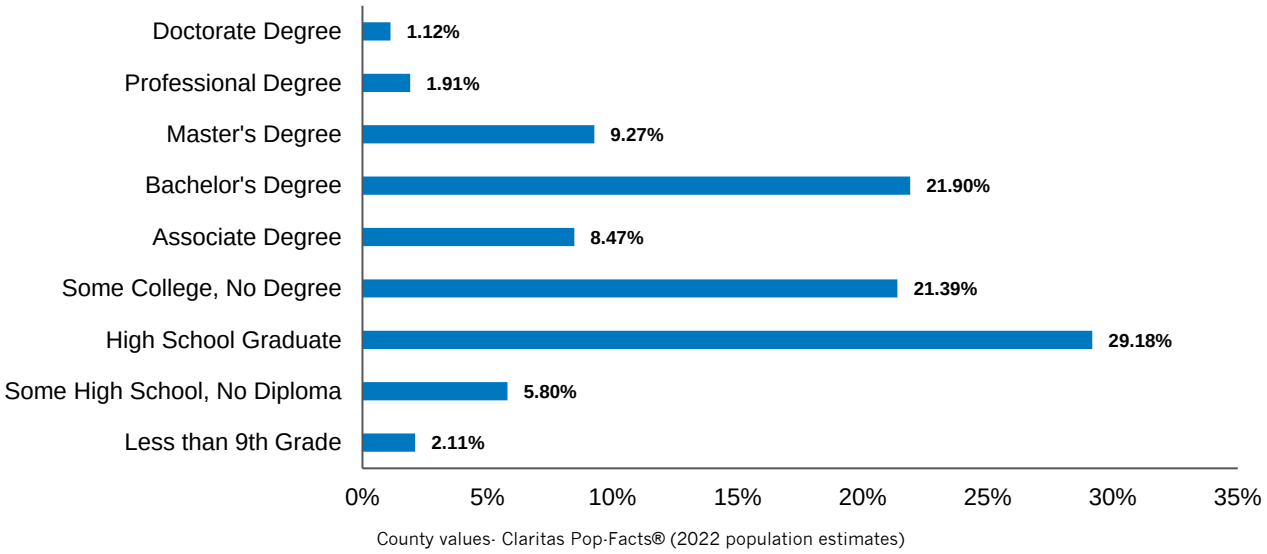
Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[10]

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

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

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

Figure 15: Population 25+ by Education Attainment: CCRH Edwin Shaw Community



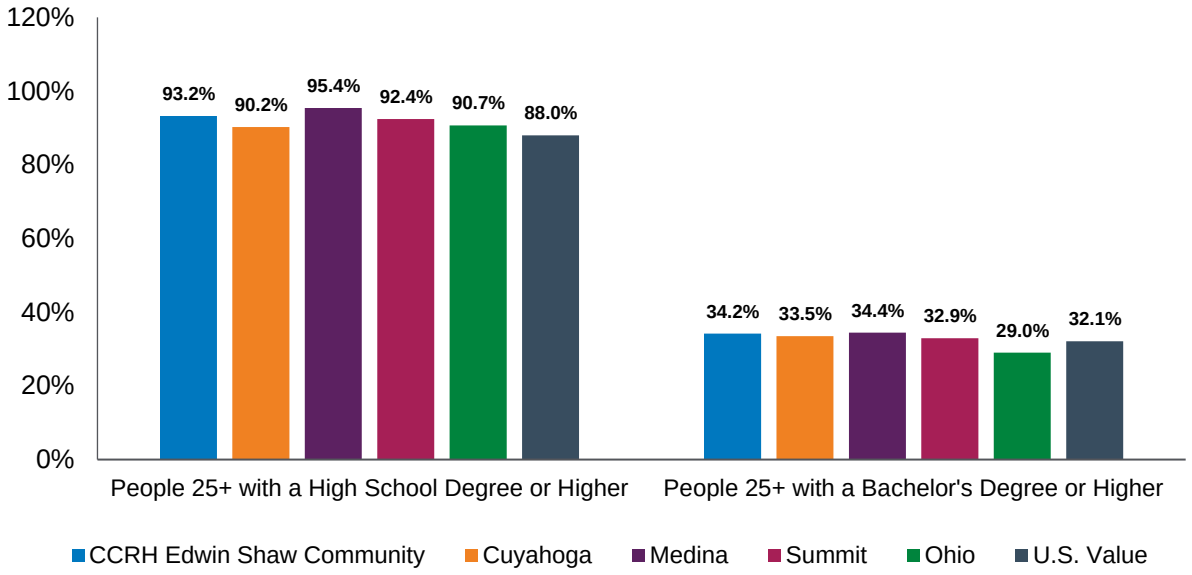
County values- Claritas Pop-Facts® (2022 population estimates)

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.[11]

Figure 16 shows that the CCRH Edwin Shaw Community has a higher percentage of residents with a high school degree or higher (91.2%) and bachelor's degree or higher (34.2%) when compared to the state of Ohio value (90.7% and 29.0%) and the U.S. value (88.0% and 32.1%) respectively.

[11] 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

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



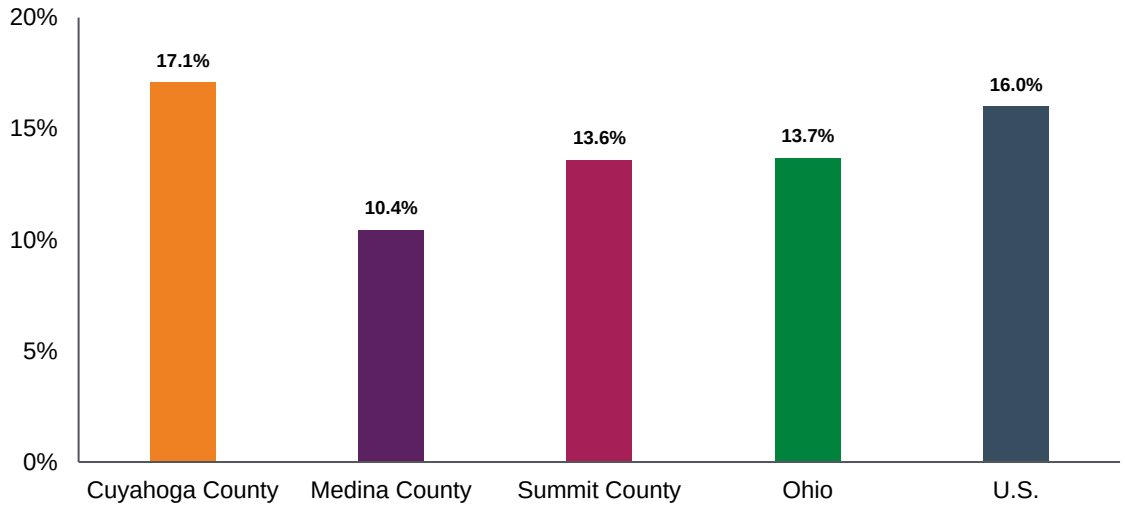
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

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.[12]

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



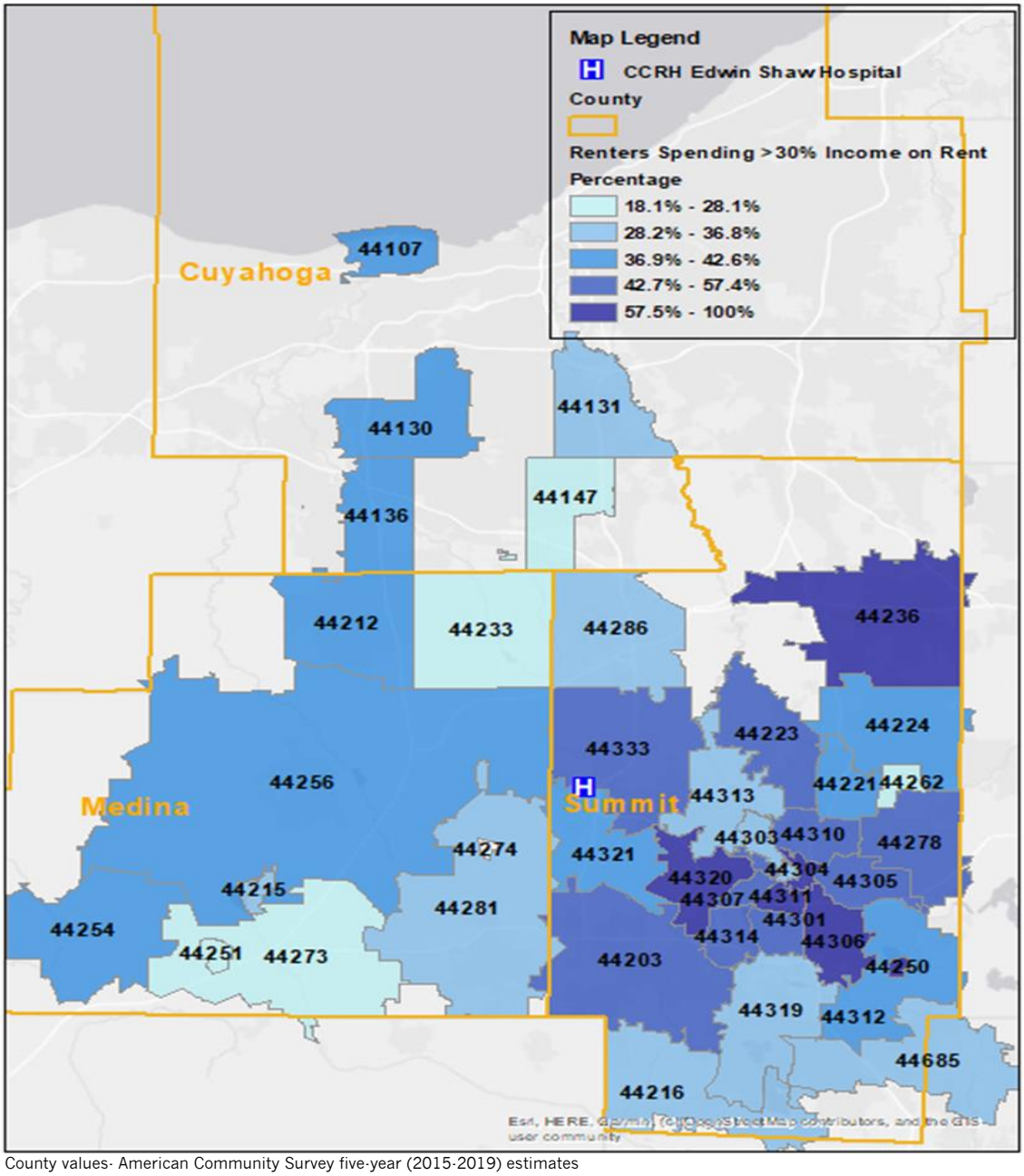
County, state values, and U.S. values taken from County Health Rankings (2013-2017)

[12] 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

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.[13]

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

Figure 18: Renters Spending 30% Or More Of Household Income on Rent



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

[13] 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

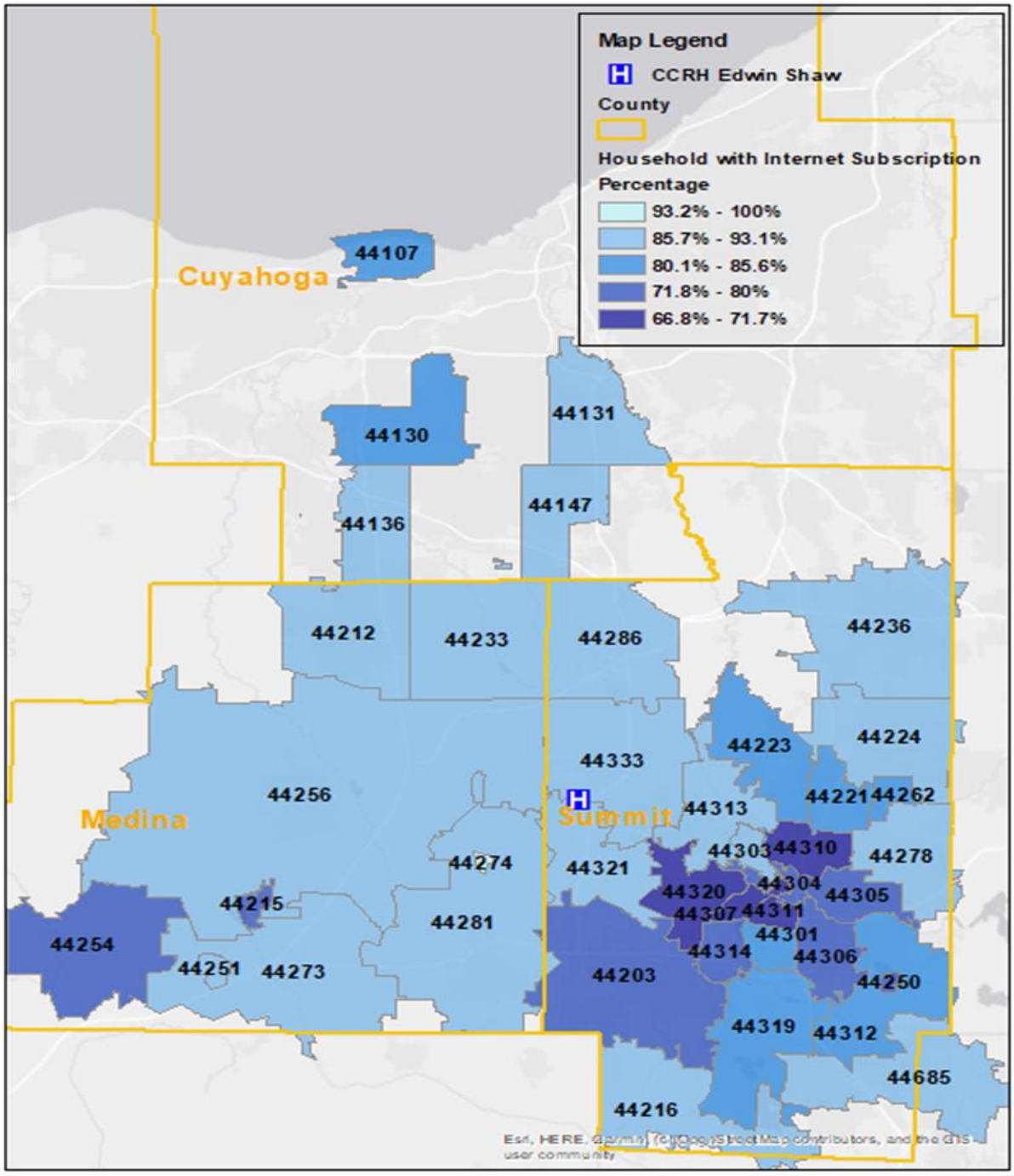
Neighborhood and Built Environment

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.[14] Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[14]

Figure 19 shows the percentage of households that have an internet subscription. Zip code 44109 (Cleveland) has the lowest percentage of households with internet connection, represented by darkest shade of blue on the map.

