Cleveland Clinic
Avon Hospital

Community Health Needs Assessment

2025



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Avon Hospital 2025 Community Health Needs Assessment

Introduction

Avon Hospital, a member of the Cleveland Clinic health system, is a 126 staffed-bed[1] state-of-the-art, full-service hospital located in Lorain County, adjacent to the Cleveland Clinic Richard E. Jacobs Health Center. Opened in 2016, the five-story, 212,000-square-foot facility was the first Cleveland Clinic hospital built from the ground up in the region and is among the most technologically advanced in Northeast Ohio. Avon Hospital offers a broad range of services, including critical care, orthopedic surgery, and outpatient procedures, along with advanced surgical capabilities supported by six operating rooms.

As part of the broader Cleveland Clinic health system, Avon Hospital upholds the tripartite mission of clinical care, research, and education. Cleveland Clinic is a nonprofit, multispecialty academic medical center that integrates hospital-based services with innovative research and the training of future healthcare professionals. Currently, with more than 82,000 caregivers, 23 hospitals, and 280 outpatient facilities around the world, Cleveland Clinic is recognized as one of the world's leading healthcare systems. Its collaborative, patient-centered model of care promotes improved outcomes and enhances quality of life for patients both locally and internationally.

The Cleveland Clinic health system includes its flagship academic medical center near downtown Cleveland, fifteen regional hospitals in Northeast Ohio, a children's hospital and children's rehabilitation hospital, and additional hospitals and facilities in Florida and Nevada. Each hospital, including Avon, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Avon Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Avon Hospital also plays a vital role within its immediate neighborhood, advancing the Cleveland Clinic's mission of improving community health. The hospital actively supports programs, partnerships, and services that address local health needs and promote equal health access. It has received national recognition for excellence in patient safety and care quality, and remains committed to treating every patient with kindness, dignity, and respect.

The Cleveland Clinic's legacy as a pioneering institution began in 1921 as a multispecialty group practice, and it continues to lead through medical firsts, global expansion, and a commitment to community health. Today, Avon Hospital exemplifies this vision by delivering high-quality care, supporting health-focused research, and fostering community partnerships that help address both medical and social drivers of health.

[1] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q3 2025) interim financial statement is referenced for official bed count. We acknowledge that staffed bed count may fluctuate and may differ from registered or licensed bed counts reflected in other descriptions.

Avon Hospital is a trusted part of the community and continues to grow and improve to meet the needs of its patients. To learn more, visit: my.clevelandclinic.org/locations/avon-hospital.

CHNA Background

As part of its mission to improve health and well-being in the communities it serves, Avon Hospital led a Community Health Needs Assessment (CHNA) process to better understand the most important health issues facing residents. The Patient Protection and Affordable Care Act, enacted on March 23, 2010, requires not-for profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements of the Internal Revenue Code 501(r). Cleveland Clinic engaged Conduent Healthy Communities Institute (HCI) to guide the 2025 CHNA process using national, state, and local secondary data as well as qualitative community feedback.

Avon Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Avon Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Avon Hospital community that served as a guide for data collection and analysis for this CHNA. Table 1 lists zip codes and associated neighborhoods that comprise the community definition.

Figure 1: Avon Hospital Community Definition

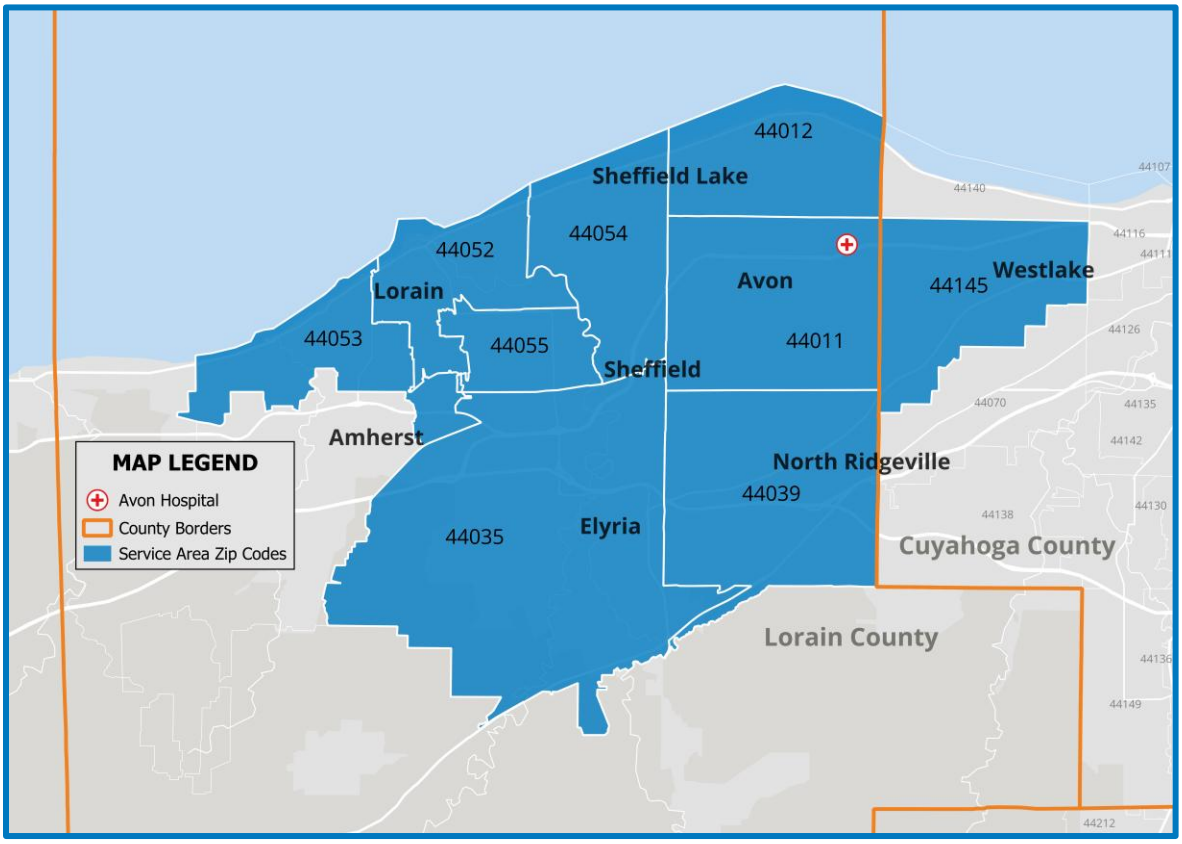


Table 1: Avon Hospital Community Definition

Zip Code	Postal Name
44011	Avon
44012	Avon Lake
44035	Elyria
44039	North Ridgeville
44052	Lorain
44053	Lorain
44054	Sheffield
44055	Lorain
44145	Westlake

Secondary Data Methodology and Key Findings

Secondary Data Scoring

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, health-related social needs, and quality of life. The data are primarily derived from state and national public secondary data sources such as the U.S. Census American Community Survey (ACS Survey), Centers for Disease Control & Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), County Health Rankings, Feeding America, and the National Cancer Institute. These indicators were analyzed at the county level and within defined zip-codes of the Avon Hospital community area. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced five key health priorities, Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, highlighting differences in outcomes by group.

Other Community Assessment and Improvement Plans

An environmental scan was conducted to supplement quantitative data and further contextualize health needs across the hospital's defined community. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts, including reports from the nonprofits, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs prioritized in this 2025 CHNA process for Avon Hospital.

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; behavioral health treatment gaps remain significant; chronic disease management is challenged by food insecurity and inadequate recreational infrastructure; differences in maternal and child health outcomes, and health-related social needs, particularly poverty, housing insecurity, and gun violence, impact all other areas of health.

Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations with community stakeholders were conducted across the Avon Hospital community. Community stakeholders from 12 organizations provided feedback for the Avon Hospital community. Participants represented sectors including public health, mental health, housing, food access, child and family services, and grassroots organizations. Feedback consistently reinforced the five identified health priorities and revealed community-specific challenges affecting health outcomes, such as long wait times for pediatric care, gaps in behavioral health support, housing-related health risks, and challenges accessing culturally competent prenatal care. Economic hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and systems-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

Avon Hospital's 2025 Community Health Needs Assessment reaffirms its commitment to addressing five core health priorities based on a rigorous synthesis of primary data in the form of community stakeholder interviews, secondary indicators from national and state data sources, and a regional environmental scan. The following five prioritized health needs will help shape the hospital's Implementation Strategy Reports (ISR) for the subsequent three years:

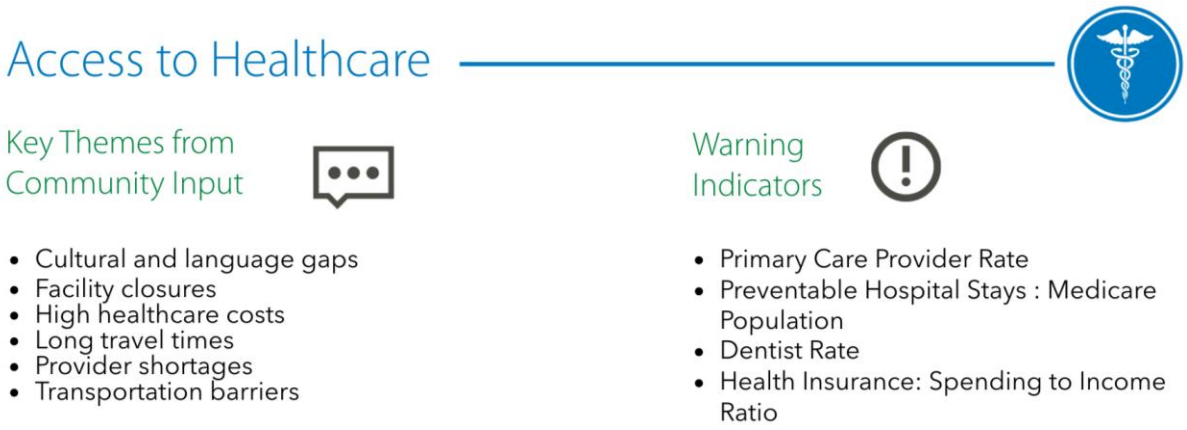


These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that Lorian County continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to improve health outcomes across populations in the community served by Avon Hospital.

The five prioritized community health needs identified in this 2025 Avon Hospital CHNA are summarized below. Within each summary, pertinent information pertaining to secondary data findings, primary data findings and relevant demographics, social drivers

of health, and differences in health outcomes are highlighted. Full data details are included in the appendices section at the end of this report.

Prioritized Health Need #1: Access to Healthcare



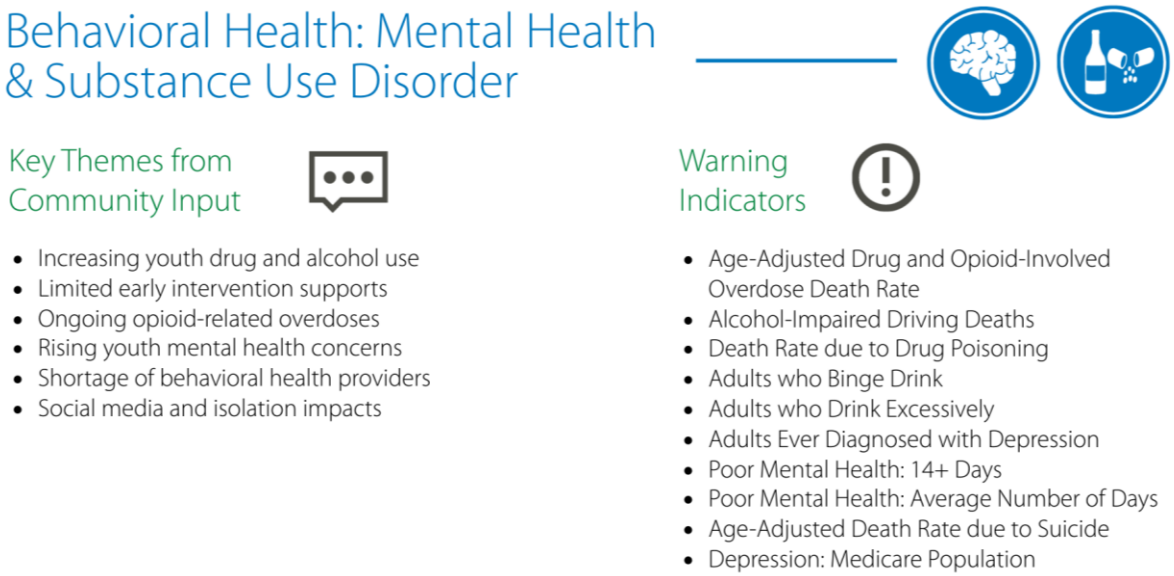
Access to Healthcare emerged as a significant concern, with stakeholders citing both geographic and service-related barriers that limit timely and equal care. Residents in rural and under resourced pockets of the county face difficulties accessing medical services, including primary and specialty care, emergency services, and preventive screenings. The closure of certain facilities and the limited availability of emergency rooms have increased travel times and reduced local options, particularly affecting older adults and individuals without reliable transportation. Challenges are compounded by shortages in providers and uneven distribution of healthcare resources, leaving some communities without adequate access to pharmacies, clinics, or urgent care centers.

Affordability and health literacy were also identified as key factors influencing access. Even where services are physically available, cost and insurance coverage gaps remain barriers, especially for prescription drugs and ongoing treatment. Participants noted that families with limited financial means may delay care or forego preventive services, increasing the risk of avoidable complications. Stakeholders also mentioned a need for more culturally and linguistically appropriate services to meet the needs of the community. Expanding outreach, improving transportation options, and strengthening local healthcare infrastructure were viewed as essential steps toward ensuring that all residents can obtain timely, affordable, and appropriate care.

Secondary data demonstrate that Lorain County has especially low rates of primary care providers and dentists, compared to both Ohio and the nation. Across the county, there are an average of 51.6 primary care providers per 100,000 persons, and this rate has been significantly decreasing over time. The county also has a high rate of avoidable hospital stays. Among the county's Medicare enrollees, the rate of hospital stays that could have been avoided with routine care (3,494 per 100,000) is higher than most other Ohio counties. These hospital stays are especially common among the county's Black/African American Medicare (5,104 per 100,000).

Geospatial data from Conduent HCI's Community Health Index (CHI) further underscore the magnitude of access challenges. The CHI estimates health risk based on health-related social needs associated with preventable hospitalizations and poor health outcomes. Within the Avon Hospital community, the highest scoring zip codes were 44055 and 44052 in the city of Lorain, with index values of 92.2 and 94.1, respectively. Notably, these two zip codes received the highest index values in the region for all three of Conduent HCI's Community Health Indices, indicating a confluence of particularly high needs around general health outcomes as well as food access and mental health, specifically. These findings demonstrate that barriers to healthcare are not only widespread across the hospital community but are also particularly concentrated in the city of Lorain. Additional details including charts, maps, and additional findings from primary and secondary data for this health need can be found in the appendices section of this report.

Prioritized Health Need #2: Behavioral Health



Behavioral health was identified by stakeholders as a major community health priority, with significant concern for mental health challenges, substance use, and addiction. Participants noted rising rates of anxiety, depression, and suicidal ideation, particularly among youth, citing social media pressures, isolation, and family stress as contributing factors. Limited access to early intervention and school-based supports were viewed as missed opportunities for preventing more severe issues. Substance use disorder, including drug and alcohol use, was also reported as a growing concern, with stakeholders highlighting increased youth drug use, persistent opioid-related challenges, and the need for coordinated prevention and treatment strategies.

Barriers to behavioral health care include provider shortages, long wait times, high costs, and stigma associated with seeking help. Stakeholders emphasized the need to integrate mental health services into primary care, expand the behavioral health workforce, and improve collaboration between healthcare, law enforcement, and social services to ensure treatment-focused responses. Addressing behavioral health needs will require

investment in prevention, expanded community and school-based supports, and efforts to reduce stigma, which together can improve health outcomes and reduce the strain on emergency, criminal justice, and acute care systems.

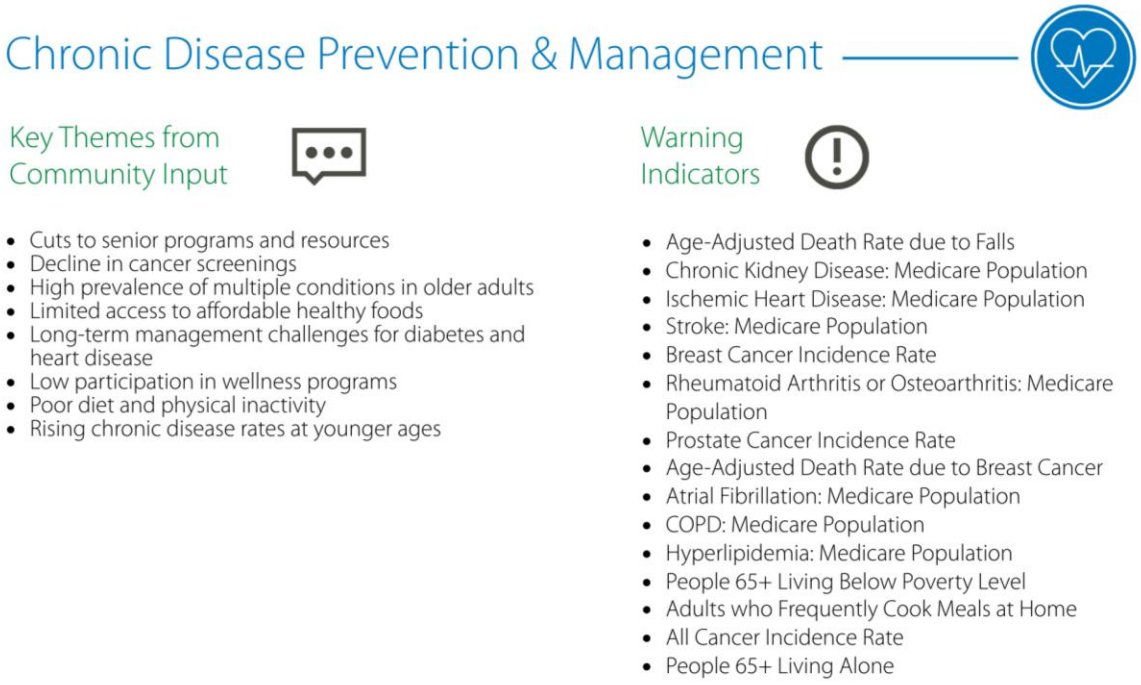
Secondary data findings demonstrate mental health challenges across Lorain County. More than a quarter of adults (27.6%) have been diagnosed with depression, which is among the highest county rates across the nation. Similarly, about one in five residents (19.6%) report experiencing at least two weeks of poor mental health in a month, placing the county in the highest quartile of all U.S. counties.

Geographic analysis using Conduent HCI's Mental Health Index (MHI), which assesses mental health risk based on local health-related social needs, demonstrates a significant burden of behavioral health needs across the Avon Hospital community. The 44052 and 44055 zip codes in the city of Lorain had the highest index scores in the region (97.6 and 95.7, respectively), highlighting a concentrated area of behavioral health need.

The topic of Alcohol and Drug Use ranked as the fourth most concerning health topic across Lorain County, based on secondary data findings. The death rate related to opioid overdose is nearly twice the U.S. rate (42.1 vs. 23.5 deaths per 100,000). More than a third of all driving deaths (37.3%) involve alcohol, which is in the highest quartile of all U.S. counties, despite recent improvements. These data reflect both the prevalence and severity of substance use issues.

Together, these primary and secondary findings highlight the profound and intersecting challenges of mental health and substance misuse within the Avon Hospital community.

Prioritized Health Need #3: Chronic Disease Prevention and Management



Chronic Disease Prevention and Management continues to be an important priority for the Avon Hospital Community based on primary and secondary data findings. Stakeholders input highlighted chronic disease prevention and management as a persistent priority with particular concern for conditions such as cancer, diabetes, heart disease, stroke, and other long-term illnesses. Participants noted that many of these conditions are being diagnosed at younger ages than in the past, often linked to lifestyle factors, gaps in preventive care, and barriers to early detection. Stakeholders also expressed concern about the community's aging population, with older adults experiencing high rates of multiple chronic conditions and facing challenges in accessing ongoing care and supportive services. These needs are compounded by limited nutrition education, uneven access to healthy food options, and differences in participation in wellness programs. Chronic Disease Prevention and Management remains a high priority for the Avon Hospital community due to its cross-cutting impact on health outcomes, resource utilization, and quality of life.

The following subsections highlight key primary and secondary data findings. Findings across all subtopics, including nutrition, cancer, cardiovascular disease, and aging, highlight persistent barriers tied to income, race, geography, and systems of care.

Nutrition, Healthy Eating, and Wellness

Stakeholders emphasized the importance of promoting healthy eating habits and improving access to nutritious food as part of chronic disease prevention. Limited availability of affordable healthy options and inconsistent participation in wellness programs were cited as barriers to maintaining healthy lifestyles. Participants also noted the role of physical activity and overall wellness in reducing the risk of chronic illnesses.

Food insecurity limits access to nutritious foods, increasing the risk of poor diet quality and contributing to the development and progression of chronic diseases such as diabetes, heart disease, and certain cancers. Conduent HCI's Food Insecurity Index (FII) can help to identify specific geographies with greater levels of food hardship, assigning standardized index values of 0 to 100 based on widely available health-related social needs data. Across the Avon Hospital community, four zip codes received an index value above 80, indicating a high prevalence of issues related to food access in the area: 44052 (Index Value: 97.5), 44055 (96.8), 44035 (87.1), and 44053 (80.3).

Cancer

Cancer was identified by stakeholders as one of the leading health concerns in the community. Individuals expressed concern about a decline in cancer screenings during recent years, which could result in delayed diagnoses. With an average caseload of approximately 1,800 new cancer cases annually, a significant drop to around 900 in one year indicated that many residents may be living with undetected disease. Early detection and screening remain a top priority.

Secondary data indicate that in Lorain County, the rate of new breast cancer cases (142.9 cases per 100,000 females) and the death rate due to breast cancer (22.0 deaths per 100,000 females) are both among the highest quartile of all Ohio counties, with the rate of new cases steadily increasing. The rate of new prostate cancer cases (124.7 cases per 100,000 males) is also among the highest quartile of all Ohio counties.

