Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Avon

Community Health Needs Assessment

2025

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Cleveland Clinic Rehabilitation Hospital Avon
2025 Community Health Needs Assessment

Introduction

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

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

The hospital is a joint venture between Cleveland Clinic health system and Select Medical. As part of the broader Cleveland Clinic health system, CCRH Avon 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 CCRH Avon, contributes to the system-wide advancement of clinical research and medical innovation. Patients at CCRH Avon benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Select Medical is one of the largest providers of post-acute care encompassing three areas of expertise: critical illness recovery, inpatient medical rehabilitation, and outpatient physical therapy, all of which are delivered and supported by talented healthcare professionals across the U.S. Additional information about Select Medical is available at https:www.selectmedical.com/.

CHNA Background

As part of its mission to improve health and well-being in the communities it serves, CCRH Avon 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.

CCRH Avon Community Definition

The community definition describes the zip codes where approximately 75% of CCRH Avon Hospital discharges originated in 2024. Figure 1 shows the specific geography for this 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: CCRH Avon Community Definition

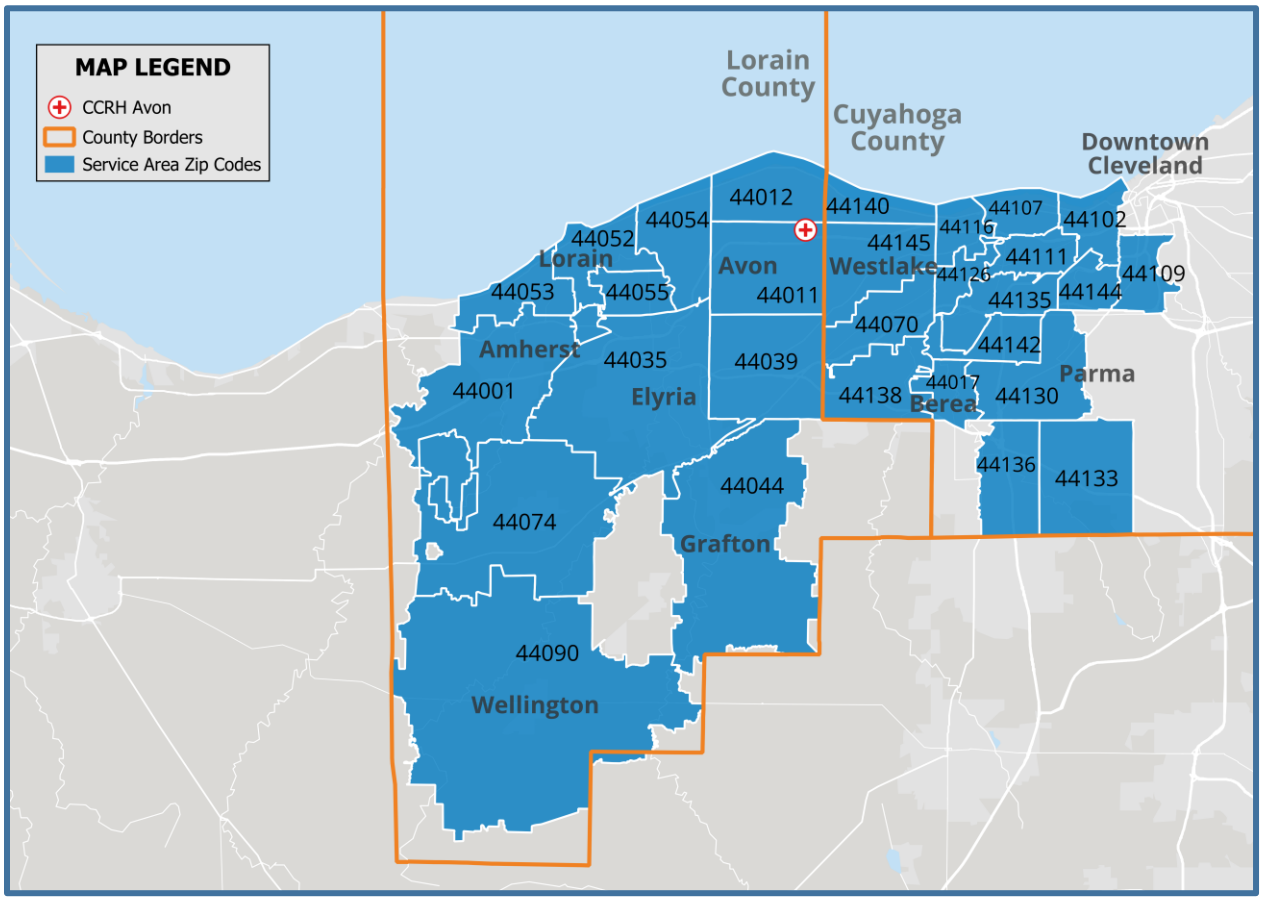


Table 1: CCRH Avon Community Definition

Zip Code	Municipality	Zip Code	Municipality
44102	Cleveland (Detroit-Shoreway)	44145	Westlake
44055	Lorain	44054	Sheffield
44052	Lorain	44039	North Ridgeville
44109	Cleveland (Brooklyn-Centre)	44011	Avon
44135	Cleveland	44012	Avon Lake
44111	Cleveland (Jefferson)	44001	Amherst
44035	Elyria	44136	Strongsville
44053	Lorain	44116	Rocky River
44144	Cleveland	44140	Bay Village
44107	Lakewood	44133	North Royalton
44130	Cleveland	44138	Olmsted Falls
44070	North Olmsted	44145	Westlake
44142	Brookpark		
44126	Cleveland		
44017	Berea		

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 both the county level and within a defined zip-code CCRH Avon community area. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced three key health priorities, Access to Healthcare, Adult Health, and Community Safety, 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 United Way, hospital systems, and regional health collaboratives, corroborated the relevance of the three prioritized needs prioritized in this 2025 CHNA process.

Across communities, consistent themes emerged. Access to Healthcare continues to be limited by cost barriers, transportation challenges, and shortages of primary and behavioral health providers. Adult Health is affected by high rates of chronic disease, food insecurity, and limited access to affordable opportunities for physical activity and preventive care. Community Safety is shaped by social and economic factors such as poverty, housing instability, substance use, and increasing rates of violence, all of which intersect to influence overall health and well-being across the region.

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 CCRH Avon community. These conversations included individuals from nine organizations who spoke directly to the needs within the community. Participants represented sectors including public health, mental health, housing, food access, and other community organizations.

Conversations with stakeholders across the CCRH Avon community highlighted pressing needs related to Access to Healthcare, Adult Health, and Community Safety. Stakeholders emphasized that residents often delay care because of affordability, insurance gaps, and difficulty navigating the healthcare system, with transportation and language barriers creating additional obstacles. Concerns about Adult Health centered on the growing burden of chronic disease, limited access to preventive care, and the risks of isolation among older adults, particularly those living alone without sufficient supports. Community Safety was described as a daily challenge in some neighborhoods, where gun violence, overdoses, and crime contribute to chronic stress, limit outdoor activity, and undermine community trust. Stakeholders called for greater investment in prevention efforts and coordinated community partnerships that address both clinical services and the broader conditions shaping health outcomes.

Summary

2025 Prioritized Health Needs

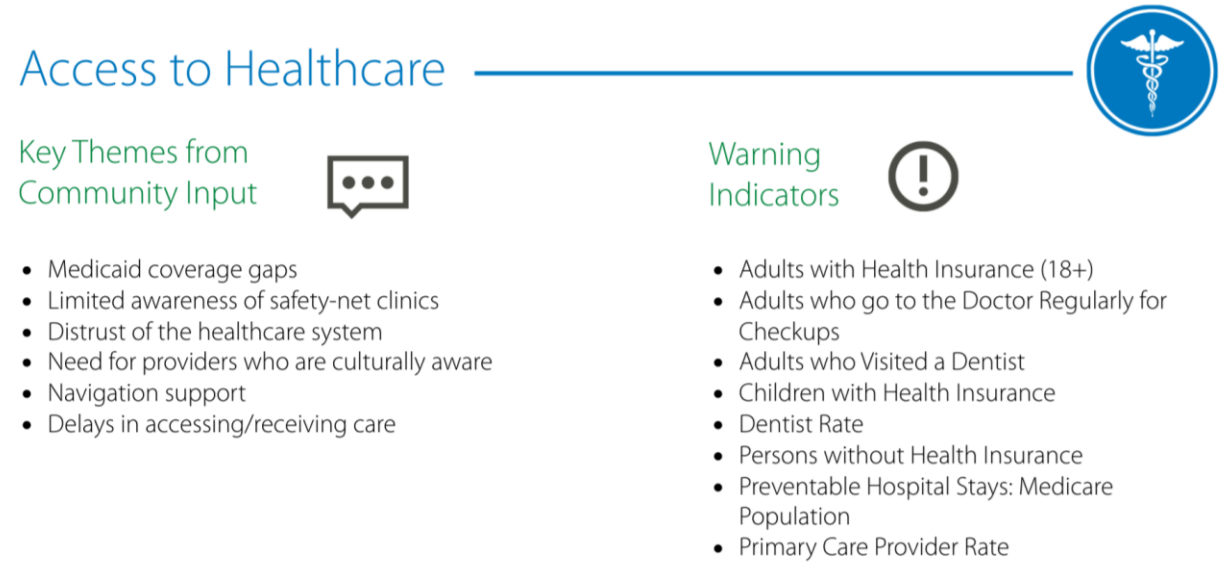
CCRH Avon's 2025 Community Health Needs Assessment reaffirms its commitment to addressing three core health priorities based on a rigorous synthesis of primary data in the form of community stakeholder interviews, secondary indicators from national and state data sources, and a regional environmental scan. The following three 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 Cuyahoga and Lorian counties continue to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to address difference in health outcomes and improve health outcomes for all populations in the community served by CCRH Avon.

The three prioritized community health needs identified in this 2025 CCRH Avon 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 central theme across stakeholder interviews, with participants emphasizing persistent barriers related to coverage, navigation, and affordability. Respondents noted that many community members eligible for Medicaid or safety-net programs are either unaware of their options or struggle to remain enrolled due to administrative challenges. Education around presumptive eligibility, improved outreach on available services, and promotion of safety-net clinics were identified as critical opportunities. Several stakeholders stressed that distrust of the healthcare system continues to prevent individuals from seeking needed care. Access challenges are not only tied to insurance coverage but also to the ability to connect patients with providers who are culturally responsive and capable of meeting their needs.

In addition, interviewees underscored the importance of access that extends beyond simply providing services. Navigation support and community health workers were identified as effective strategies for improving health literacy and helping residents distinguish between urgent, emergent, and preventive care. Several stakeholders also pointed to gaps in mental health and behavioral health services, where long wait times and limited number of providers constrain access.

Overall, findings highlight that Access to Healthcare in the CCRH Avon community is shaped by both structural and social barriers. Coverage gaps, lack of knowledge about available resources, and cultural or trust-related barriers reduce utilization of preventive and routine services, perpetuating differences in health outcomes. Stakeholders called for stronger collaboration among safety-net providers, targeted outreach to under resources communities, and investment in patient navigation and culturally relevant care models to ensure that healthcare is truly accessible and responsive to community needs.

Secondary data reveal concerning trends in healthcare access across the CCRH Avon community. Medicare data show particularly high rates of preventable hospitalizations in Cuyahoga and Lorain counties. In Lorain County, the rate of avoidable hospital stays among Medicare enrollees, 3,494 per 100,000, is higher than in most other Ohio

counties. This issue is compounded by a significant decline in the availability of primary care providers and dentists. Lorain County averages 51.6 primary care providers per 100,000 residents, a figure that continues to decrease and remains well below state and national averages. Cuyahoga County, while having one of the highest concentrations of primary care providers in Ohio, faces a different challenge: low rates of routine checkups among adults. Additionally, limited health insurance coverage in both counties may be a barrier to accessing regular, preventive care.