[14] 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.[15] 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.[16]

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 are 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[17] 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 Edwin Shaw Community, based on the Index of Disparity.

[15] 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

[16] 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/

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

Table 1: Indictors with Significant Race or Ethnic Disparities

Health Indicator	Group(s) Negatively Impacted
Age-Adjusted Death Rate due to Diabetes	Black/African American
Age-Adjusted Death Rate due to Kidney Disease	Black/African American
Age-Adjusted Death Rate due to Prostate Cancer	Black/African American
Babies with Very Low Birth Weight	Black/African American, Asian/Pacific Islander
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, Asian
HIV/AIDS Prevalence Rate	Black/African American, Hispanic/Latino
People 65+ Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino
People Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, Two or More Races, Asian
Persons without Health Insurance	Asian/Pacific Islander, Two or More Races, Hispanic/Latino
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

The Index of Disparity analysis for Cuyahoga, Medina, and Summit counties reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Two or More Races, and Asian, 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 populations are disproportionately impacted by HIV/AIDS Prevalence Rate. Black/African American and Asian/Pacific Islander populations experience higher rates of Babies with Very Low Birth Weight. Additionally, Black/African American populations experience a heavier burden related to chronic diseases, such as diabetes, prostate cancer, and kidney disease. Hispanic/Latino, Asian/Pacific Islander, and Two or More Race groups also have the highest rates of Persons without Health Insurance, compared to other races/ethnicities in the region.

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

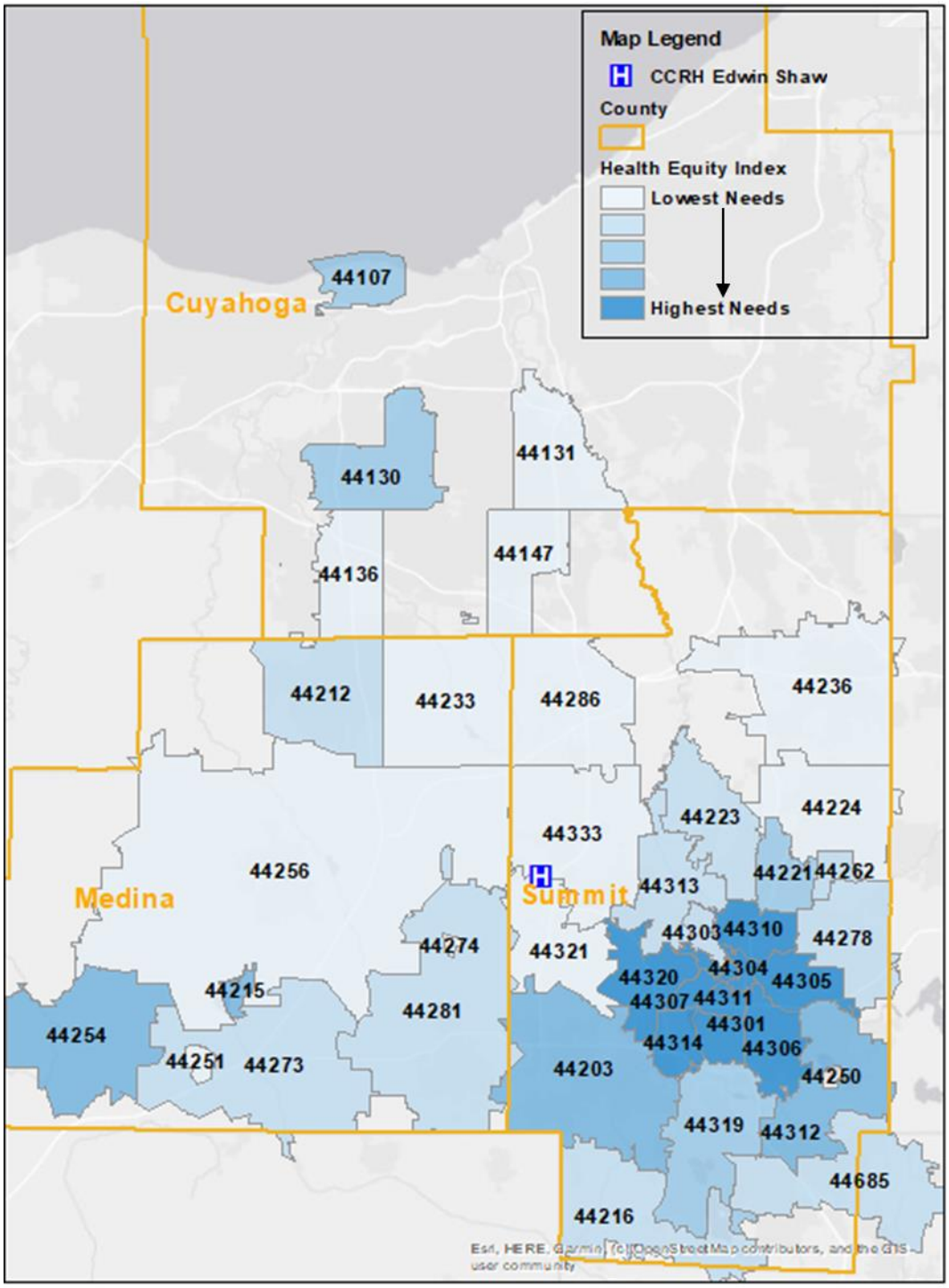
Geographic Disparities

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 SocioNeeds Index® Suite, which includes 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 Edwin Shaw Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44310, 44304, 44320, 44307, 44314, 44311, 44301, 44306, and 44305 in Summit County. Appendix A provides the index values for each zip code.

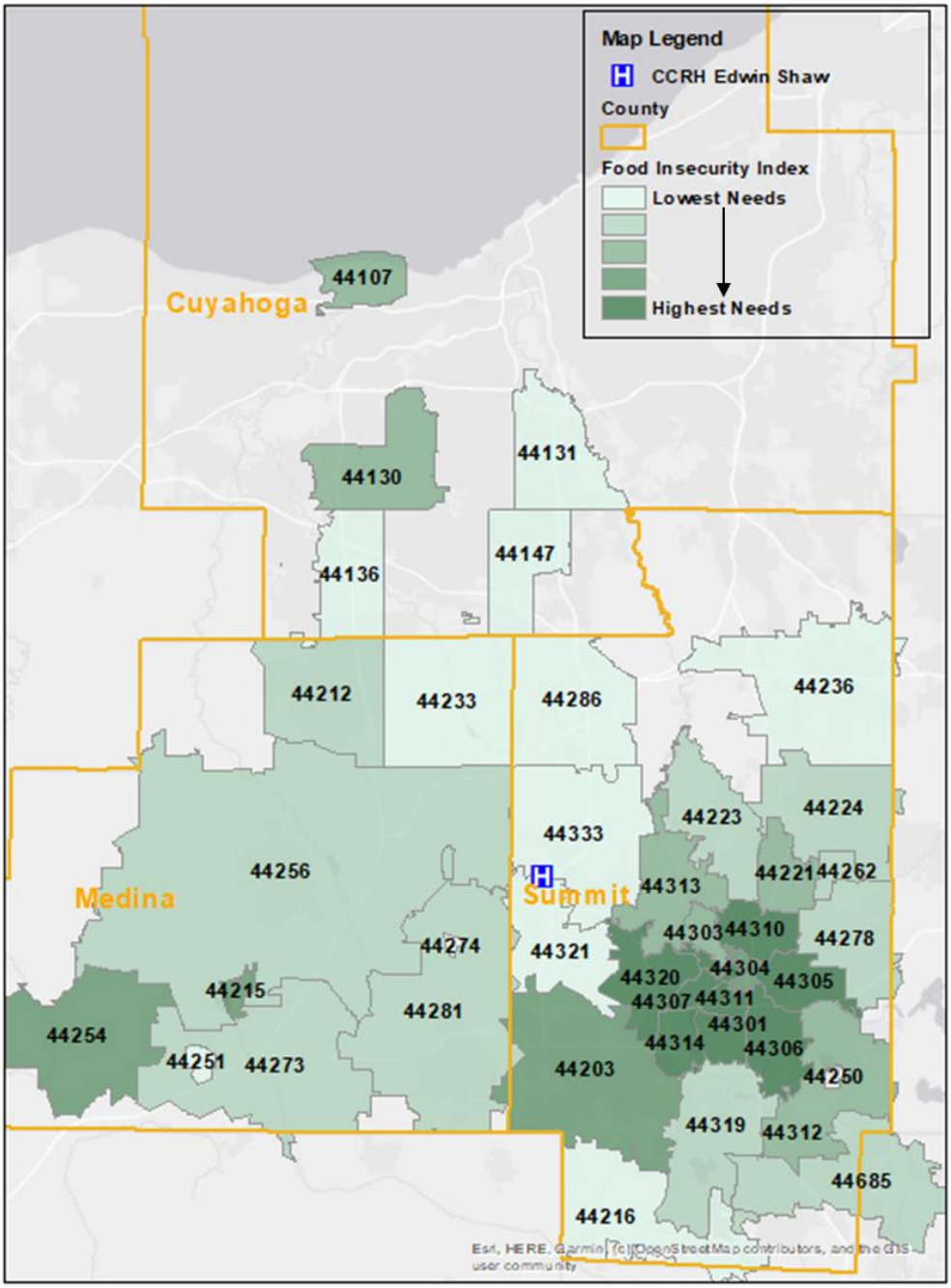
Figure 20: Health Equity Index



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): 44310, 44320, 44307, 44314, 44301, 44306, 44311, and 44305 in Summit County. Appendix A provides the index values for each zip code.

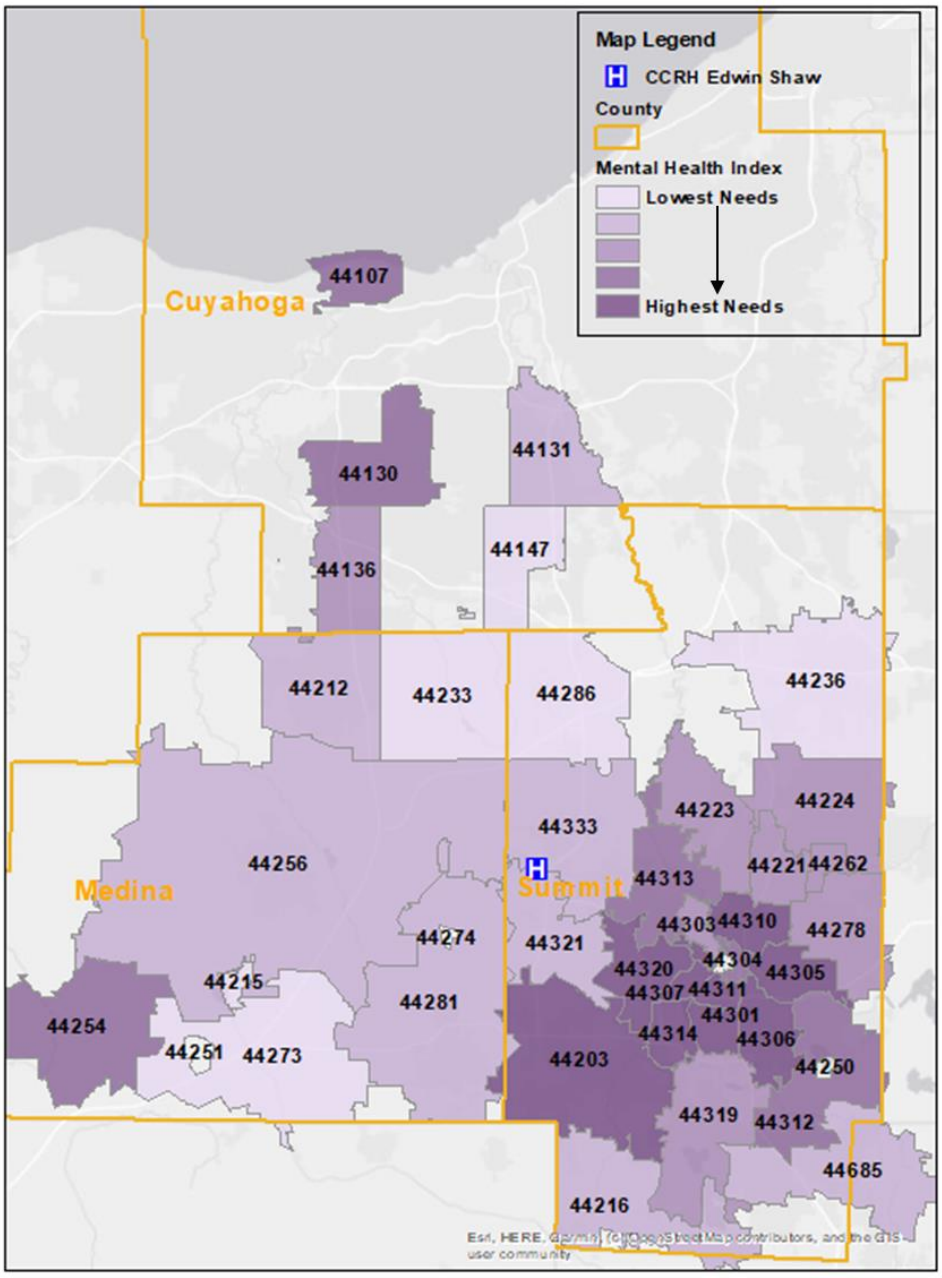
Figure 21: Food Insecurity Index



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): 44203, 44314, 44307, 44320, 44310, 44305, 44311, 44301, and 44306 in Summit County. Appendix A provides the index values for all zip codes within the CCRH Edwin Shaw 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 Edwin Shaw 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

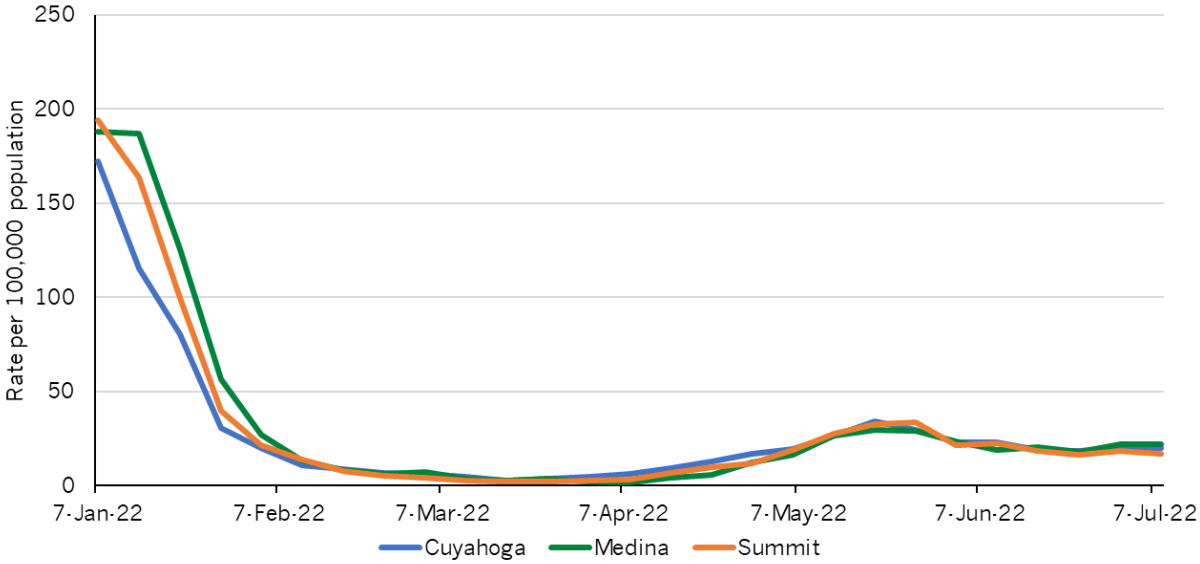
Community Input

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 outputs. Top responses focused on mental health challenges that spanned all age groups. Older adult health suffered both because of isolation borne of the fear of exposure to the COVID-19 virus, followed by sense of well-being, security, or hope, and social support/connection.