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions
Diabetes, heart disease, and hypertension were described by stakeholders as widespread and growing issues, often interconnected with and exacerbated by poor diet and physical inactivity. Participants noted that these conditions are affecting people at younger ages and that diabetes, in particular, is often managed over many years with significant impacts on quality and length of life. Stroke and other chronic illnesses were also mentioned as part of a broader pattern of preventable and manageable health issues that require better education, prevention, and care coordination.

According to secondary data, about one in ten adults in Lorain County (9.6%) have diabetes. About one in four Medicare recipients (25.0%) in the county have diabetes, and nearly the same percentage have chronic kidney disease (23.0%), which is a concern often related to unmanaged diabetes. Notably, diabetes is more common among the county's Black/African American (37.0%), Asian American/Pacific Islander (37.0%), and Hispanic/Latino (36.0%) Medicare populations. However, chronic kidney disease is more common only among the county's Black Medicare recipients (35.0%), which may indicate a significant gap in care for this specific population.

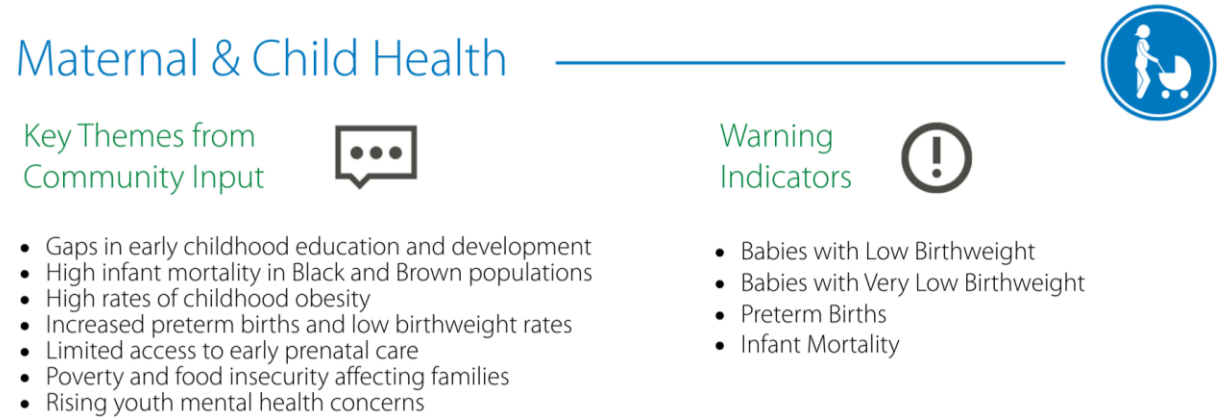
Heart disease stroke are also burdensome health issues, especially for older adults. Among Lorain County's Medicare population, one in four (25.0%) have ischemic heart disease and 7.0% have had a stroke, with both rates falling in the highest quartile of all Ohio counties. Stroke mortality in Lorain County is 40.5 deaths per 100,000—lower than the state average but well above the Healthy People 2030 goal (33.4) and rising.

Older Adult Health
The aging population in the Avon Hospital community faces unique challenges in managing chronic diseases. Stakeholders noted a lack of dedicated senior service funding, including the absence of a senior services levy in Lorain County. Cuts to senior programs have further strained resources, limiting access to transportation, nutrition support, and ongoing care. Older adults living with multiple chronic conditions often require more coordinated medical and social services than are currently available.

The secondary data scoring ranked Older Adult Health as the third most concerning health topic in Lorain County. Fall-related deaths are especially common, which typically occur among older adults and may be related to declines in mobility or cognitive function. The county rate is 50% higher than the U.S. rate (14.6 vs. 9.8 deaths per 100,000) and increasing. Over one-fourth of the county's population aged 65+ live alone (29.9%), and 10.3% live below the federal poverty level—both figures increasing over time.

Adult day care may help to mitigate health complications and injury related to chronic health conditions and aging, although this care may be less accessible for certain communities. The typical cost of adult day care in Lorain is 11.0% of one's household income. This spending-to-income ratio is nearly double for the county's Hispanic/Latino population (21.6%), and also higher for the Black/African American (19.5%) and Asian (16.7%) communities.

Prioritized Health Need #4: Maternal and Child Health



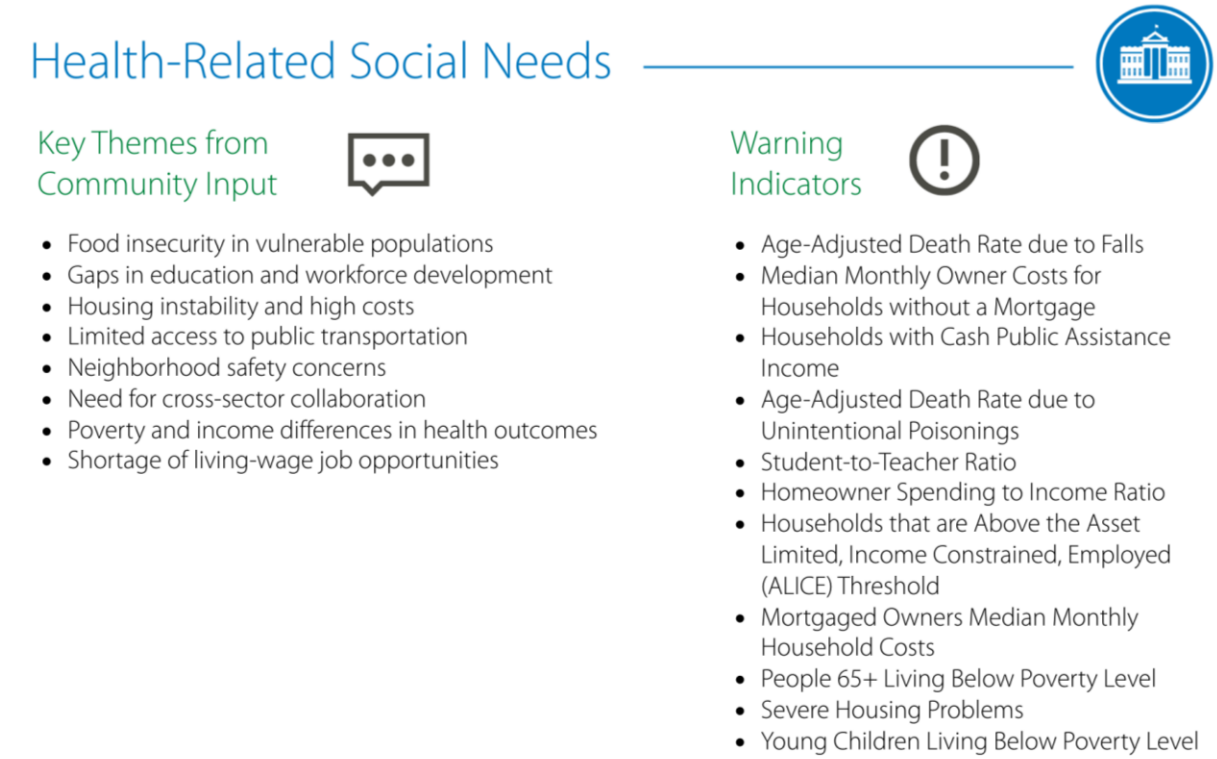
Maternal and Child Health emerged as a priority area in the Avon Hospital community, with stakeholders expressing concern over persistently high rates of infant mortality. Contributing factors identified include limited access to prenatal care, higher rates of preterm births, and health-related social needs that impact maternal and child well-being. Some participants noted that a lack of early and consistent prenatal care remains a key driver of adverse birth outcomes, while systemic challenges continue to exacerbate differences in health outcomes. Nutrition, health literacy, and access to pediatric care were also identified as areas where improvements could help strengthen health outcomes for children.

Stakeholders also discussed adolescent health, with attention to teen pregnancy prevention, reproductive health education, and the mental health needs of youth. Several emphasized that parents' attitudes toward healthcare directly influence whether children receive preventive and routine care. Other concerns included the high prevalence of childhood obesity, gaps in early childhood education and developmental support, and the need for community programs that address both physical and mental health for young people. Overall, feedback highlighted the importance of coordinated, culturally appropriate, and family-centered approaches to improving maternal, infant, and child health outcomes in the community.

Based on available secondary data, the topic of Maternal, Fetal, and Infant Health ranked as the fifth most concerning health topic in Lorain County. The rates of babies with low birthweight (9.7% of births) and preterm births (12.4%) are among the highest across Ohio and rising. The county's infant mortality rate (6.3 deaths per 1,000 live births) is also increasing, and higher than both the U.S. rate (5.4) and Healthy People 2030 target (5.0).

About one in five (19.3%) children in Lorain County are food insecure. More than a fifth (23.3%) of children under the age of five live below the federal poverty level. This poverty rate is more than two-fifths (42.3%) for the county's Hispanic/Latino population, and nearly two-thirds (63.4%) for the county's Black/African American population of young children.

Prioritized Health Need #5: Health-Related Social Needs



Health-Related Social Needs were identified by stakeholders as persistent barriers to health and well-being in the Avon Hospital community. Participants emphasized the interconnected nature of poverty, transportation, housing stability, and food insecurity, noting that these factors directly influence access to healthcare, employment opportunities, and quality of life. Significant differences exist within the community, ranging from residents living in subsidized housing to those with high incomes, creating uneven access to resources and opportunities. Many working families face challenges meeting basic needs due to low wages, inflexible work schedules, and the inability to take time off for medical care.

Transportation emerged as a recurring concern, with limited public transit options making it difficult for residents, especially older adults and low-income individuals, to reach jobs, healthcare appointments, and essential services. Housing insecurity, including the lack of affordable and stable housing, was also noted as a contributing factor to stress, instability, and poor health outcomes. Food insecurity remains a pressing issue, particularly among seniors and families with children, and is compounded by limited access to affordable, healthy food options in certain areas. Stakeholders emphasized the importance of addressing these root causes through coordinated cross-sector strategies that expand access to reliable transportation, affordable housing, and healthy food, while also creating economic opportunities that provide a living wage and job stability.

Secondary data help demonstrate some of the economic challenges experienced by the Avon Hospital community. Poverty in this community is especially concentrated in zip codes 44052 and 44055 in the city of Lorain, where more than a quarter of households

live below the poverty level (25.3% and 25.7%, respectively). Lorain County, broadly, has a higher percentage of ALICE[2] households than Ohio (27.1% vs. 25.0%), and households in Lorain County are also more likely to receive cash public assistance income than Ohio (12.3% vs. 9.5%), with this rate of public assistance rising.

Housing concerns present additional hardships for the Avon Hospital community. Households in Lorain County are more likely to spend 50% or more of their income on housing than the Ohio population (12.1% vs. 11.5%), and the median monthly housing costs for homeowners is about 15% higher than that of Ohio ($615 vs. $570).

Among the Avon Hospital community, specifically, the median household income for the community's Hispanic/Latino ($43,834), American Indian/Alaskan Native ($40,697), and Black/African American ($38,754) populations are all substantially lower than the community-wide median income ($73,463). Across Lorain County, the percentage of people living in poverty is lower than the Ohio rate; however, the percentage of young children in poverty (23.3%) and percentage of older adults in poverty (10.3%) both exceed the Ohio rates.

Prioritized Health Needs in Context

Each of the five community health needs explored above reflect persistent and interconnected challenges shaped by broader social, economic, and environmental conditions. Together, these findings underscore the importance of place and needs-based approaches to improve health outcomes. The following sections provide an overview of the demographic characteristics and social needs influencing health in the Avon Hospital community, offering additional context for understanding the differences and opportunities outlined in this report.

Secondary Data Overview

Demographics and Health-Related Social Needs

The demographics of a community significantly impacts its health profile.[3] Different groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community served by Avon Hospital, including the economic, environmental, and social drivers of health. The social drivers 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,

[2] Asset Limited, Income Constrained, Employed (or, ALICE) households have an income above the federal poverty level, but below the basic cost of living.
[3] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/

social policies, and political systems[4]. In addition to these highlights, detailed findings from the secondary data analysis can be found in Appendix B.

Geography and Data Sources

Data are presented at various geographic levels (county, zip code, and/or census tract) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data may mask issues 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 differences in health outcomes.

All data estimates are sourced from Claritas Pop-Facts® (2024 population estimates) and American Community Survey one-year (2023) or five-year (2019-2023) estimates unless otherwise indicated.

Population Demographics of the Avon Hospital Community

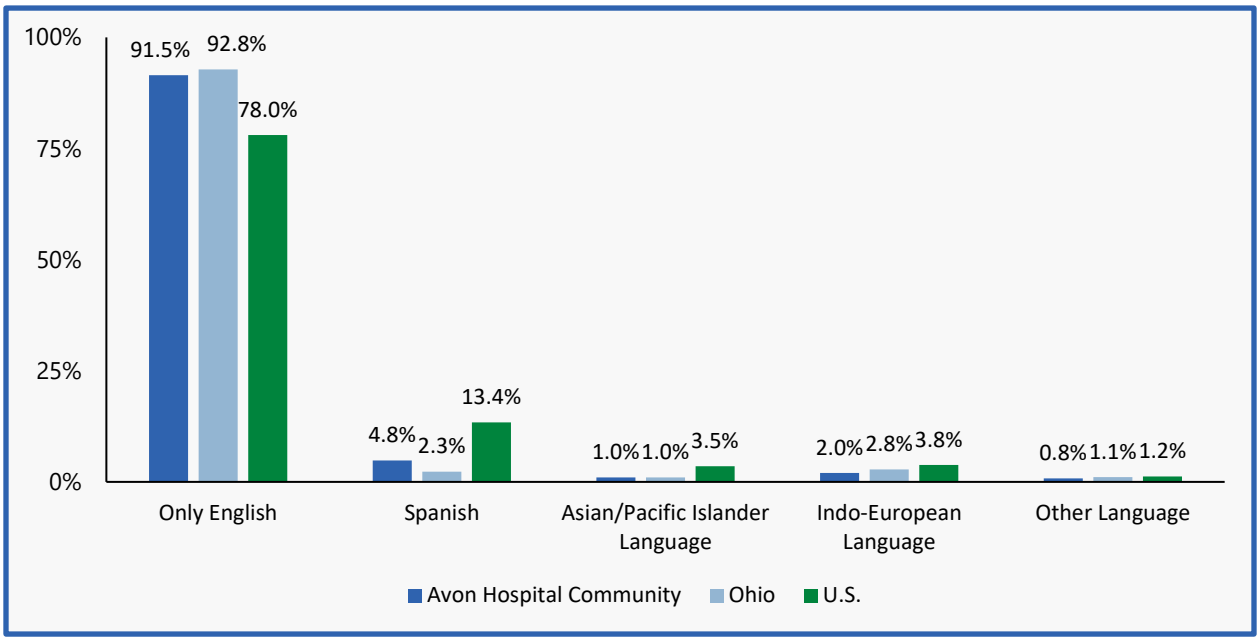
The Avon Hospital community consists of nine zip codes, including eight in Lorain County and one in Cuyahoga County, with an estimated total population of 267,958 persons. The median age in the community is 42.3 years, which is older than that of Ohio (40.3 years). About a quarter of individuals (25.6%) are between 45-64 years old.

Most of the Avon Hospital community is White (75.7%). The percentage of Hispanic/Latino residents is 12.7%, or more than twice that of the overall Ohio population. Additionally, 8.8% of the population are Black or African American and 2.0% are Asian.

Among those aged five and above, 8.5% speak a language other than English at home, including 4.8% who speak Spanish in the Avon Hospital community (Figure 2). Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

[4] Centers for Medicare and Medicaid (CMS) (2025). Social Drivers of Health and Health-Related Social Needs. https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs

Figure 2: Population 5+ by Language Spoken at Home: Hospital Community, State, and Nation



Community and state values: Claritas Pop-Facts® (2024 population estimates)

U.S. value: American Community Survey five-year (2019-2023) estimates

There has been a steady increase of Hispanic/Latino residents in Lorain County in particular. Based on American Community Survey 5-Year estimates, between 2013 and 2023 the size of the county's Hispanic and Latino population increased by nearly a third (31.3%).

Income and Poverty

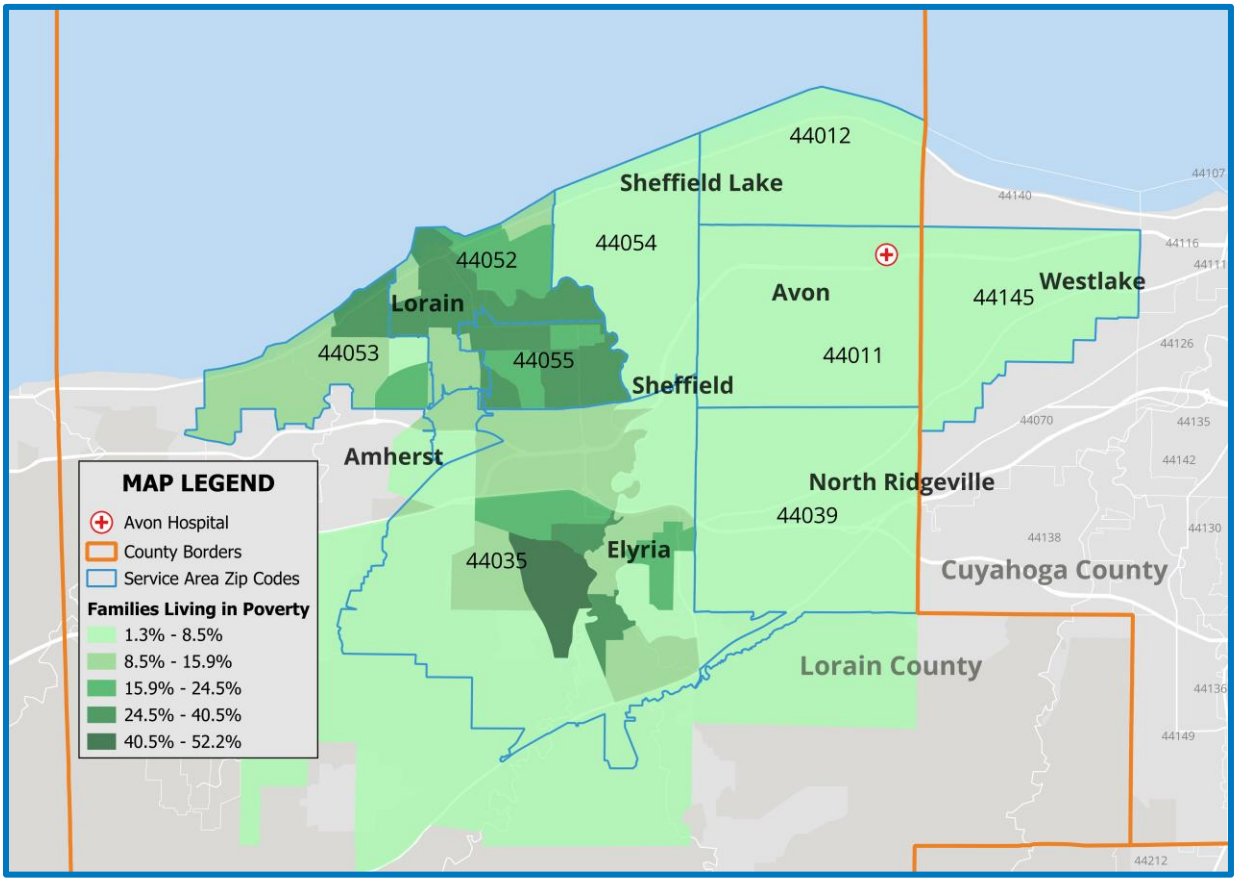
The median household income for the Avon Hospital community is $73,463, which is higher than the overall median income for Ohio ($68,488).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Overall, 11.1% of families in the Avon Hospital community live below the poverty level, which is higher than the state value (9.4%). Within the Avon Hospital community, poverty is most prevalent in the immediate vicinity of the city of Lorain. In the zip codes 44055 and 44052, about a quarter of families (25.7% and 25.2%, respectively) live below the poverty level (Figure 3).

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.[5]

[5] 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 3: Families in Poverty by Census Tract, Avon Hospital Community



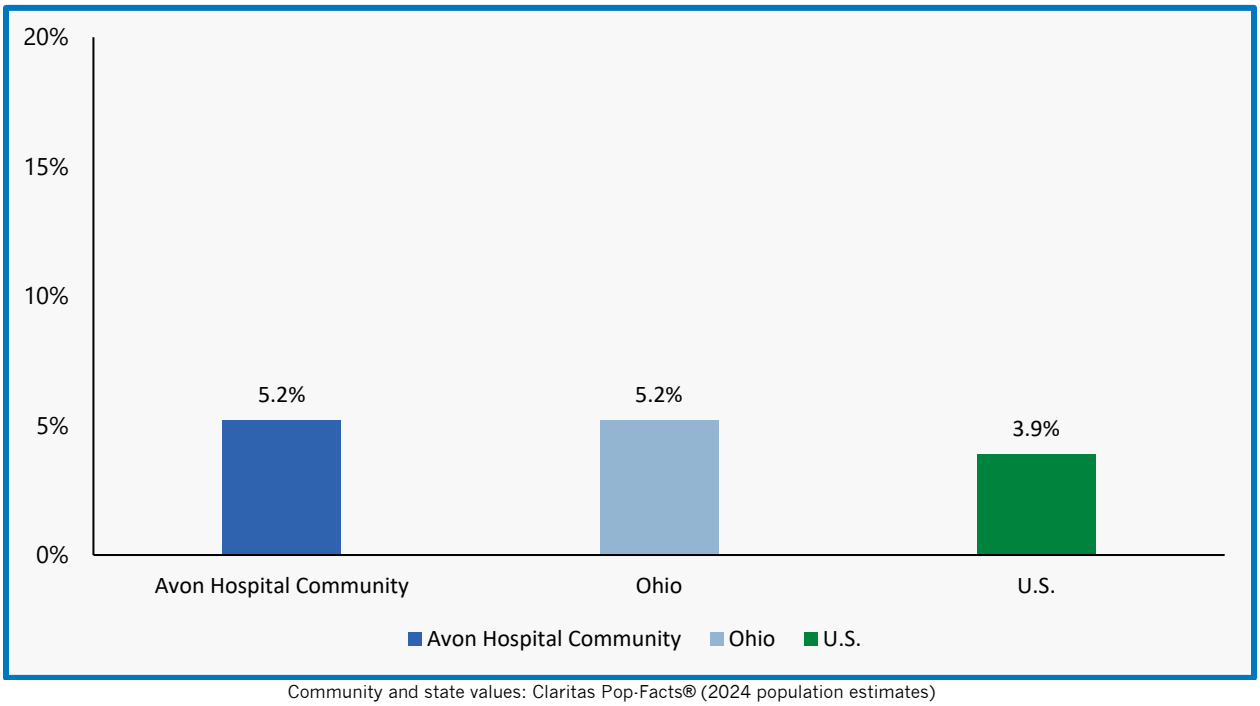
Claritas Pop-Facts® (2024 population estimates)

Education and Employment

The majority of the population within the Avon Hospital community has a high school degree or higher (92.0%), similar to both the Ohio and U.S. high school graduate rates (91.4% and 89.4%, respectively). Nearly a third of the Avon Hospital community has a bachelor's degree or higher (30.3%), which is a higher rate than the surrounding Lorain County (26.5%), but similar to the Ohio population (30.1%).