Geospatial data from Conduent HCI's Community Health Index (CHI) can help to estimate health risk at a more granular level, based on health-related social needs. Across the CCRH Avon community, the zip codes with the greatest healthcare needs are 44102, 44109, and 44052, with CHI values of 95.9, 94.5, and 94.1, respectively. Additional details about the CHI, 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: Adult Health

Adult Health

Key Themes from Community Input

- Rising chronic disease rates
- Younger age of onset
- Poor diet and inactivity
- Low screening participation
- Food insecurity challenges
- Social isolation among older adults
- Need for community prevention programs

Warning Indicators

- Prostate Cancer Incidence Rate
- People 65+ Living Alone
- People 65+ Living Below Poverty Level
- Age-Adjusted Death Rate due to Falls
- Age-Adjusted Death Rate due to Kidney Disease
- Chronic Kidney Disease (Medicare Population)
- Ischemic Heart Disease (Medicare Population)
- Stroke (Medicare Population)
- Breast Cancer Incidence Rate
- Rheumatoid Arthritis or Osteoarthritis (Medicare Population)
- Adult Day Care Spending-to-Income Ratio
- Age-Adjusted Death Rate due to Breast Cancer
- Self-Reported General Health (Good or Better)
- Age-Adjusted Death Rate due to Prostate Cancer
- Atrial Fibrillation (Medicare Population)
- COPD (Medicare Population)
- Hyperlipidemia (Medicare Population)
- Cancer (Medicare Population)

Adult Health was a dominant theme across stakeholder interviews, with participants emphasizing the growing burden of chronic disease and the lifestyle and environmental factors contributing to these trends. Diabetes, hypertension, heart disease, and cancer were repeatedly identified as leading concerns across the community. Stakeholders noted that these conditions are being diagnosed at younger ages and are increasingly linked to dietary habits, physical inactivity, and access to nutritious food. Several respondents mentioned that food insecurity and the prevalence of unhealthy food options

continue to impact disease prevention efforts, particularly for lower-income adults and those living in less walkable suburban areas.

Interviewees also described a decline in preventive behaviors, including lower rates of cancer screenings and limited participation in exercise and wellness activities. Screening delays have contributed to missed diagnoses, particularly for cancer, while social isolation and lack of physical activity among older adults further exacerbate chronic health conditions. Stakeholders identified opportunities to expand the use of community health workers and neighborhood-based wellness programs to improve disease prevention, health education, and early detection. Initiatives that promote outdoor recreation, community engagement, and access to affordable, healthy foods were highlighted as essential to improving adult health outcomes.

Overall, respondents emphasized that Adult Health in the hospital community is shaped by complex and interconnected factors, including lifestyle behaviors, healthcare access, health-related social needs, and community infrastructure. They pointed to the need for sustained investment in prevention, stronger partnerships between healthcare and community organizations, and a coordinated focus on chronic disease management and health promotion to reduce differences in health outcomes and support long-term well-being across the adult population.

Secondary data show that Adult Health across the CCRH Avon Hospital community is strongly shaped by food insecurity and the burden of chronic disease. Adults in Cuyahoga County are less likely to cook meals at home than most other Ohio counties, and fast-food use in Cuyahoga County is among the highest across the state. Conduent HCI's Food Insecurity Index (FII) highlights particularly acute needs in zip codes 44052, 44055, and 44102, with scores of 97.5, 96.8, and 96.4, respectively, reflecting severe food access challenges surrounding the cities of Lorain and Cleveland.

The prevalence of diabetes is high in both Lorain County (9.6%) and Cuyahoga County (9.9%), exceeding rates seen in most other U.S. counties. Diabetes is especially common among the region's Medicare recipients. In Lorain County, 25.0% of the Medicare population has diabetes, and nearly the same share (23.0%) is affected by chronic kidney disease, a frequent complication of unmanaged diabetes. Medicare data also indicate that in Lorain County, diabetes affects 37.0% of Black/African American Medicare recipients, 37.0% of Asian American/Pacific Islander recipients, and 36.0% of Hispanic/Latino recipients. Similarly, Medicare data from Cuyahoga County indicate elevated rates of both diabetes and chronic kidney disease among the county's Black/African American Medicare recipients. The mortality rate due to kidney disease in Cuyahoga County is also high, underscoring the seriousness of these conditions.

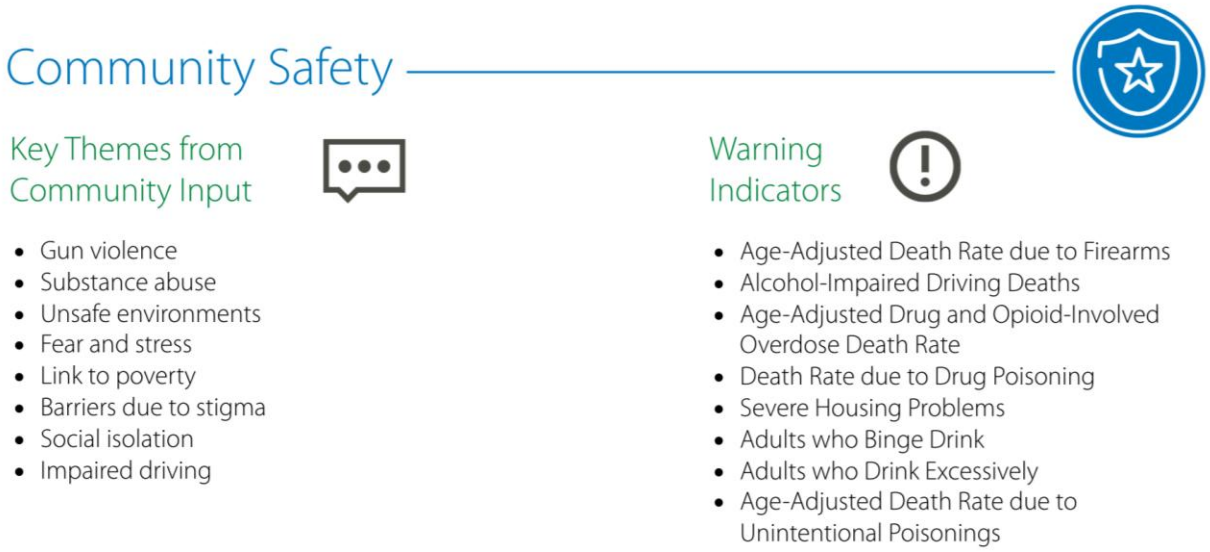
Cardiovascular disease is another major concern. In Lorain County, 25.0% of Medicare recipients have ischemic heart disease and 7.0% have experienced a stroke, placing the county in the highest quartile nation-wide for both conditions. The stroke mortality rate in Lorain County is 40.5 deaths per 100,000, which is lower than the state average, but which exceeds the Healthy People 2030 target of 33.4 and continues to rise.

Breast cancer incidence is notably high and steadily increasing in both Lorain and Cuyahoga counties, with both counties experiencing elevated mortality rates. Prostate

cancer is also a concern, with both counties ranking among the highest in Ohio for new diagnoses; Lorain County reports 124.7 cases per 100,000 males. Cuyahoga County not only has high incidence rates but also a particularly high mortality rate due to prostate cancer. Cuyahoga County's Black/African American population experiences especially high death rates from both breast and prostate cancer, compared to the general county population.

Most of these disease outcomes have an especially pronounced burden on older adults. Both Cuyahoga County and Lorain County report especially high percentages of older adults living alone, which can further increase vulnerability to health and safety risks. Fall-related deaths are also particularly concerning in Lorain County, with a rate of 14.6 deaths per 100,000, which is 50% higher than the national average of 9.8 and rising over time.

Prioritized Health Need #3 Community Safety



Community Safety emerged as a significant concern throughout stakeholder interviews, reflecting both environmental and social conditions that influence health and well-being. Participants described challenges related to housing stability, neighborhood safety, and substance use, emphasizing that these issues are interconnected with broader health-related social needs such as poverty and access to services. Housing insecurity was highlighted as a major factor affecting safety and stability, particularly for older adults, individuals with disabilities, and low-income families. Stakeholders noted that the rise in homelessness among older adults has increased vulnerability to violence, poor health outcomes, and prolonged shelter stays due to limited financial and support resources. Substance use and addiction were also identified as major safety concerns. Several respondents discussed the ongoing impacts of opioid use and overdose, noting that progress made through collaboration among local agencies has reduced deaths but that challenges remain in sustaining long-term recovery supports. Mental health and substance use were viewed as deeply intertwined, with stress, trauma, and isolation contributing to risky behaviors. Stakeholders underscored the need for consistent,

coordinated messaging and funding structures across agencies to enhance prevention, reduce duplication of services, and strengthen accountability for outcomes.

Interviewees further described how perceptions of safety vary across the community, with some neighborhoods experiencing higher rates of crime, unsafe housing, and limited access to reliable transportation or social supports. These environmental and structural barriers were seen as undermining residents' sense of security and contributing to differences in health outcomes. Respondents emphasized that improving community safety requires collaboration across sectors, linking housing, behavioral health, and social service systems, to ensure that residents have the stability, protection, and resources needed to live in safe and supportive environments.

Data from secondary sources further illustrate concerns regarding community safety. The topic of *Alcohol and Drug Use* ranked as the fourth most concerning health issue in Lorain County. In Cuyahoga and Lorain counties, the percentage of driving deaths that involve alcohol is among the highest of all U.S. counties, and rates of binge drinking are also elevated in both counties. Additionally, the death rate due to drug poisoning in both counties is more than double the Healthy People 2030 target (20.7 deaths per 100,000).

Environmental safety issues are also a concern across the region. The death rate due to falls in Lorain County is one of the highest across Ohio and significantly increasing. Severe housing problems, which may include unsafe living conditions, are also especially common in both Cuyahoga and Lorain counties. Gun violence is also a pressing issue in Cuyahoga County. The county's death rate due to firearms (20.2 per 100,000) is double the Healthy People 2030 target (10.7 per 100,000).

Prioritized Health Needs in Context

Each of the three 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 and health-related social needs factors influencing health in the CCRH Avon 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 impact its health profile.[1] 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 CCRH Avon 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, social policies, and political systems.[2] 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 (zip code and/or county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data 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 CCRH Avon Community

According to the 2024 Claritas Pop-Facts® population estimates, the CCRH Avon community has approximately 790,476 residents. The median age in the hospital community is 42.0. Similar to the rest of Ohio, most individuals fall within the 25 to 74 age range.

Three-fourths of the CCRH Avon community is White (75.6%), which is similar to the state average of 75.7%. Black/African American residents make up 8.4% of the population, significantly lower than both the state (12.8%) and national (12.4%) averages. Hispanic/Latino individuals account for 8.5% of the community.

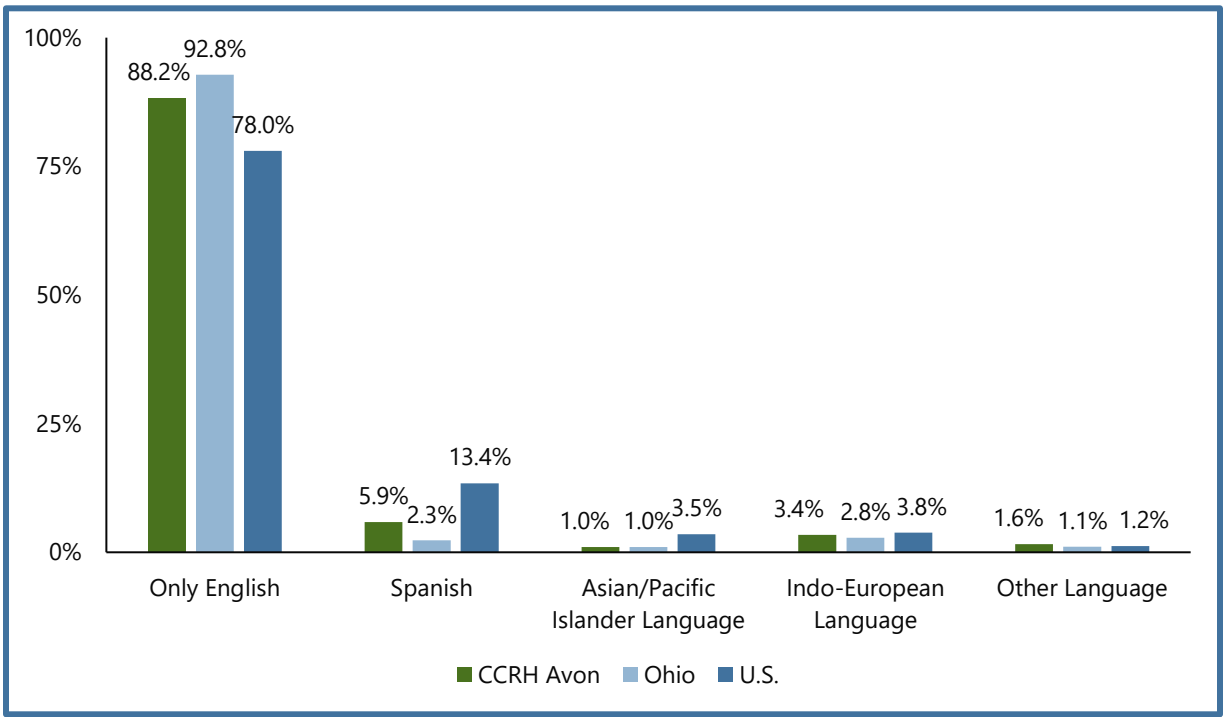
As shown in Figure 2, 88.2% of residents aged five and older in the community primarily speak English at home. This rate is higher than the national average (78.0%) but lower

[1] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/
[2] 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

than Ohio's overall rate (92.8%). Community residents are more likely to speak Spanish than the surrounding Ohio population (5.9% vs. 2.3%).