The COVID-19 Daily Average Case Incidence Rate by County

Figure 23 shows the daily average COVID-19 case incidence rate for Cuyahoga, Medina, and Summit 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)

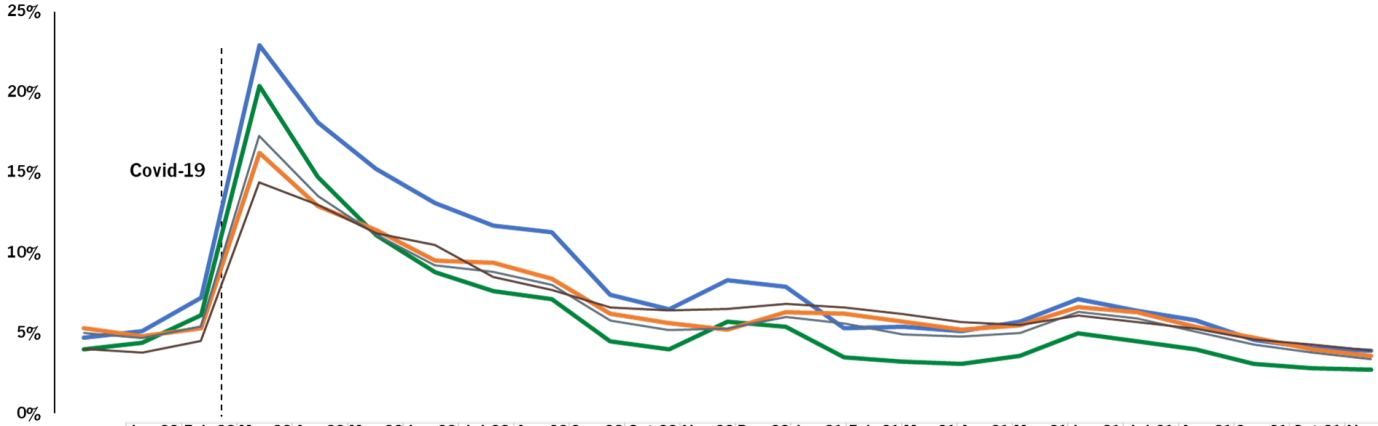
Vaccination Rates

As of June 2022, at least 64% of the population residing in counties within the CCRH Edwin Shaw Community Definition are fully vaccinated against COVID-19. Cuyahoga County has the highest vaccination rates (65.5%), followed by Medina County (64.6%) and Summit (64.0%).

Unemployment Rates

Unemployment rates rose between March and April 2020 for Cuyahoga, Medina, and Summit 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%
Medina	4.0%	4.4%	6.1%	20.4%	14.7%	11.1%	8.8%	7.6%	7.1%	4.5%	4.0%	5.7%	5.4%	3.5%	3.2%	3.1%	3.6%	5.0%	4.5%	4.0%	3.1%	2.8%	2.7%
Summit	5.3%	4.8%	5.3%	16.2%	12.9%	11.4%	9.5%	9.4%	8.4%	6.2%	5.6%	5.2%	6.3%	6.2%	5.7%	5.2%	5.5%	6.6%	6.3%	5.4%	4.7%	4.0%	3.6%
Ohio	5.0%	4.7%	5.4%	17.3%	13.5%	11.1%	9.2%	8.8%	8.0%	5.8%	5.2%	5.3%	6.0%	5.6%	4.9%	4.8%	5.0%	6.3%	5.9%	5.1%	4.3%	3.8%	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)

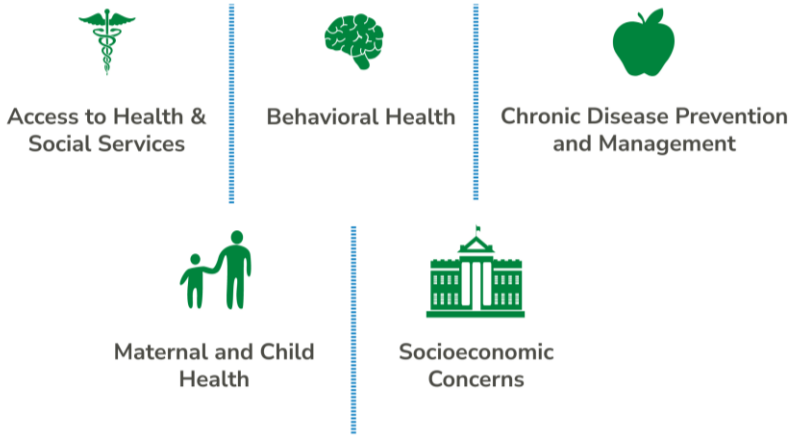
Synthesis and Prioritization

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.

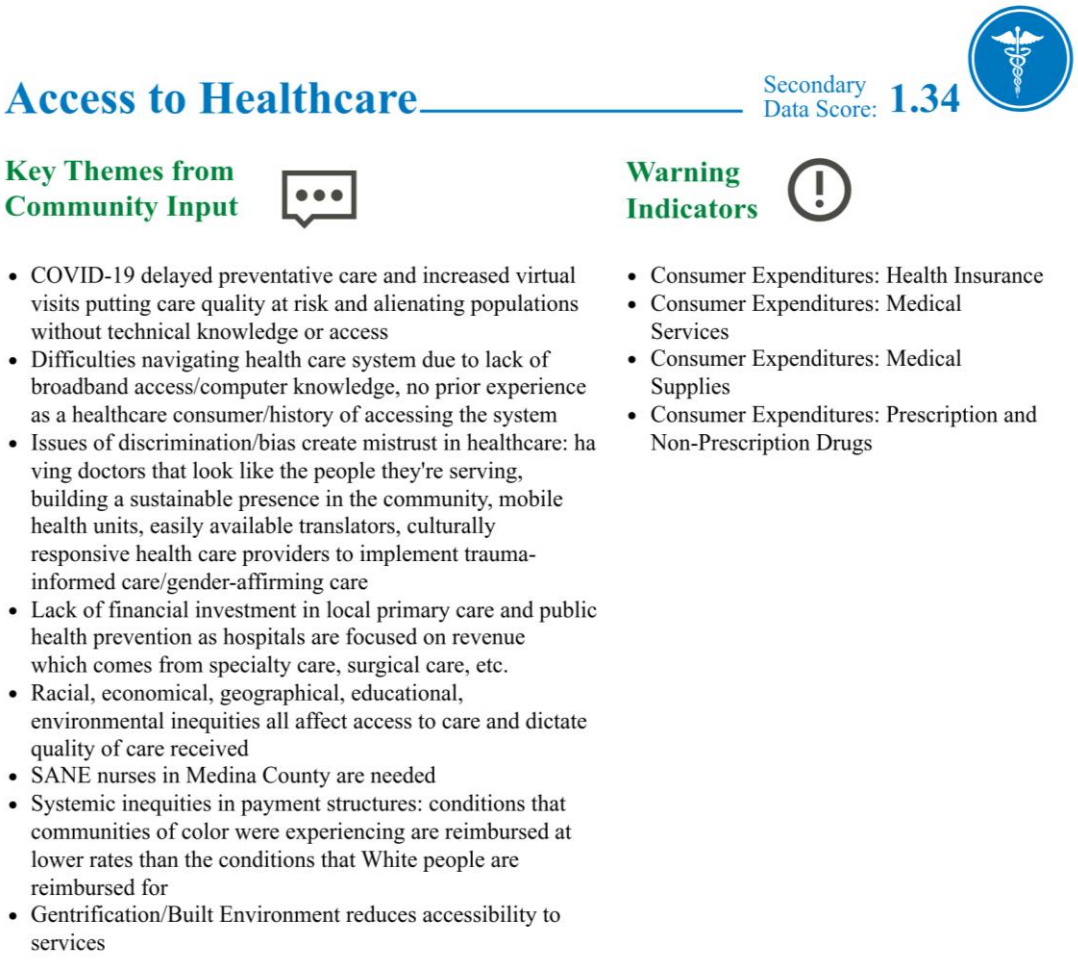
To gain a comprehensive understanding of the significant health needs for the CCRH Edwin Shaw Community, the findings from both data sets were compared and studied simultaneously. The secondary data scores and key stakeholder responses were considered equally important in understanding the health issues of the community. The top health needs identified from each of these data sources were analyzed for areas of overlap. Four 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, Medina and Summit 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



Primary Data: Key Stakeholder Interviews

Access to Health Care was described as a top health need by key stakeholders with access, and access-related topics including transportation and resources, described as among the top barriers to improving health. Key stakeholders noted a lack of investment in prevention practices including accessibility of primary services at a local level. Interviews revealed 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.

> 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

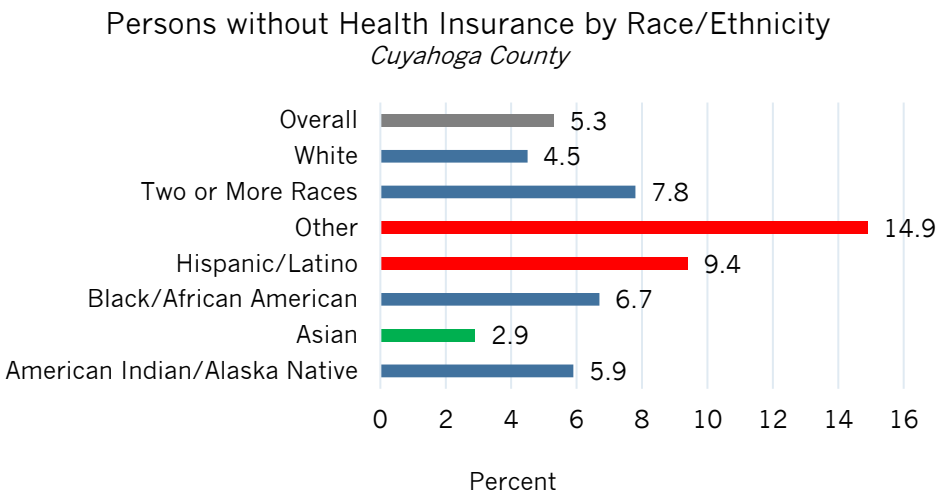
From the secondary data scoring results, Health Care Access & Quality ranked as the 13th highest scoring health need, with a score of 1.34. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

The average dollar amount per consumer unit for health insurance in Medina County is $5, 410.8, which is higher than the average dollar amount spent on health insurance in the state of Ohio, where that amount is $4,371.7 dollars per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. For this indicator, Medina County fell in the worst 25% of all counties in the nation. Additionally, in Cuyahoga County, 89.8% of adults have health insurance, compared to 90.6% in the United States. Medical costs in the United States are high. Therefore, people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat.[18] Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.[19]

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 Edwin Shaw 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).

[18] Kaiser Family Foundation, 2020 and 2015
[19] 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 among all three 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. Medina County residents spent the most on medical services at $1,419.1 per consumer unit.

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.

NUTRITION AND HEALTHY EATING

Nutrition & Healthy Eating

Secondary Data Score: 1.54

Key Themes from Community Input

- Access to healthy food limited by transportation, minimal grocery stores nearby, built environment
- Conditions such as hypertension asthma, diabetes, COPD, coronary heart disease, all related to the quality of food one has access to
- Effects of redlining are still seen—these are the neighborhoods that do not always have grocery stores in a close mile radius
- Heart disease, diabetes, obesity, cancer—all inherently tied to healthy food accessibility, built environment/walkability, safety, access to care

Warning Indicators

- Consumer Expenditures: Fast Food Restaurants
- Consumer Expenditures: High Sugar Beverages
- Consumer Expenditures: High Sugar Foods
- People 65+ with Low Access to a Grocery Store

Primary Data: Key Stakeholder Interviews

Key stakeholders discussed that access to healthy food was often limited by a lack of public or private transportation and disproportionately affected older adults with lower incomes. Participants shared that there were few grocery stores in the community and stores were not within walking distance for most community members. Those interviewed shared concerns that the effects of redlining limited access to grocery stores, which were more likely to offer fresh fruits and vegetables. Furthermore, key informants shared concerns that COVID-19 had impacted the need for food increased levels of food insecurity in the community 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.[20]

[20] 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

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

OLDER ADULT HEALTH & OTHER CONDITIONS

Older Adult Health & Other Conditions

Secondary Data Score: 1.54 (Older Adults) 1.73 (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
- COVID-19 was a disruptor of programs for older adults leading to more social isolation
  - Increased reports of depression, anxiety, suicide attempt, death by suicide
  - Some people with dementia progressed to Alzheimer's
- Difficulties navigating health care system due to lack of broadband access/computer knowledge
- Expanded Medicaid access exposed gaps in knowledge or services navigation for older adults
- Lower income older adults disproportionately affected by chronic conditions, access to healthy food, poor housing conditions
- Mass vaccination sites were difficult for non-English speaking older adults to navigate (language barriers) and those not technologically savvy
- Social cohesion & connectedness:
  - Isolation in LGBTQ+ elderly patients because they come from a generation where they may have been rejected by family members, may have lost loved ones
  - Wasn't common for LGBT folks to have families, so they're really alone
  - Isolation is an independent risk factor for adverse outcomes

Warning Indicators

- Adults with Arthritis
- 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
- Depression: Medicare Population
- Hyperlipidemia: Medicare Population
- Osteoporosis: Medicare Population
- People 65+ Living Alone
- People 65+ with Low Access to a Grocery Store
- Rheumatoid Arthritis or Osteoarthritis: 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.