The Avon Hospital community, similar to the larger Ohio population, has an unemployment rate of about one in twenty (5.2%) persons age 16 and above (Figure 4). Each of these rates is higher than that of the U.S. population (3.9%).

Figure 4: Population 16+ Unemployed: Hospital Community, State, and Nation



Community and state values: Claritas Pop-Facts® (2024 population estimates)

U.S. value: American Community Survey five-year (2019-2023) estimates

Education is an important indicator of 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.[6] Higher levels of education may also lead to better job opportunities which, in turn, impact health. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes.[7]

Housing and Built Environment

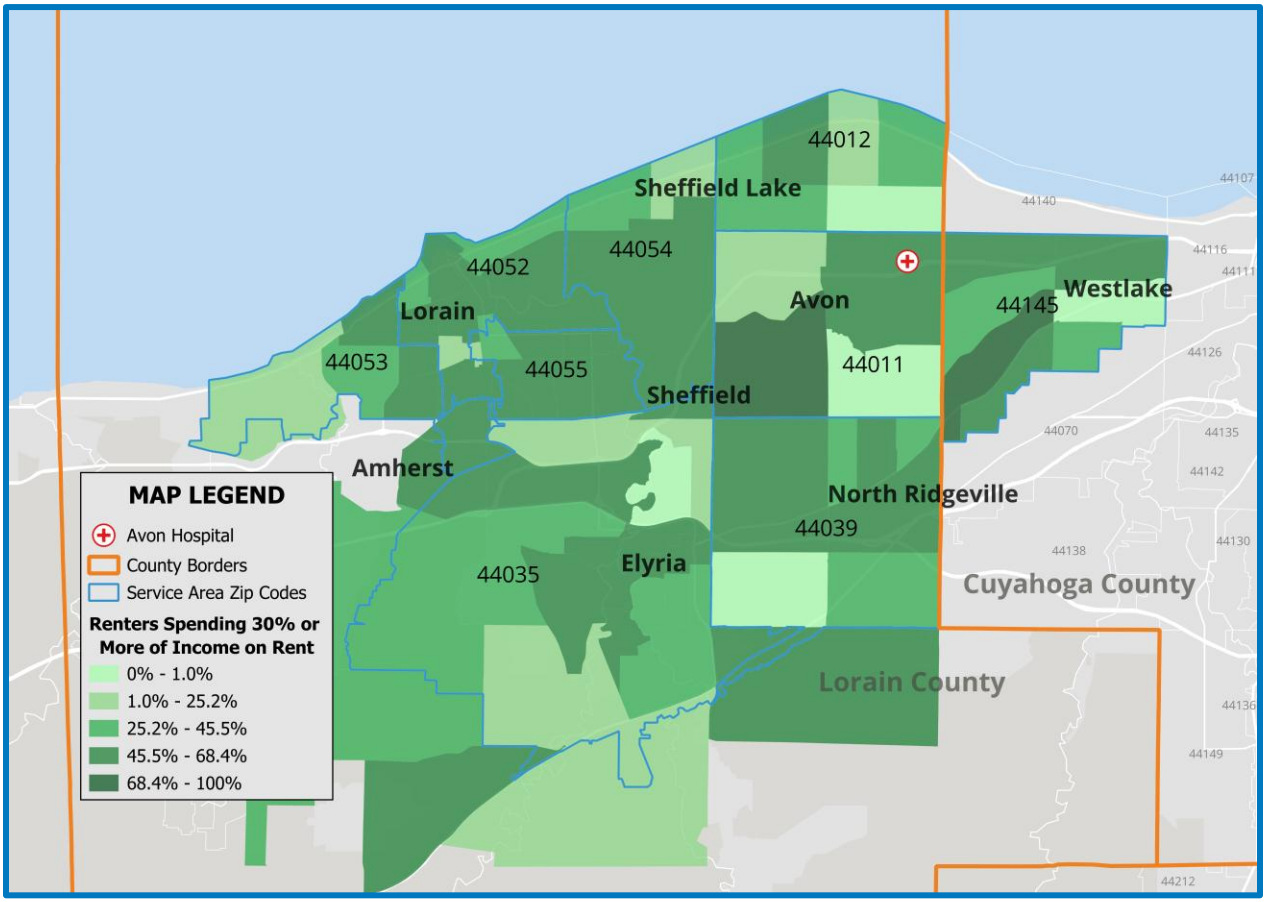
Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Severe housing problems impact 12.9% of homes in Lorain County, and 15.9% of homes in Cuyahoga County. These include problems such as overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities.

The map in Figure 5 illustrates where housing costs are especially burdensome across the community. In the zip codes 44055 and 44052, more than half of renters (54.5% and 51.8%, respectively) spend at least 30% of their income on rent.

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

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

Figure 5: High Rent Burden by Census Tract, Avon Hospital Community



American Community Survey five-year (2019-2023) estimates

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. Although the majority of those living in the Avon Hospital community have internet access, large segments of the population remain that do not have home internet access. In the zip codes 44055 and 44052, about three fourths of households have an internet subscription (72.3% and 75.6%, respectively).

Community Health Indices

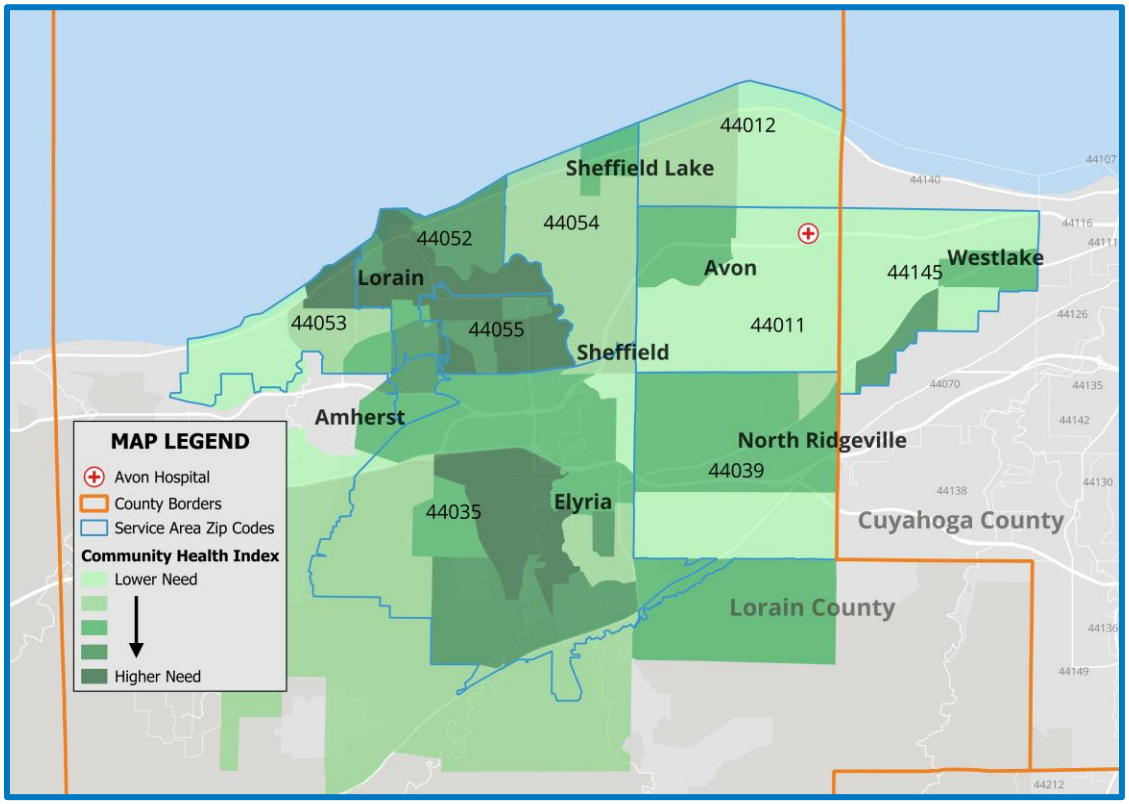
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the Avon Hospital community at the census tract level.

Community Health Index

Conduent HCI's Community Health Index (CHI) can help to identify geographic differences in health outcomes across the county, down to the census tract level. The CHI uses data on social needs and demographic characteristics that are strongly associated with poor health outcomes, such as preventable hospitalization or premature death, to estimate which geographic areas have the greatest health needs. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 6 illustrates which census tracts experience the greatest relative health needs in the Avon Hospital community, as indicated by the darkest shade of green. At the zip code level, 44052 and 44055 (Lorain) have the highest index values of the Avon Hospital Community. See Appendix B for additional details about the CHI and a table of CHI values for each zip code and census tract in the Avon Hospital community.

Figure 6: Community Health Index by Census Tract, Avon Hospital Community

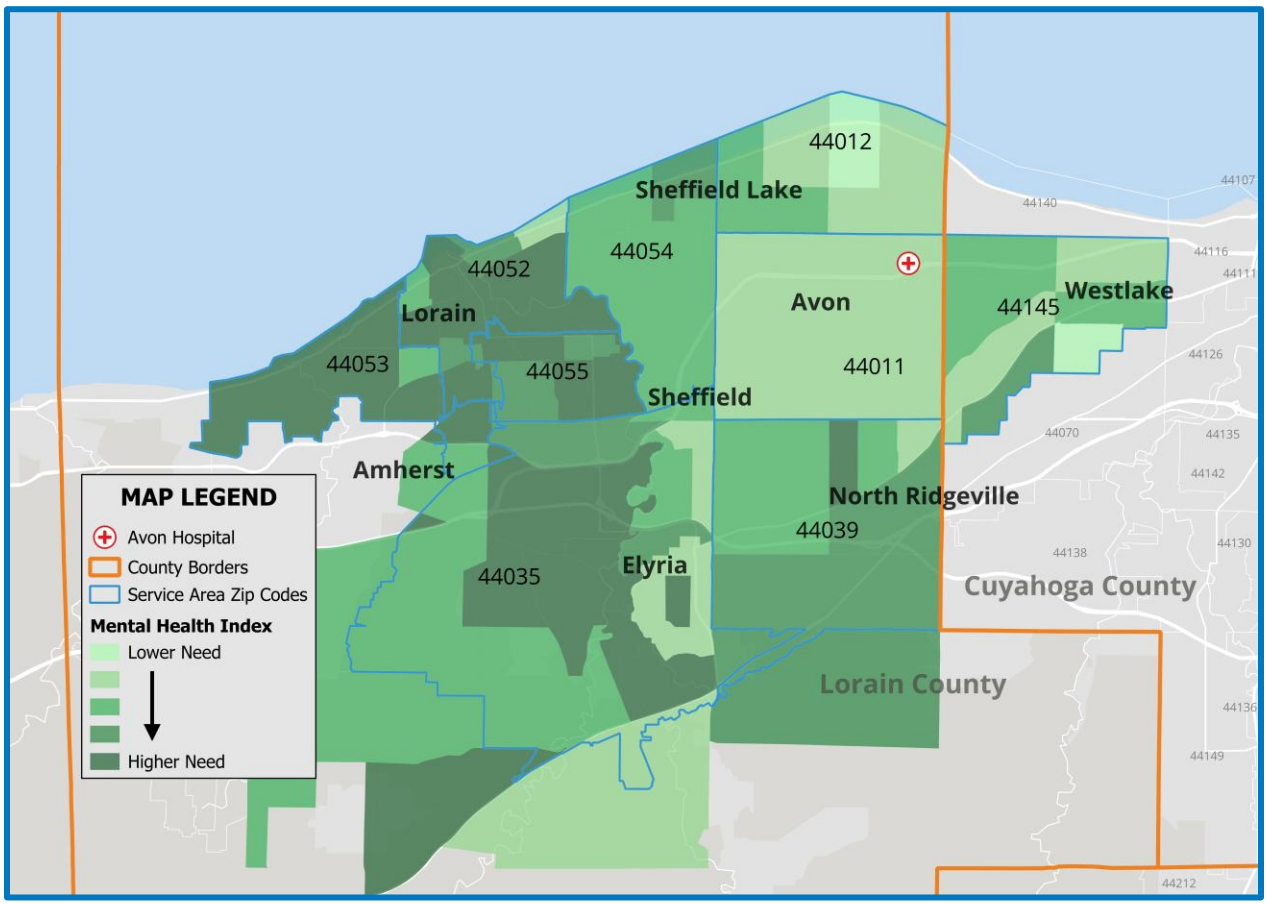


Mental Health Index

Conduent HCI's Mental Health Index (MHI) can help to identify geographic differences in mental health outcomes across the county, down to the census tract level. The MHI uses health-related social needs data that is strongly associated with self-reported poor mental health to estimate which geographic regions have the greatest mental health needs. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 7 illustrates which census tracts experience the greatest relative need related to mental health in the Avon Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44052 and 44055 (Lorain) have the highest index values of the Avon Hospital Community. See Appendix B for additional details about the MHI and a table of MHI values for each zip code and census tract in the Avon Hospital community.

Figure 7: Mental Health Index by Census Tract, Avon Hospital Community



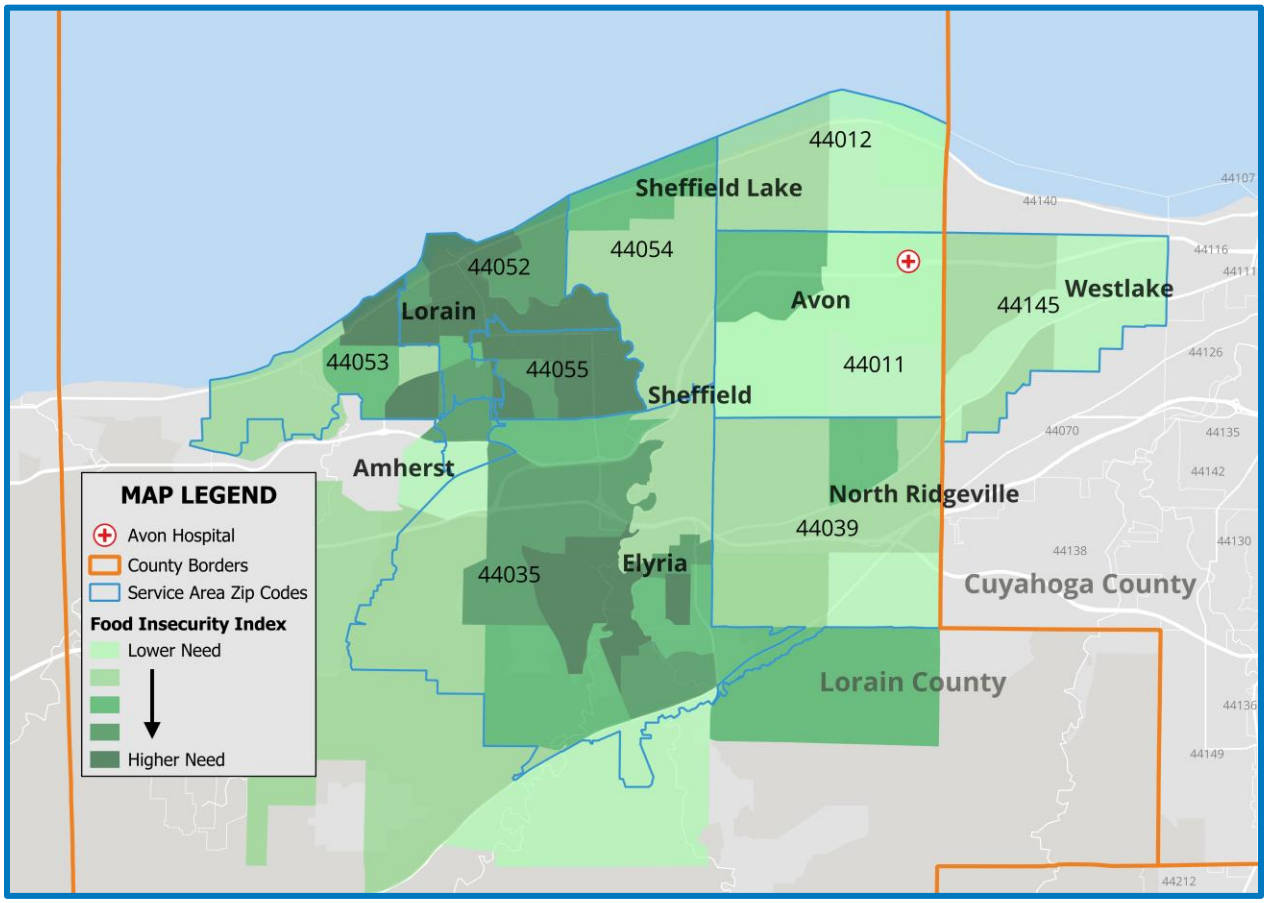
Food Insecurity Index

Conduent HCI's Food Insecurity Index (FII) can help to identify geographic differences in food access across the county, down to the census tract level. The FII uses health-related social needs data that are strongly associated with poor food access to estimate which geographic regions have the greatest needs regarding food insecurity. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the Avon Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44052 and 44055 (Lorain) have the highest index values of

the Avon Hospital Community. See Appendix B for additional details about the FII and a table of FII values for each zip code and census tract in the Avon Hospital community.

Figure 8: Food Insecurity Index by Census Tract, Avon Hospital Community



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the Avon Hospital community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the five prioritized health needs identified in Avon Hospital's 2025 CHNA. Highlights of each of the relevant documents are provided below. The methodology for conducting the environmental scan is described in Appendix C.

2023 Ohio State Health Assessment[8]

The following points summarize the key alignment between the 2023 Ohio State Health Assessment and Avon Hospital's prioritized health needs:

[8] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.

- Access to Healthcare:
    - Widespread healthcare provider shortages, especially in primary care and mental health.
    - Many Ohioans face barriers such as limited insurance coverage, low health literacy, and lack of cultural and linguistically appropriate care.
- Behavioral Health:
    - Increased rates of depression, anxiety, and suicide among both youth and adults.
    - Significant unmet mental health needs and high levels of substance use, including youth drug use and adult overdose deaths.
- Chronic Disease Prevention and Management:
    - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
    - Obesity and poor nutrition are identified as key contributors to chronic conditions.
- Maternal and Child Health:
    - Stagnant or worsening maternal morbidity and infant mortality rates.
    - Persistent differences in birth outcomes.
- Health-Related Social Needs:
    - Ongoing challenges related to poverty, housing affordability and quality, food insecurity, and transportation.
    - These social drivers of health are strongly linked to poor health outcomes across all priority areas.

2025 Lorain County Community Health Needs Assessment[9]

- Financial stability
- Housing
- Food and nutrition
- Health
- Families and children
- Employment

[9] Lorain County Public Health. (2025). *Community Health Assessment* [PDF]. Lorain County. https://www.loraincountyhealth.com/cha

2022 Greater Cleveland LGBTQ+ Community Needs Assessment[10]

- Promote a culture of respect, empathy, and mutual support within and beyond the LGBTQ+ community
- Implement and enforce anti-discrimination laws related to healthcare, workplace rights, reproductive and family rights, identification, housing, and taxation
- Combat community helplessness by offering clear, actionable solutions and encouraging engagement
- Expand access to community education in health, civic matters, cultural awareness, and emergency preparedness

2023 United Way of Greater Cleveland Community Needs Assessment[11]

Economic Mobility

- Most children are unprepared for kindergarten; enrollment in preschool
- Childcare access hindered by staffing shortages
- Cleveland ranks as the 2nd poorest large U.S. city
- Significant income differences

Health Pathways

- Differences in life expectancy
- High levels of food insecurity and poor air quality
- Poor mental health outcomes; need for trauma-informed approaches

Housing Stability

- Rent affordability challenges, especially for older adults on fixed incomes
- High volume of homeless shelter information requests

[10] Kent State University College of Public Health. (2024). *Greater Cleveland LGBTQ+ community needs assessment* [PDF]. The Greater Cleveland LGBTQ+ Community Needs Assessment Research Team. https://www.lgbtqohio.org/sites/default/files/docs/KSU-028_CommunityReport_102124_FA.pdf

[11] United Way of Greater Cleveland. (2023). *Cuyahoga County community needs assessment* [PDF]. https://www.unitedwaycleveland.org/our-work/publications/community-needs-assessment/#cc-assessment

Primary Data Overview

Community Stakeholder Conversations

Community stakeholders from 12 organizations provided feedback specifically for the Avon Hospital community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

Individuals from the following organizations participated as key informants for the Avon Hospital community:

- Avon School District
- Boys and Girls Clubs of Northeast Ohio
- Cleveland Clinic Children's Hospital
- Cuyahoga County Board of Health
- El Centro
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Lorain County Commissioners
- Lorain County Public Health
- Lorain County Veteran Service Commission
- Mental Health Addiction & Recovery Services Board of Lorain County
- Second Harvest Food Bank of North Central Ohio
- United Way of Lorain County

Across the Avon Hospital community stakeholder conversations, participants consistently emphasized the importance of addressing behavioral health, with particular concern for mental health, substance use, and youth well-being. Stakeholders described rising rates of anxiety, depression, and suicidal ideation among young people, increased youth drug use, and ongoing opioid-related overdoses. They noted that behavioral health services are often difficult to access due to provider shortages, long wait times, affordability issues, and stigma. Access to healthcare in general was also identified as a significant concern, with stakeholders citing geographic barriers, uneven service availability, and the need for culturally and linguistically appropriate care. Chronic diseases such as diabetes, heart disease, and cancer were mentioned frequently, often linked to lifestyle factors such as poor nutrition, physical inactivity, and limited participation in preventive care. Housing conditions, food insecurity, and transportation limitations were also described as contributing to the difficulty of managing these health issues.