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.

Figure 2: Population 5+ by Language Spoken at Home: Hospital, State, and U.S. Comparisons



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

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

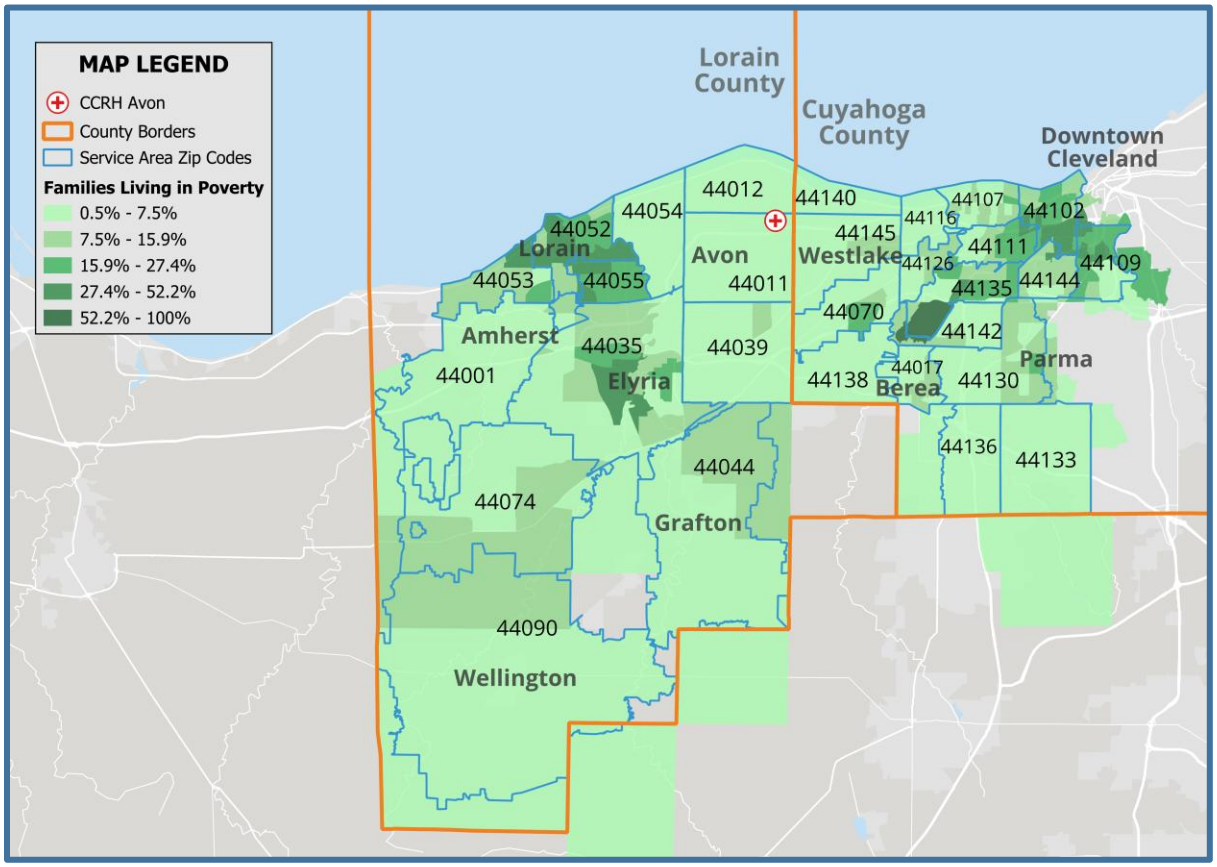
Income and Poverty

The median household income in the CCRH Avon Hospital community is $68,837, higher than Cuyahoga County ($63,671), and similar to the median incomes of Lorain County ($68,630) and Ohio overall ($68,488).

Federal poverty thresholds, set annually by the U.S. Census Bureau, vary by family size and the ages of household members. In the CCRH Avon community, 10.0% of families live below the poverty level—somewhat higher than the state average (9.4%). Within this community, ZIP code 44102 has the highest concentration of poverty, with a quarter of families (25.7%) living below the poverty line (see 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.[4]

Figure 3: Families Living Below Poverty



Community, census tract, zip code, and state values: Claritas Pop-Facts® (2024 population estimates)

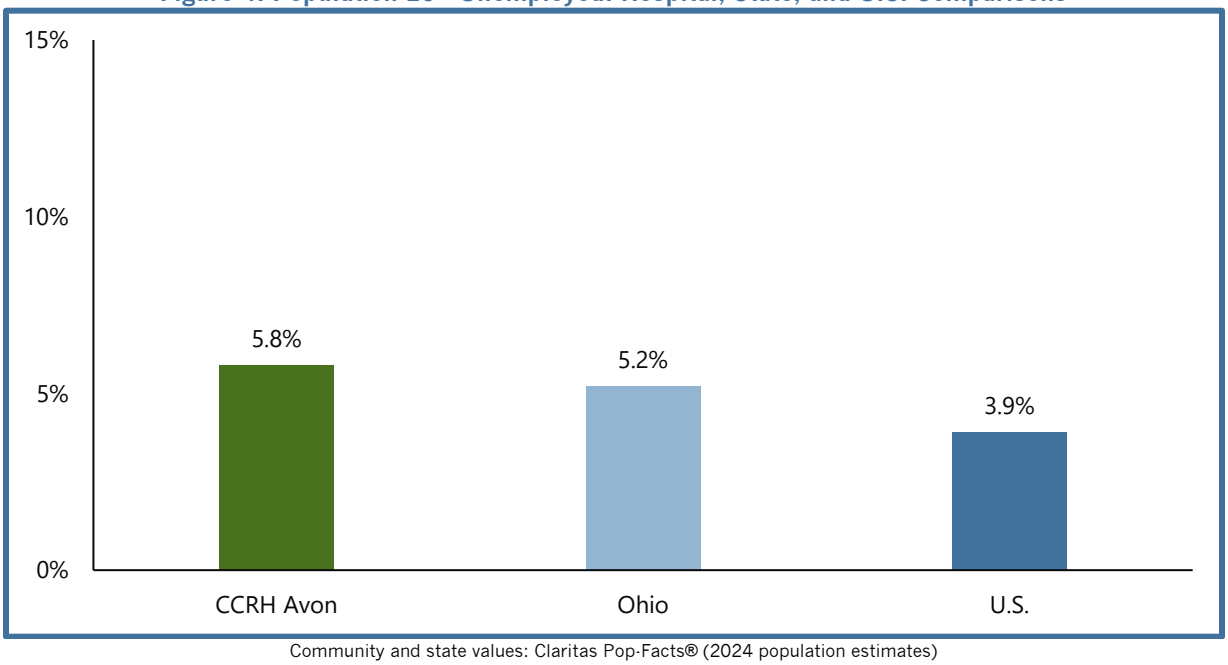
U.S. value: American Community Survey five-year (2019-2023) estimates

Education and Employment

In the CCRH Avon Hospital community, 91.1% of residents have earned at least a high school diploma, closely aligning with Ohio (91.4%) and the national average (89.4%). Nearly a third of the hospital community has a Bachelor's, Master's, Doctorate, or Professional degree (31.9%).

The unemployment rate in the CCRH Avon community is 5.8% — similar to Ohio's unemployment rate (5.2%), and higher than the national average of 3.9%.

Figure 4: Population 16+ Unemployed: Hospital, State, and U.S. Comparisons



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

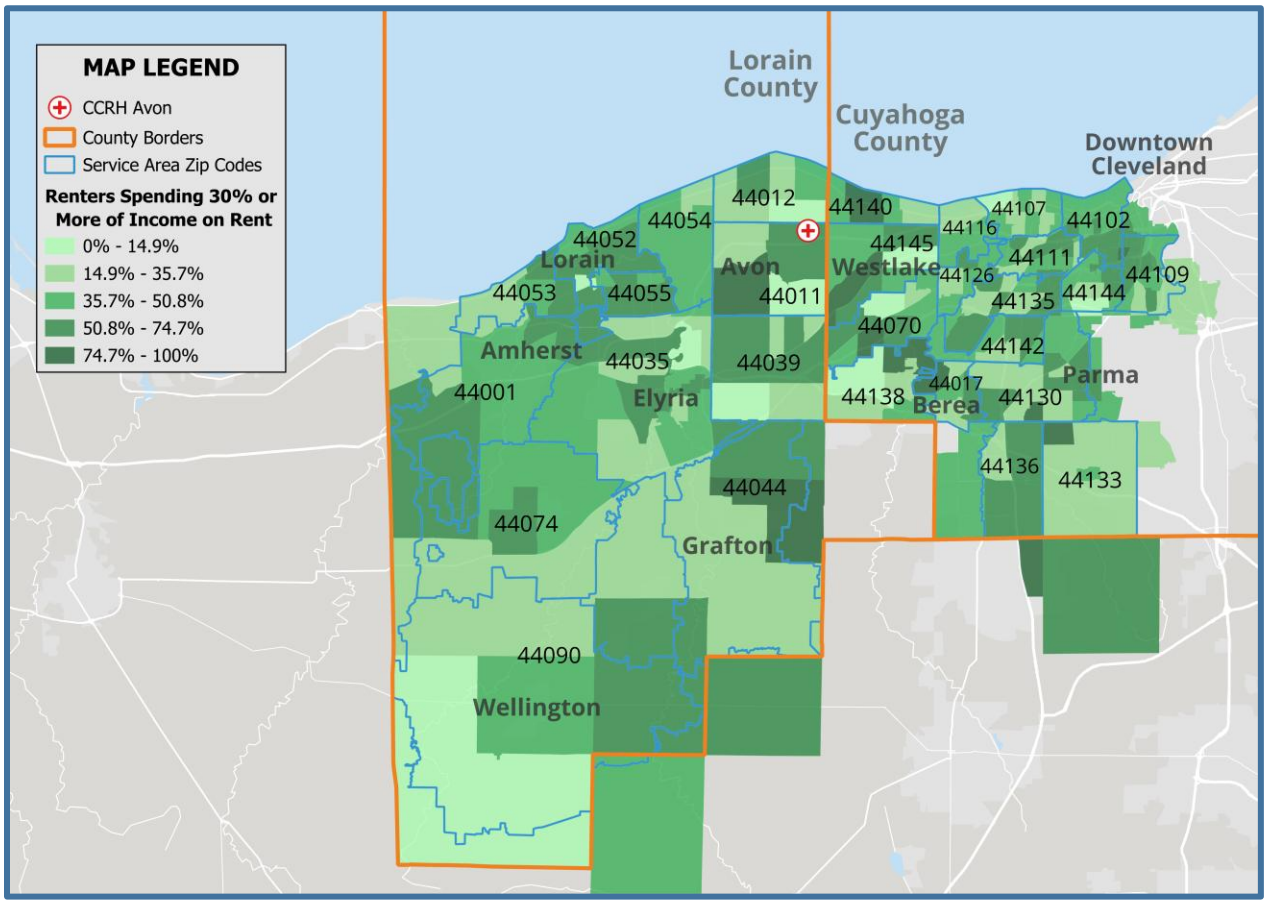
U.S. value: American Community Survey five-year (2019-2023) estimates

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.[5] 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.[6]

Housing and Built Environment

Safe, stable, and affordable housing is a critical foundation for health and well-being. In Cuyahoga County, 15.9% of households—and in Lorain County, 12.9%—experience severe housing problems, including overcrowding, high housing costs, and lack of basic amenities such as a kitchen or plumbing. Housing costs, in particular, are a significant burden across both counties: nearly half of renters in Cuyahoga (47.5%) and Lorain County (46.3%) spend at least 30% of their income on rent (Figure 5).