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

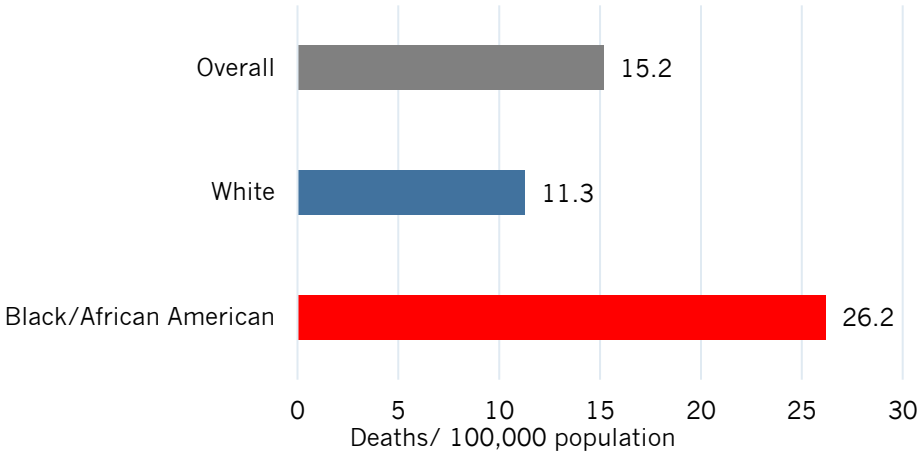
Secondary Data

Nutrition & Healthy Eating had the fifth highest data score of all topic areas with a score of 1.54. The Older Adult Health topic area had the fourth highest score at 1.54 and the related Other Conditions health topic ranked second with a score of 1.73. All topic areas in this group demonstrate need as they each scored above 1.5. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

The Age-Adjusted Death Rate due to Prostate Cancer is the worst performing indicator in Cuyahoga County with an indicator 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. Similarly, the Prostate Cancer Incidence Rate is the worst-performing indicator in Medina County with a data score of 2.64. There are 135.8 cases per 100,000 males in 2014-2018.

Disparities also exist within CCRH Edwin Shaw community and Chronic Diseases. Black/African American residents of Cuyahoga 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.

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

Prioritized Health Topic #3: Community Safety

ALCOHOL & DRUG USE

Alcohol & Drug Use

Secondary Data Score: 1.57

Key Themes from Community Input

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

Warning Indicators

- Adults who Drink Excessively
- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
- Alcohol-Impaired Driving Deaths
- Consumer Expenditures: Alcoholic Beverages
- Death Rate due to Drug Poisoning

Primary Data: Key Stakeholder Interview

Key stakeholders spoke at length about the rising rates of opioid overdoses during the pandemic and an overall increase in alcohol intake due to isolation. Many people experiencing mental health challenges started to self-medicate as a result of the absence of healthy coping skills. Generally, there is a lack of providers and treatment sites to the meet the overwhelming needs of those with substance use disorders. Finally, key stakeholders noted than substance abuse treatment was one of the hardest hit places during COVID-19 because of difficulties transitioning to telehealth as so much of the recovery process is grounded in relationship building.

> "Those collective recovery experiences had to shift from in person to virtual, and some measure of our community in the city of Cleveland had a considerable challenge, just even being connected with Internet. I know with our substance abuse program in the city making that shift, we saw people drop off because all of these things are predicated on relationships, and if you don't have presence, oftentimes you don't have strong relationship."
>
> - Key Stakeholder

Secondary Data

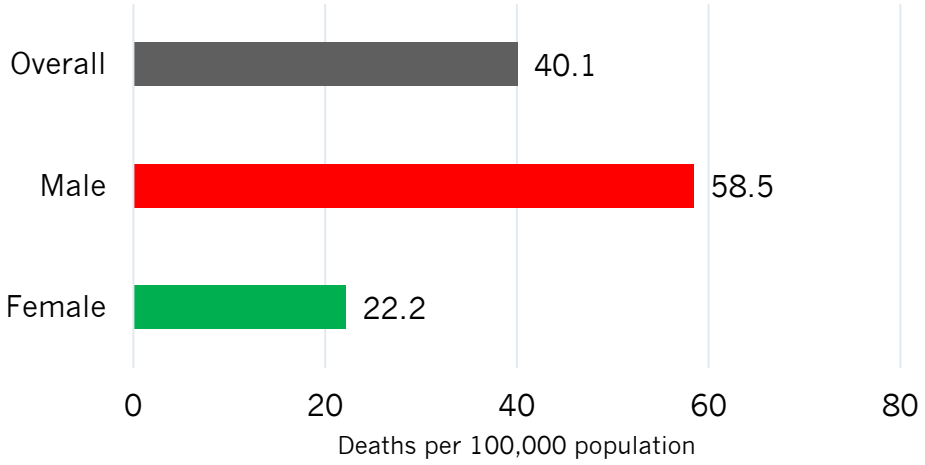
Alcohol & Drug Use ranked third among all health topics with a score of 1.57. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix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

In Cuyahoga County in 2017-2019, there were 42.6 deaths due to drug poisoning per 100,000 people, which is higher than both the state and national values, and in the worst quartile (25%) of counties in the U.S.

Alcohol-Impaired Driving Deaths was the worst performing indicator in Medina County where the county's value of 40.7% of driving deaths involving alcohol placed it in the worst quartile (25%) of both Ohio counties and counties across the nation. Fortunately, the value is decreasing over time.

Gender disparities within drug and opioid-involved overdose death rates have shown to be prominent in Summit County. Males have higher rates of death involving overdoses than their female counterparts, as shown in Figures 28.

Figure 28. Age-Adjusted Drug and Opioid-Involved Overdose Death Rate by Gender in Summit 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, Medina, and Summit 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 Edwin Shaw 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 Edwin Shaw 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

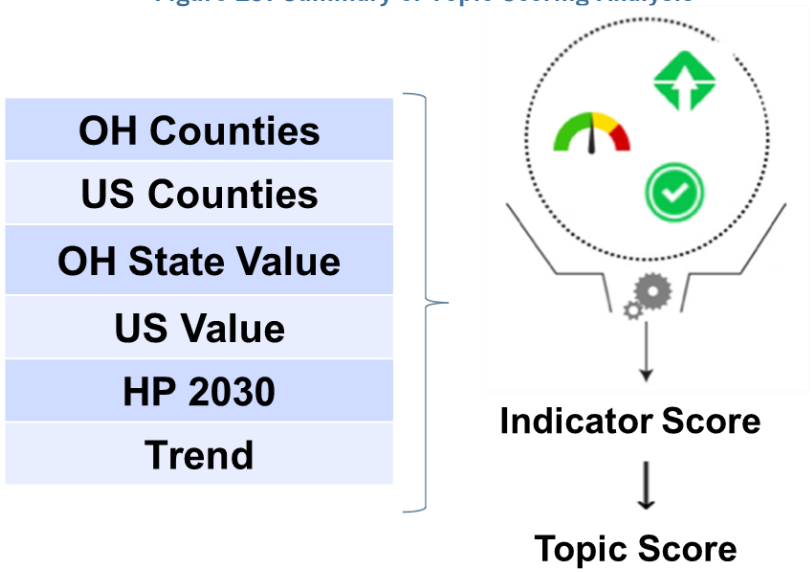
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food Environment Atlas
- U.S. Environmental Protection Agency
- United For ALICE

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

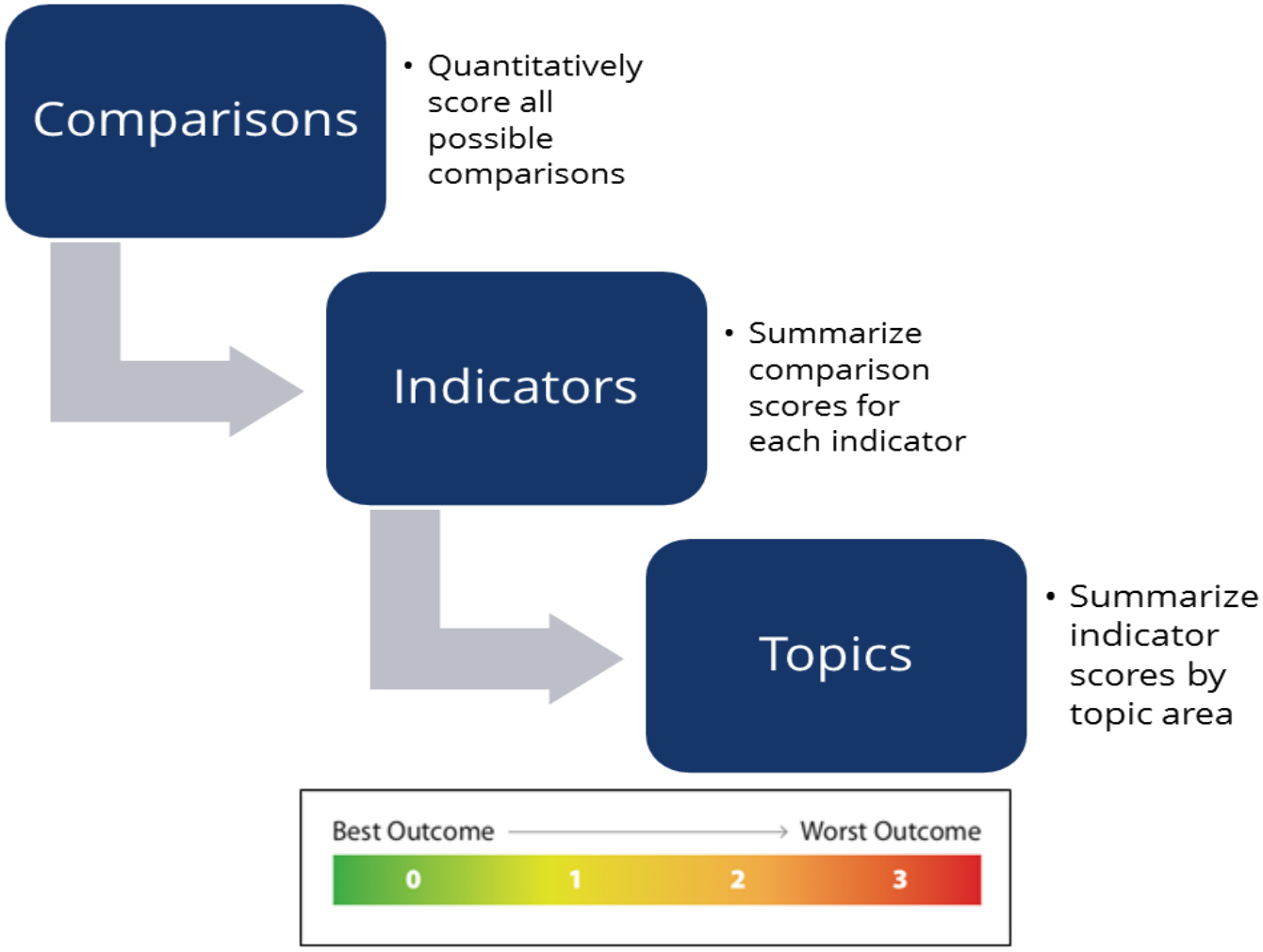
HCI's Data Scoring Tool (Figure 29) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national 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 29: 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 Edwin Shaw Community: Cuyahoga, Medina, and Summit counties. To calculate the overall highest needs topic area scores, an average was taken for each topic area across the three counties. Each county's values were weighted the same. More details about topics scores and the average score for the CCRH Edwin Shaw 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 Edwin Shaw Community, ranked in order of highest need. Medications & Prescriptions scored as the poorest performing topic area with a score of 2.15, followed by Other Conditions with a score of 1.73. Topics that received a score of 1.50 or higher were considered a significant health need. Six topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 2: Top Secondary Data Health Needs

Top Secondary Data Health Needs
Medications & Prescriptions
Other Conditions
Alcohol & Drug Use
Older Adults
Nutrition & Healthy Eating
Cancer

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 (HEI) (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 (FII) 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 (MHI) 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 Edwin Shaw Community and their respective HEI, FII, and MHI values.