Community stakeholders also discussed the critical role of social needs including poverty, education, employment, transportation, and housing, as key drivers of health outcomes in the Avon Hospital community. These issues were often described as interconnected, with housing instability and food insecurity exacerbating residents' challenges in managing chronic conditions or accessing timely preventive and routine care. Several participants pointed to structural challenges such as limited funding for essential services, and underinvestment in certain neighborhoods. Concerns about trust in healthcare providers, the lack of preventive care infrastructure, and insufficient

integration of health and social services further underscored the need for coordinated, community-based strategies to improve health outcomes across the Avon Hospital community. The following quotes highlight key themes identified in stakeholder feedback.

Priority Area	Key Quote	Additional Context
Access to Healthcare	"There are families in our community that do not have access to medical care or even basic needs like food, which makes it harder for students to stay healthy and engaged in school."	A school system stakeholder noted that lack of medical care and basic resources directly impact student health, attendance, and performance.
Behavioral Health	"We have a student mental health crisis, and social media plays a big role in that."	A youth-focused stakeholder linked rising student mental health challenges to social media pressures and the need for more school-based supports.
Chronic Disease Prevention and Management	"We have more people living with diabetes, and while we can keep them alive, their quality of life is often diminished."	A stakeholder noted that long-term management of diabetes remains a major challenge, with the disease significantly affecting both life expectancy and day-to-day well-being in the community.
Maternal and Child Health	"We are seeing our moms not getting prenatal care, which is leading to more preterm births."	A stakeholder expressed concern that lack of early and consistent prenatal care is contributing to preventable adverse birth outcomes in the community.
Health-Related Social Needs	"Transportation, housing, and poverty all play into whether people can get the healthcare they need or participate in preventive services."	A stakeholder highlighted how interconnected social and economic barriers limit access to both routine and preventive healthcare in the community.

Prioritization Methodology

Avon Hospital's 2025 Community Health Needs Assessment (CHNA) reaffirmed its focus on the same five core health priorities identified in the previous assessment through a comprehensive and data-driven prioritization process. This decision was guided by a rigorous review of primary data, including stakeholder interviews with community leaders and subject matter experts, alongside secondary data analysis from national, state, and regional sources. An environmental scan further contextualized the findings, providing insight into persistent systemic and community-level challenges. The convergence of qualitative and quantitative findings demonstrated continued differences in areas such as access to care, behavioral health, chronic disease, and health-related social needs. Consistent community feedback, coupled with county-level data showing outcomes that continue to exceed state and national benchmarks in these domains, reinforced the need for ongoing, coordinated efforts. As a result, Avon Hospital has prioritized the same five health needs for its 2026–2028 Implementation Strategy Report, ensuring continuity in addressing longstanding health challenges and advancing improved outcomes for the populations it serves.

Collaborating Organizations

The fifteen regional hospitals within the Cleveland Clinic health system in Northeast Ohio collaborate to share community health data and resources throughout the CHNA and implementation strategy processes. Avon Hospital is part of the Cleveland Clinic West Submarket which includes Lutheran, Fairview, and Avon hospitals.

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[12] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services. In Ohio, the Ohio Association of Community Health Centers (OACHC) represents 57 Community Health Centers operating at over 400 locations, including mobile units, and supports access to care through federal funding and enhanced Medicaid and Medicare reimbursement. Within the community served by Avon Hospital, community health services are further supported by local public health agencies, including Lorain County Public Health and the Cuyahoga County Board of Health. The following FQHC clinics and networks operate in the Avon Hospital community:

- Asian Services in Action, Inc.
- Care Alliance

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

- Health Source of Ohio
- Lorain County Health & Dentistry
- MetroHealth Community Health Centers
- 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 Avon Hospital community:

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

Other Community Resources

A network of agencies, coalitions, and organizations provides a broad array of health and social services within the region served by Avon Hospital. United Way 2-1-1 Ohio offers a comprehensive, statewide online resource directory that connects individuals to essential health and human services. This service, supported by the Ohio Department of Social Services in partnership with the Council of Community Services, The Planning Council, and local United Way chapters serves as a vital referral tool. United Way 2-1-1 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
- Healthcare
- 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 www.211oh.org.

Comments Received on Previous CHNA

Community Health Needs Assessment reports from 2022 were published on the Avon Hospital and Cleveland Clinic websites. No community feedback has been received as of the drafting of this report. For more information regarding Cleveland Clinic Community Health Needs Assessment and Implementation Strategy reports, please visit www.clevelandclinic.org/CHNAreports or contact CHNA@ccf.org

Request for Public Comment

Comments and feedback about this report are welcome. Please contact: chna@clevelandclinic.org.

Appendices Summary

A. Avon Hospital Community Definition

B. Secondary Data Sources and Analysis

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

C. Environmental Scan and Key Findings

Environmental scan findings from the region comparing significant and prioritized health needs as well as identifying other relevant contextual data and associated programs and interventions.

D. Community Input Assessment Tools and Key Findings

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
- Summary Qualitative Findings

E. Impact Evaluation

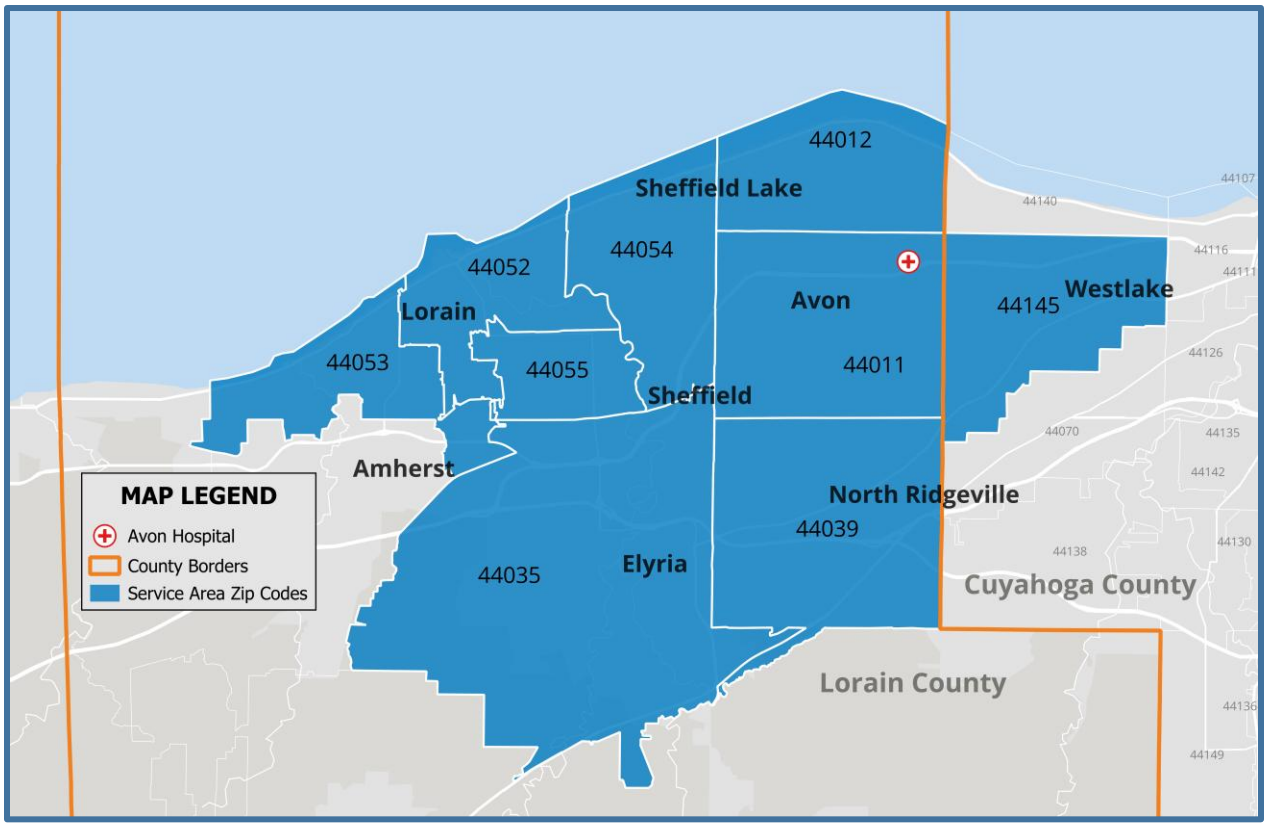
An overview of progress made on the 2022 Implementation Strategies.

F. Acknowledgements

Appendix A: Avon Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Avon Hospital Emergency Department discharges originated in 2023. Figure 9 shows the specific geography for the Avon Hospital community that served as a guide for data collection and analysis for this CHNA. The Avon Hospital community consists of nine zip codes, including eight in Lorain County and one in Cuyahoga County.

Figure 9: Avon Hospital Community Definition



Appendix B: Secondary Data Sources and Analysis

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 (HCI). This database includes more than 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.

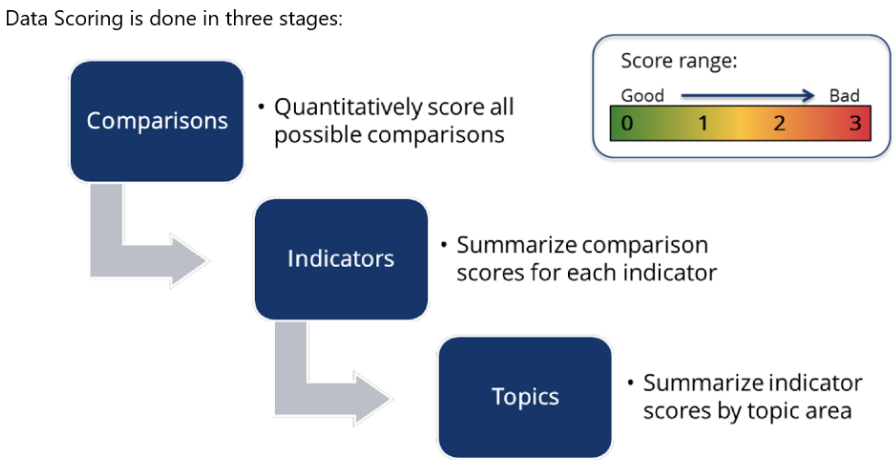
The following is a list of both local and national sources used in the Avon Hospital Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Feeding America
- 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
- Purdue Center for Regional Development
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Census Bureau - Small Area Health Insurance Estimates
- U.S. Environmental Protection Agency
- United For ALICE

Secondary Data Scoring

HCI's Data Scoring Tool was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. Due to restrictions regarding data availability, analysis was completed at the county level. For each indicator, the county value was compared to a distribution of other Ohio and U.S. counties, state and national values, targets defined by Healthy People 2030, and significant trends over time (see Figure 10). Based on these comparisons, each indicator is scored on a standardized scale ranging from 0 to 3, where 0 indicates least concern and 3 indicates greatest concern. Availability of each type of comparison depends on the indicator's data source, comparability with other communities, and changes in methodology over time. After scoring all available indicators, we grouped indicators into topic areas to assign summary scores for topic areas. Indicators may be categorized into more than one topic area, and topic areas with fewer than three indicators were not scored.

Figure 10: Summary of Topic Scoring Analysis



For the purposes of the Avon Hospital Community, this analysis was completed for Lorain County. A complete breakdown of topic and indicator scores can be found below.

Comparison to a Distribution of County Values: State and Nation

For ease of interpretation and analysis, distribution data for each indicator is visually represented as a green-yellow-red gauge illustrating how the county fares against a distribution of counties across either the state or across the nation. 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, and red) based on their order. Counties with the most concerning scores are "in the red" and those with the least concerning scores are "in the green."

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and the target value. Target values are defined by nation-wide Healthy People 2030 (HP2030) goals. HP2030 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 more or less concerning 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 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, 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 found below.

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 to 3, where a higher score indicates more concerning outcomes. A topic score is only calculated if it includes at least three indicators. See Figure 11 for a complete list of the potential health and quality of life topic areas examined in this analysis.

Figure 11: Health and Quality of Life Topic Areas



Topics that received a score of 1.50 or higher were considered a significant health need. Nine health topics scored at or above this threshold in Lorain County (see Tables 2 and 3).

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 2 and 3 below. The highest scoring health need in Lorain County was *Other Chronic Conditions* with a score of 2.07.

Table 2: Health Topic Scores: Lorain County

Health Topic	Score
Other Chronic Conditions	2.07
Weight Status	1.89
Older Adults	1.76
Alcohol & Drug Use	1.76
Maternal, Fetal & Infant Health	1.73
Prevention & Safety	1.68
Heart Disease & Stroke	1.65
Women's Health	1.51
Mental Health & Mental Disorders	1.50
Wellness & Lifestyle	1.49
Nutrition & Healthy Eating	1.49
Oral Health	1.42
Respiratory Diseases	1.40
Health Care Access & Quality	1.35
Mortality Data	1.35
Physical Activity	1.33
Cancer	1.31
Diabetes	1.27
Tobacco Use	1.17
Children's Health	1.17

Sexually Transmitted Infections	1.07
Immunizations & Infectious Diseases	0.91

Table 3: Quality of Life Topic Scores: Lorain County

Quality of Life Topic	Score
Community	1.45
Education	1.42
Economy	1.36
Environmental Health	1.28

Conduent's SocioNeeds Index Suite®

Conduent HCI's SocioNeeds Index Suite® provides analytics around non-medical drivers of health to better understand how health outcomes differ by geography and identify areas for action. The suite includes the Community Health Index, Food Insecurity Index, and Mental Health Index. See Table 4 for a full list of index values for each zip code in the Avon Hospital community.

Table 4: Community Health Index, Food Insecurity Index, and Mental Health Index Values for Avon Hospital Community Zip Codes

Zip Code	CHI Value	FII Value	MHI Value
44011	8.9	15.9	38.9
44012	8.0	17.1	30.4
44035	75.1	87.1	94.7
44039	30.3	37.1	67.5
44052	94.1	97.5	97.6
44053	45.8	80.3	87.5
44054	33.3	48.7	69.8
44055	92.2	96.8	95.7
44145	14.8	15.8	64.4

Census Tract Key

The figures and tables below should serve as a guide for identifying census tracts that are described in various maps throughout this report. Figure 12 and Table 5 show the census tracts for each zip code in the eastern portion of the Avon Hospital Community.

Figure 12: Census Tract Key (Avon Hospital, East)

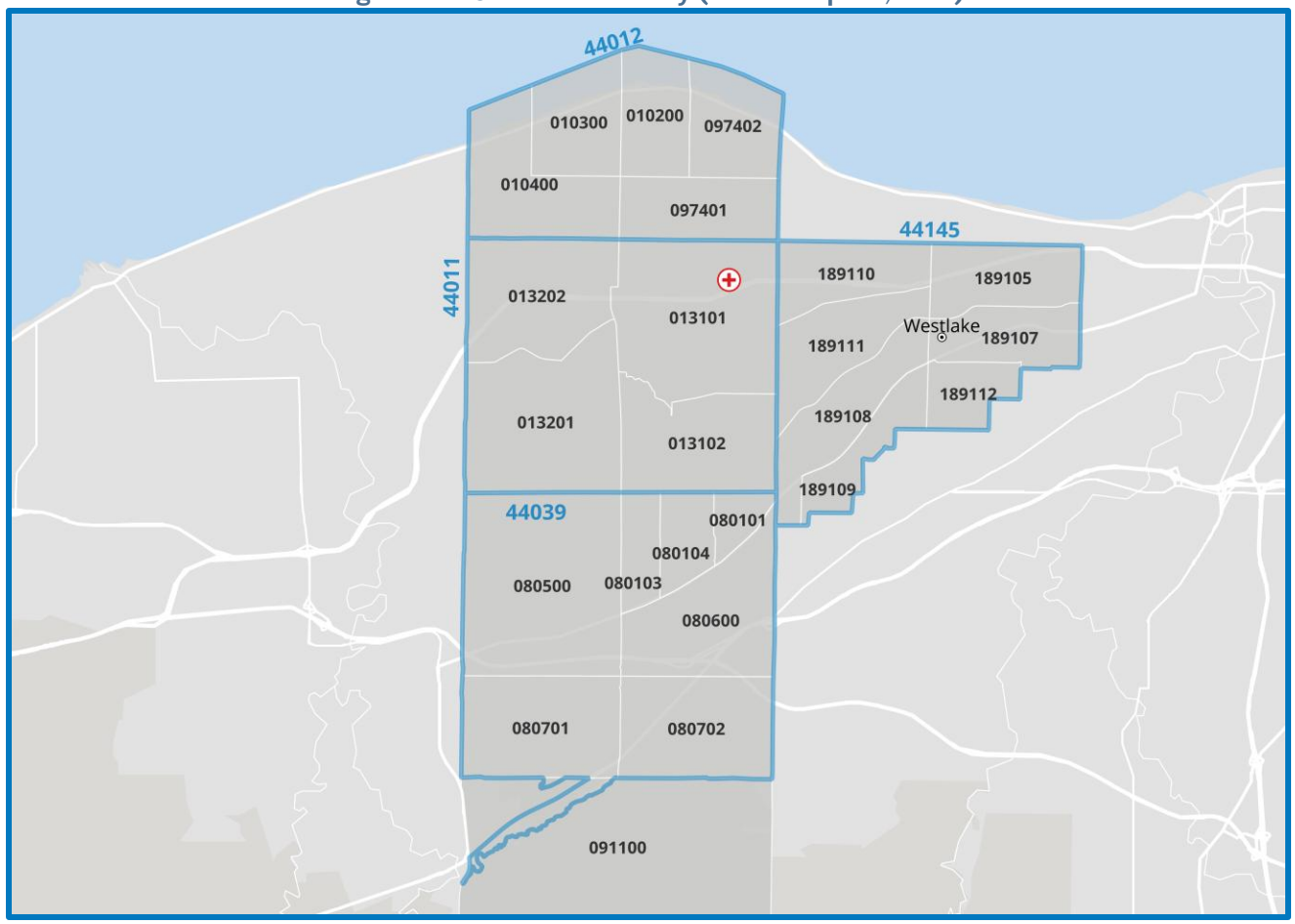


Table 5: Census Tracts by Zip Code (Avon Hospital, East)

44011	44012	44039	44145
013101	010200	080101	189105
013102	010300	080103	189107
013201	010400	080104	189108
013202	097401	080500	189109
	097402	080600	189110
		080701	189111
		080702	189112
		091100	

Figure 13 and Table 6 show the census tracts for each zip code in the western portion of the Avon Hospital Community.

Figure 13: Census Tract Key (Avon Hospital, West)

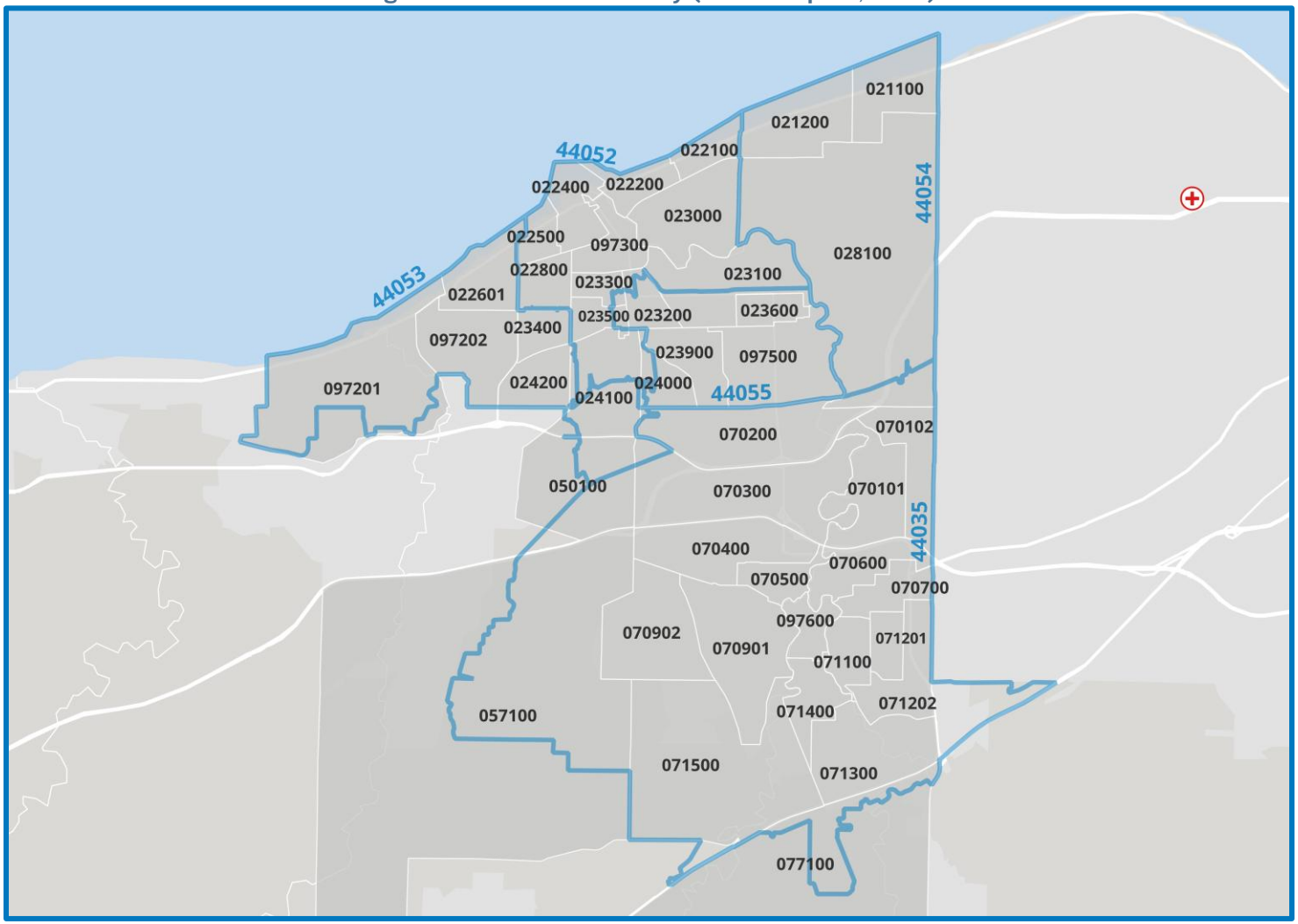


Table 6: Census Tracts by Zip Code (Avon Hospital, West)

44035	44052	44053	44054	44055
050100	022100	022601	021100	023100
057100	022200	023400	021200	023200
070101	022400	024100	028100	023600
070102	022500	024200		023900
070200	022800	050100		024000
070300	023000	097201		097500
070400	023100	097202		
070500	023300			
070600	023500			
070700	024100			
070901	097300			
070902				
071100				
071201				
071202				
071300				
071400				
071500				
077100				
097600				

Community Health Index (CHI)

Every community can be described by various demographic and economic factors that can contribute to differences in health outcomes. Conduent HCI's Community Health Index (CHI) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing concerning health outcomes.