Figure 5: Renters Spending 30% Or More Of Household Income on Rent



Census tract and zip code values: American Community Survey five-year (2019-2023) estimates

Home internet access is an essential utility for accessing healthcare services, such as scheduling appointments, viewing test results, and managing medical records. While 87.5% of households in Cuyahoga County and 86.9% in Lorain County have internet access, significant differences exist at the neighborhood level. In ZIP code 44104, within the CCRH Avon Hospital community, only 69.3% of households have internet access.

Community Health Indices

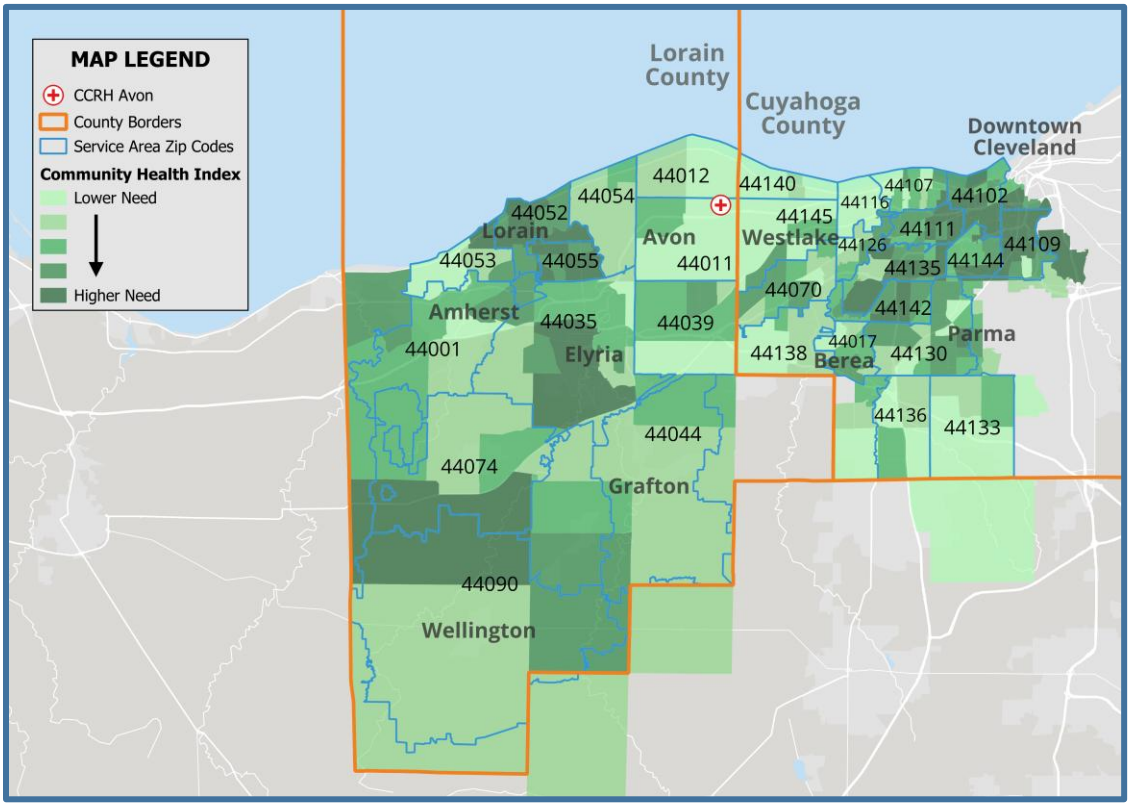
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the CCRH Avon community at the zip code 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 health-related social needs data that is 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 CCRH Avon community, as indicated by the darkest shade of green. At the zip code level, the greatest area of need is in the zip code 44104 (Cleveland), with an index value of 99.8. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the community.

Figure 6: Community Health Index: CCRH Avon Community by Census Tract

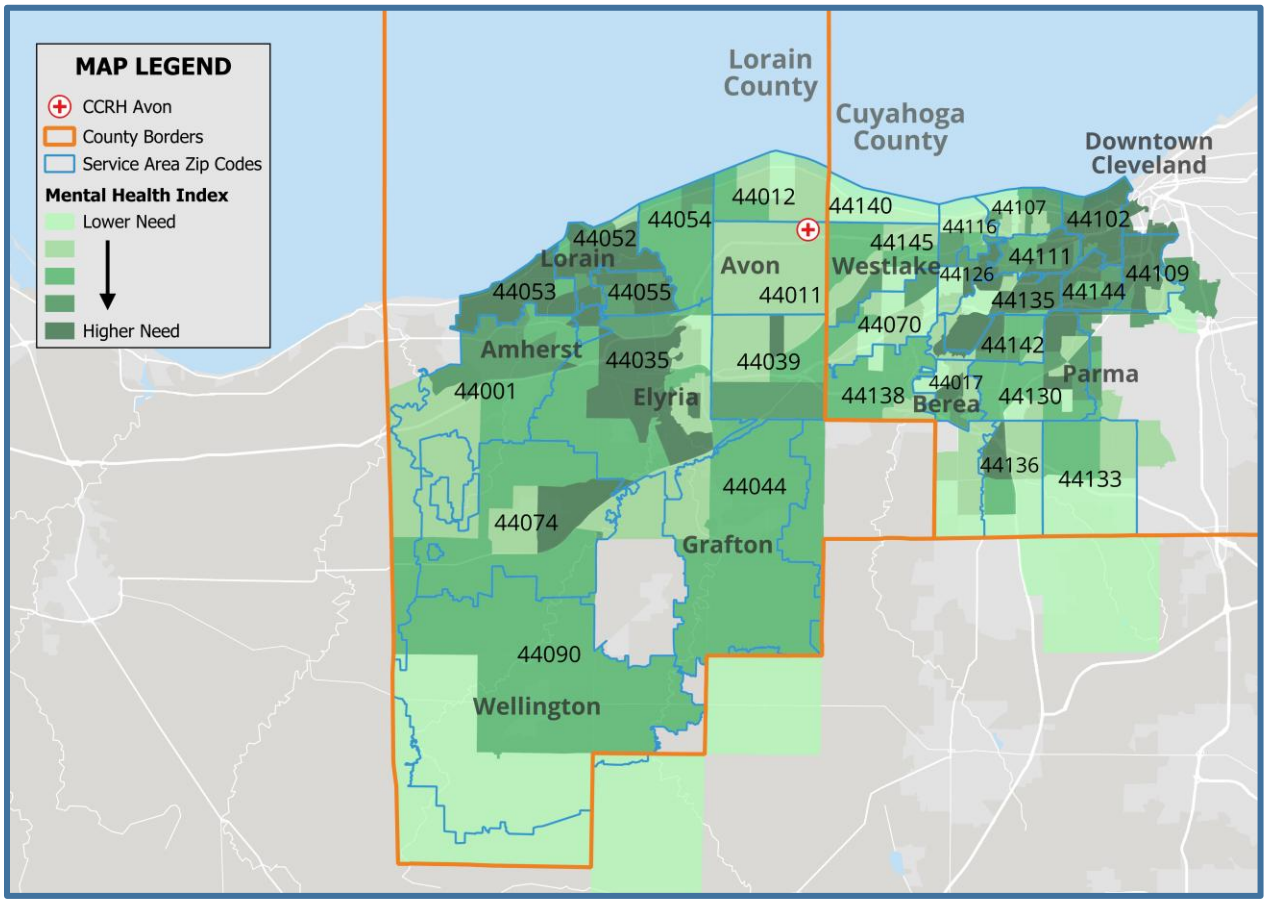


Mental Health Index

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 CCRH Avon community, as indicated by the darkest shade of green. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the CCRH Avon community.

Figure 7: Mental Health Index: CCRH Avon Community by Census Tract



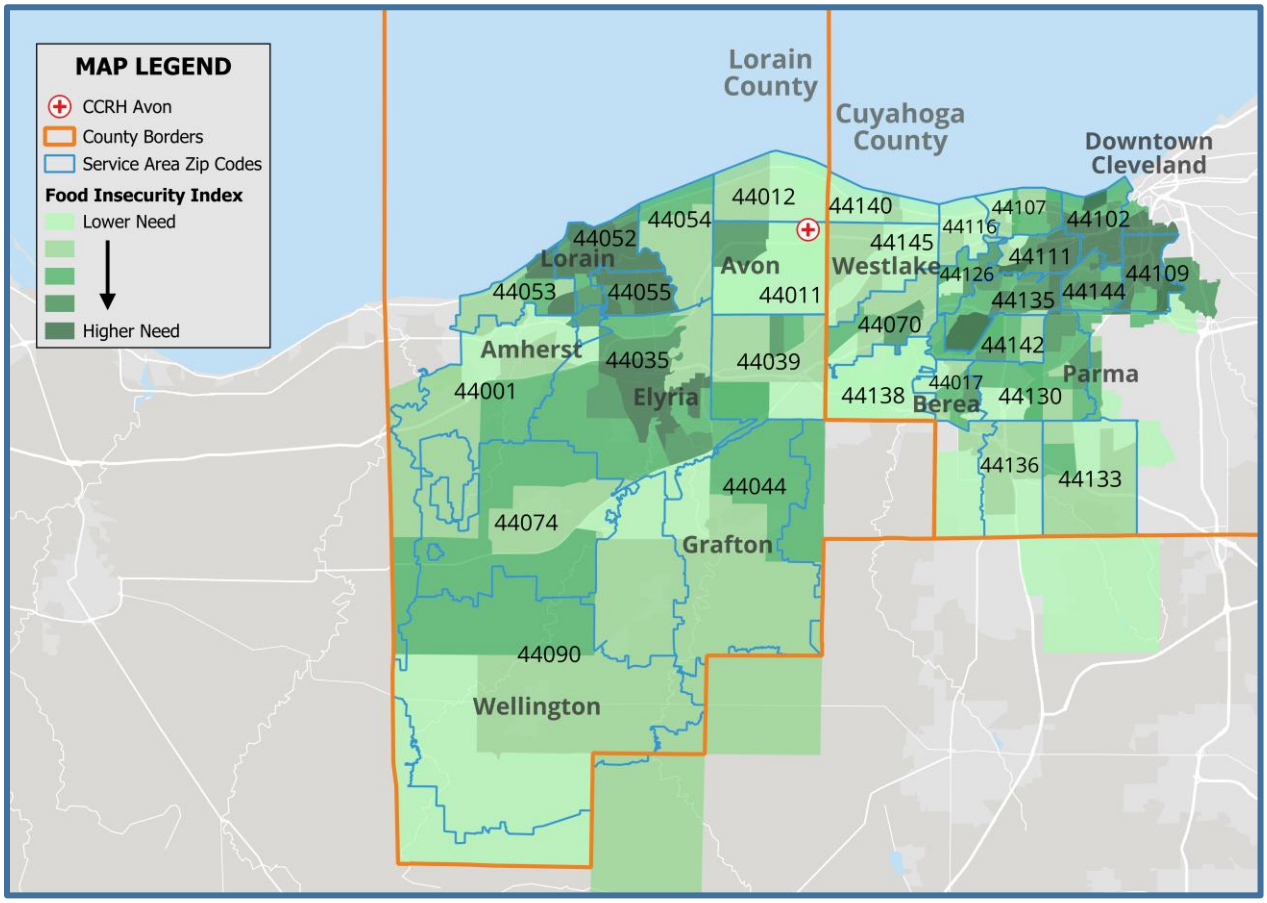
Food Insecurity Index

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 is 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 CCRH Avon community, as indicated by the darkest shade of green. See Appendix B for additional details about the FII and a table of FII values for each zip code and census tract in the hospital community.