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

Zip Code	HEI Value	FII Value	MHI Value
44107	35.3	50.8	77
44130	36.6	45.8	81.6
44131	10.8	4.9	52.3
44136	10.7	12.2	55.7
44147	5.8	10.5	25.8
44203	59	57.3	91.2
44212	16.9	26.6	42.6
44215	48.6	62.5	29
44216	18.6	11.4	42.3
44221	33.6	47.3	62.5
44223	17.9	32.2	66.2
44224	11.7	22.9	57.6
44233	5.8	2.6	29.9
44236	2.4	2.2	34.9
44250	N/A	N/A	N/A
44251	6.7	7.4	N/A
44254	58.2	63.1	76.4
44256	11.7	19.9	43.3
44262	18.4	18	66.8

44273	20	28.6	27.4
44274	N/A	N/A	N/A
44278	24.6	23	69
44281	14.6	24.3	40
44286	2.5	3.8	14.9
44301	83.1	84.7	97.1
44302	84	93	97.4
44303	22.9	37.3	67.5
44304	97	72.2	87.3
44305	80.8	85.6	94.3
44306	96.2	97.3	99
44307	98.3	99.6	99.7
44308	98.1	85.7	N/A
44310	91.5	85.3	90.8
44311	98.4	97.9	97.6
44312	49.7	51.2	84
44313	20.9	40.7	88.1
44314	81.7	86.2	92.9
44319	26.9	21	69.6
44320	86.7	91.7	99.1
44321	6.5	9.7	40.5
44333	6.2	7.5	53.3
44685	15.3	16.1	51.4

Data Considerations

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

Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover,

many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

Primary Data Collection & Analysis

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

Key Stakeholder Interviews Methodology and Results

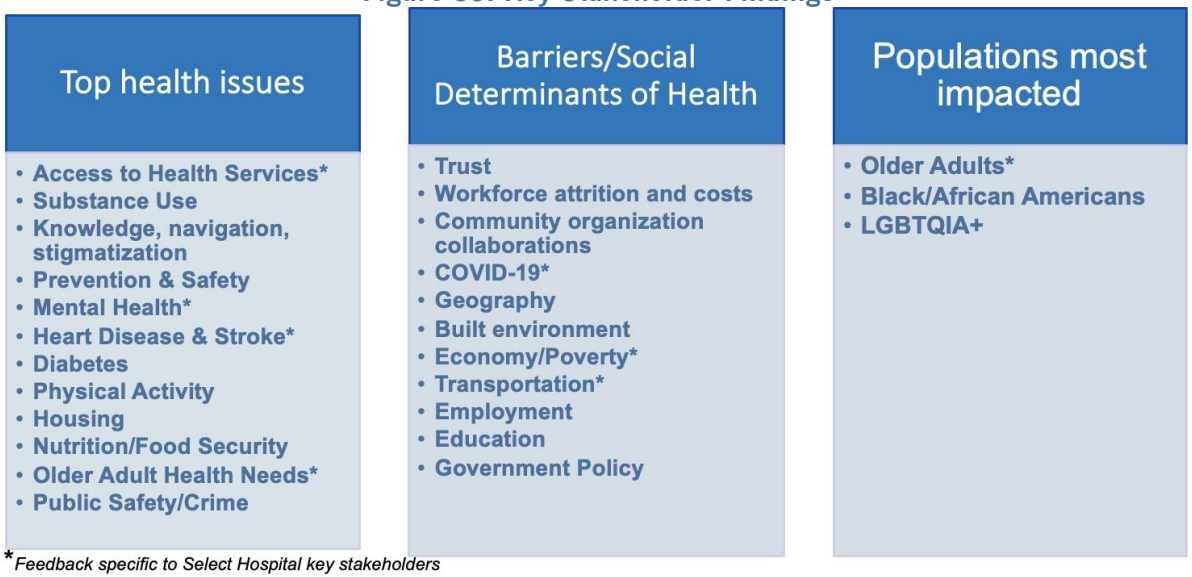
The project team captured detailed transcripts of the key stakeholder interviews. Table 4 describes the key stakeholder organizations contributing to the primary data collection process.

Table 4: CCRH Edwin Shaw Key Stakeholder Organizations

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

The transcripts were analyzed using the qualitative analysis program Dedoose 2®. Text was coded using a pre-designed codebook-organized by themes and analyzed for significant observations. Figure 30 shows key findings from community stakeholder interviews specific to the CCRH Edwin Shaw Community.

Figure 30: Key Stakeholder Findings



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

Appendix B: Impact Evaluation

The CHNA process should be viewed as a three-year cycle to evaluate the impact of actions taken to address priority areas. This step affirms organizations focus and target efforts during the next CHNA cycle. The top health priorities for the CCRH Edwin Shaw 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

Edwin Shaw 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 Edwin Shaw 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 Edwin Shaw Rehabilitation. Access barriers include cost, poverty, inadequate transportation, a lack of awareness regarding available services, and an undersupply of providers.

Highlighted Impacts:

- Financial Assistance - Edwin Shaw 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 to include donation of medical equipment as needed to support safe discharge to home/community.
- 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 Edwin Shaw Rehabilitation developed support groups and educational sessions for families and community residents. Stroke, Brain Injury, Spinal

Cord Injury and COVID survivor support groups were offered in person and virtually to support and enhance access to care and resources.

Chronic Disease Prevention and Management

Actions:

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

Highlighted Impacts:

- Physicians, pharmacist, nurses, PT, OT and SLP therapists, respiratory therapists, case managers, dietician and psychologist 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 to also include peer support and other disease specific support groups.
- Edwin Shaw Rehabilitation developed a large network of clinical liaisons throughout the community to assist elderly consumers in understanding their post-acute care options.
- Edwin Shaw 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 Edwin Shaw Rehabilitation goals for our patients. The hospital is a smoke free campus. A formalized smoking cessation program will 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 Edwin Shaw 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 Edwin Shaw Hospital Community Definition

Zip code	Postal Name
44107	Lakewood
44130	Cleveland
44131	Independence
44136	Strongsville
44147	Broadview Heights
44203	Barberton
44212	Brunswick
44215	Chippewa Lake
44216	Clinton
44221	Cuyahoga Falls
44223	Cuyahoga Falls
44224	Stow
44233	Hinckley
44236	Hudson
44250	Lakemore
44251	Westfield Center
44254	Lodi
44256	Medina
44262	Munroe Falls
44273	Seville
44274	Sharon Center
44278	Tallmadge
44281	Wadsworth
44286	Richfield
44301	Akron
44302	Akron
44303	Akron

44304	Akron
44305	Akron
44306	Akron
44307	Akron
44308	Akron
44310	Akron
44311	Akron
44312	Akron
44313	Akron
44314	Akron
44319	Akron
44320	Akron
44321	Akron
44333	Akron
44685	Uniontown

Table 6: Population Estimates for Each Zip Code

Zip code	City	Population
44107	Lakewood	50,128
44130	Cleveland	48,243
44131	Independence	19,872
44136	Strongsville	25,115
44147	Broadview Heights	20,276
44203	Barberton	40,694
44212	Brunswick	45,649
44215	Chippewa Lake	2,191
44216	Clinton	9,442
44221	Cuyahoga Falls	28,965
44223	Cuyahoga Falls	19,102
44224	Stow	39,855
44233	Hinckley	8,228

44236	Hudson	25,338
44250	Lakemore	1,166
44251	Westfield Center	869
44254	Lodi	4,683
44256	Medina	66,686
44262	Munroe Falls	4,956
44273	Seville	6,815
44274	Sharon Center	#N/A
44278	Tallmadge	18,464
44281	Wadsworth	32,770
44286	Richfield	6,283
44301	Akron	14,307
44302	Akron	4,800
44303	Akron	7,040
44304	Akron	5,847
44305	Akron	21,088
44306	Akron	21,745
44307	Akron	7,869
44308	Akron	1,280
44310	Akron	21,854
44311	Akron	8,161
44312	Akron	31,700
44313	Akron	24,560
44314	Akron	17,961
44319	Akron	22,526
44320	Akron	19,139
44321	Akron	17,022
44333	Akron	18,532
44685	Uniontown	30,033

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

Zip code	City	Population
44107	Lakewood	9.6%
44130	Cleveland	6.4%
44131	Independence	2.6%
44136	Strongsville	3.0%
44147	Broadview Heights	1.7%
44203	Barberton	9.6%
44212	Brunswick	3.8%
44215	Chippewa Lake	7.1%
44216	Clinton	3.1%
44221	Cuyahoga Falls	7.8%
44223	Cuyahoga Falls	4.7%
44224	Stow	5.2%
44233	Hinckley	3.7%
44236	Hudson	1.5%
44250	Lakemore	7.6%
44251	Westfield Center	4.6%
44254	Lodi	7.7%
44256	Medina	4.4%
44262	Munroe Falls	4.3%
44273	Seville	3.8%
44274	Sharon Center	#N/A
44278	Tallmadge	4.6%
44281	Wadsworth	3.7%
44286	Richfield	0.8%
44301	Akron	14.5%
44302	Akron	25.9%
44303	Akron	10.5%
44304	Akron	38.9%

44305	Akron	16.6%
44306	Akron	29.4%
44307	Akron	42.5%
44308	Akron	48.7%
44310	Akron	24.4%
44311	Akron	38.7%
44312	Akron	7.3%
44313	Akron	7.7%
44314	Akron	16.2%
44319	Akron	4.8%
44320	Akron	20.3%
44321	Akron	2.1%
44333	Akron	4.0%
44685	Uniontown	5.2%

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

HEALTH TOPICS	CUYAHOGA	MEDINA	SUMMIT	AVG
Alcohol & Drug Use	1.73	1.47	1.51	1.57
Cancer	1.71	1.34	1.51	1.52
Children's Health	1.72	1.34	1.41	1.49
Diabetes	1.17	0.89	1.29	1.12
Health Care Access & Quality	1.21	1.54	1.26	1.34
Heart Disease & Stroke	1.35	1.19	1.28	1.27
Immunizations & Infectious Diseases	1.20	0.82	1.27	1.10
Maternal, Fetal & Infant Health	1.56	1.03	1.63	1.41
Medications & Prescriptions	1.72	2.5	2.22	2.15
Mental Health & Mental Disorders	1.39	1.34	1.66	1.46

Nutrition & Healthy Eating	1.31	1.64	1.67	1.54
Older Adults	1.65	1.35	1.63	1.54
Oral Health	1.14	1.11	0.86	1.04
Other Conditions	1.83	1.53	1.83	1.73
Physical Activity	1.39	1.36	1.47	1.41
Prevention & Safety	2.21	1	1.24	1.48
Respiratory Diseases	1.23	0.96	1.38	1.19
Tobacco Use	1.19	1.11	1.36	1.22
Wellness & Lifestyle	1.49	1.1	1.33	1.31
Women's Health	1.46	1.22	1.58	1.42
QUALITY OF LIFE TOPIC	**SCORE**			
Community	1.66	1.09	1.30	1.35
Economy	1.68	0.74	1.28	1.23
Education	1.55	1.22	1.54	1.44
Environmental Health	1.53	1.19	1.43	1.38

Secondary Data Scoring Indicators of Concern

From the secondary data scoring results, Health Care Access & Quality ranked as the 13th highest scoring health need, with a score of 1.34. 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 31) 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 31: 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 Edwin Shaw Community

Cuyahoga County

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

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

Medina County

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

2.50	Consumer Expenditures: Health Insurance	5410.8		4371.7	4321.1			...
2.50	Consumer Expenditures: Medical Services	1419.1		1098.6	1047.4			...
2.50	Consumer Expenditures: Medical Supplies	259.4		204.8	194.9			...
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	781.2		638.9	609.6			...
1.72	Primary Care Provider Rate	60.3		76.7				
1.50	Non-Physician Primary Care Provider Rate	63.4		108.9				

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

Summit County

SCORE	HEALTH CARE ACCESS & QUALITY	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.33	Consumer Expenditures: Medical Services	1153.1		1098.6	1047.4			...

2.17	Consumer Expenditures: Health Insurance	4543.8		4371.7	4321.1			...
2.17	Consumer Expenditures: Medical Supplies	213.4		204.8	194.9			...
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	664.9		638.9	609.6			...
1.56	Persons without Health Insurance	6.5		6.6		...	...	...
1.50	Adults with Health Insurance	90		90.9	87.1	...	...	...

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

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

Nutrition & Healthy Eating had the fifth highest data score of all topic areas with a score of 1.54. The Older Adult Health topic area had the fourth highest score at 1.54 and the related Other Conditions health topic ranked second with a score of 1.73. All topic areas in this group demonstrate need as they each scored above 1.5. 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.

Medina County

SCORE	ADULT HEALTH	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.64	Prostate Cancer Incidence Rate	135.8		107.2	106.2			
2.58	Breast Cancer Incidence Rate	134.7		129.6	126.8			
2.58	Cancer: Medicare Population	9		8.4	8.4			
2.25	All Cancer Incidence Rate	486.3		467.5	448.6			
1.92	Adults with Cancer	8.3			7.1			...
2.50	Consumer Expenditures: Fast Food Restaurants	1814.2		1461	1638.9			...
2.50	Consumer Expenditures: High Sugar Foods	627		519	530.2			...
2.33	Consumer Expenditures: High Sugar Beverages	370		319.7	357			...

2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	37.2		36.1	33.5			...
2.31	Atrial Fibrillation: Medicare Population	9.4		9	8.4			
2.14	Osteoporosis: Medicare Population	6.6		6.2	6.6			
1.92	Depression: Medicare Population	19		20.4	18.4			
1.81	Hyperlipidemia: Medicare Population	50		49.4	47.7			...
1.75	Adults with Arthritis	30			25.1			...
1.67	Consumer Expenditures: Eldercare	24.4		20.5	34.3			...
1.50	People 65+ with Low Access to a Grocery Store	2.5						...

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Summit County

SCORE	ADULT HEALTH	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.75	Depression: Medicare Population	21.8		20.4	18.4			
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	37.7		36.1	33.5			
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	41		34	30.5			
2.42	Cancer: Medicare Population	8.5		8.4	8.4			
2.36	Asthma: Medicare Population	5.8		4.8	5			
2.19	People 65+ Living Alone	30.1		28.8	26.1			
2.17	Consumer Expenditures: High Sugar Foods	531.5		519	530.2			...
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.3		10.4	10.8			

2.14	Osteoporosis: Medicare Population	6.6		6.2	6.6			
2.00	Consumer Expenditures: Fast Food Restaurants	1508.4		1461	1638.9			...
1.92	Chronic Kidney Disease: Medicare Population	24.7		25.3	24.5			
1.83	Consumer Expenditures: High Sugar Beverages	324		319.7	357			...
1.83	Colon Cancer Screening	62.2	74.4		66.4			...
1.83	People 65+ with Low Access to a Grocery Store	4.3						...
1.81	Atrial Fibrillation: Medicare Population	8.9		9	8.4			
1.81	Hyperlipidemia: Medicare Population	49.9		49.4	47.7			
1.58	Adults with Arthritis	29.8			25.1			...

1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	41.2		41.5	41.2			...
1.50	Consumer Expenditures: Fruits and Vegetables	885.9		864.6	1002.1			...

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 #3: Community Safety

Alcohol & Drug Use ranked third among all health topics with a score of 1.57. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 11 below. See Appendix C for the full list of indicators categorized within this topic.

Cuyahoga County

SCORE	ALCOHOL & DRUG USE	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.64	Death Rate due to Drug Poisoning	42.6		38.1	21			
2.44	Alcohol-Impaired Driving Deaths	41.4	28.3	32.2	27			
2.00	Adults who Drink Excessively	19.6		18.5	19			...

1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	43.8		42	22.8			...
1.67	Consumer Expenditures: Alcoholic Beverages	637.1		651.5	701.9			...

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

Medina County

SCORE	ALCOHOL & DRUG USE	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.58	Alcohol-Impaired Driving Deaths	40.7	28.3	32.2	27			
2.50	Consumer Expenditures: Alcoholic Beverages	821.2		651.5	701.9			...
1.92	Adults who Binge Drink	17.6			16.7			...