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 nation. Communities with the highest index values are estimated to have the highest health-related social 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 CHI, with darker coloring associated with higher relative need.

Food Insecurity Index (FII)

Every community can be described by various demographic and economic factors that can contribute to differences in health outcomes. 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 nation. Communities with the highest index values are estimated to have the highest risk of food insecurity, which is correlated with correlated with household and community measures of food-related 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 FII, with darker coloring associated with higher relative need.

Mental Health Index (MHI)

Every community can be described by various demographic and economic factors that can contribute to differences in 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 mental health challenges.

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 nation. Communities with the highest index values are estimated to have the highest risk of 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 MHI, with darker coloring associated with higher relative need.

Data Considerations

Several data limitations 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 viability 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 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 health-related social needs that are 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 represent the population at large, these measures are subject to instability, especially for smaller populations.

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 naming conventions. 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 covers ZCTAs 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 sources from the U.S. 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.

Indicators of Concern for Prioritized Health Needs

Below are details regarding indicators of concern for all prioritized health needs discussed in this report. Each indicator includes a county-level value and standardized score, as well as the following comparison data, where available: state value, national value, state county distribution, national county distribution, and over-time trend. Table 7 describes how to interpret the icons used to describe county distributions and trend data.

Table 7: Icon Legend

Icon(s)	Definition
	If the needle is in the green, the county value is among the least concerning 50% of counties in the state or nation.
	If the needle is in the red, the county value is in the most concerning 25% (or worst quartile) of counties in the state or nation.
	The county value is significantly trending in a concerning direction.
	The county value is trending in a concerning direction, but not significantly.
	The county value is significantly trending in the ideal direction.
	The county value is trending in the ideal direction, but not significantly.

Indicators of Concern: Access to Healthcare

As shown below, the topic *Health Care Access and Quality* was ranked as the fourteenth highest scoring health need, with a score of 1.35 out of 3. Those indicators scoring at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.29	Primary Care Provider Rate	*providers/ 100,000 population*	51.6	--	75.3	74.9			
2.03	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3494	--	3269	2769			--
1.85	Dentist Rate	*dentists/ 100,000 population*	49.0	--	65.2	73.5			
1.71	Health Insurance Spending-to-Income Ratio	*Percent*	6.8	--	6.6	5.9			
1.50	Adults With Group Health Insurance	*Percent*	37.3	--	37.4	39.8			--

Indicators of Concern: Behavioral Health

The prioritized health topic *Behavioral Health* was captured under three health topic areas: *Mental Health and Mental Disorders*, *Alcohol and Drug Use*, and *Tobacco Use*. As shown below, the most concerning of these topics was *Alcohol and Drug Use* (Score: 1.76), followed by *Mental Health and Mental Disorders* (1.50), and the least concerning was *Tobacco Use* (1.17). Indicators from these three topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.29	Adults Ever Diagnosed with Depression	*percent*	27.6	--	--	20.7			--
2.21	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	42.1	--	40.4	23.5			--
2.15	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	37.3	--	32.1	--			
2.12	Poor Mental Health: 14+ Days	*percent*	19.6	--	--	15.8			--
2.09	Poor Mental Health: Average Number of Days	*days*	6.3	--	6.1	--			
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7	--			--
1.76	Adults who Binge Drink	*percent*	18.1	--	--	16.6			--
1.76	Adults who Smoke	*percent*	18.7	6.1	--	12.9			--
1.74	Adults who Drink Excessively	*percent*	20.9	--	21.2	--			
1.68	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	15.4	12.8	14.7	13.9			
1.68	Depression: Medicare Population	*percent*	18	--	18	17			--
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1	--	2.1	1.9			

Indicators of Concern: Chronic Disease Prevention and Management

The prioritized health topic *Chronic Disease Prevention and Management* was captured under the following health topics: *Nutrition and Healthy Eating*, *Wellness and Lifestyle*, *Cancer*, *Diabetes*, *Heart Disease and Stroke*, *Other Chronic Conditions*, and *Older Adults*. As seen below, the most concerning of these topics was *Other Chronic Conditions* (Score: 2.07), followed by *Older Adults* (1.76), *Heart Disease and Stroke* (1.65), *Wellness and Lifestyle* (1.49), *Nutrition and Healthy Eating* (1.49), *Cancer* (1.31), and the least concerning topic was *Diabetes* (1.27). Indicators from these seven topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6	--	10.8	9.8			
2.56	Chronic Kidney Disease: Medicare Population	*percent*	23	--	19	18			--
2.56	Ischemic Heart Disease: Medicare Population	*percent*	25	--	22	21			--
2.56	Stroke: Medicare Population	*percent*	7	--	5	6			--
2.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.9	--	132.3	129.8			
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	42	--	39	36			--
2.35	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	124.7	--	118.1	113.2			
2.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	20.2	19.3			
2.21	Atrial Fibrillation: Medicare Population	*percent*	16	--	15	14			--
2.21	COPD: Medicare Population	*percent*	15	--	13	11			--

2.21	Hyperlipidemia: Medicare Population	*percent*	71	--	67	66			--
2.12	People 65+ Living Below Poverty Level	*percent*	10.3	--	9.5	10.4			
2.03	Adults who Frequently Cook Meals at Home	*Percent*	67.3	--	67.6	67.7			--
2.00	All Cancer Incidence Rate	*cases/ 100,000 population*	487.6	--	470.0	444.4			
2.00	People 65+ Living Alone	*percent*	29.9	--	30.2	26.5			
1.94	People 65+ Living Alone (Count)	*people*	18231	--	--	--	--	--	
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116	--	--	--	--	--	
1.94	High Blood Pressure Prevalence	*percent*	38.2	41.9	--	32.7			--
1.94	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.5	33.4	43.4	37.6			
1.85	Hypertension: Medicare Population	*percent*	70	--	67	65			--
1.85	Osteoporosis: Medicare Population	*percent*	12	--	11	12			--
1.85	Adults Happy with Weight	*Percent*	41.9	--	42.1	42.6			--
1.82	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.2	--	14.2	12.8			
1.82	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.3	--	12.8	12.0			
1.76	Adults with Arthritis	*percent*	31.7	--	--	26.6			--

1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.5	--	--	6.8			--
1.76	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.7	--	--	17.9			--
1.76	Poor Physical Health: 14+ Days	*percent*	14.7	--	--	12.7			--
1.68	Depression: Medicare Population	*percent*	18	--	18	17			--
1.59	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.2	--	--	8.2			--
1.56	Food Environment Index	--	7.6	--	7.0	--			
1.50	Asthma: Medicare Population	*percent*	7	--	7	7			--
1.50	Cancer: Medicare Population	*percent*	12	--	12	12			--

Indicators of Concern: Maternal and Child Health

The prioritized health topic *Maternal and Child Health* was captured under two health topic areas: *Maternal, Fetal, and Infant Health* and *Children's Health*. As seen below, the most concerning of these topics was *Maternal, Fetal, and Infant Health*, with a score of 1.73, followed by *Children's Health*, with a score of 1.17. Indicators from these topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.74	Babies with Low Birthweight	*percent*	9.7	--	8.7	8.6		--	
2.18	Babies with Very Low Birthweight	*percent*	1.8	--	1.5	--		--	
2.18	Preterm Births	*percent*	12.4	9.4	10.8	--		--	
1.62	Infant Mortality Rate	*deaths/ 1,000 live births*	6.3	5.0	6.7	5.4	--	--	

Indicators of Concern: Health-Related Social Needs

The prioritized health topic *Health-Related Social Needs* was captured under the quality of life topics *Community, Economy,* and Education, as well as the health topic *Prevention and Safety*. As shown below, *Prevention and Safety* was the sixth highest scoring health topic with a score of 1.68. As seen in the table below, the most concerning quality of life topic was *Community* (Score: 1.45), followed by *Education* (1.42), and the least concerning topic was *Economy* (1.36). Indicators from these four health and quality of life topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6	--	10.8	9.8			
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	615	--	570	612			
2.41	Households with Cash Public Assistance Income	*percent*	3.1	--	2.5	2.7			
2.35	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42.1	--	40.5	23.5			
2.35	Student-to-Teacher Ratio	*students/ teacher*	17.1	--	16.6	15.2			
2.24	Homeowner Spending-to-Income Ratio	*percent*	15.0	--	14.3	13.5			
2.12	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	59.9	--	61.0	--		--	
2.12	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	27.1	--	25.0	--		--	
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1495	--	1472	1902			
2.12	People 65+ Living Below Poverty Level	*percent*	10.3	--	9.5	10.4			

2.09	Severe Housing Problems	*percent*	12.9	--	12.7	--			
2.06	Young Children Living Below Poverty Level	*percent*	23.3	--	20.0	17.6			
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116	--	--	--	--	--	
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7	--			--
1.88	Children Living Below Poverty Level	*percent*	18.8	--	18.0	16.3			
1.88	Unemployed Veterans	*percent*	3.5	--	2.8	3.2			
1.85	Income Inequality	--	0.5	--	0.5	0.5			
1.85	High School Graduation	*percent*	90.8	90.7	92.5	--		--	
1.82	Food Insecurity Rate	*percent*	15.4	--	15.3	14.5			
1.76	Median Household Gross Rent	*dollars*	916	--	988	1348			
1.76	Death Rate due to Injuries	*deaths/ 100,000 population*	101.7	--	100.7	--			--
1.71	Health Insurance Spending-to-Income Ratio	*percent*	6.8	--	6.6	5.9			
1.71	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.9	43.2	69.9	51.6			
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2	--	7.4	7.1			
1.68	Households Spending 50% or More of Household Income on Housing	*percent*	12.1	--	11.5	14.3			--

1.53	4th Grade Students Proficient in English/Language Arts	*percent*	63.0	--	64.1	--		--	
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1	--	2.1	1.9			
1.53	College Tuition Spending-to-Income Ratio	*percent*	12.3	--	12.6	11.9			
1.53	Renters Spending 30% or More of Household Income on Rent	*percent*	46.3	25.5	45.1	50.4			
1.53	Utilities Spending-to-Income Ratio	*percent*	6.2	--	6.1	5.6			

All Indicator Scores by Topic Area

Below is a complete list of all indicators that were scored as part of the secondary data analysis. Indicators are grouped under their respective health and quality of life topic areas and include information about both the indicator data source and measurement period. Please refer to Table 8 below as a reference key for indicator data sources.

Table 8: Indicator Scoring Data Source Key

Key	Data Source
1	American Community Survey 1-Year
2	American Community Survey 5-Year
3	American Lung Association
4	Annie E. Casey Foundation
5	CDC - PLACES
6	Centers for Disease Control and Prevention
7	Centers for Medicare & Medicaid Services
8	Claritas Consumer Profiles
9	Claritas Consumer Spending Dynamix
10	County Health Rankings
11	Feeding America
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	Purdue Center for Regional Development
22	U.S. Bureau of Labor Statistics
23	U.S. Census - County Business Patterns
24	U.S. Census Bureau - Small Area Health Insurance Estimates
25	U.S. Environmental Protection Agency
26	United For ALICE

Table 9: All Lorain County Secondary Data Indicators

SCORE	ALCOHOL & DRUG USE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	42.1		40.4	23.5	*2018-2020*	6
2.15	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	37.3		32.1		*2018-2022*	10
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7		*2020-2022*	10
1.76	Adults who Binge Drink	*percent*	18.1			16.6	*2022*	5
1.74	Adults who Drink Excessively	*percent*	20.9		21.2		*2022*	10
1.32	Mothers who Smoked During Pregnancy	*percent*	8.1	4.3	7.9	3.7	*2022*	17
1.18	Liquor Store Density	*stores/ 100,000 population*	7		5.6	10.9	*2022*	23

SCORE	CANCER	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.9		132.3	129.8	*2017-2021*	12
2.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	20.2	19.3	*2018-2022*	12
2.35	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	124.7		118.1	113.2	*2017-2021*	12
2.00	All Cancer Incidence Rate	*cases/ 100,000 population*	487.6		470	444.4	*2017-2021*	12
1.82	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.3		12.8	12	*2017-2021*	12
1.59	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.2			8.2	*2022*	5
1.50	Cancer: Medicare Population	*percent*	12		12	12	*2023*	7

1.41	Colon Cancer Screening: USPSTF Recommendation	*percent*	65.4			66.3	*2022*	5
1.41	Mammogram in Past 2 Years: 50-74	*percent*	74.4	80.3		76.5	*2022*	5
1.24	Cervical Cancer Screening: 21-65	*Percent*	82.4			82.8	*2020*	5
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.6		64.3	53.1	*2017-2021*	12
1.00	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	37.3		38.9	36.4	*2017-2021*	12
0.91	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.8	7.5	*2017-2021*	12
0.71	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	158.4	122.7	161.1	146	*2018-2022*	12
0.71	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	35.8	25.1	39.8	32.4	*2018-2022*	12
0.62	Mammography Screening: Medicare Population	*percent*	53		51	39	*2023*	7
0.29	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	16.3	16.9	19.3	19	*2018-2022*	12
0.00	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	11.4	8.9	13.9	12.9	*2018-2022*	12

SCORE	CHILDREN'S HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.47	Child Food Insecurity Rate	*percent*	19.3		20.1	18.4	*2023*	11
1.47	Substantiated Child Abuse Rate	*cases/ 1,000 children*	6.6	8.7	6.9		*2021*	4
1.41	Child Care Centers	*per 1,000 population under age 5*	7.8		8	7	*2022*	10
1.06	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	51		59.2		*2019-2022*	10

1.00	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.1		0.5	*2022*	19
1.00	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.9		1.9	*2022*	19
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
0.91	Children with Health Insurance	*percent*	98.1		95.1	94.6	*2023*	1

SCORE	COMMUNITY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.71	Children in Single-Parent Households	*percent*	29.2		26.1	24.8	*2019-2023*	2
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	615		570	612	*2019-2023*	2
2.35	Workers who Walk to Work	*percent*	1.6		2	2.4	*2019-2023*	2
2.15	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	37.3		32.1		*2018-2022*	10
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1495		1472	1902	*2019-2023*	2
2.09	Social Associations	*membership associations/ 10,000 population*	9.5		10.8		*2022*	10
2.09	Solo Drivers with a Long Commute	*percent*	37.1		30.5		*2019-2023*	10
2.06	Young Children Living Below Poverty Level	*percent*	23.3		20	17.6	*2019-2023*	2
2.00	Adults with Internet Access	*percent*	80.8		80.9	81.3	*2024*	8
2.00	Linguistic Isolation	*percent*	1.7		1.5	4.2	*2019-2023*	2
2.00	People 65+ Living Alone	*percent*	29.9		30.2	26.5	*2019-2023*	2
2.00	Workers Commuting by Public Transportation	*percent*	0.4	5.3	1.1	3.5	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	18231				*2019-2023*	2

1.88	Children Living Below Poverty Level	*percent*	18.8		18	16.3	*2019-2023*	2
1.82	Mean Travel Time to Work	*minutes*	25.4		23.6	26.6	*2019-2023*	2
1.76	Median Household Gross Rent	*dollars*	916		988	1348	*2019-2023*	2
1.74	Grandparents Who Are Responsible for Their Grandchildren	*percent*	40.8		41.3	32	*2019-2023*	2
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2		7.4	7.1	*2025*	9
1.68	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	6.9	5.5	9		*2020-2022*	19
1.50	Adults With Group Health Insurance	*percent*	37.3		37.4	39.8	*2024*	8
1.50	Social Vulnerability Index	*Score*	0.4				*2022*	6
1.47	Substantiated Child Abuse Rate	*cases/ 1,000 children*	6.6	8.7	6.9		*2021*	4
1.44	Persons with Health Insurance	*percent*	92.7	92.4	92.9		*2022*	24
1.41	Households with an Internet Subscription	*percent*	86.9		89	89.9	*2019-2023*	2
1.41	Workers who Drive Alone to Work	*percent*	78.6		76.6	70.2	*2019-2023*	2
1.38	Residential Segregation - Black/White	*Score*	58.9		69.6		*2025*	10
1.35	Adult Day Care Spending-to-Income Ratio	*percent*	11		11.1	11.9	*2025*	9
1.35	Female Population 16+ in Civilian Labor Force	*percent*	57.5		59.2	58.7	*2019-2023*	2
1.35	Violent Crime Rate	*crimes/ 100,000 population*	233		331		*2024*	18
1.32	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	85.7		84.9	85.1	*2024*	8
1.24	People 25+ with a Bachelor's Degree or Higher	*percent*	27.9		30.9	35	*2019-2023*	2
1.24	Persons with an Internet Subscription	*percent*	89.4		91.3	92	*2019-2023*	2

1.24	Population 16+ in Civilian Labor Force	*percent*	58		60.1	59.8	*2019-2023*	2
1.18	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3		3.3	3.1	*2025*	9
1.18	Households with a Computer	*percent*	85.8		85.2	86	*2024*	8
1.18	People Living Below Poverty Level	*percent*	12.8	8	13.2	12.4	*2019-2023*	2
1.06	Households with a Smartphone	*percent*	87.1		87.5	88.2	*2024*	8
1.06	Voter Turnout: Presidential Election	*percent*	72.7	58.4	71.7		*2024*	20
1.06	Youth not in School or Working	*percent*	1.7		1.7	1.7	*2019-2023*	2
0.97	Digital Distress		1				*2022*	21
0.97	Total Employment Change	*percent*	5.5		2.9	5.8	*2021-2022*	23
0.91	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	11.1	10.7	13.5	12	*2018-2020*	6
0.88	Median Household Income	*dollars*	70693		69680	78538	*2019-2023*	2
0.88	People 25+ with a High School Diploma or Higher	*percent*	91.5		91.6	89.4	*2019-2023*	2
0.82	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.1		2.7	2.6	*2016-2020*	6
0.79	Adults With Individual Health Insurance	*percent*	20.9		20.5	20.2	*2024*	8
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	9.3		11.1		*2016-2022*	10
0.71	Households with One or More Types of Computing Devices	*percent*	94.4		93.6	94.8	*2019-2023*	2
0.62	Digital Divide Index	*DDI Score*	16.7		40.1	50	*2022*	21
0.53	Per Capita Income	*dollars*	39638		39455	43289	*2019-2023*	2
0.44	Broadband Quality Score	*BQS Score*	66.7		53.4	50	*2022*	21

SCORE	DIABETES	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.41	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	22.8		26.4	22.6	*2018-2020*	6
1.24	Adults 20+ with Diabetes	*percent*	9.6				*2021*	6
1.15	Diabetes: Medicare Population	*percent*	25		25	24	*2023*	7

SCORE	ECONOMY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	615		570	612	*2019-2023*	2
2.41	Households with Cash Public Assistance Income	*percent*	3.1		2.5	2.7	*2019-2023*	2
2.24	Homeowner Spending-to-Income Ratio	*percent*	15		14.3	13.5	*2025*	9
2.12	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	59.9		61		*2022*	26
2.12	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	27.1		25		*2022*	26
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1495		1472	1902	*2019-2023*	2
2.12	People 65+ Living Below Poverty Level	*percent*	10.3		9.5	10.4	*2019-2023*	2
2.09	Severe Housing Problems	*percent*	12.9		12.7		*2017-2021*	10
2.06	Young Children Living Below Poverty Level	*percent*	23.3		20	17.6	*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116				*2019-2023*	2
1.88	Children Living Below Poverty Level	*percent*	18.8		18	16.3	*2019-2023*	2
1.88	Unemployed Veterans	*percent*	3.5		2.8	3.2	*2019-2023*	2

1.85	Income Inequality		0.5		0.5	0.5	*2019-2023*	2
1.82	Food Insecurity Rate	*percent*	15.4		15.3	14.5	*2023*	11
1.76	Median Household Gross Rent	*dollars*	916		988	1348	*2019-2023*	2
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2		7.4	7.1	*2025*	9
1.71	Health Insurance Spending-to-Income Ratio	*percent*	6.8		6.6	5.9	*2025*	9
1.68	Households Spending 50% or More of Household Income on Housing	*percent*	12.1		11.5	14.3	*2019-2023*	2
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1		2.1	1.9	*2025*	9
1.53	College Tuition Spending-to-Income Ratio	*percent*	12.3		12.6	11.9	*2025*	9
1.53	Renters Spending 30% or More of Household Income on Rent	*percent*	46.3	25.5	45.1	50.4	*2019-2023*	2
1.53	Utilities Spending-to-Income Ratio	*percent*	6.2		6.1	5.6	*2025*	9
1.47	Child Food Insecurity Rate	*percent*	19.3		20.1	18.4	*2023*	11
1.38	Residential Segregation - Black/White	*Score*	58.9		69.6		*2025*	10
1.35	Adult Day Care Spending-to-Income Ratio	*percent*	11		11.1	11.9	*2025*	9
1.35	Families Living Below Poverty Level	*percent*	9.1		9.2	8.7	*2019-2023*	2
1.35	Female Population 16+ in Civilian Labor Force	*percent*	57.5		59.2	58.7	*2019-2023*	2
1.35	Home Renter Spending-to-Income Ratio	*percent*	15.6		16.3	17	*2025*	9
1.35	Households with a 401k Plan	*percent*	38.2		38.4	40.8	*2024*	8
1.35	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.6		1.6	1.5	*2025*	9
1.29	Unemployed Workers in Civilian Labor Force	*percent*	4.5		5.2	4.2	*45717*	22