Figure 8: Food Insecurity Index: CCRH Avon Community by Census Tract



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the CCRH Avon community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the three prioritized health needs identified in the 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[3]

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

- 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 culturally and linguistically appropriate care.
- Adult Health:
  - 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.
- Community Safety:
  - Ongoing challenges related to poverty, housing affordability and quality, food insecurity, and transportation.
  - Significant unmet mental health needs and elevated levels of substance use, including youth drug use and adult overdose deaths.

2023 City of Cleveland Parks and Recreation Community Needs Assessment[4]

- Nature and Green Space: Value placed on preserving and expanding natural areas
- Connectivity and Accessibility: Importance of walkability, ADA compliance, and transportation access
- Safety: Emphasis on secure, well-lit, and welcoming environments

2024 Cuyahoga County ADAMHS Board Needs Assessment[5]

- Significant gap between those with substance use disorders and those receiving treatment in Cuyahoga County
- Large difference between individuals with mental health disorders and those accessing treatment or services
- High need for publicly funded behavioral health services
- Elevated rates of uninsured individuals limit access to necessary care

[3] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[4] Cleveland Parks & Recreation Plan Team. (2024). *Community needs assessment report* [PDF]. City of Cleveland Department of Parks & Recreation. https://cleparksrecplan.com/wp-content/uploads/240102_Community-Needs-Assessment-Report_web.pdf
[5] Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County (2024). *Community health needs assessment* [PDF]. https://www.adamhscc.org/about-us/budgets-reports/needs-assessments

2023 Cuyahoga County Planning Commission Data Book[6]

- Population is declining, but the number of households is increasing
- Large labor force, but low participation rate
- Lower levels of post-secondary education attainment
- Household income is low; poverty rate is high
- Educational and health services are the most common employment sectors
- Housing costs are low, but affordability remains a challenge
- Minimal new housing development in recent years
- County has more multi-modal transportation options than others
- Commute times are shorter than in other areas
- The county is more urbanized compared to the surrounding regions

2022 Greater Cleveland LGBTQ+ Community Needs Assessment[7]

- 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

Joint 2022 Cuyahoga County CHNA (Collaborating Organizations: University Hospital, Cuyahoga County Board of Health, and the City of Cleveland Department of Health)[8]

Priority Health Areas Identified:

- Behavioral Health (mental health challenges and substance use/misuse)
- Accessible and Affordable Healthcare
- Community Conditions (including access to healthy food and neighborhood safety)

Prioritized Populations:

- Maternal, Fetal, and Infant Health
- Older Adults

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[6] Cuyahoga County Planning Commission. (December 2023). *Our County: The 2023 data book* [PDF]. Cuyahoga County Planning Commission. https://s3.countyplanning.us/wp-content/uploads/2023/12/Our-County-2023-reduced.pdf?

[7] 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

[8] Cuyahoga County CHNA Steering Committee. (2022). *2022 Cuyahoga County community health needs assessment* [PDF]. Conduent Healthy Communities Institute & Cuyahoga County Community Partners. https://www.healthyneo.org/content/sites/cuyahoga/Resources/CHNA-Cuy-Cty-11.22.pdf

2023 Livable Cuyahoga Needs Assessment[9]

Community & Health Services

- Cleveland has the highest disability rates among older adults in the county
- Access to doctors and hospitals is high, but other barriers persist
- Black and low-income residents are more likely to report poor mental health

Outdoor Spaces

- Sidewalks connect older adults to the community
- Parks are highly valued; safety remains a key concern

Transportation

- Transportation access and cost vary by municipality
- Driving makes travel easy, but more medical transport options are needed

Housing

- Older adults want to age in place in Cuyahoga County
- Renters face higher housing cost burdens than homeowners
- Support needed to find housing that meets mobility and accessibility needs

Social Participation

- 30% of residents lack companionship
- Older adults prefer socializing at restaurants, museums, and libraries
- Adults aged 50–64 socialize less than those over 65

Respect & Engagement

- Residents 75+ feel more respected than younger age groups
- Awareness of community events fosters connection
- Lower-income residents feel more disconnected

Workforce & Civic Engagement

- Older job seekers face ageism and tech-related challenges
- Most plan to stay in the county after retirement

2023 United Way of Greater Cleveland Community Needs Assessment[10]

Economic Mobility

- Most children are unprepared for kindergarten and preschool enrollment is lower for some across communities
- Childcare access hindered by staffing shortages
- Cleveland ranks as the 2nd poorest large U.S. city
- Significant difference in income across populations

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[9] Cuyahoga County Department of Health and Human Services, Division of Senior & Adult Services. (2023). *Livable Cuyahoga needs assessment report*. Cuyahoga County. Retrieved June 2025, from https://hhs.cuyahogacounty.gov/docs/default-source/default-document-library/reports/livable-cuyahoga-needs-assessment-report.pdf?sfvrsn=b1f65b31_1

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

Health Pathways

- Gaps in life expectancy across communities
- Elevated 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

2025 Lorain County Community Health Needs Assessment[11]

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

Primary Data Overview

Community Stakeholder Conversations

A total of nine organizations provided feedback for the CCRH Avon 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:

- Cuyahoga County Board of Health
- El Centro
- Greater CLE/Akron LGBTQ+ CHA
- Lorain County Commissioners
- Lorain County Public Health
- Lorain County Veteran Services Commission
- Mental Health, Addiction & Recovery Services Board of Lorain County
- Second Harvest Food Bank of North Central Ohio
- United Way of Lorain County

Across stakeholder interviews conducted for the 2025 Community Health Needs Assessment, Access to Healthcare, Adult Health, and Community Safety emerged as interrelated and persistent priorities for the CCRH Avon community. Participants emphasized that affordability, chronic disease burden, and neighborhood safety are intertwined with social and structural conditions that shape health outcomes. Stakeholders described the need for stronger collaboration between healthcare

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

providers, social service agencies, and community organizations to address these challenges comprehensively and sustainably.

Access to Healthcare was identified as an ongoing concern across Lorain and Cuyahoga counties. Respondents cited challenges such as limited awareness of safety-net clinics, coverage lapses following Medicaid re-enrollment changes, and long wait times for specialty and mental health care. Geographic barriers, including limited public transportation and few providers in southern parts of the county, further restricted access. Participants also noted that distrust in the healthcare system and a lack of culturally relevant, affirming care, discouraged timely and preventive care. Expanding navigation support, community health worker programs, and integrated care models that link medical, behavioral, and social supports were highlighted as critical opportunities to improve access and continuity of care.

Adult Health concerns were strongly associated with chronic disease and lifestyle-related risk factors. Stakeholders consistently cited high rates of diabetes, hypertension, heart disease, and cancer, with conditions increasingly affecting younger adults. Food insecurity, limited access to healthy and affordable food, and sedentary lifestyles were viewed as major drivers of chronic disease. Participants also described differences in screening participation, particularly for cancer, resulting in delayed diagnosis and poorer outcomes. For older adults, isolation, mobility barriers, and the high cost of adult day care were noted as contributors to declining health and safety. Respondents emphasized the importance of community-based prevention programs, physical activity initiatives, and targeted supports for aging residents.

Community Safety was also a major theme, reflecting the connections between neighborhood environments, behavioral health, and overall well-being. Interviewees highlighted concerns about substance use, opioid overdoses, and the lingering effects of trauma and instability across communities. Housing insecurity and homelessness, particularly among older adults and individuals with disabilities, were described as urgent safety issues. Stakeholders also discussed the need for collaborative, cross-sector efforts that link housing, behavioral health, and prevention services. Efforts to improve community safety, they noted, must include strategies that reduce violence, expand recovery supports, and promote safe and stable living environments for all residents. The following quotes highlight key themes identified in stakeholder feedback.

Priority Area	Key Quote	Additional Context
Access to Healthcare	“We don’t do enough to educate people about Medicaid. Many are eligible and haven’t even applied. We also don’t really promote our safety-net system enough, and I think there’s still distrust that keeps people from using it.”	This perspective reflects a recurring theme across interviews: that access issues extend beyond affordability to include system navigation, trust, and culturally responsive engagement. Stakeholders emphasized the value of community health workers and navigators who can connect residents to care and help improve health literacy, especially among uninsured groups.

Adult Health	"We hear about the same issues over and over, diabetes, hypertension, heart problems. People aren't cooking at home and we see more obesity, even among children. Changing eating and activity habits is difficult."	Interviewees also linked chronic disease prevention to access to fresh food and safe opportunities for exercise. Community programs that promote healthy behaviors, enhance social connection, and increase access to nutritious foods were described as essential strategies for improving adult health and reducing differences across neighborhoods.
Community Safety	"We have a faster-growing population of people over 60 who are homeless or disabled. They're staying in shelters longer because they can't get the help they need or afford housing and medical care."	Respondents emphasized that safety cannot be addressed in isolation from broader social conditions. Many pointed to the need for stronger collaboration between behavioral health agencies, housing providers, and local governments to promote safer, more stable environments and reduce risks linked to violence, substance use, and economic hardship.

Prioritization Methodology

The CCRH Avon 2025 Community Health Needs Assessment (CHNA) reaffirmed its focus on the same three health priorities identified in the previous assessment through a comprehensive and data-driven prioritization process. This decision was guided by a 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 in areas such as Access to Care, Adult Health, and Community Safety. 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, the same three health needs were prioritized for the 2026-2028 Implementation Strategy Report, ensuring continuity in addressing longstanding health challenges and advancing improved outcomes for the populations it serves.

Collaborating Organizations

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.

Community Partners and Resources

This section identifies other facilities and resources available in the community 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 geography served by the CCRH Avon, community health services are further supported by other local public health agencies such as Cuyahoga County Board of Health and Lorain County Public Health.

Other Community Resources

A network of agencies, coalitions, and organizations provides a broad array of health and social services within the region. 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 serve as a vital referral tool. Additional information is available at www.211oh.org.

Comments Received on Previous CHNA

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

Request for Public Comment

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

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

Appendices Summary

A. Hospital Community Definition

B. Secondary Data Methodology and Secondary Data

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

C. Environmental Scan Methodology 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: Community Definition

The community definition describes the zip codes where approximately 75% of CCRH Avon discharges originated in 2024. Figure 9 shows the specific geography for this community that served as a guide for data collection and analysis for this CHNA. Table 2 lists zip codes and associated neighborhoods that comprise the community definition.