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.

Summit County

SCORE	ALCOHOL & DRUG USE	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend

2.17	Alcohol-Impaired Driving Deaths	38.3	28.3	32.2	27			...
2.00	Consumer Expenditures: Alcoholic Beverages	679.3		651.5	701.9			...
1.86	Death Rate due to Drug Poisoning	36.7		38.1	21			...
1.75	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	40.1		42	22.8			...

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

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

HEALTH TOPICS	AVG
Medications & Prescriptions	2.15
Other Conditions	1.73
Alcohol & Drug Use	1.57
Older Adults	1.54
Nutrition & Healthy Eating	1.54
Cancer	1.52
Children's Health	1.49
Prevention & Safety	1.48
Mental Health & Mental Disorders	1.46
Women's Health	1.42
Maternal, Fetal & Infant Health	1.41
Physical Activity	1.41
Health Care Access & Quality	1.34
Wellness & Lifestyle	1.31
Heart Disease & Stroke	1.27
Tobacco Use	1.22
Respiratory Diseases	1.19
Diabetes	1.12
Immunizations & Infectious Diseases	1.10
Oral Health	1.04
QUALITY OF LIFE TOPIC	**SCORE**
Education	1.44
Environmental Health	1.38
Community	1.35
Economy	1.23

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**

SCORE	ENVIRONMENTAL HEALTH	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

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	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	38.3	28.3	32.2	27	*2015-2019*	9
2.00	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	679.3		651.5	701.9	*2021*	7
1.86	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	36.7		38.1	21	*2017-2019*	9

1.75	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	40.1		42	22.8	*2017-2019*	5
1.42	Health Behaviors Ranking	*ranking*	27				*2021*	9
1.36	Mothers who Smoked During Pregnancy	*percent*	11.1	4.3	11.5	5.5	*2020*	17
1.17	Adults who Drink Excessively	*percent*	17.3		18.5	19	*2018*	9
1.08	Adults who Binge Drink	*percent*	15.4			16.7	*2019*	4
0.75	Liquor Store Density	*stores/ 100,000 population*	6.3		5.6	10.5	*2019*	22

SCORE	CANCER	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.3		129.6	126.8	*2014-2018*	12
2.42	Cancer: Medicare Population	*percent*	8.5		8.4	8.4	*2018*	6
2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.8	15.3	21.6	19.9	*2015-2019*	12
2.06	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	20	16.9	19.4	18.9	*2015-2019*	12
1.83	Colon Cancer Screening	*percent*	62.2	74.4		66.4	*2018*	4
1.75	All Cancer Incidence Rate	*cases/ 100,000 population*	454.7		467.5	448.6	*2014-2018*	12
1.61	Mammogram in Past 2 Years: 50-74	*percent*	71.3	77.1		74.8	*2018*	4
1.58	Adults with Cancer	*percent*	8			7.1	*2019*	4
1.44	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	166.4	122.7	169.4	152.4	*2015-2019*	12
1.28	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	41	25.1	45	36.7	*2015-2019*	12

1.19	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.4		67.3	57.3	*2014-2018*	12
1.19	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	100.1		107.2	106.2	*2014-2018*	12
1.14	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	37.2		41.3	38	*2014-2018*	12
1.11	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.1	8.9	14.8	13.4	*2015-2019*	12
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.5	84.3		84.7	*2018*	4
0.69	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11		12.2	11.9	*2014-2018*	12
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5		7.9	7.7	*2014-2018*	12

SCORE	CHILDREN'S HEALTH	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Children with Low Access to a Grocery Store	*percent*	7.2				*2015*	23
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.75	Projected Child Food Insecurity Rate	*percent*	19.1		18.5		*2021*	10
1.50	Child Food Insecurity Rate	*percent*	17.4		17.4	14.6	*2019*	10
1.33	Children with Health Insurance	*percent*	98		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*	1.2		1.9		*2020*	19
0.78	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.1	8.7	6.8		*2020*	3

SCORE	COMMUNITY	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Workers who Walk to Work	*percent*	1.4		2.2	2.7	*2015-2019*	1
2.19	People 65+ Living Alone	*percent*	30.1		28.8	26.1	*2015-2019*	1
2.17	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	38.3	28.3	32.2	27	*2015-2019*	9
2.17	Single-Parent Households	*percent*	28.5		27.1	25.5	*2015-2019*	1
1.89	Violent Crime Rate	*crimes/ 100,000 population*	336.5		303.5	394	*2017*	18
1.86	Households without a Vehicle	*percent*	8.5		7.9	8.6	*2015-2019*	1
1.75	Workers who Drive Alone to Work	*percent*	85		82.9	76.3	*2015-2019*	1
1.67	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	123.1		121.7	148.8	*2021*	7
1.64	Linguistic Isolation	*percent*	1.4		1.4	4.4	*2015-2019*	1
1.58	Social and Economic Factors Ranking		47				*2021*	9
1.56	Workers Commuting by Public Transportation	*percent*	1.5	5.3	1.6	5	*2015-2019*	1
1.50	Households with One or More Types of Computing Devices	*percent*	88.6		89.1	90.3	*2015-2019*	1

1.42	Solo Drivers with a Long Commute	*percent*	29.2		31.1	37	*2015-2019*	9
1.36	Children Living Below Poverty Level	*percent*	19.2		19.9	18.5	*2015-2019*	1
1.33	Voter Turnout: Presidential Election	*percent*	74.7		74		*2020*	20
1.31	Social Associations	*membership associations/ 10,000 population*	11.3		11	9.3	*2018*	9
1.19	Young Children Living Below Poverty Level	*percent*	21.4		23	20.3	*2015-2019*	1
1.14	Mean Travel Time to Work	*minutes*	23.2		23.7	26.9	*2015-2019*	1
1.11	People Living Below Poverty Level	*percent*	13.2	8	14	13.4	*2015-2019*	1
1.00	Adults with Internet Access	*percent*	95		94.5	95	*2021*	8
1.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	1.4		2.8	2.5	*2015-2019*	5
1.00	Households with a Computer	*percent*	86.2		85.2	86.3	*2021*	8
1.00	Households with a Smartphone	*percent*	81.4		80.5	81.9	*2021*	8
1.00	Households with an Internet Subscription	*percent*	83		82.4	83	*2015-2019*	1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
1.00	Households with Wireless Phone Service	*percent*	97		96.8	97	*2020*	8
1.00	Persons with an Internet Subscription	*percent*	87.1		86.2	86.2	*2015-2019*	1

0.92	Homeownership	*percent*	60.1		59.4	56.2	*2015-2019*	1
0.92	Median Household Income	*dollars*	57181		56602	62843	*2015-2019*	1
0.78	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.1	8.7	6.8		*2020*	3
0.58	Per Capita Income	*dollars*	33606		31552	34103	*2015-2019*	1
0.42	Youth not in School or Working	*percent*	1.6		1.8	1.9	*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	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.64	Adults 20+ with Diabetes	*percent*	9.5				*2019*	5
1.36	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	23.7		25.3	21.5	*2017-2019*	5
0.86	Diabetes: Medicare Population	*percent*	25.1		27.2	27	*2018*	6

SCORE	ECONOMY	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.36	Households with Cash Public Assistance Income	*percent*	5.1		2.9	2.4	*2015-2019*	1
2.00	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	8092.4		7828	8900.1	*2021*	7
2.00	Income Inequality		0.5		0.5	0.5	*2015-2019*	1
1.75	Projected Child Food Insecurity Rate	*percent*	19.1		18.5		*2021*	10

1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.7			*2015*	23
1.67	Renters Spending 30% or More of Household Income on Rent	*percent*	46.4	44.9	49.6	*2015-2019*	1
1.58	Persons with Disability Living in Poverty (5-year)	*percent*	30.2	29.5	26.1	*2015-2019*	1
1.58	Social and Economic Factors Ranking	*ranking*	47			*2021*	9
1.58	Unemployed Workers in Civilian Labor Force	*percent*	4.7	4.3	4.6	*Sep-21*	21
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.8			*2017*	23
1.50	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.4	14.6	14.4	*2021*	8
1.50	Child Food Insecurity Rate	*percent*	17.4	17.4	14.6	*2019*	10
1.50	Food Insecurity Rate	*percent*	12.7	13.2	10.9	*2019*	10
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.36	Children Living Below Poverty Level	*percent*	19.2	19.9	18.5	*2015-2019*	1
1.36	Size of Labor Force	*persons*	264940			*44440*	21
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	22.2	24.5		*2018*	25
1.25	Projected Food Insecurity Rate	*percent*	13.8	14.1		*2021*	10

1.19	Families Living Below Poverty Level	*percent*	9.4		9.9	9.5	*2015-2019*	1
1.19	Young Children Living Below Poverty Level	*percent*	21.4		23	20.3	*2015-2019*	1
1.17	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	66.1		61.6		*2018*	25
1.17	Households that are Below the Federal Poverty Level	*percent*	11.7		13.8		*2018*	25
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
1.11	People Living Below Poverty Level	*percent*	13.2	8	14	13.4	*2015-2019*	1
1.08	Severe Housing Problems	*percent*	13.6		13.7	18	*2013-2017*	9
0.97	People 65+ Living Below Poverty Level	*percent*	7.1		8.1	9.3	*2015-2019*	1
0.92	Homeownership	*percent*	60.1		59.4	56.2	*2015-2019*	1
0.92	Median Household Income	*dollars*	57181		56602	62843	*2015-2019*	1
0.86	Students Eligible for the Free Lunch Program	*percent*	15.4				*2019-2020*	13
0.83	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3632.3		3798.7	5460.2	*2021*	7
0.83	Households with a Savings Account	*percent*	70.4		68.8	70.2	*2021*	8
0.78	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.2		19.7	26.5	*2019*	1

0.75	People Living 200% Above Poverty Level	*percent*	69.9		68.8	69.1	*2015-2019*	1
0.58	Per Capita Income	*dollars*	33606		31552	34103	*2015-2019*	1
0.42	Youth not in School or Working	*percent*	1.6		1.8	1.9	*2015-2019*	1

SCORE	EDUCATION	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.86	4th Grade Students Proficient in English/Language Arts	*percent*	56.5		63.3		*2018-2019*	15
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.83	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1208.5		1200.4	1492.4	*2021*	7
1.81	Student-to-Teacher Ratio	*students/ teacher*	16.8				*2019-2020*	13
1.69	4th Grade Students Proficient in Math	*percent*	67.4		74.3		*2018-2019*	15
1.58	8th Grade Students Proficient in English/Language Arts	*percent*	51.1		58.3		*2018-2019*	15
1.58	8th Grade Students Proficient in Math	*percent*	48.7		57.3		*2018-2019*	15
1.39	High School Graduation	*percent*	91.1	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

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

2.36	Asthma: Medicare Population	*percent*	5.8	4.8	5	*2018*	6
2.00	Children with Low Access to a Grocery Store	*percent*	7.2			*2015*	23
1.92	Adults with Current Asthma	*percent*	10.3		8.9	*2019*	4
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.75	Physical Environment Ranking	*ranking*	74			*2021*	9
1.72	Annual Ozone Air Quality		3			*2017-2019*	2
1.69	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8			*2016*	23
1.67	Grocery Store Density	*stores/ 1,000 population*	0.2			*2016*	23
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.7			*2015*	23
1.64	Number of Extreme Precipitation Days	*days*	32			*2019*	14
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.8			*2017*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1			*2016*	23
1.44	Annual Particle Pollution		B			*2017-2019*	2
1.42	Houses Built Prior to 1950	*percent*	27	26.2	17.5	*2015-2019*	1
1.36	Food Environment Index	*index*	7.5	6.8	7.8	*2021*	9
1.36	Number of Extreme Heat Days	*days*	14			*2019*	14
1.36	Recognized Carcinogens Released into Air	*pounds*	97811.5			*2020*	24

1.36	Weeks of Moderate Drought or Worse	*weeks per year*	1				*2020*	14
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
1.08	Severe Housing Problems	*percent*	13.6		13.7	18	*2013-2017*	9
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*	1.2		1.9		*2020*	19
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
0.75	Liquor Store Density	*stores/ 100,000 population*	6.3		5.6	10.5	*2019*	22
0.50	Access to Exercise Opportunities	*percent*	94.1		83.9	84	*2020*	9

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1153.1		1098.6	1047.4	*2021*	7
2.17	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4543.8		4371.7	4321.1	*2021*	7
2.17	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	213.4		204.8	194.9	*2021*	7

2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	664.9		638.9	609.6	*2021*	7
1.56	Persons without Health Insurance	*percent*	6.5		6.6		*2019*	1
1.50	Adults with Health Insurance	*percent*	90		90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	98		95.2	94.3	*2019*	1
1.25	Clinical Care Ranking	*ranking*	9				*2021*	9
1.00	Adults with Health Insurance: 18+	*percent*	90.9		90.2	90.6	*2021*	8
0.92	Adults who have had a Routine Checkup	*percent*	79.8			76.6	*2019*	4
0.83	Adults who Visited a Dentist	*percent*	53		51.6	52.9	*2021*	8
0.75	Adults without Health Insurance	*percent*	11.3			13	*2019*	4
0.75	Primary Care Provider Rate	*providers/ 100,000 population*	98		76.7		*2018*	9
0.67	Dentist Rate	*dentists/ 100,000 population*	64.1		64.2		*2019*	9
0.50	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	116.5		108.9		*2020*	9
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	292		261.3		*2020*	9

SCORE	**HEART DISEASE & STROKE**	**UNITS**	**SUMMIT COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.81	Atrial Fibrillation: Medicare Population	*percent*	8.9		9	8.4	*2018*	6

1.81	Hyperlipidemia: Medicare Population	*percent*	49.9		49.4	47.7	*2018*	6
1.58	Adults who Experienced a Stroke	*percent*	3.8			3.4	*2019*	4
1.56	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	39.1	33.4	42.5	37.2	*2017-2019*	5
1.42	Adults who Experienced Coronary Heart Disease	*percent*	7			6.2	*2019*	4
1.42	Cholesterol Test History	*percent*	85.6			87.6	*2019*	4
1.42	Stroke: Medicare Population	*percent*	3.9		3.8	3.8	*2018*	6
1.33	High Blood Pressure Prevalence	*percent*	34.7	27.7		32.6	*2019*	4
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.6			76.2	*2019*	4
1.17	Hypertension: Medicare Population	*percent*	57.3		59.5	57.2	*2018*	6
1.00	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	47.2		55.4		*2019*	14
0.92	Heart Failure: Medicare Population	*percent*	14.1		14.7	14	*2018*	6
0.92	High Cholesterol Prevalence: Adults 18+	*percent*	30.4			33.6	*2019*	4
0.86	Ischemic Heart Disease: Medicare Population	*percent*	24.8		27.5	26.8	*2018*	6
0.78	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	85.5	71.1	101.4	90.5	*2017-2019*	5