1.24	Population 16+ in Civilian Labor Force	*percent*	58		60.1	59.8	*2019-2023*	2
1.18	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3		3.3	3.1	*2025*	9
1.18	Households Living Below Poverty Level	*percent*	13		14		*2022*	26
1.18	Households with a Savings Account	*percent*	71.5		70.9	72	*2024*	8
1.18	People Living Below Poverty Level	*percent*	12.8	8	13.2	12.4	*2019-2023*	2
1.18	Student Loan Spending-to-Income Ratio	*percent*	4.4		4.6	4.5	*2025*	9
1.09	Gender Pay Gap	*cents on the dollar*	0.8		0.7	0.8	*2023*	1
1.06	Children Living Below 200% of Poverty Level	*percent*	32.6		38.3	36.1	*2023*	1
1.06	Size of Labor Force	*persons*	156358				*45717*	22
1.06	Youth not in School or Working	*percent*	1.7		1.7	1.7	*2019-2023*	2
1.03	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	20.5	25.5	21.2	28.5	*2023*	1
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
1.00	Veterans Living Below Poverty Level	*percent*	7.1		7.4	7.2	*2019-2023*	2
0.97	Total Employment Change	*percent*	5.5		2.9	5.8	*2021-2022*	23
0.94	Students Eligible for the Free Lunch Program	*percent*	24.4		23.6	43.6	*2023-2024*	13
0.88	Households with Student Loan Debt	*percent*	8.3		9.1	9.8	*2024*	8
0.88	Median Household Income	*dollars*	70693		69680	78538	*2019-2023*	2
0.88	Median Household Income: Householders 65+	*dollars*	52950		51608	57108	*2019-2023*	2
0.79	Adults who Feel Overwhelmed by Financial Burdens	*percent*	32.7		34	33.6	*2024*	8
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2

0.74	Families Living Below 200% of Poverty Level	*Percent*	19.1		22.8	22.3	*2023*	1
0.74	People 65+ Living Below 200% of Poverty Level	*percent*	23.9		28.4	28.1	*2023*	1
0.74	People Living Below 200% of Poverty Level	*percent*	24.8		29.6	28.2	*2023*	1
0.53	Adults with Disability Living in Poverty	*percent*	24.5		28.2	24.6	*2019-2023*	2
0.53	Per Capita Income	*dollars*	39638		39455	43289	*2019-2023*	2
0.35	Homeowner Vacancy Rate	*percent*	0.8		0.9	1	*2019-2023*	2
0.18	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	1.8		2	2	*2024*	8

SCORE	EDUCATION	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Student-to-Teacher Ratio	*students/ teacher*	17.1		16.6	15.2	*2023-2024*	13
1.85	High School Graduation	*percent*	90.8	90.7	92.5		*2022-2023*	15
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2		7.4	7.1	*2025*	9
1.53	4th Grade Students Proficient in English/Language Arts	*percent*	63		64.1		*2023-2024*	15
1.53	College Tuition Spending-to-Income Ratio	*percent*	12.3		12.6	11.9	*2025*	9
1.41	4th Grade Students Proficient in Math	*percent*	67.1		67.2		*2023-2024*	15
1.41	Child Care Centers	*per 1,000 population under age 5*	7.8		8	7	*2022*	10
1.35	8th Grade Students Proficient in Math	*percent*	46.9		46.3		*2023-2024*	15

1.35	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.6		1.6	1.5	*2025*	9
1.32	8th Grade Students Proficient in English/Language Arts	*percent*	52		49.4		*2023-2024*	15
1.24	People 25+ with a Bachelor's Degree or Higher	*percent*	27.9		30.9	35	*2019-2023*	2
1.24	Veterans with a High School Diploma or Higher	*percent*	94.2		94.4	95.2	*2019-2023*	2
1.18	Student Loan Spending-to-Income Ratio	*percent*	4.4		4.6	4.5	*2025*	9
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
0.88	People 25+ with a High School Diploma or Higher	*percent*	91.5		91.6	89.4	*2019-2023*	2

SCORE	ENVIRONMENTAL HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Daily Dose of UV Irradiance	*Joule per square meter*	3701		3384		*2020*	14
2.12	Proximity to Highways	*percent*	7.7		7.2		*2020*	14
2.09	Severe Housing Problems	*percent*	12.9		12.7		*2017-2021*	10
1.76	Adults with Current Asthma	*percent*	11			9.9	*2022*	5
1.65	Weeks of Moderate Drought or Worse	*weeks per year*	2				*2021*	14
1.56	Annual Particle Pollution	*Grade*	B				*2019-2021*	3
1.56	Food Environment Index		7.6		7		*2025*	10
1.53	Utilities Spending-to-Income Ratio	*percent*	6.2		6.1	5.6	*2025*	9
1.50	Asthma: Medicare Population	*percent*	7		7	7	*2023*	7
1.50	Social Vulnerability Index	*Score*	0.4				*2022*	6
1.35	Number of Extreme Heat Days	*days*	12				*2023*	14
1.35	Number of Extreme Heat Events	*events*	7				*2023*	14

1.35	PBT Released	*pounds*	4376.6			*2023*	25
1.35	Recognized Carcinogens Released into Air	*pounds*	2437.3			*2023*	25
1.26	Annual Ozone Air Quality	*Grade*	B			*2020-2022*	3
1.18	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3	3.3	3.1	*2025*	9
1.18	Liquor Store Density	*stores/ 100,000 population*	7	5.6	10.9	*2022*	23
1.06	Number of Extreme Precipitation Days	*days*	3			*2023*	14
1.00	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.1	0.5		*2022*	19
1.00	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.9	1.9		*2022*	19
0.88	Access to Parks	*percent*	61.7	59.6		*2020*	14
0.88	Houses Built Prior to 1950	*percent*	19.5	24.9	16.4	*2019-2023*	2
0.76	Overcrowded Households	*percent*	1.2	1.4	3.4	*2019-2023*	2
0.74	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	6.8	7.9		*2020*	10
0.71	Access to Exercise Opportunities	*percent*	95	84.2		*2025*	10
0.62	Digital Divide Index	*DDI Score*	16.7	40.1	50	*2022*	21
0.44	Broadband Quality Score	*BQS Score*	66.7	53.4	50	*2022*	21

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Primary Care Provider Rate	*providers/ 100,000 population*	51.6		75.3	74.9	*2021*	10
2.03	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3494		3269	2769	*2023*	7
1.85	Dentist Rate	*dentists/ 100,000 population*	49		65.2	73.5	*2022*	10

1.71	Health Insurance Spending-to-Income Ratio	*percent*	6.8		6.6	5.9	*2025*	9
1.50	Adults With Group Health Insurance	*percent*	37.3		37.4	39.8	*2024*	8
1.47	Adults with Health Insurance: 18+	*percent*	75.3		74.7	75.2	*2024*	8
1.44	Persons with Health Insurance	*percent*	92.7	92.4	92.9		*2022*	24
1.32	Adults who go to the Doctor Regularly for Checkups	*percent*	66.4		65.2	65.1	*2024*	8
1.32	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	92.2		148.7		*2024*	10
1.29	Adults who Visited a Dentist	*percent*	45.6		44.3	45.3	*2024*	8
1.24	Adults without Health Insurance	*percent*	6.3			10.8	*2022*	5
1.15	Mental Health Provider Rate	*providers/ 100,000 population*	224		349.4		*2024*	10
1.09	Adults with Health Insurance	*percent*	93.2		91.6	89	*2023*	1
0.91	Children with Health Insurance	*percent*	98.1		95.1	94.6	*2023*	1
0.88	Adults who have had a Routine Checkup	*percent*	79.6			76.1	*2022*	5
0.79	Adults With Individual Health Insurance	*percent*	20.9		20.5	20.2	*2024*	8
0.74	Persons without Health Insurance	*percent*	5.3		6.4	8.6	*2019-2023*	2

SCORE	HEART DISEASE & STROKE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	Ischemic Heart Disease: Medicare Population	*percent*	25		22	21	*2023*	7
2.56	Stroke: Medicare Population	*percent*	7		5	6	*2023*	7
2.21	Atrial Fibrillation: Medicare Population	*percent*	16		15	14	*2023*	7
2.21	Hyperlipidemia: Medicare Population	*percent*	71		67	66	*2023*	7
1.94	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.5	33.4	43.4	37.6	*2018-2020*	6

1.94	High Blood Pressure Prevalence	*percent*	38.2	41.9		32.7	*2021*	5
1.85	Hypertension: Medicare Population	*percent*	70		67	65	*2023*	7
1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.5			6.8	*2022*	5
1.41	Adults who Experienced a Stroke	*percent*	3.9			3.6	*2022*	5
1.41	High Cholesterol Prevalence	*percent*	35.6			35.5	*2021*	5
1.32	Heart Failure: Medicare Population	*percent*	12		12	11	*2023*	7
1.24	Adults who Have Taken Medications for High Blood Pressure	*percent*	81.3			78.2	*2021*	5
1.24	Cholesterol Test History	*percent*	85.3			86.4	*2021*	5
0.71	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.5		60.9		*2021*	14
0.35	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	81.9	71.1	101.9	90.2	*2018-2020*	6

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.29	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	12.3	11.5	13.8		*2023*	16
1.21	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.9	1.4	1.6	2.9	*2023*	16
1.09	Chlamydia Incidence Rate	*cases/ 100,000 population*	374		464.2	492.2	*2023*	16
1.09	Gonorrhea Incidence Rate	*cases/ 100,000 population*	99.9		168.8	179.5	*2023*	16
1.03	Syphilis Incidence Rate	*cases/ 100,000 population*	6		16.4	15.8	*2023*	16
0.91	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.8	7.5	*2017-2021*	12
0.82	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.3		13.9	13.4	*2018-2020*	6

0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	60.8		59.8	60.4	*2024*	8
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.62	Flu Vaccinations: Medicare Population	*percent*	53		50	3	*2023*	7
0.44	Pneumonia Vaccinations: Medicare Population	*percent*	10		9	9	*2023*	7

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.74	Babies with Low Birthweight	*percent*	9.7		8.7	8.6	*2022*	17
2.18	Babies with Very Low Birthweight	*percent*	1.8		1.5		*2022*	17
2.18	Preterm Births	*percent*	12.4	9.4	10.8		*2022*	17
1.62	Infant Mortality Rate	*deaths/ 1,000 live births*	6.3	5	6.7	5.4	*2020*	17
1.32	Mothers who Smoked During Pregnancy	*percent*	8.1	4.3	7.9	3.7	*2022*	17
1.09	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	5.5		6.1	5.6	*2022*	17
0.97	Mothers who Received Early Prenatal Care	*percent*	70.3		68.6	75.3	*2022*	17

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Adults Ever Diagnosed with Depression	*percent*	27.6			20.7	*2022*	5
2.12	Poor Mental Health: 14+ Days	*percent*	19.6			15.8	*2022*	5
2.09	Poor Mental Health: Average Number of Days	*days*	6.3		6.1		*2022*	10
1.68	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	15.4	12.8	14.7	13.9	*2018-2020*	6
1.68	Depression: Medicare Population	*percent*	18		18	17	*2023*	7

1.47	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.4	86	*2024*	8
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6		6	6	*2023*	7
1.15	Mental Health Provider Rate	*providers/ 100,000 population*	224		349.4		*2024*	10
0.97	Adults who Feel Life is Slipping Out of Control	*Percent*	23.1		24.1	23.9	*2024*	8
0.18	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	27.1		35.5	31	*2018-2020*	6

SCORE	NUTRITION & HEALTHY EATING	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.03	Adults who Frequently Cook Meals at Home	*Percent*	67.3		67.6	67.7	*2024*	8
1.56	Food Environment Index		7.6		7		*2025*	10
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8
0.97	Adults who Drank Soft Drinks: Past 7 Days	*percent*	47.7		48.6	47.5	*2024*	8

SCORE	OLDER ADULTS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6		10.8	9.8	*2018-2020*	6
2.56	Chronic Kidney Disease: Medicare Population	*percent*	23		19	18	*2023*	7
2.56	Ischemic Heart Disease: Medicare Population	*percent*	25		22	21	*2023*	7
2.56	Stroke: Medicare Population	*percent*	7		5	6	*2023*	7
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	42		39	36	*2023*	7

2.35	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	124.7	118.1	113.2	*2017-2021*	12
2.21	Atrial Fibrillation: Medicare Population	*percent*	16	15	14	*2023*	7
2.21	COPD: Medicare Population	*percent*	15	13	11	*2023*	7
2.21	Hyperlipidemia: Medicare Population	*percent*	71	67	66	*2023*	7
2.12	People 65+ Living Below Poverty Level	*percent*	10.3	9.5	10.4	*2019-2023*	2
2.00	People 65+ Living Alone	*percent*	29.9	30.2	26.5	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	18231			*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116			*2019-2023*	2
1.85	Hypertension: Medicare Population	*percent*	70	67	65	*2023*	7
1.85	Osteoporosis: Medicare Population	*percent*	12	11	12	*2023*	7
1.68	Depression: Medicare Population	*percent*	18	18	17	*2023*	7
1.50	Asthma: Medicare Population	*percent*	7	7	7	*2023*	7
1.50	Cancer: Medicare Population	*percent*	12	12	12	*2023*	7
1.35	Adult Day Care Spending-to-Income Ratio	*percent*	11	11.1	11.9	*2025*	9
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6	6	6	*2023*	7
1.32	Heart Failure: Medicare Population	*percent*	12	12	11	*2023*	7
1.15	Diabetes: Medicare Population	*percent*	25	25	24	*2023*	7
0.88	Median Household Income: Householders 65+	*dollars*	52950	51608	57108	*2019-2023*	2
0.71	Adults 65+ with Total Tooth Loss	*percent*	8.5		12.2	*2022*	5
0.62	Mammography Screening: Medicare Population	*percent*	53	51	39	*2023*	7
0.18	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	27.1	35.5	31	*2018-2020*	6

SCORE	ORAL HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.85	Dentist Rate	*dentists/ 100,000 population*	49		65.2	73.5	*2022*	10
1.82	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.3		12.8	12	*2017-2021*	12
1.29	Adults who Visited a Dentist	*percent*	45.6		44.3	45.3	*2024*	8
0.71	Adults 65+ with Total Tooth Loss	*percent*	8.5			12.2	*2022*	5

SCORE	OTHER CHRONIC CONDITIONS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	Chronic Kidney Disease: Medicare Population	*percent*	23		19	18	*2023*	7
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	42		39	36	*2023*	7
1.85	Osteoporosis: Medicare Population	*percent*	12		11	12	*2023*	7
1.82	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.2		14.2	12.8	*2018-2020*	6
1.76	Adults with Arthritis	*percent*	31.7			26.6	*2022*	5

SCORE	PHYSICAL ACTIVITY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Workers who Walk to Work	*percent*	1.6		2	2.4	*2019-2023*	2
1.53	Adults 20+ Who Are Obese	*percent*	33.9	36			*2021*	6
1.18	Adults 20+ who are Sedentary	*percent*	20				*2021*	6
0.88	Access to Parks	*percent*	61.7		59.6		*2020*	14
0.71	Access to Exercise Opportunities	*percent*	95		84.2		*2025*	10

SCORE	PREVENTION & SAFETY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6		10.8	9.8	*2018-2020*	6

2.35	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42.1		40.5	23.5	*2018-2020*	6
2.09	Severe Housing Problems	*percent*	12.9		12.7		*2017-2021*	10
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7		*2020-2022*	10
1.76	Death Rate due to Injuries	*deaths/ 100,000 population*	101.7		100.7		*2018-2022*	10
1.71	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.9	43.2	69.9	51.6	*2018-2020*	6
0.91	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	11.1	10.7	13.5	12	*2018-2020*	6
0.82	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.1		2.7	2.6	*2016-2020*	6
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	9.3		11.1		*2016-2022*	10

SCORE	RESPIRATORY DISEASES	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	COPD: Medicare Population	*percent*	15		13	11	*2023*	7
2.12	Proximity to Highways	*percent*	7.7		7.2		*2020*	14
2.06	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	53.7		46.5	38.1	*2018-2020*	6
1.76	Adults who Smoke	*percent*	18.7	6.1		12.9	*2022*	5
1.76	Adults with COPD	*Percent of adults*	9.7			6.8	*2022*	5
1.76	Adults with Current Asthma	*percent*	11			9.9	*2022*	5
1.50	Asthma: Medicare Population	*percent*	7		7	7	*2023*	7
1.21	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.9	1.4	1.6	2.9	*2023*	16
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.6		64.3	53.1	*2017-2021*	12
0.82	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.3		13.9	13.4	*2018-2020*	6

0.79	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.4		6.9	6.8	*2024*	8
0.71	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	35.8	25.1	39.8	32.4	*2018-2022*	12
0.47	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.4		1.7	1.6	*2024*	8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.09	Chlamydia Incidence Rate	*cases/ 100,000 population*	374		464.2	492.2	*2023*	16
1.09	Gonorrhea Incidence Rate	*cases/ 100,000 population*	99.9		168.8	179.5	*2023*	16
1.03	Syphilis Incidence Rate	*cases/ 100,000 population*	6		16.4	15.8	*2023*	16

SCORE	TOBACCO USE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.76	Adults who Smoke	*percent*	18.7	6.1		12.9	*2022*	5
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1		2.1	1.9	*2025*	9
1.41	Tobacco Use: Medicare Population	*percent*	7		7	6	*2023*	7
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.6		64.3	53.1	*2017-2021*	12
0.79	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.4		6.9	6.8	*2024*	8
0.47	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.4		1.7	1.6	*2024*	8

SCORE	WEIGHT STATUS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Obesity: Medicare Population	*percent*	31		25	20	*2023*	7
1.85	Adults Happy with Weight	*Percent*	41.9		42.1	42.6	*2024*	8
1.53	Adults 20+ Who Are Obese	*percent*	33.9	36			*2021*	6

SCORE	WELLNESS & LIFESTYLE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.03	Adults who Frequently Cook Meals at Home	*Percent*	67.3		67.6	67.7	*2024*	8
1.94	High Blood Pressure Prevalence	*percent*	38.2	41.9		32.7	*2021*	5
1.85	Adults Happy with Weight	*Percent*	41.9		42.1	42.6	*2024*	8
1.76	Poor Physical Health: 14+ Days	*percent*	14.7			12.7	*2022*	5
1.76	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.7			17.9	*2022*	5
1.47	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.4	86	*2024*	8
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8
1.24	Life Expectancy	*years*	76		75.2		*2020-2022*	10
1.21	Poor Physical Health: Average Number of Days	*days*	4.3		4.3		*2022*	10
0.97	Adults who Feel Life is Slipping Out of Control	*Percent*	23.1		24.1	23.9	*2024*	8
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	60.8		59.8	60.4	*2024*	8

SCORE	WOMEN'S HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.9		132.3	129.8	*2017-2021*	12
2.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	20.2	19.3	*2018-2022*	12
1.41	Mammogram in Past 2 Years: 50-74	*percent*	74.4	80.3		76.5	*2022*	5
1.24	Cervical Cancer Screening: 21-65	*Percent*	82.4			82.8	*2020*	5
0.91	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.8	7.5	*2017-2021*	12
0.62	Mammography Screening: Medicare Population	*percent*	53		51	39	*2023*	7

Additional Demographic Data

The following tables detail the demographic, social, and economic characteristics of the Avon Hospital Community described in the body of this CHNA report. All data are sourced from Claritas Pop-Facts® (2024 population estimates), unless otherwise noted.

Table 10: Population Size of Hospital Community by Zip Code

Zip Code	Population
44011	25,690
44012	25,714
44035	62,843
44039	37,266
44052	29,360
44053	21,336
44054	12,624
44055	19,552
44145	33,573
Avon Hospital Community (Total)	267,958

Table 11: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Avon Hospital Community	Ohio
0-4	5.5%	5.6%
5-9	5.8%	5.7%
10-14	6.3%	6.1%
15-17	3.9%	3.8%
18-20	3.8%	4.4%
21-24	4.8%	5.3%
25-34	10.9%	12.4%
35-44	11.8%	12.2%
45-54	12.4%	11.7%
55-64	13.2%	13.0%
65-74	12.3%	11.6%
75-84	6.7%	6.1%
85+	2.6%	2.2%
Median Age	42.7 years	40.5 years

Table 12: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	Avon Hospital Community	Ohio	U.S.
White	75.7%	75.7%	63.4%
Black/African American	8.8%	12.8%	12.4%
American Indian/Alaskan Native	0.3%	0.3%	0.9%
Asian	2.0%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.1%	0.2%
Another Race	3.9%	2.1%	6.6%
Two or More Races	9.3%	6.4%	10.7%
Hispanic or Latino (any race)	12.7%	5.0%	19.0%

U.S. value: American Community Survey (2019-2023)

Table 13: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	Avon Hospital Community	Ohio	U.S.
Only English	91.5%	92.8%	78.0%
Spanish	4.8%	2.3%	13.4%
Asian/Pacific Islander Language	1.0%	1.0%	3.5%
Indo-European Language	2.0%	2.8%	3.8%
Other Language	0.8%	1.1%	1.2%

U.S. value: American Community Survey (2019-2023)

Table 14: Household Income of Hospital Community and Surrounding Geographies

Income Category	Avon Hospital Community	Ohio
Under $15,000	9.6%	9.5%
$15,000 - $24,999	7.5%	7.8%
$25,000 - $34,999	8.2%	8.0%
$35,000 - $49,999	12.3%	12.2%
$50,000 - $74,999	16.6%	17.0%
$75,000 - $99,999	12.8%	13.0%
$100,000 - $124,999	9.9%	9.9%
$125,000 - $149,999	6.5%	7.0%
$150,000 - $199,999	7.0%	7.2%
$200,000 - $249,999	3.6%	3.5%
$250,000 - $499,999	4.0%	3.4%
$500,000+	2.1%	1.6%
Median Household Income	$73,463	$68,488

Table 15: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Avon Hospital Community	11.1%
Ohio	9.4%
U.S.	8.8%
Avon Hospital Zip Codes	-
44011	3.6%
44012	3.1%
44035	14.9%
44039	4.5%
44052	25.3%
44053	12.2%
44054	4.8%
44055	25.7%
44145	4.8%

U.S. value: American Community Survey (2019-2023)

Table 16: Educational Attainment of Hospital Community and Surrounding Geographies

	Avon Hospital Community	Ohio	U.S.
Less than High School Graduate	8.0%	8.6%	10.6%
High School Graduate	29.8%	32.8%	26.2%
Some College, No Degree	21.8%	19.6%	19.4%
Associate Degree	10.1%	8.9%	8.8%
Bachelor's Degree	19.1%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	11.2%	11.5%	13.7%

U.S. value: American Community Survey (2019-2023)

Table 17: High Rent Burden in Hospital Community and Surrounding Geographies

	Renters Spending 30% or More of Income on Rent
Lorain County	46.3%
Cuyahoga County	47.5%
Ohio	45.1%
U.S.	50.4%
Avon Hospital Zip Codes	-
44011	35.1%
44012	32.8%
44035	46.3%
44039	35.5%
44052	51.8%
44053	44.1%
44054	25.6%
44055	54.5%
44145	49.8%

All values: American Community Survey (2019-2023)

Table 18: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Lorain County	86.9%
Cuyahoga County	87.5%
Ohio	89.0%
U.S.	89.9%
Avon Hospital Zip Codes	-
44011	94.7%
44012	90.8%
44035	81.2%
44039	93.3%
44052	75.6%
44053	80.6%
44054	89.2%
44055	72.3%
44145	92.9%

All values: American Community Survey (2019-2023)

Appendix C: Environmental Scan and Key Findings

An environmental scan was conducted to supplement quantitative data and further contextualize health needs across Cuyahoga and Lorain counties. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts—including reports from the United Way, hospital systems, and regional health collaboratives—corroborated the relevance of the five prioritized needs prioritized in this 2025 CHNA process for Avon Hospital.