Figure 9: CCRH Avon Community Definition

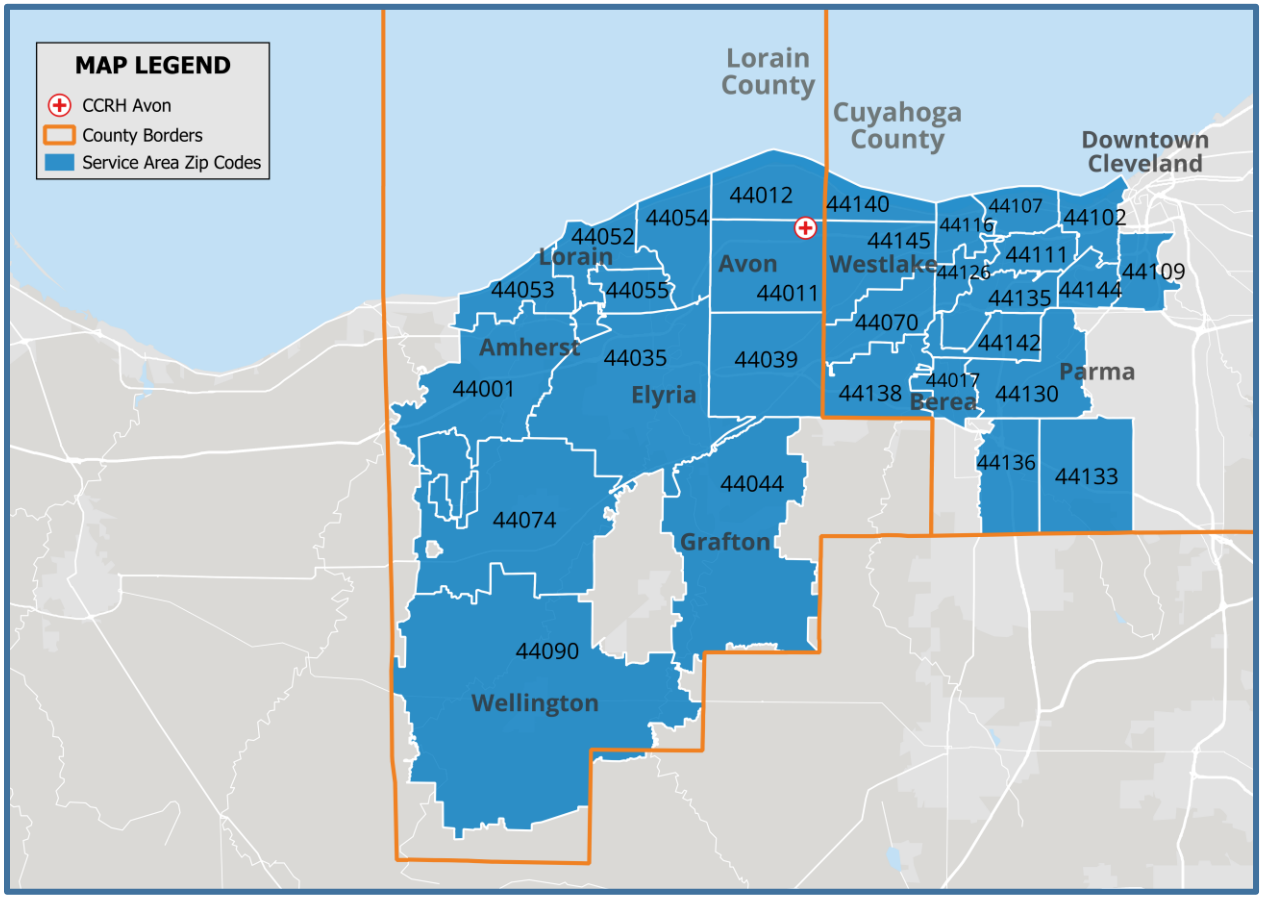


Table 2: CCRH Avon Rehab Community Definition

Zip Code	Municipality	Zip Code	Municipality
44102	Cleveland (Detroit-Shoreway)	44145	Westlake
44055	Lorain	44054	Sheffield
44052	Lorain	44039	North Ridgeville
44109	Cleveland (Brooklyn-Centre)	44011	Avon
44135	Cleveland	44012	Avon Lake
44111	Cleveland (Jefferson)	44001	Amherst
44035	Elyria	44136	Strongsville
44053	Lorain	44116	Rocky River
44144	Cleveland	44140	Bay Village
44107	Lakewood	44133	North Royalton
44130	Cleveland	44138	Olmsted Falls
44070	North Olmsted	44145	Westlake
44142	Brookpark		
44126	Cleveland		
44017	Berea		

Appendix B: Secondary Data Methodology and Secondary Data

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 CCRH Avon Community Health Needs Assessment:

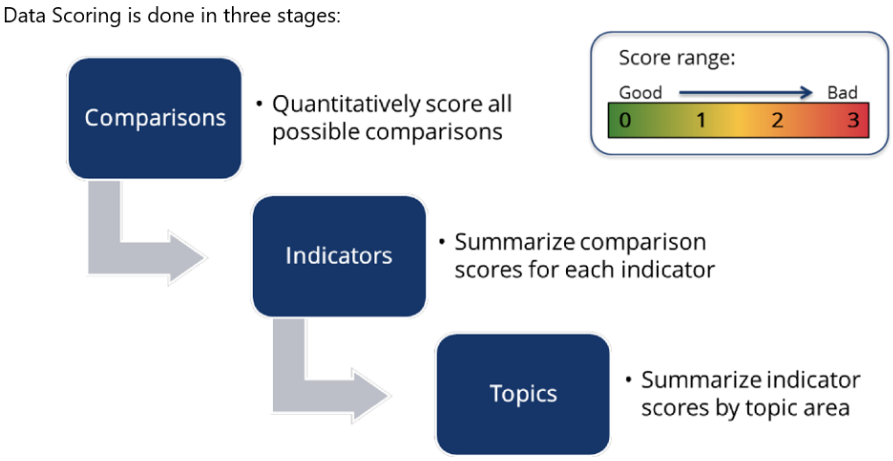
- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Early Ages Healthy Stages
- 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 Health's Ohio Healthy Homes Lead Poisoning Prevention Program
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- Prevention Research Center for Healthy Neighborhoods
- Purdue Center for Regional Development
- The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
- 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 CCRH Avon community, this analysis was completed for Cuyahoga and Lorain counties. 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



Topic Scores by County:

CUYAHOGA COUNTY

Results from the secondary data topic scoring can be seen in Tables 3 and 4 below. The highest scoring health need in Cuyahoga County was Sexually Transmitted Infections with a score of 2.04.

Table 3: Health Topic Scores: Cuyahoga County

Health Topic	Score
Sexually Transmitted Infections	2.04
Other Chronic Conditions	1.85
Children's Health	1.65
Older Adults	1.60
Family Planning	1.56
Wellness & Lifestyle	1.55
Weight Status	1.52
Maternal, Fetal & Infant Health	1.51
Nutrition & Healthy Eating	1.47
Diabetes	1.46
Prevention & Safety	1.40
Alcohol & Drug Use	1.38
Cancer	1.37
Adolescent Health	1.33
Health Care Access & Quality	1.30
Mental Health & Mental Disorders	1.29
Immunizations & Infectious Diseases	1.27
Heart Disease & Stroke	1.24
Respiratory Diseases	1.23
Women's Health	1.17

Oral Health	1.16
Tobacco Use	1.05
Physical Activity	0.96

Table 4: Quality of Life Topic Scores: Cuyahoga County

Quality of Life Topic	Score
Economy	1.90
Education	1.72
Community	1.56
Environmental Health	1.56

LORAIN COUNTY

Results from the secondary data topic scoring can be seen in Tables 5 and 6 below. The highest scoring health need in Lorain County was Other Chronic Conditions with a score of 2.07.

Table 5: Health Topic Scores: Lorain County

Health Topic	Score
Other 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 6: 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 7 for a full list of index values for each zip code in the CCRH Avon community. Figures 12 to 16 illustrate the census tracts included for each portion of the community served by the hospital. Tables 8 to 12 list the census tracts of each portion of the community.

Table 7: Community Health Index, Food Insecurity Index, and Mental Health Index Values for CCRH Avon Community Zip Codes

Zip Code	CHI Value	FIIValue	MHI Value
44001	36.5	22.6	71.3
44011	8.9	15.9	38.9
44012	8.0	17.1	30.4
44017	43.3	50.0	72.1
44035	75.1	87.1	94.7
44039	30.3	37.1	67.5
44044	31.2	25.9	61.7
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
44070	38.2	40.6	62.9
44074	46.0	32.3	73.4
44090	37.4	19.6	49.0
44102	95.9	96.4	98.5
44107	41.2	49.4	77.2
44109	94.5	93.8	97.9
44111	86.9	90.5	94.6
44116	7.8	12.9	55.2
44126	33.8	42.7	66.6
44130	50.5	54.0	82.6
44133	13.1	33.5	58.5
44135	90.7	92.0	97.4
44136	20.0	14.4	59.4
44138	12.7	5.4	50.9
44140	8.5	10.2	19.4
44142	72.6	48.3	84.7
44144	77.3	83.6	93.2
44145	14.8	15.8	64.4

Figure 12: Census Tract Key, CCRH Avon (Cuyahoga County, Central)

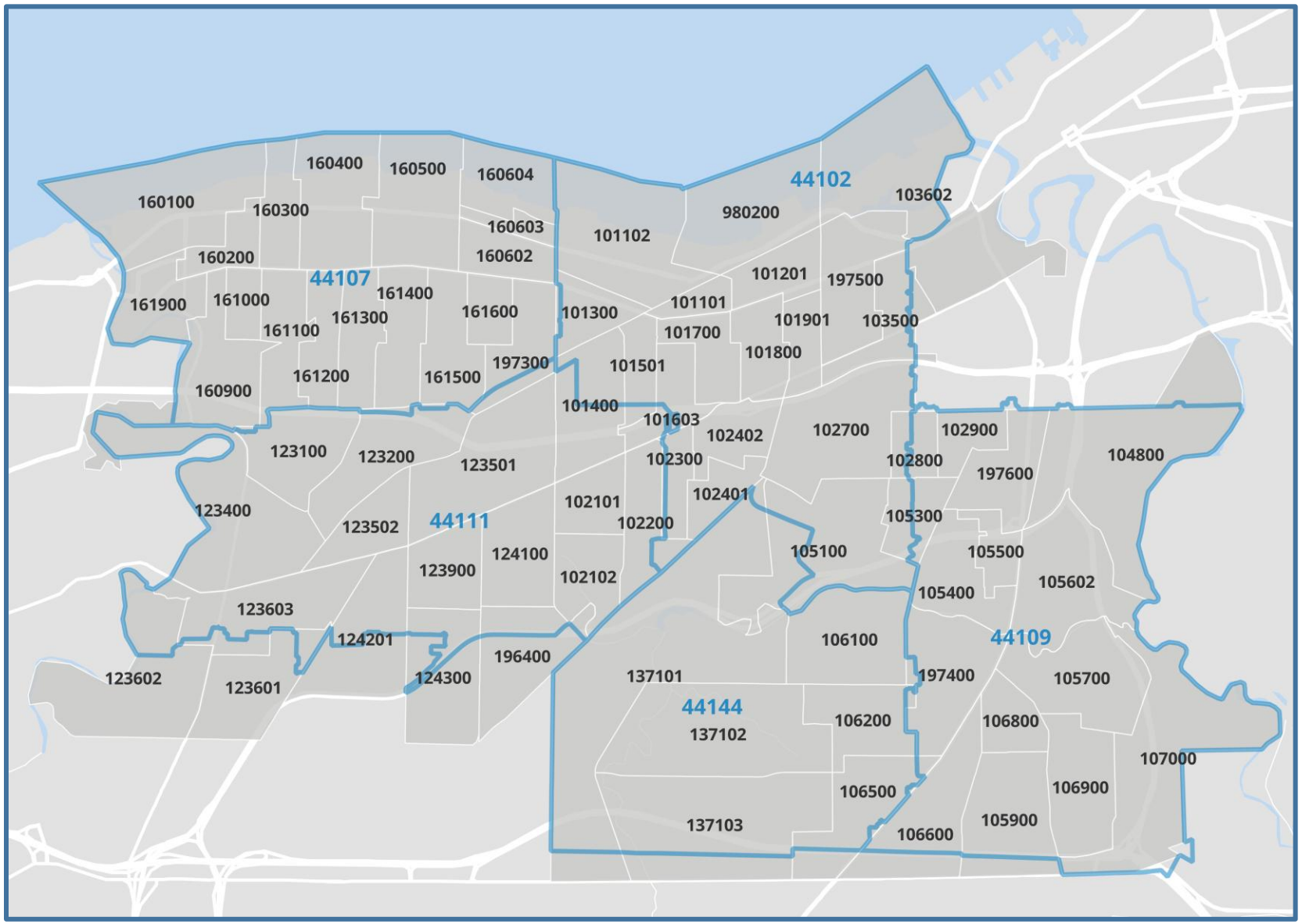


Table 8: Census Tracts by Zip Code (Cuyahoga County, Central)