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.39	Chlamydia Incidence Rate	*cases/ 100,000 population*	640.8		561.9	551	*2019*	16
2.22	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.2	1.4	1.1		*2020*	16
2.08	Gonorrhea Incidence Rate	*cases/ 100,000 population*	241.2		224	187.8	*2019*	16
1.56	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	12.5	11.1	12.9		*2018*	16
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.1		0	0.5	*28-Jan-22*	11
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.4		48.6	49.4	*2021*	8
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	61.5				*28-Jan-22*	5
0.25	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.4		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	40		128.4	177.3	*28-Jan-22*	11

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.67	Babies with Low Birth Weight	*percent*	9.4		8.5	8.2	*2020*	17
2.39	Babies with Very Low Birth Weight	*percent*	1.7		1.4	1.3	*2020*	17

1.97	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	8		6.8		*2020*	17
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.50	Preterm Births	*percent*	9.9	9.4	10.3		*2020*	17
1.36	Mothers who Smoked During Pregnancy	*percent*	11.1	4.3	11.5	5.5	*2020*	17
1.08	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	18.7		19.5		*2016*	17
1.00	Mothers who Received Early Prenatal Care	*percent*	71.7		68.9	76.1	*2020*	17
0.83	Infant Mortality Rate	*deaths/ 1,000 live births*	6	5	6.9		*2019*	17

SCORE	MEDICATIONS & PRESCRIPTIONS	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1153.1		1098.6	1047.4	*2021*	7
2.17	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	213.4		204.8	194.9	*2021*	7
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	664.9		638.9	609.6	*2021*	7

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Depression: Medicare Population	*percent*	21.8		20.4	18.4	*2018*	6

2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	41		34	30.5	*2017-2019*	5
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.3		10.4	10.8	*2018*	6
1.83	Poor Mental Health: Average Number of Days	*days*	4.8		4.8	4.1	*2018*	9
1.61	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	16.2	12.8	15.1	14.1	*2017-2019*	5
1.58	Poor Mental Health: 14+ Days	*percent*	15.4			13.6	*2019*	4
1.25	Adults Ever Diagnosed with Depression	*percent*	19.5			18.8	*2019*	4
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	86.5		85.6	86.5	*2021*	8
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	292		261.3		*2020*	9

SCORE	NUTRITION & HEALTHY EATING	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	531.5		519	530.2	*2021*	7
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1508.4		1461	1638.9	*2021*	7
1.83	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	324		319.7	357	*2021*	7

1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.2		41.5	41.2	*2021*	8
1.50	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	885.9		864.6	1002.1	*2021*	7
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.6		80.9	80.4	*2021*	8

SCORE	OLDER ADULTS	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Depression: Medicare Population	*percent*	21.8		20.4	18.4	*2018*	6
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.7		36.1	33.5	*2018*	6
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	41		34	30.5	*2017-2019*	5
2.42	Cancer: Medicare Population	*percent*	8.5		8.4	8.4	*2018*	6
2.36	Asthma: Medicare Population	*percent*	5.8		4.8	5	*2018*	6
2.19	People 65+ Living Alone	*percent*	30.1		28.8	26.1	*2015-2019*	1
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.3		10.4	10.8	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6
1.92	Chronic Kidney Disease: Medicare Population	*percent*	24.7		25.3	24.5	*2018*	6

1.83	Colon Cancer Screening	*percent*	62.2	74.4	66.4	*2018*	4
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4.3			*2015*	23
1.81	Atrial Fibrillation: Medicare Population	*percent*	8.9	9	8.4	*2018*	6
1.81	Hyperlipidemia: Medicare Population	*percent*	49.9	49.4	47.7	*2018*	6
1.58	Adults with Arthritis	*percent*	29.8		25.1	*2019*	4
1.47	COPD: Medicare Population	*percent*	12.4	13.2	11.5	*2018*	6
1.42	Stroke: Medicare Population	*percent*	3.9	3.8	3.8	*2018*	6
1.25	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	33.7		32.4	*2018*	4
1.25	Adults 65+ with Total Tooth Loss	*percent*	14.8		13.5	*2018*	4
1.17	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	21.1	20.5	34.3	*2021*	7
1.17	Hypertension: Medicare Population	*percent*	57.3	59.5	57.2	*2018*	6
0.97	People 65+ Living Below Poverty Level	*percent*	7.1	8.1	9.3	*2015-2019*	1
0.92	Heart Failure: Medicare Population	*percent*	14.1	14.7	14	*2018*	6
0.86	Diabetes: Medicare Population	*percent*	25.1	27.2	27	*2018*	6
0.86	Ischemic Heart Disease: Medicare Population	*percent*	24.8	27.5	26.8	*2018*	6

0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	35.4			28.4	*2018*	4
0.08	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	6.9		10.5	9.5	*2017-2019*	5

SCORE	ORAL HEALTH	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.25	Adults 65+ with Total Tooth Loss	*percent*	14.8			13.5	*2018*	4
0.83	Adults who Visited a Dentist	*percent*	53		51.6	52.9	*2021*	8
0.69	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11		12.2	11.9	*2014-2018*	12
0.67	Dentist Rate	*dentists/ 100,000 population*	64.1		64.2		*2019*	9

SCORE	OTHER CONDITIONS	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.75	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.7		36.1	33.5	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6
1.92	Chronic Kidney Disease: Medicare Population	*percent*	24.7		25.3	24.5	*2018*	6
1.58	Adults with Arthritis	*percent*	29.8			25.1	*2019*	4
1.42	Adults with Kidney Disease	*Percent of adults*	3.2			3.1	*2019*	4
1.14	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	12.4		14.5	12.9	*2017-2019*	5

SCORE	PHYSICAL ACTIVITY	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Workers who Walk to Work	*percent*	1.4		2.2	2.7	*2015-2019*	1
2.00	Children with Low Access to a Grocery Store	*percent*	7.2				*2015*	23
1.83	People 65+ with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.72	Adults 20+ who are Obese	*percent*	32.2	36			*2019*	5
1.69	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*	23
1.67	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.7				*2015*	23
1.53	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.42	Health Behaviors Ranking	*ranking*	27				*2021*	9
1.36	Adults 20+ who are Sedentary	*percent*	24.7				*2019*	5
1.36	Food Environment Index	*index*	7.5		6.8	7.8	*2021*	9
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.6		80.9	80.4	*2021*	8

1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
0.50	Access to Exercise Opportunities	*percent*	94.1		83.9	84	*2020*	9

SCORE	PREVENTION & SAFETY	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	38.7		40.2	21.4	*2017-2019*	5
1.86	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	36.7		38.1	21	*2017-2019*	9
1.44	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	59.6	43.2	68.8	48.9	*2017-2019*	5
1.08	Severe Housing Problems	*percent*	13.6		13.7	18	*2013-2017*	9
1.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	1.4		2.8	2.5	*2015-2019*	5
0.08	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	6.9		10.5	9.5	*2017-2019*	5

SCORE	RESPIRATORY DISEASES	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.36	Asthma: Medicare Population	*percent*	5.8		4.8	5	*2018*	6
2.22	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.2	1.4	1.1		*2020*	16
1.92	Adults who Smoke	*percent*	23.3	5	21.4	17	*2018*	9

1.92	Adults with Current Asthma	*percent*	10.3			8.9	*2019*	4
1.83	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	483.4		487.9	422.4	*2021*	7
1.58	Adults with COPD	*Percent of adults*	8.9			6.6	*2019*	4
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.1		0	0.5	*28-Jan-22*	11
1.47	COPD: Medicare Population	*percent*	12.4		13.2	11.5	*2018*	6
1.36	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	44.8		47.8	39.6	*2017-2019*	5
1.28	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	41	25.1	45	36.7	*2015-2019*	12
1.19	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.4		67.3	57.3	*2014-2018*	12
1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.1		4.3	4.1	*2021*	8
0.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2		2.2	2	*2021*	8
0.25	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.4		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	40		128.4	177.3	*28-Jan-22*	11

SCORE	TOBACCO USE	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.92	Adults who Smoke	*percent*	23.3	5	21.4	17	*2018*	9

1.83	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	483.4		487.9	422.4	*2021*	7
1.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.1		4.3	4.1	*2021*	8
0.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2		2.2	2	*2021*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1508.4		1461	1638.9	*2021*	7
1.58	Insufficient Sleep	*percent*	38.6	31.4	40.6	35	*2018*	9
1.58	Morbidity Ranking	*ranking*	47				*2021*	9
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.2		41.5	41.2	*2021*	8
1.50	Life Expectancy	*years*	77.2		77	79.2	*2017-2019*	9
1.42	Poor Physical Health: 14+ Days	*percent*	14.2			12.5	*2019*	4
1.33	High Blood Pressure Prevalence	*percent*	34.7	27.7		32.6	*2019*	4
1.25	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.1			18.6	*2019*	4
1.17	Poor Physical Health: Average Number of Days	*days*	3.9		4.1	3.7	*2018*	9

1.00	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.6		80.9	80.4	*2021*	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	49.4		48.6	49.4	*2021*	8
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	86.5		85.6	86.5	*2021*	8

SCORE	WOMEN'S HEALTH	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.3		129.6	126.8	*2014-2018*	12
2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.8	15.3	21.6	19.9	*2015-2019*	12
1.61	Mammogram in Past 2 Years: 50-74	*percent*	71.3	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.5	84.3		84.7	*2018*	4
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5		7.9	7.7	*2014-2018*	12

Summit County Data Sources

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

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

SCORE	CANCER	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	135.8		107.2	106.2	*2014-2018*	12

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

0.61	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	36.5	25.1	45	36.7	*2015-2019*	12
0.44	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	11.4	8.9	14.8	13.4	*2015-2019*	12

SCORE	CHILDREN'S HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.72	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.4	8.7	6.8		*2020*	3
1.33	Children with Health Insurance	*percent*	95.4		95.2	94.3	*2019*	1
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	19
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2020*	19
0.75	Projected Child Food Insecurity Rate	*percent*	11.7		18.5		*2021*	10
0.50	Child Food Insecurity Rate	*percent*	10.6		17.4	14.6	*2019*	10

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

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

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

0.36	Single-Parent Households	*percent*	16		27.1	25.5	*2015-2019*	1
0.28	People Living Below Poverty Level	*percent*	6	8	14	13.4	*2015-2019*	1
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	33.9		28.3	32.1	*2015-2019*	1
0.08	Median Household Income	*dollars*	76600		56602	62843	*2015-2019*	1
0.08	Per Capita Income	*dollars*	37788		31552	34103	*2015-2019*	1

SCORE	DIABETES	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.50	Adults 20+ with Diabetes	*percent*	9.2				*2019*	5
0.81	Diabetes: Medicare Population	*percent*	23.9		27.2	27	*2018*	6
0.36	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	18.8		25.3	21.5	*2017-2019*	5

SCORE	ECONOMY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	9561.5		7828	8900.1	*2021*	7
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.64	Size of Labor Force	*persons*	93296				*44440*	21
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23

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

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

0.28	People Living Below Poverty Level	*percent*	6	8	14	13.4	*2015-2019*	1
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9
0.25	Unemployed Workers in Civilian Labor Force	*percent*	3.1		4.3	4.6	*Sep-21*	21
0.08	Median Household Income	*dollars*	76600		56602	62843	*2015-2019*	1
0.08	People Living 200% Above Poverty Level	*percent*	82.8		68.8	69.1	*2015-2019*	1
0.08	Per Capita Income	*dollars*	37788		31552	34103	*2015-2019*	1

SCORE	EDUCATION	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
2.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1490.7		1200.4	1492.4	*2021*	7
1.58	Student-to-Teacher Ratio	*students/ teacher*	18.3				*2019-2020*	13
1.50	8th Grade Students Proficient in Math	*percent*	62.1		57.3		*2018-2019*	15
1.00	4th Grade Students Proficient in Math	*percent*	86.3		74.3		*2018-2019*	15
0.86	4th Grade Students Proficient in English/Language Arts	*percent*	79		63.3		*2018-2019*	15
0.72	High School Graduation	*percent*	96.3	90.7	92		*2019-2020*	15

0.58	8th Grade Students Proficient in English/Language Arts	*percent*	74		58.3		*2018-2019*	15
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	33.9		28.3	32.1	*2015-2019*	1

SCORE	ENVIRONMENTAL HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	23
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.5				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.36	Number of Extreme Heat Days	*days*	14				*2019*	14
1.36	Number of Extreme Precipitation Days	*days*	28				*2019*	14
1.36	PBT Released	*pounds*	676.8				*2020*	24

1.36	Recognized Carcinogens Released into Air	*pounds*	447			*2020*	24
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	1			*2020*	14
1.33	Farmers Market Density	*markets/ 1,000 population*	0			*2018*	23
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.2			*2015*	23
1.25	Adults with Current Asthma	*percent*	9.4		8.9	*2019*	4
1.25	Physical Environment Ranking	*ranking*	10			*2021*	9
1.19	Asthma: Medicare Population	*percent*	4.7	4.8	5	*2018*	6
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2	0.5		*2020*	19
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6	1.9		*2020*	19
1.11	Annual Ozone Air Quality		A			*2017-2019*	2
1.11	Annual Particle Pollution		A			*2017-2019*	2
1.03	Overcrowded Households	*percent of households*	1.1	1.4		*2015-2019*	1
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	Access to Exercise Opportunities	*percent*	92.1		83.9	84	*2020*	9
0.53	Houses Built Prior to 1950	*percent*	12.5		26.2	17.5	*2015-2019*	1
0.36	Food Environment Index	*index*	8.6		6.8	7.8	*2021*	9
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9
0.08	Liquor Store Density	*stores/ 100,000 population*	1.7		5.9	10.6	*2018*	22

SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	5410.8		4371.7	4321.1	*2021*	7
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1419.1		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	259.4		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	781.2		638.9	609.6	*2021*	7
1.72	Primary Care Provider Rate	*providers/ 100,000 population*	60.3		76.7		*2018*	9
1.50	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	63.4		108.9		*2020*	9
1.44	Dentist Rate	*dentists/ 100,000 population*	53.4		64.2		*2019*	9