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; behavioral health treatment gaps remain significant; chronic disease management is challenged by food insecurity and inadequate recreational infrastructure; differences in maternal and child health outcomes persist among certain groups; and health-related social factors, particularly poverty, housing insecurity, and gun violence, impact all other areas of health.

The following reports were reviewed. The full reports can be accessed via the hyperlinks in the footnotes:

- 2023 Ohio State Health Assessment[13]
- 2025 Lorain County Community Health Needs Assessment[14]
- 2022 Greater Cleveland LGBTQ+ Community Needs Assessment[15]
- 2023 United Way of Greater Cleveland Community Needs Assessment[16]

[13] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[14] Lorain County Public Health. (2025). *Community Health Assessment* [PDF]. Lorain County. https://www.loraincountyhealth.com/cha
[15] Kent State University College of Public Health. (2024). *Greater Cleveland LGBTQ+ community needs assessment* [PDF]. The Greater Cleveland LGBTQ+ Community Needs Assessment Research Team. https://www.lgbtqohio.org/sites/default/files/docs/KSU-028_CommunityReport_102124_FA.pdf
[16] United Way of Greater Cleveland. (2023). *Cuyahoga County community needs assessment* [PDF]. https://www.unitedwaycleveland.org/our-work/publications/community-needs-assessment/#cc-assessment

Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

Cleveland Clinic

Building a healthy community together.

WELCOME: Cleveland Clinic is in the process of conducting our 2025 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 in [XXXX] County. During this interview, we will ask a series of questions related to health issues in your community. Our goal is to gain various perspectives on the major issues affecting the population that your organization 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 accessible 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 Questions and Probes

- **From your perspective, what does a community need to be healthy?**
    - What are your community's strengths?

- **What are the top health-related issues that residents are facing in your community that you would change or improve?**
    - What makes them the most important health issues?

- What do you think is the cause of these problems in your community?

- **From the health issues and challenges we've just discussed, which do you think are the most difficult to overcome?**
    - Which of these issues are more urgent or important than others?
    - Which groups in your community face particular health issues or challenges?
    - What health challenges are different if the person is a particular age, or gender, race, or ethnicity?

- **What do you think causes residents to be healthy or unhealthy in your community?**
    - What types of things influence their health, to make it better or worse?
    - What might prevent someone from accessing care for these health challenges? Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.

- **What could be done to promote equal access to care and reduction of barriers? (Equal Access is the idea that everyone should have the same chance to be healthy, regardless of their circumstances)**

- **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?
    - What specific community organizations or agencies can you see taking a strong leadership role in improving the health of your community?
    - What resources does your community have that can be used to improve community health?

- **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 community health changes have you seen over the past three years (since 2022)?**

- **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.

Community Input Key Findings

Community stakeholders from 12 organizations provided feedback specifically for the Avon Hospital community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

Individuals from the following organizations participated as key informants for the Avon Hospital community:

- Avon School District
- Boys and Girls Clubs of Northeast Ohio
- Cleveland Clinic Children's Hospital
- Cuyahoga County Board of Health
- El Centro
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Lorain County Commissioners
- Lorain County Public Health
- Lorain County Veteran Service Commission
- Mental Health Addiction & Recovery Services Board of Lorain County
- Second Harvest Food Bank of North Central Ohio
- United Way of Lorain County

The following are summary findings for each of the five prioritized health needs identified in the 2025 Community Health Needs Assessment.

Access to Healthcare

The following highlights key insights from key stakeholder interviews regarding access to healthcare in the community Avon Hospital serves. Stakeholder conversations emphasized that access to healthcare is a persistent challenge in the Avon Hospital community, particularly for residents in rural areas, older adults, and populations experiencing economic hardship. Participants identified a combination of geographic, service-related, and financial barriers that limit the ability to obtain timely and appropriate care. Transportation limitations, provider shortages, and the uneven distribution of healthcare resources were described as major obstacles, while the closure of certain facilities has further reduced local options for primary, specialty, and emergency healthcare services. These challenges are compounded by affordability issues and gaps in health literacy, which can lead to delayed care, preventable hospitalizations, and differences in health outcomes.

The following are highlights of participant feedback regarding access to healthcare:

- Rural and under-resourced pockets of the county face longer travel times to reach healthcare providers, pharmacies, and urgent care centers.
- Limited availability of primary care, specialty care, and dental providers restricts timely access to needed services.

- The closure or consolidation of healthcare facilities has heightened concerns about emergency care access, especially for older adults and those without reliable transportation.
- Cost of care, gaps in insurance coverage, and prescription drug affordability remain significant barriers even when services are physically available.
- There is a need for culturally and linguistically appropriate services.
- Low health literacy contributes to underutilization of preventive care and reliance on emergency services for non-emergent needs.
- Stakeholders emphasized the importance of expanding outreach, improving transportation, and strengthening healthcare infrastructure to ensure equal access.

The following are a few select quotes illustrating feedback about healthcare access by key informants:

"Lorain County is now under resourced in the healthcare world, especially when it comes to emergency room care."

"In the central to southern part of the county, it is very rural, so providing access means making sure there are pharmacies, clinics, and providers within reach."

"Families without financial means will sometimes delay care or skip preventive visits, which can lead to more serious problems later."

"We need more culturally and linguistically appropriate services to truly meet the needs of all community members."

Stakeholders consistently described access to healthcare as a multifaceted issue driven by both structural and economic factors. Rural geography, provider shortages, and facility closures have combined to limit service availability, while affordability, transportation, and health literacy challenges further restrict utilization. These conditions contribute to differences in health outcomes, with certain populations experiencing greater difficulty obtaining preventive and ongoing care. Stakeholders stressed that improving access will require coordinated efforts to expand provider availability, enhance transportation systems, and address financial and cultural barriers, ensuring that all residents can obtain the care they need when they need it.

Behavioral Health: Mental Health and Substance Use Disorder

Mental Health

Stakeholders identified mental health as a critical and growing concern across the Avon Hospital community, with particular urgency around youth mental health. Rising rates of anxiety, depression, and suicidal ideation were linked to social media pressures, family stress, and social isolation. Limited early intervention, long wait times, and insufficient school-based supports were cited as missed opportunities to prevent escalation of mental health needs. Stigma surrounding mental illness continues to deter individuals from seeking help, while provider shortages and uneven access to services further exacerbate the problem.

The following are highlights of participant feedback regarding mental health:

- Increasing youth mental health concerns, including anxiety, depression, and suicide risk
- Social media, isolation, and family stress as contributing factors
- Lack of early intervention and limited school-based mental health supports
- Shortages of mental health providers and long wait times for appointments
- Stigma that discourages individuals from seeking care
- Uneven access to culturally and linguistically appropriate services

The following are a few select quotes illustrating feedback about mental health by key informants:

"We have a student mental health crisis, and social media plays a big role in that."

"The lack of mental health supports in schools means we miss the chance to help early."

"There are not enough providers and wait times can be months long."

Stakeholder feedback reflects an urgent need to address mental health through expanded access to care, targeted prevention efforts, and stigma reduction. Investment in school-based programs, early intervention, and workforce expansion was viewed as essential to meeting current and future needs. Strengthening culturally appropriate and community-based resources will help ensure that individuals can access timely and effective mental health support.

Substance Use Disorder

Substance Use Disorder, including drug and alcohol misuse, was highlighted as a significant challenge that intersects closely with mental health concerns. Stakeholders reported increases in youth drug use, ongoing opioid-related overdoses, and persistent alcohol misuse. There was broad agreement on the need for comprehensive prevention, treatment, and recovery services, with an emphasis on addressing root causes and ensuring treatment-focused responses rather than punitive measures.

The following are highlights of participant feedback regarding substance use:

- Rising youth drug use and associated risks
- Continued impact of the opioid crisis, including fatal overdoses
- Alcohol misuse contributing to health and safety issues
- Gaps in access to treatment and recovery services
- Stigma surrounding addiction that limits willingness to seek help
- Need for coordinated community-wide prevention and intervention strategies

The following are a few select quotes illustrating feedback about substance use disorder by key informants:

"Youth drug use is increasing, and it is not just an urban issue."

"We are still seeing far too many opioid overdoses in this community."

"Addiction should be treated as a health condition, not a crime."

Stakeholders emphasized that substance use disorder remains a pervasive issue requiring sustained, coordinated action. Expanding prevention programs, treatment access, and recovery supports will be critical to reducing harm and improving outcomes. Addressing stigma and building community partnerships between healthcare, law enforcement, schools, and social services can help ensure that individuals affected by substance use receive timely, effective, and compassionate care.

Chronic Disease Prevention & Management

Nutrition & Healthy Eating and Wellness & Lifestyle

Stakeholders emphasized that improving nutrition, healthy eating habits, and overall wellness is critical to preventing and managing chronic diseases in the Avon Hospital community. Limited access to affordable, healthy food options, coupled with gaps in nutrition education, creates barriers to adopting healthier lifestyles. Participants linked poor diet quality and inactivity to higher rates of diabetes, heart disease, and other chronic conditions, noting that many of these issues are being diagnosed at younger ages. Wellness and lifestyle factors, such as physical activity, preventive screenings, and stress management, were also identified as essential in reducing the long-term burden of chronic disease.

The following are highlights of participant feedback regarding nutrition and healthy eating and wellness and lifestyle:

- Limited access to affordable healthy foods in some neighborhoods
- Lack of consistent nutrition education and community awareness programs
- Poor diet quality contributing to obesity, diabetes, and heart disease
- Low participation in preventive wellness and fitness programs
- Physical inactivity as a key driver of chronic disease risk
- The importance of early lifestyle changes to reduce future disease burden

The following are a few select quotes illustrating feedback about nutrition and healthy eating and wellness and lifestyle by key informants:

"Healthy eating options are limited, especially for those with low incomes."

"When we are not promoting good nutrition and activity, we increase the risk for heart disease and cancer."

"Wellness programs are available, but participation is low and not consistent."

Cancer

Stakeholders identified cancer as a significant and ongoing health concern in the Avon Hospital community, citing both the prevalence of the disease and the challenges associated with early detection and treatment. A notable decline in cancer screenings during recent years was reported, raising concerns about delayed diagnoses and more

advanced disease at the time of treatment. Participants emphasized that prevention and early detection through regular screenings are essential to improving outcomes, yet barriers such as cost, transportation, awareness, and access to providers continue to limit participation.

The following are highlights of participant feedback regarding cancer:

- Cancer remains one of the top chronic disease concerns in the community
- Decline in cancer screenings leading to delayed diagnoses
- Estimated 900 fewer cancer diagnoses in one year due to missed screenings
- Need for expanded outreach and education on prevention and screening
- Barriers to screening include transportation, cost, and lack of awareness
- Importance of timely access to diagnostic and treatment services

The following is a select quote illustrating feedback about cancer by a key informant:

"We saw a huge decrease in the number of people getting screened, meaning many have cancer and do not know it yet."

"Cancer, heart disease, and diabetes are the top three concerns we hear about in the community."

"Early detection is key, but too many people face barriers to getting regular screenings."

Diabetes, Heart Disease, & Stroke

Stakeholders described diabetes, heart disease, and stroke as some of the most prevalent and costly chronic health challenges in the Avon Hospital community. These conditions often occur together and are strongly influenced by diet, physical activity, and other lifestyle factors. Participants noted that these diseases are being diagnosed at younger ages than in the past, with diabetes in particular requiring long-term management that impacts both quality and length of life. Gaps in prevention, limited participation in health education programs, and barriers to consistent care contribute to the persistence of these conditions.

The following are highlights of participant feedback regarding diabetes, heart disease, stroke, and other chronic conditions:

- High prevalence of diabetes, heart disease, and hypertension in the community
- Many cases were diagnosed at younger ages than in previous decades
- Diabetes often requires years of ongoing management, affecting quality of life
- Poor diet and physical inactivity are key contributing factors
- Lack of consistent participation in preventive and self-management programs
- Interconnection of these conditions with other chronic diseases, including cancer

The following are a selection of quotes from key informants about diabetes, heart disease, stroke, and other chronic conditions:

"Diabetes, heart disease, and cancer are the top three chronic conditions we see."

"We have more people living with diabetes, and while we can keep them alive, their quality of life is often diminished."

"Heart disease and diabetes are showing up at younger ages, which is very concerning."

Older Adult Health

Stakeholders highlighted older adult health as a significant area of concern, noting that the Avon Hospital community has a growing aging population with high rates of multiple chronic conditions. Older adults often face additional challenges such as mobility limitations, transportation barriers, and reduced access to coordinated care. Participants reported that cuts to senior programs and the absence of a dedicated senior services levy in Lorain County have further limited resources for this population. Many older adults struggle to access affordable nutrition, preventive care, and support services needed to manage their health effectively.

The following are highlights of participant feedback regarding older adult health:

- Growing older adult population with complex health needs
- High prevalence of multiple chronic diseases among older adults
- Mobility, transportation, and access barriers to medical and support services
- Lack of a senior services levy to fund dedicated programs in Lorain County
- Cuts to existing senior programs reducing available resources
- Limited access to affordable, nutritious food and preventive health services

The following are a selection of quotes illustrating feedback about Older Adult Health by key informants:

"We still have an aging population, and geriatric care is becoming more important every year."

"Lorain County does not have a senior services levy, which limits what can be offered."

"Cuts to senior programs are worrying, especially when the need is growing."

Stakeholders described chronic disease prevention and management as a major community health priority, with concerns spanning cancer, diabetes, heart disease, stroke, and the health of older adults. Poor nutrition, limited access to affordable healthy foods, and low participation in wellness programs were cited as key contributors to chronic disease risk, while physical inactivity and lifestyle factors were viewed as driving forces behind rising rates of these conditions at younger ages. Cancer was highlighted due to declines in screenings and delayed diagnoses, diabetes and heart disease for their long-term management challenges and impact on quality of life, and older adult health for the compounded barriers of multiple chronic conditions, mobility limitations, and reduced program funding. Across all conditions, stakeholders emphasized the need for greater

prevention efforts, improved access to screenings and early intervention, expanded community education, and stronger support systems to help residents manage chronic illnesses and improve overall quality of life.

Maternal and Child Health

Stakeholders identified Maternal and Child Health as a significant community priority, noting persistent differences in birth outcomes, access to care, and child well-being across the Avon Hospital community. Infant mortality rates remain high, with contributing factors such as limited prenatal care, preterm births, and barriers related to health-related social needs. Participants also expressed concern about the broader health and development of children, citing challenges such as childhood obesity, access to pediatric care, food insecurity, and the influence of parental attitudes toward healthcare. Stakeholders emphasized the importance of prevention, early intervention, and culturally responsive, family-centered supports to improve outcomes for mothers, infants, and children.

The following are highlights of participant feedback regarding maternal and child health:

Maternal, Fetal & Infant Health

- Persistently high infant mortality rates.
- Higher-than-average rates of preterm births and low birthweight infants
- Limited access to early and consistent prenatal care
- Health-related social needs, including poverty and food insecurity, which affect maternal and infant health
- Need for culturally appropriate outreach and education for expectant mothers

Children's Health

- High prevalence of childhood obesity
- Gaps in early childhood education and developmental support
- Parental attitudes strongly influence children's access to preventive and routine care
- Food insecurity impacting child nutrition and overall well-being
- Mental health needs among youth, including suicide prevention and emotional support services

The following are a selection of quotes illustrating feedback about Maternal and Child Health by key informants:

"We are seeing our moms not getting prenatal care, which is leading to more preterm births."

"There are much higher rates of infant mortality affecting our communities."

"Nutrition and prenatal support can make a real difference, but not everyone has access."

"If a child's parents do not see healthcare as important, the child often does not get the care they need."

"We have a large portion of obese children in the community."

"Youth suicides are increasing, and we need to respond as a community."

Stakeholder feedback reflects significant and interconnected challenges in maternal, infant, and child health. Persistent differences in birth outcomes, limited prenatal care, and health-related social needs create risks for mothers and infants, while children face challenges related to nutrition, preventive care, education, and mental health. Addressing these concerns will require a coordinated, multi-sector approach that combines medical care with social supports, culturally responsive outreach, and family-centered interventions to improve health outcomes across the lifespan.

Health-Related Social Needs

Prevention & Safety

Stakeholders emphasized that prevention and safety are closely tied to health-related social needs in the Avon Hospital community. Limited access to safe housing, reliable transportation, and stable employment can increase residents' exposure to unsafe environments and reduce their ability to engage in preventive health measures. Concerns were raised about neighborhood safety, the role of community infrastructure in preventing injury and illness, and the importance of ensuring equal access to programs and resources that address both health and safety. Participants also noted that economic hardship can lead to delayed maintenance of homes and vehicles, reduced participation in preventive care, and greater reliance on emergency services, which increases risk and costs for the community.

The following are highlights of participant feedback regarding prevention and safety:

- Safe, stable housing as a foundation for community safety
- Transportation barriers limiting access to preventive services and safe environments
- The influence of neighborhood safety on physical activity and outdoor recreation
- Economic hardship increasing reliance on emergency services rather than prevention
- The role of cross-sector partnerships in promoting community safety and injury prevention
- Need for more community-based safety and prevention education

The following are a selection of quotes illustrating feedback about Prevention and Safety by key informants:

"Stable housing is not just about shelter; it is about safety and health."

"If people cannot get to preventive services, they are more likely to end up in the ER."

"Neighborhood safety directly impacts whether people feel comfortable being active outdoors."

Quality of Life (Community, Economy, Education)
Stakeholders described quality of life in the Avon Hospital community as closely tied to economic stability, educational opportunity, and community connectedness. They noted that differences in income, job opportunities, and educational attainment create uneven access to resources that support long-term health and well-being. Limited access to living-wage jobs and workforce development opportunities affects economic mobility, while gaps in educational resources can impact early childhood development, graduation rates, and career readiness. Participants emphasized that strong community networks, safe and supportive environments, and equal access to economic and educational opportunities are essential to improving overall quality of life and reducing differences in health outcomes.

The following are highlights of participant feedback regarding Quality of Life, including Community, Economy, and Education:

- Economic differences influencing access to resources and opportunities
- Limited access to living-wage employment and job training programs
- Education quality and resource gaps affecting child and youth development
- The role of community connectedness in promoting health and well-being
- The influence of economic stability on long-term health outcomes
- Need for partnerships between healthcare, education, and economic development sectors

The following are a selection of quotes illustrating feedback about Quality of Life, including Community, Economy, and Education by key informants:

"There is a big gap between those living in subsidized housing and those earning high incomes, and it affects access to opportunity."

"We can do a better job providing our youth with opportunities to see what is possible for their future."

"Economic stability is one of the strongest predictors of overall health."

Stakeholders identified health-related social needs as powerful determinants of health in the Avon Hospital community, influencing access to care, health behaviors, and overall quality of life. Poverty, food insecurity, housing instability, and limited transportation options were cited as persistent barriers that disproportionately affect certain populations. Economic differences, including unequal access to living-wage jobs and workforce development opportunities, contribute to uneven health outcomes, while gaps in education and community resources limit opportunities for long-term success. Participants emphasized that improving health-related social needs through coordinated efforts in housing, transportation, employment, education, and community safety is essential to reducing differences in health outcomes.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

Avon Hospital's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2022 CHNA: Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-related Social Needs.

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

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

Access to Affordable Healthcare

Actions and Highlighted Impacts:

A. Cleveland Clinic provided medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. The hospital has a financial assistance policy that is among the most generous in the region that covers both hospital services and physician services provided by physicians employed by the Cleveland Clinic. In 2024, Cleveland Clinic health system provided over $337 million in financial assistance to its communities in Ohio, Florida, and Nevada.

B. Avon Hospital supported the Lorain Free Clinic to provide individuals with a medical home, improve screening rates, improve chronic care management, increase medication adherence, and improve access to medical testing and specialized care.

C. Utilizing medically secure online and mobile platforms, Avon Hospital connected patients with Cleveland Clinic providers for telehealth and virtual visits. In 2024, Cleveland Clinic provided 1.1 million virtual visits.

Behavioral Health

Actions and Highlighted Impacts:

A. Through the Opioid Awareness Center, the hospital participated in the Northeast Ohio Hospital Opioid Consortium and Cuyahoga County Opiate Task Force, and community-based classes and presentations. Cleveland Clinic continued to provide preventative education and share evidence-based practices.