44102	44107	44109	44111	44144
101101	101102	102700	101400	105100
101102	101300	102800	101501	106100
101201	123100	102900	101603	106200
101300	123200	103800	102101	106500
101400	123400	104400	102102	137101
101501	160100	104800	102200	137102
101603	160200	105300	102300	137103
101700	160300	105400	123100	197400
101800	160400	105500	123200	
101901	160500	105602	123400	
102200	160602	105700	123501	
102300	160603	105900	123502	
102401	160604	106200	123601	
102402	160900	106500	123602	
102700	161000	106600	123603	
102800	161100	106800	123900	
103500	161200	106900	124100	
103602	161300	107000	124201	
105100	161400	177303	124300	
105300	161500	192300	196400	
137101	161600	196100	197300	
177403	161900	197400		
197500	197300	197600		
980200		197700		

Figure 13: Census Tract Key, CCRH Avon (Cuyahoga County, South)

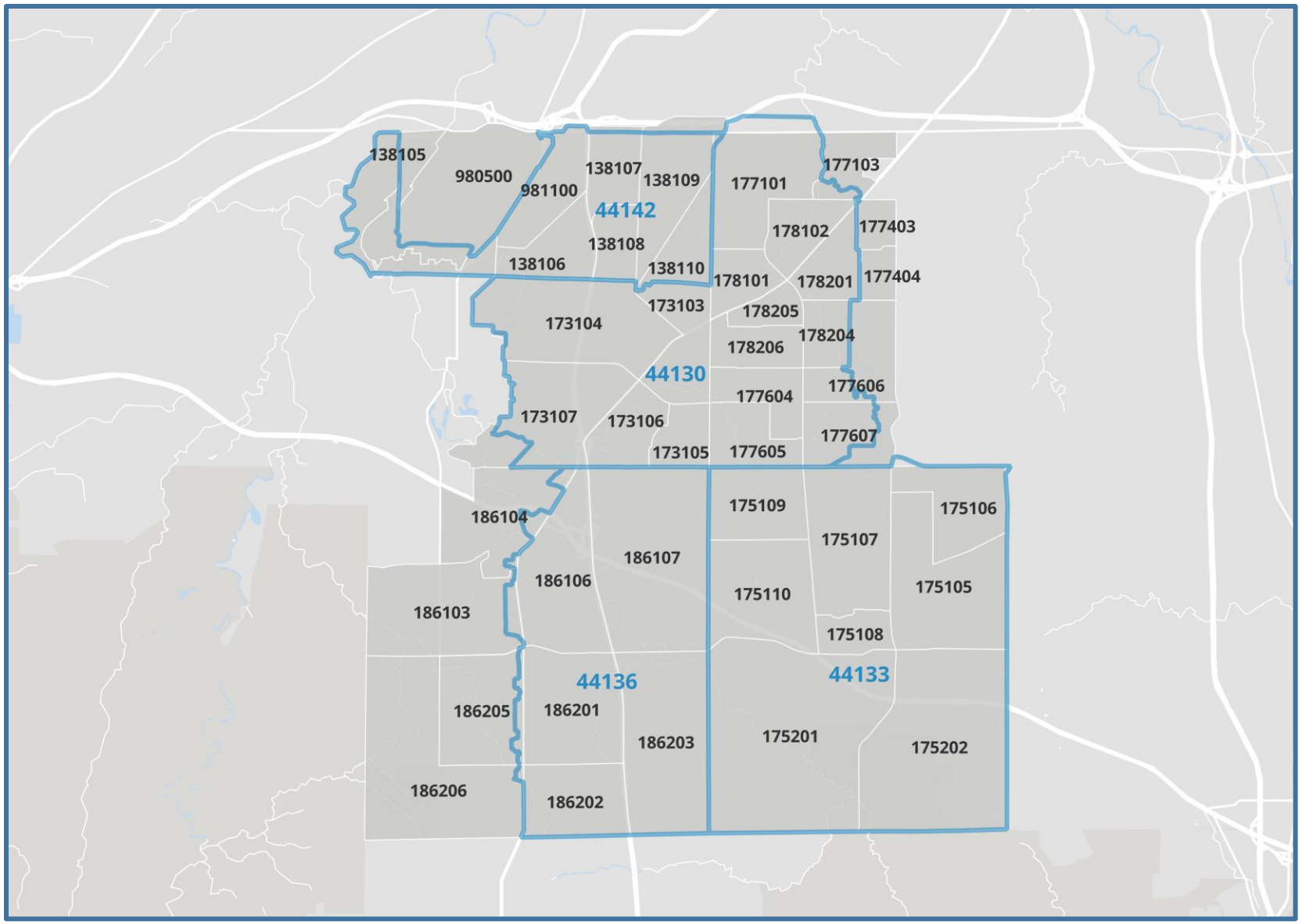


Table 9: Census Tracts by Zip Code (Cuyahoga County, South)

44130	44133	44136	44142
124600	175105	186103	138105
137101	175106	186104	138106
137103	175107	186106	138107
173103	175108	186107	138108
173104	175109	186201	138109
173105	175110	186202	138110
173106	175201	186203	177101
173107	175202	186205	980500
177101		186206	981100
177103		415100	
177403			
177404			
177604			
177605			
177606			
177607			
178101			
178102			
178201			
178204			
178205			
178206			

Figure 14: Census Tract Key, CCRH Avon (Cuyahoga County, West)

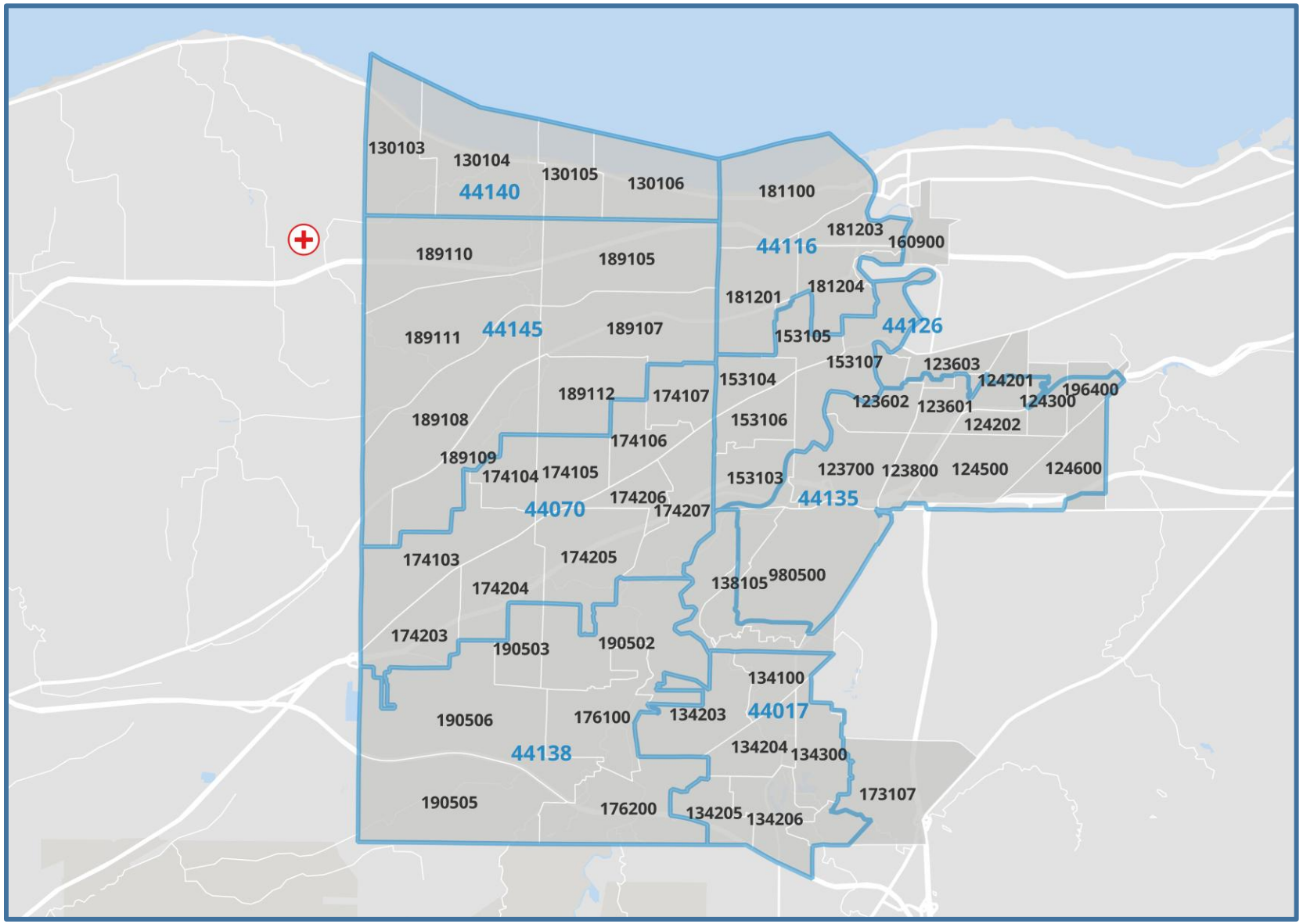


Table 10: Census Tracts by Zip Code (Cuyahoga County, West)

44017	44070	44116	44126	44135	44138	44140	44145
134100	174103	153105	153103	123601	176100	130103	189105
134203	174104	160900	153104	123602	176200	130104	189107
134204	174105	181100	153105	123603	190502	130105	189108
134205	174106	181201	153106	123700	190503	130106	189109
134206	174107	181203	153107	123800	190505		189110
134300	174203	181204		124201	190506		189111
173107	174204			124202			189112
	174205			124300			
	174206			124500			
	174207			124600			
	189112			138107			
				138109			
				153103			
				196400			
				980500			
				981100			

Figure 15: Census Tract Key, CCRH Avon (Lorain County, North)

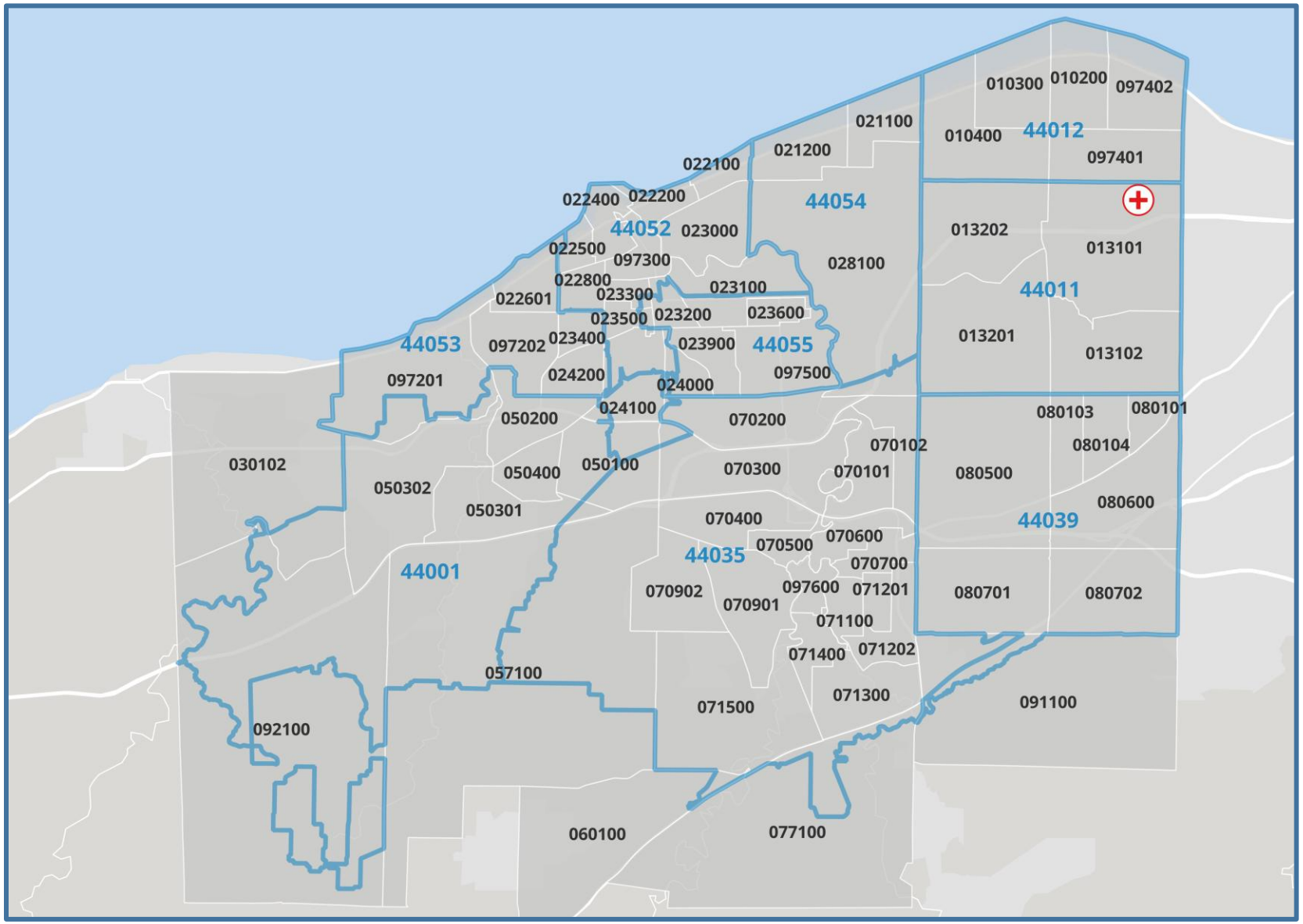


Table 11: Census Tracts by Zip Code (Lorain County, North)