1.39	Persons without Health Insurance	*percent*	4.3	6.6		*2019*	1
1.33	Adults with Health Insurance	*percent*	94.4	90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	95.4	95.2	94.3	*2019*	1
1.33	Mental Health Provider Rate	*providers/ 100,000 population*	140.8	261.3		*2020*	9
1.25	Clinical Care Ranking	*ranking*	4			*2021*	9
0.92	Adults who have had a Routine Checkup	*percent*	79.5		76.6	*2019*	4
0.83	Adults who Visited a Dentist	*percent*	56.6	51.6	52.9	*2021*	8
0.83	Adults with Health Insurance: 18+	*percent*	92.4	90.2	90.6	*2021*	8
0.75	Adults without Health Insurance	*percent*	9.5		13	*2019*	4

SCORE	HEART DISEASE & STROKE	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.4		9	8.4	*2018*	6
1.81	Hyperlipidemia: Medicare Population	*percent*	50		49.4	47.7	*2018*	6
1.42	Adults who Have Taken Medications for High Blood Pressure	*percent*	78			76.2	*2019*	4

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

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

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source

2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
1.19	Mothers who Smoked During Pregnancy	*percent*	6.9	4.3	11.5	5.5	*2020*	17
1.11	Mothers who Received Early Prenatal Care	*percent*	74.7		68.9	76.1	*2020*	17
0.86	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	1.6		6.8		*2020*	17
0.86	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	13.4		19.5		*2016*	17
0.78	Infant Mortality Rate	*deaths/ 1,000 live births*	1.8	5	6.9		*2019*	17
0.78	Preterm Births	*percent*	7.6	9.4	10.3		*2020*	17
0.75	Babies with Low Birth Weight	*percent*	5.7		8.5	8.2	*2020*	17
0.61	Babies with Very Low Birth Weight	*percent*	0.6		1.4	1.3	*2020*	17

SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1419.1		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	259.4		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	781.2		638.9	609.6	*2021*	7

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

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

2.50	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1814.2		1461	1638.9	*2021*	7
2.50	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	627		519	530.2	*2021*	7
2.33	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	370		319.7	357	*2021*	7
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.2		41.5	41.2	*2021*	8
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.67	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	1043.8		864.6	1002.1	*2021*	7

SCORE	OLDER ADULT HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.2		36.1	33.5	*2018*	6
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.4		9	8.4	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6

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

0.94	Colon Cancer Screening	*percent*	68.2	74.4		66.4	*2018*	4
0.81	Diabetes: Medicare Population	*percent*	23.9		27.2	27	*2018*	6
0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	36.5			28.4	*2018*	4
0.75	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	38.5			32.4	*2018*	4
0.75	Adults 65+ with Total Tooth Loss	*percent*	11			13.5	*2018*	4
0.69	Heart Failure: Medicare Population	*percent*	12.9		14.7	14	*2018*	6
0.69	Ischemic Heart Disease: Medicare Population	*percent*	24.7		27.5	26.8	*2018*	6
0.64	People 65+ Living Below Poverty Level	*percent*	5.2		8.1	9.3	*2015-2019*	1

SCORE	ORAL HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.44	Dentist Rate	*dentists/ 100,000 population*	53.4		64.2		*2019*	9
1.42	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.4		12.2	11.9	*2014-2018*	12
0.83	Adults who Visited a Dentist	*percent*	56.6		51.6	52.9	*2021*	8

0.75	Adults 65+ with Total Tooth Loss	*percent*	11			13.5	*2018*	4

SCORE	OTHER CONDITIONS	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.2		36.1	33.5	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6
1.75	Adults with Arthritis	*percent*	30			25.1	*2019*	4
1.42	Chronic Kidney Disease: Medicare Population	*percent*	23		25.3	24.5	*2018*	6
0.92	Adults with Kidney Disease	*Percent of adults*	2.8			3.1	*2019*	4
0.36	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	8.7		14.5	12.9	*2017-2019*	5

SCORE	PHYSICAL ACTIVITY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Workers who Walk to Work	*percent*	0.9		2.2	2.7	*2015-2019*	1
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23

1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	23
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.5				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.2				*2015*	23
1.25	Health Behaviors Ranking		4				*2021*	9
1.03	Adults 20+ who are Sedentary	*percent*	21.1				*2019*	5
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
0.94	Adults 20+ who are Obese	*percent*	27.8	36			*2019*	5
0.83	Access to Exercise Opportunities	*percent*	92.1		83.9	84	*2020*	9
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.36	Food Environment Index		8.6		6.8	7.8	*2021*	9

SCORE	PREVENTION & SAFETY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.7		10.5	9.5	*2017-2019*	5
1.47	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	23.6		40.2	21.4	*2017-2019*	5
1.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.1		38.1	21	*2017-2019*	9
0.67	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	43.8	43.2	68.8	48.9	*2017-2019*	5
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9

SCORE	RESPIRATORY DISEASES	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.72	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.1	1.4	1.1		*2020*	16
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	472.9		487.9	422.4	*2021*	7
1.47	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	43.7		47.8	39.6	*2017-2019*	5
1.42	Adults with COPD	*Percent of adults*	7.9			6.6	*2019*	4

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

1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	472.9		487.9	422.4	*2021*	7
1.33	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.3		2.2	2	*2021*	8
0.92	Adults who Smoke	*percent*	17.9	5	21.4	17	*2018*	9
0.50	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.7		4.3	4.1	*2021*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1814.2		1461	1638.9	*2021*	7
1.42	Insufficient Sleep	*percent*	37.5	31.4	40.6	35	*2018*	9
1.33	High Blood Pressure Prevalence	*percent*	33.7	27.7		32.6	*2019*	4
1.25	Morbidity Ranking	*ranking*	4				*2021*	9
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.2		41.5	41.2	*2021*	8
0.92	Poor Physical Health: 14+ Days	*percent*	12.5			12.5	*2019*	4

0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	50.9		48.6	49.4	*2021*	8
0.83	Life Expectancy	*years*	80.1		77	79.2	*2017-2019*	9
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	88.2		85.6	86.5	*2021*	8
0.75	Self-Reported General Health Assessment: Poor or Fair	*percent*	16.5			18.6	*2019*	4
0.67	Poor Physical Health: Average Number of Days	*days*	3.6		4.1	3.7	*2018*	9

SCORE	WOMEN'S HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.7		129.6	126.8	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.8	77.1		74.8	*2018*	4
0.89	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5.1		7.9	7.7	*2014-2018*	12
0.89	Cervical Cancer Screening: 21-65	*Percent*	86.8	84.3		84.7	*2018*	4

0.78	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.2	15.3	21.6	19.9	*2015-2019*	12

Medina County Data Sources

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

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

Appendix D: Community Input Assessment Tools

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health and Well-being

- From your perspective, what does a community need to be healthy?

- What do you believe are the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

Section #3: Barriers to Health

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

Section #4: COVID-19

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

Section #5: Addressing the Challenges & Solutions

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

Section #6: Conclusion

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

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

Appendix E: Community Partners and Resources

This section identifies other facilities and resources available in the community served by CCRH Edwin Shaw 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).[21] 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 Edwin Shaw Community:

- Asian Services in Action, Inc.
- Axesspointe Community Health Center, Inc.
- Care Alliance
- Community Support Services, Inc.
- Health Source of Ohio
- Medina County Health Department
- MetroHealth Community Health Centers (MHCHC)
- Neighborhood Family Practice
- Northeast Ohio Neighborhood Health Services
- Signature Health, Inc.
- The Centers

Hospitals

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

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

- Akron Children's Hospital
- Crystal Clinic Orthopedic Center
- Grace Hospital
- MetroHealth Medical Centers (Multiple Locations)
- Select Specialty Hospital- Akron
- St. Vincent Charity Medical Center
- Summa Health System – Akron Campus
- University Hospitals (Multiple Locations)
- Western Reserve Hospital

Other Community Resources

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

Edwin Shaw

Implementation Strategy Report

2022

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

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CEVELAND CLINIC REHABILITATION HOSPITAL, EDWIN SHAW 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 Edwin Shaw 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

Edwin Shaw 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/.

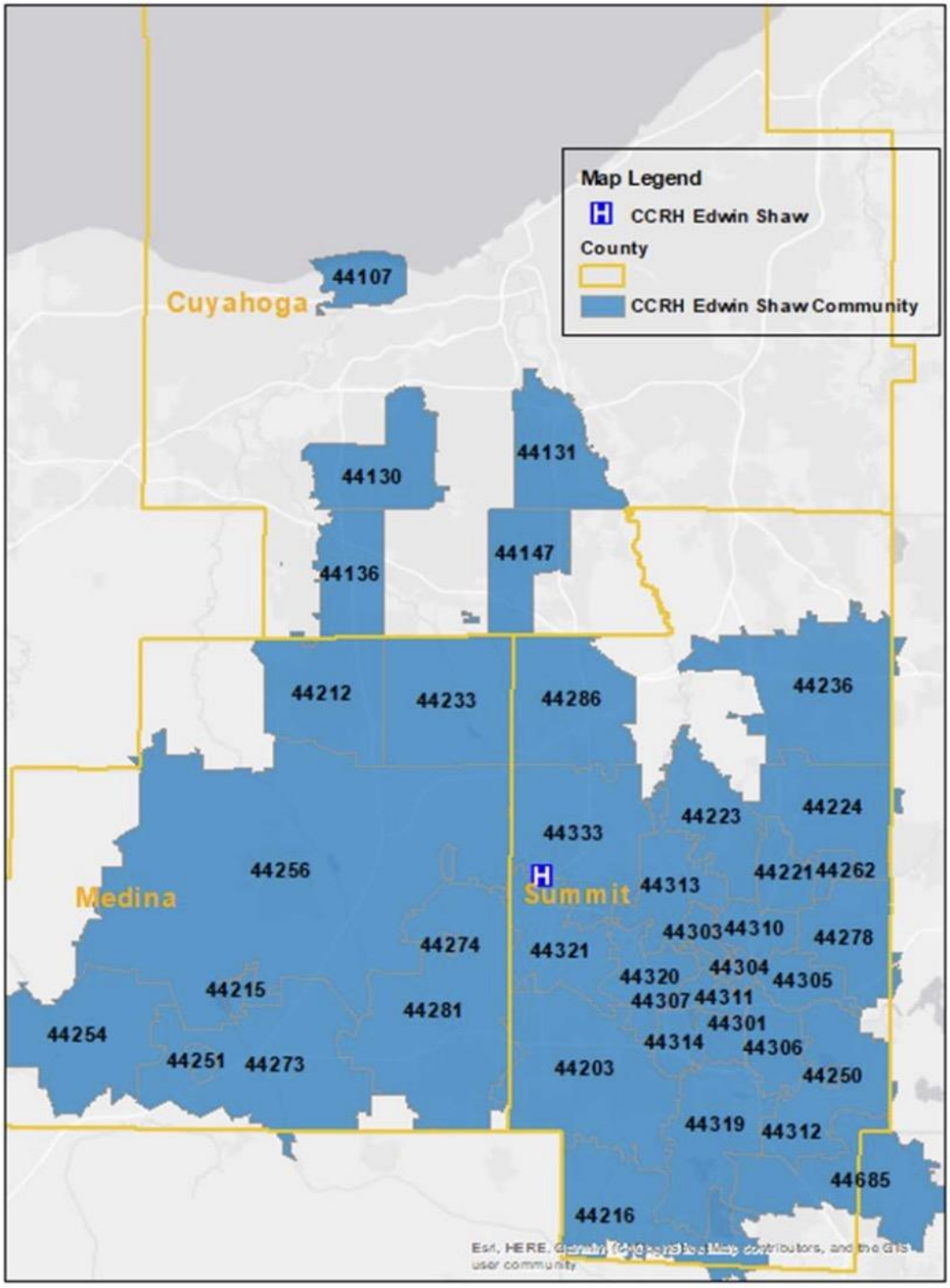
Edwin Shaw's mission is:

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, Edwin Shaw's community definition is an aggregate of 42 zip codes in Cuyahoga, Medina and Summit Counties comprising approximately 75% of inpatient visits in 2021 (Figure 1).

Figure 1: Edwin Shaw Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of senior leadership at Edwin Shaw 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 Edwin Shaw 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

Edwin Shaw'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 health 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 Edwin Shaw 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. Edwin Shaw 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. Edwin Shaw Rehabilitation provides medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. Edwin Shaw 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: Edwin Shaw Rehabilitation Financial Assistance.
2. The term "rehabilitation" is widely used to describe many different levels of care, which contributes to confusion among stakeholders. The physical medicine & rehabilitation offered at Edwin Shaw 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. Edwin Shaw 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, Stroke and Spinal Cord Injury Program teams at Edwin Shaw Rehabilitation provide a variety of 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, Edwin Shaw Rehabilitation hopes to impact concerns for older adult mental health from isolation with virtual and in person support group activities and education, the management of chronic conditions, and access/education 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/family medicine, pulmonologists, and nephrologists that are available for consultation regarding secondary diagnoses or complications related to the new injury/illness. Additionally, through Edwin Shaw 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. The attending psychiatrist often will start 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 help patients realize and replicate common activities of daily living that will need to be performed after discharge.
5. The population in Edwin Shaw 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. Edwin Shaw 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, Edwin Shaw 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 Edwin Shaw'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. Edwin Shaw actively collaborates with the Northeast Ohio Brain Injury Foundation and the Ohio Brain Injury Association to assist individuals and their families recovering from brain injury to identify resources and support community reintegration where possible. Our Heads Up No Boundaries Brain Injury support group provides ongoing support to current and former patients, their caregivers as well as an interdisciplinary education series addressing a variety of life span topics related to brain injury recovery.
8. Edwin Shaw's group of interdisciplinary caregivers consisting of physicians, nurses, therapists, case managers, respiratory therapists, recreation therapists, pharmacists, nurse assistants and administration regularly sponsors activities to support and benefit the local community including but not limited to healthcare fairs, participating in the American Heart Walk, Breast Cancer Survivor Walk; organizing annual food drives and donations to the Akron/Canton Food Bank and also sponsor 2-3 families residing at the Haven of Rest Homeless Shelter.

C. Community Safety

Community Safety Issues, though similar in nature to social determinants of health (SDOH), stand 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. Edwin Shaw 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 Edwin Shaw Rehabilitation's goals for our patients. Since Edwin Shaw 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 has been developed 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. Edwin Shaw 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.
    a. 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.
    b. 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 Edwin Shaw 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 Edwin Shaw 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 .

clevelandclinic.org/**CHNAreports**

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