B. Avon Hospital collected unused opioid and controlled substance medications through community-based drop boxes and a collection service. Community-based drop boxes and collective services are in ambulatory pharmacy locations on the hospital campus.

C. Similar to CPR training, which helps a person without medical training assist an individual experiencing a heart attack, Cleveland Clinic offered Mental Health First Aid (MHFA) training to all US caregivers. MHFA is an 8-hour virtual training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis.

D. Avon Hospital collaborated with the Nord Center, Clear Vista, Lorain County Health and Dentistry, and the Mental Health, Addiction and Recovery Services Board of Lorain County, to promote mental health and suicide prevention education.

E. In collaboration with Lorain County, the hospital continued to provide school-based prevention programs and promote policies to increase the perception of risk of marijuana use for youth, decrease underage binge-drinking, tobacco use, and vaping.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. Avon Hospital promoted early cancer detection through community outreach and education classes related to breast, colon, cervical, lung, and prostate cancer.

B. Avon Hospital collaborated with partners to provide health screenings through free community events, including screening for pre-diabetes and diabetes.

C. The hospital supported a media awareness campaign focused on health promotion, health education, and an outreach program that reached over 2,200 people. Avon Hospital supported a community cancer prevention event.

D. In collaboration with United Way of Lorain County, Avon Hospital launched free community fitness programs for Lorain County residents. Participation from 2023 to 2024 showed a 65% increase.

Maternal and Child Health

Actions and Highlighted Impacts:

A. Cleveland Clinic continued to participate in First Year Cleveland and the Cuyahoga and Lorain County Infant Mortality Task Forces to gather data, align programs, and coordinate a systemic approach to improving infant mortality. Supported expanded evidence-based health education to expecting mothers and families.

B. Through Cleveland Clinic's Center for Infant and Maternal Health, the hospital continued to provide services for pregnant women to improve their health and support babies reaching their first birthday. Cleveland Clinic's Community Health Workers (CHWs) provided education on safe sleep, diet, nutrition, and screened for social drivers of health. CHWs connected families to resources and reinforced healthcare access. If eligible, mothers received food vouchers.

C. The hospital continued to offer and expand capacity for Centering Pregnancy group prenatal care model to expecting mothers and increased the number of families who participate in evidence-based home visiting programs.

D. Avon Hospital partnered with the thirty-five community-based organizations to host a *Community Baby Shower* for families, encouraging enrollment in supportive evidence-based programs, providing healthy nutrition education.

Health-related Social Needs

Actions and Highlighted Impacts:

A. Avon Hospital continued a Cleveland Clinic community referral data platform (Unite Us) to coordinate health services and ensure optimal communication among social service providers. The hospital employed a system-wide health-related social needs screening tool for adult patients to identify categories of community support, including alcohol abuse, depression, financial strain, food insecurity, intimate partner violence, and stress. Collaborating hospitals included University Hospitals and Metro Health. Cleveland Clinic Unite Us referrals from January 2023 to July 2025 reflected a gap closure of 41%.

B. Avon Hospital partnered with community-based organizations to host food drives and volunteer at food banks to improve access to healthy foods. The hospital launched a food pantry in collaboration with Second Harvest Food Bank.

C. Cleveland Clinic supported the Summer Meals Program, which ensures children and teens have access to nutritious meals during the summer when schools no longer provide student meals. We partnered with over 100 local organizations to provide more than 200,000 meals to approximately 10,000 children across Northeast Ohio. This initiative is part of Cleveland Clinic's larger $10.4 million commitment to addressing food insecurity across our communities by helping families access the resources they need to thrive.

D. Through community partnerships, the hospital supported early childhood learning education with focus on Lorain County's kindergarten readiness program.

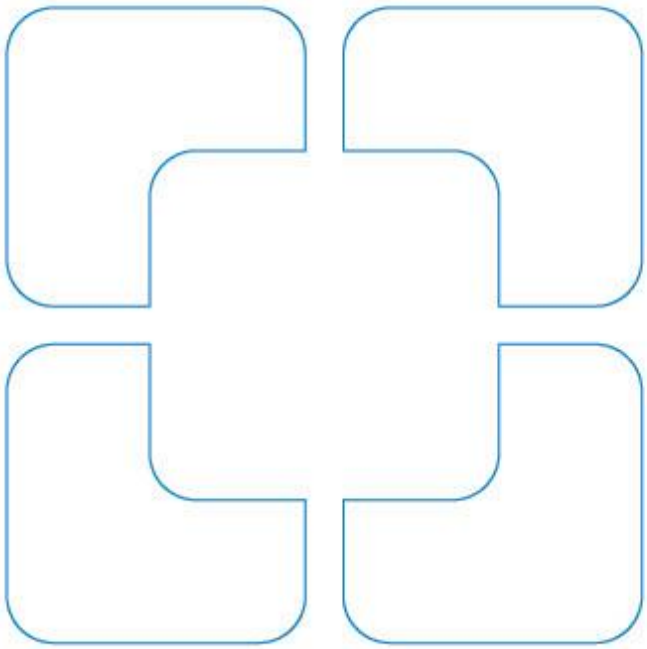
E. Avon Hospital engaged students from multiple school districts to experience workforce development and training opportunities for youth K-12 in clinical and non-clinical areas. The hospital also hosted tours and career fairs. Cleveland Clinic's Center for Youth and College Education provided youth and college learners with career exploration opportunities in a healthcare environment, offering programming that prepares the next generation of caregivers to join the healthcare workforce.

Appendix F: Acknowledgements

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

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Cleveland Clinic
Avon Hospital

Implementation Strategy Report

2025

AVON HOSPITAL
2025 Community Health Needs Assessment
Implementation Strategy Report for Years 2026 – 2028

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Avon Hospital Implementation Strategy Report

I. Introduction and Purpose

This written plan is intended to satisfy the requirements set forth in 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 Avon Hospital findings of the Community Health Needs Assessment (CHNA). The Implementation Strategy Report (ISR) includes the priority community health needs identified during the 2025 CHNA for Avon Hospital. This report includes strategies for years 2026 through 2028.

The ISR serves as the foundational framework for each hospital's community health efforts and guides how Cleveland Clinic translates identified community needs into coordinated action. The ISR aligns hospital-level strategies with enterprise-wide community priorities, including food security, maternal and child health, and lead safety, ensuring that local initiatives contribute to broader system goals.

Community engagement is embedded throughout the Community Health Needs Assessment process, from the data collection and prioritization of needs to the design, implementation, and evaluation of strategies, so that community voice meaningfully informs decision-making at every stage. Cleveland Clinic recognizes that healthy communities are achieved through collective action and that sustained improvements require strong partnerships among hospitals, public health agencies, community-based organizations, and community members. These strategies reflect a shared commitment to collaborative, cross-sector approaches, recognizing that no single organization can address complex community health challenges alone.

A. Description of Hospital

Avon Hospital, a member of the Cleveland Clinic health system, is a 126 staffed-bed[17] state-of-the-art, full-service hospital located in Lorain County, adjacent to the Cleveland Clinic Richard E. Jacobs Health Center. Opened in 2016, the five-story, 212,000-square-foot facility was the first Cleveland Clinic hospital built from the ground up in the region and is among the most technologically advanced in Northeast Ohio. Avon Hospital offers a broad range of services, including critical care, orthopedic surgery, and outpatient procedures, along with advanced surgical capabilities supported by six operating rooms.

As part of the broader Cleveland Clinic health system, Avon Hospital upholds the tripartite mission of caring for life, researching for health, educating those who serve. Cleveland Clinic is a nonprofit, multispecialty academic medical center that integrates hospital-based services with innovative research and the training of future healthcare professionals. Currently, with more than 83,000 caregivers, 23 hospitals, and 280

[17] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q3 2025) interim financial statement is referenced for official bed count. We acknowledge that staffed bed count may fluctuate and may differ from registered or licensed bed counts reflected in other descriptions.

outpatient facilities around the world, Cleveland Clinic is recognized as one of the world's leading healthcare systems. Its collaborative, patient-centered model of care promotes improved outcomes and enhances quality of life for patients both locally and internationally.

The Cleveland Clinic health system includes its flagship academic medical center in Cleveland, regional hospitals in Northeast Ohio, a children's rehabilitation hospital, and additional hospitals and facilities in Florida and Nevada. Each hospital, including Avon, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Avon Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Avon Hospital also plays a vital role within its immediate neighborhood, advancing the Cleveland Clinic's mission of improving community health. The hospital actively supports programs, partnerships, and services that address local health needs and promote equal health access. It has received national recognition for excellence in patient safety and care quality, and remains committed to treating every patient with kindness, dignity, and respect.

Cleveland Clinic's legacy as a pioneering institution began in 1921 as a multispecialty group practice, and it continues to lead through medical firsts, global expansion, and a commitment to community health. Today, Avon Hospital exemplifies this vision by delivering high-quality care, supporting health-focused research, and fostering community partnerships that help address both medical and social drivers of health.

Avon Hospital is a trusted part of the community and continues to grow and improve to meet the needs of its patients. To learn more, visit: my.clevelandclinic.org/locations/avon-hospital.

II. Avon Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Avon Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Avon Hospital community that served as a guide for data collection and analysis for this CHNA. Table 1 lists zip codes and associated neighborhoods that comprise the community definition.

Figure 1: Avon Hospital Community Definition

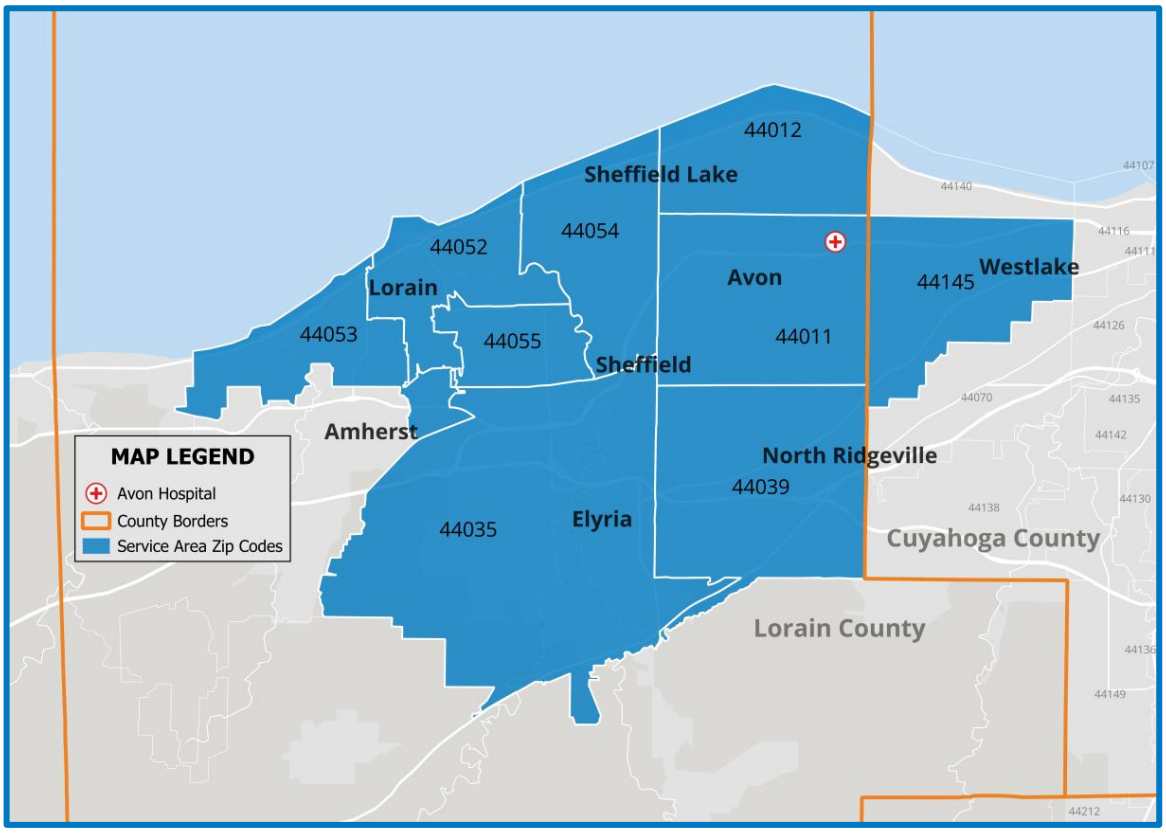


Table 1: Avon Hospital Community Definition

Zip Code	Postal Name
44011	Avon
44012	Avon Lake
44035	Elyria
44039	North Ridgeville
44052	Lorain
44053	Lorain
44054	Sheffield
44055	Lorain
44145	Westlake

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of leadership at Avon Hospital representing several departments of the organization, including clinical administration, medical operations, nursing, and community health. This team incorporated input from the hospital's community and local nonprofit organizations to prioritize selected strategies and determine possible collaborations. Leadership at Avon Hospital will utilize

this Implementation Strategy to determine whether changes should be made to better address the health needs of its communities.

IV. Summary of the Community Health Needs Identified

Avon Hospital's prioritized community health needs as determined by analyses of quantitative and qualitative data from the 2025 CHNA include:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health
- Health-Related Social Needs

These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that the hospital's defined community continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to address reducing differences in health outcomes across populations in the community served by Avon Hospital.

V. Needs Hospital Will Address

Each Cleveland Clinic hospital has adopted and is implementing an Implementation Strategy to address the significant community health needs identified through the 2025 CHNA, in accordance with the requirements of Internal Revenue Service (IRS) Section 501(r). This Implementation Strategy outlines the hospital's planned actions for the 2026–2028 implementation period and describes how identified community health needs will be addressed through hospital-led programs, services, and partnerships.

Implementation efforts focus on addressing underlying structural and social factors that influence health; strengthening and sustaining trust with community members, partners, and stakeholders; incorporating community input into the development and implementation of strategies; and monitoring and evaluating the effectiveness of programs and initiatives over time.

The strategies included in this ISR reflect collaborative efforts between Avon Hospital and local nonprofit, public health, and community-based organizations. These coordinated initiatives are intended to improve health outcomes within the community the hospital serves.

A. Access to Healthcare

The 2025 CHNA identifies Access to Healthcare as a major concern for the Avon Hospital community, with residents in rural and under-resourced areas facing significant geographic and service-related barriers. Stakeholders noted limited availability of primary

care, specialty care, emergency services, and pharmacies, exacerbated by facility closures, provider shortages, and long travel times, especially for older adults and those without transportation. Affordability, insurance gaps, and limited health literacy further delay care and reduce use of preventive services. Stakeholders emphasized the need for culturally and linguistically appropriate care, expanded outreach, and stronger transportation and healthcare infrastructure. Secondary and geospatial data reflect low provider density, high avoidable hospital stays, and elevated Community Health Index scores, particularly in Lorain's 44055 and 44052 zip codes, indicating concentrated access challenges.

Access to Healthcare Initiatives for 2026-2028 include:

Access to Healthcare Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. Initiative: Continue to provide Patient Financial Advocates to support patients in evaluating eligibility for financial assistance or public health insurance programs.

Anticipated Impacts: Increase the proportion of eligible individuals who are enrolled in assistance programs, increase access to healthcare.

B. Initiative: Collaborate with Federally Qualified Health Centers (FQHCs), community-based organizations, area hospitals, and local health department to provide access and continuum of healthcare services.

Anticipated Impacts: Improve healthcare access and connect individuals with community resources.

B. Behavioral Health

The 2025 CHNA for the Avon Hospital community identifies behavioral health as a major priority, with rising anxiety, depression, and suicidal ideation, especially among youth, driven by social media pressures, isolation, and family stress. Stakeholders also reported growing substance use concerns, including increased youth drug use and ongoing opioid-related challenges. Barriers such as provider shortages, long wait times, stigma, and high costs limit access to timely care. Participants emphasized the need for integrated mental health services, expanded school- and community-based supports, and coordinated prevention and treatment strategies. Secondary data reflect high rates of depression and poor mental health days, with the Lorain zip codes 44052 and 44055 showing the highest Mental Health Index scores and elevated opioid-related mortality, indicating severe unmet behavioral health needs.

Behavioral Health Initiatives for 2026-2028 include:

Behavioral Health Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Collaborate with community-based organizations, schools, and local healthcare providers to educate and understand behavioral health issues, available resources, and treatment options for mental health and substance misuse issues.

   Anticipated Impacts: Increase awareness of treatment, reduce stigma, and improve early identification of behavioral health conditions.

C. Chronic Disease Prevention and Management 

The 2025 CHNA for the Avon Hospital community identifies chronic disease prevention and management as a major priority, with high rates of cancer, diabetes, heart disease, stroke, and other long-term illnesses increasingly affecting residents at younger ages. Stakeholders linked these trends to limited preventive care, uneven access to healthy foods, physical inactivity, and gaps in early detection. Cancer screening declines and high breast and prostate cancer rates were cited as pressing concerns. Older adults face multiple chronic conditions alongside limited senior services, transportation challenges, and rising fall-related risks. Secondary data highlight significant disease burdens across Lorain County, underscoring the need for stronger prevention, coordinated care, and improved nutrition and wellness supports.

Chronic Disease Prevention and Management Initiatives for 2026-2028 include:

Chronic Disease Prevention and Management Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Provide community health education and screenings regarding chronic diseases and conditions for community-based organizations, residents, and faith-based organizations. Collaborate programming with local health department and area hospitals.

   Anticipated Impacts: Address chronic disease issues of diabetes, heart disease, cancer, hypertension, chronic obstructive pulmonary disease, obesity. Improve screening follow-up rates and therefore reduce behavioral risk factors.

D. Maternal and Child Health 

The 2025 CHNA for the Avon Hospital community identifies Maternal and Child Health as a key priority, driven by high infant mortality and rising rates of preterm and low-birthweight births. Stakeholders highlighted limited access to early and consistent prenatal care, health-related social needs, and low health literacy as major contributors to adverse outcomes. Concerns also centered on adolescent reproductive health, childhood obesity, developmental support gaps, and long wait times for pediatric care. Youth mental health and the influence of parental engagement were noted as critical factors. Secondary

data reinforce these concerns, showing increasing infant mortality and high rates of child poverty and food insecurity.

Maternal and Child Health Initiatives for 2026-2028 include:

Maternal and Child Health Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Continue Cleveland Clinic services of Community Health Workers and/or the co-location of community organizations with hospital facilities, providing assistance for families from pregnancy throughout baby's first year of life.

   Anticipated Impacts: Ensure connection to obstetric/pediatric medical services, improve health and birth outcomes for pregnant patients, and support families with community resources.

B. **Initiative:** Co-Design strategies with community-based organizations to connect mothers with essential resources.

   Anticipated Impacts: Gather data, align programs, and coordinate a systemic approach to improving infant mortality in communities, increase the number of babies that reach their first birthday, improve health and well-being of mother and baby.

E. Health-Related Social Needs

The 2025 CHNA for the Avon Hospital community identifies health-related social needs as persistent, interconnected barriers impacting residents' ability to achieve good health and well-being. Stakeholders emphasized how poverty, housing instability, transportation gaps, and food insecurity limit access to healthcare, employment, and basic resources, with low-wage workers and families facing the greatest strain. Limited public transit and high housing costs disproportionately affect older adults and low-income households, while food insecurity remains common among seniors and families with children. Secondary data show concentrated poverty in Lorain's 44052 and 44055 zip codes, high ALICE rates, and significant income differences across groups. These challenges underscore the need for coordinated strategies that expand transportation, affordable housing, food access, and economic opportunity.

Health-Related Social Needs Initiatives for 2026-2028 include:

Health-Related Social Needs Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Continue Cleveland Clinic referral data platform, Unite Us, to coordinate services and ensure optimal communication, connecting residents with essential community resources.

Anticipated Impacts: Enables gap closure, ensuring that social needs such as food assistance, family support, housing assistance, and mental health services are resolved.

B. **Initiative:** Expand a multi-pronged strategy to address food security through education and healthy food access options. Support key partnership with Second Harvest Food Bank.

   Anticipated Impacts: Improve self-efficacy associated with healthy eating, improve nutrition education, reduce childhood hunger.

C. **Initiative:** Strengthen the hospital's Community Advisory Council with continued integration of community voice and aligned strategic planning.

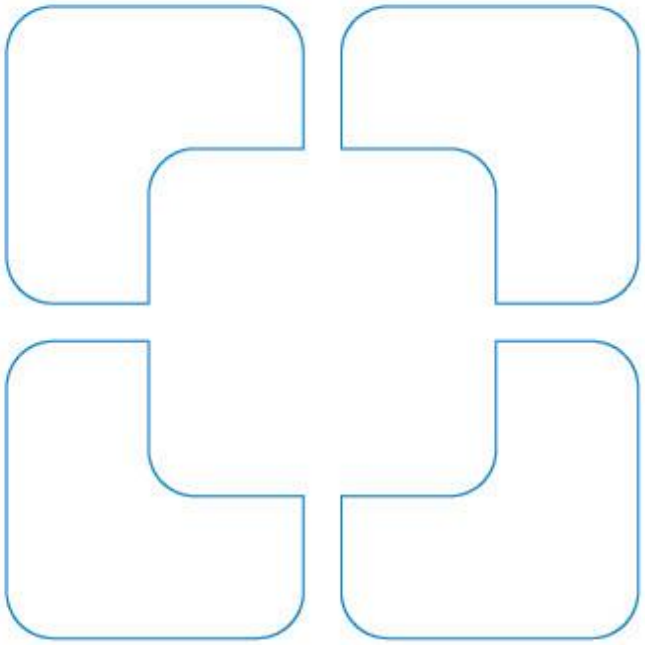
   Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives. Improve community awareness of available resources, develop a resource guide, and improve access to social supports.

D. **Initiative:** Provide workforce development and training opportunities for K-12 students in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders.

   Anticipated Impacts: Improve local employment opportunities, improve poverty rates.

While this ISR outlines specific strategies and programs identified to address the 2025 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, it does not reflect all the work being done by Avon Hospital to improve community health. Through this iterative process, opportunities are identified to grow and expand existing work in prioritized areas as well as implement additional programming in new areas. These ongoing strategic conversations will allow Avon Hospital to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

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



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