44001	44011	44012	44035	44039	44052	44053	44054	44055
030102	013101	010200	028100	080101	022100	022601	021100	023100
050100	013102	010300	050100	080103	022200	023200	021200	023200
050200	013201	010400	050301	080104	022400	023400	028100	023300
050301	013202	097401	057100	080500	022500	097201		023500
050302		097402	060100	080600	023000	097202		023600
092100			070101	080701	023100			023700
097201			070102	080702	023200			024000
			070200	091100	023300			097500
			070300		023500			
			070400		024000			
			070500		024100			
			070600		097300			
			070700					
			070901					
			070902					
			071100					
			071201					
			071202					
			071300					
			071500					
			077100					
			091100					
			097600					

Figure 16: Census Tract Key, CCRH Avon (Lorain County, South)

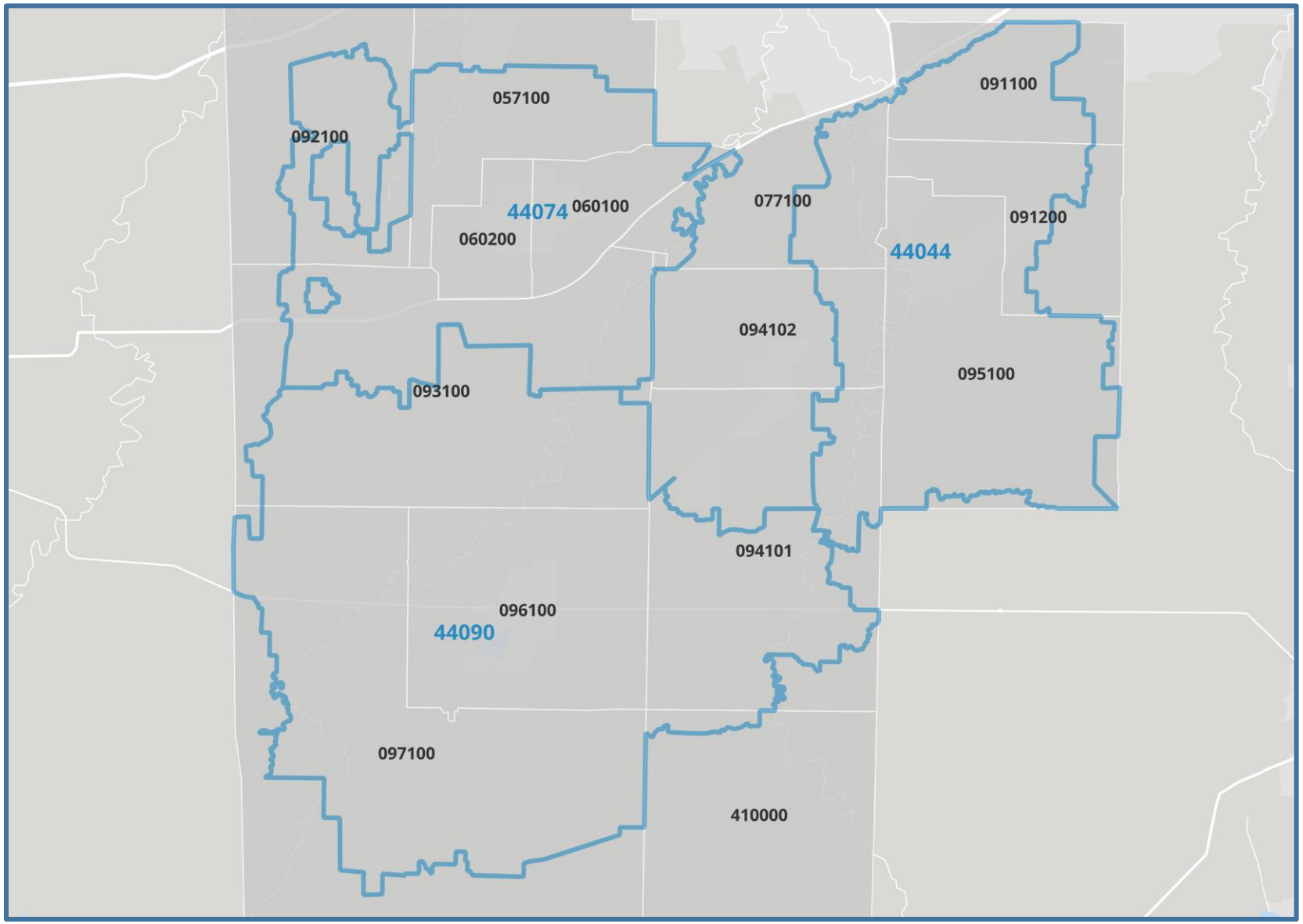


Table 12: Census Tracts by Zip Code (Lorain County, South)

44044	44074	44090
077100	057100	093100
091100	060100	094101
091200	060200	096100
094101	092100	097100
094102	093100	410000
095100		

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 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 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 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.

Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present 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 sourced 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 13 describes how to interpret the icons used to describe county distributions and trend data.

Table 13: 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.

Cuyahoga County Indicators of Concern: Access to Healthcare

As shown below, the topic *Health Care Access and Quality* was ranked as the fifteenth highest scoring health need, with a score of 1.30 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	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.38	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3,677.0	--	3,269.0	2,769.0			--
2.35	Adults with Health Insurance: 18+	*percent*	72.1	--	74.7	75.2			
2.21	Adults who go to the Doctor Regularly for Checkups	*percent*	63.3	--	65.2	65.1			--
2.00	Adults who Visited a Dentist	*percent*	43.3	--	44.3	45.3			
1.85	Health Insurance Spending-to-Income Ratio	*percent*	7.1	--	6.8	6.1			--
1.68	Adults With Group Health Insurance	*percent*	36.0	--	37.4	39.8			--

Cuyahoga County Indicators of Concern: Adult Health

The prioritized health topic of *Adult Health* includes 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: 1.85), followed by *Older Adults* (1.60), *Wellness and Lifestyle* (1.55), *Nutrition and Healthy Eating* (1.47), *Diabetes* (1.46), *Cancer* (1.37), and the least concerning topic was *Heart Disease and Stroke* (1.24). Indicators from these seven topic areas which scored at or above 1.70 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
3.00	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	139.3	--	118.1	113.2			
3.00	People 65+ Living Alone	*percent*	36.1	--	30.2	26.5			
2.82	People 65+ Living Below Poverty Level	*percent*	12.3	--	9.5	10.4			
2.47	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	18.0	--	15.1	--		--	
2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4	--	11.3	12.3			--
2.29	Self-Reported General Health Assessment: Good or Better	*percent*	84.2	--	85.4	86.0			
2.24	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	23.2	16.9	19.3	19.0	--		
2.21	Adults who Frequently Cook Meals at Home	*Percent*	66.2	--	67.6	67.7			--
2.21	Cancer: Medicare Population	*percent*	13.0	--	12.0	12.0			--
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20.0	--	19.0	18.0			--

2.00	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.1	--	132.3	129.8			
2.00	Adults 20+ with Diabetes	*percent*	9.9	--	--	--			
1.94	High School Students who Did Not Eat Any Fruit in the Past 7 Days	*percent*	6.7	--	--	--	--	--	--
1.85	Stroke: Medicare Population	*percent*	6.0	--	5.0	6.0			--
1.85	Osteoporosis: Medicare Population	*percent*	12.0	--	11.0	12.0			--
1.76	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	39.6	--	38.1	38.2			
1.76	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.8	33.4	46.0	--		--	
1.76	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.9	15.3	20.2	19.3			
1.71	All Cancer Incidence Rate	*cases/ 100,000 population*	476.4	--	470.0	444.4			

Cuyahoga County Indicators of Concern: Community Safety

The prioritized health topic *Community Safety* includes indicators related to the following sub-topics: *Prevention and Safety*, with a score of 1.40, and *Alcohol and Drug Use*, with a score of 1.38. Indicators from these two sub-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	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.44	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	20.2	10.7	13.5	12.0			--
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5	--	32.1	--			
2.03	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	39.2	--	40.4	23.5			--
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7	--			--
1.85	Severe Housing Problems	*percent*	15.7	--	12.7	--			
1.76	Adults who Binge Drink	*percent*	18.1	--	--	16.6			--
1.74	Adults who Drink Excessively	*percent*	21.0	--	21.2	--			
1.65	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	45.2	--	46.5	--		--	

Cuyahoga County 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 14 below as a reference key for indicator data sources.

Table 14: 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	Early Ages Healthy Stages
12	Feeding America
13	National Cancer Institute
14	National Center for Education Statistics
15	National Environmental Public Health Tracking Network
16	Ohio Department of Education
17	Ohio Department of Health, Infectious Diseases
18	Ohio Department of Health, Vital Statistics
19	Ohio Department of Health's Ohio Healthy Homes Lead Poisoning Prevention Program
20	Ohio Department of Public Safety, Office of Criminal Justice Services
21	Ohio Public Health Information Warehouse
22	Ohio Secretary of State
23	Prevention Research Center for Healthy Neighborhoods
24	Purdue Center for Regional Development
25	The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
26	U.S. Bureau of Labor Statistics
27	U.S. Census - County Business Patterns
28	U.S. Census Bureau - Small Area Health Insurance Estimates
29	U.S. Environmental Protection Agency
30	United For ALICE

Table 15: All Cuyahoga County Secondary Data Indicators

SCORE	ADOLESCENT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	SOURCE
2.26	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.3		6.1	5.6	*2022*	18
1.94	High School Students who Did Not Eat Any Fruit in the Past 7 Days	*percent*	6.7				*2023*	23
1.94	High School Students who have Ever Been Taught About AIDS or HIV Infection in School	*percent*	64.4				*2023*	23
1.94	High School Students who were Ever Tested for HIV	*percent*	6.2				*2023*	23
1.65	High School Students who are Obese	*percent*	17.3				*2023*	23
1.65	High School Students who had a Dental Check-up, Exam, Cleaning or Other Dental Work	*percent*	69.6				*2023*	23
1.35	High School Students who are Overweight	*percent*	15.7				*2023*	23
1.35	High School Students who Carried a Weapon on School Property	*percent*	2.0				*2023*	23
1.35	High School Students who Described Health as Excellent or Very Good	*percent*	47.9				*2023*	23
1.35	High School Students who Did Not Eat Breakfast Every Day	*percent*	74.7				*2023*	23

1.35	High School Students who Did Not Go to School Because They Felt Unsafe at School or on Their Way To or From School	*percent*	9.1	*2023*	23
1.35	High School Students who Did Something to Purposefully Hurt Themselves Without Wanting to Die	*percent*	16.3	*2023*	23
1.35	High School Students who Drove After Drinking Alcohol	*percent*	3.2	*2023*	23
1.35	High School Students who Engage in Regular Physical Activity	*percent*	42.8	*2023*	23
1.35	High School Students who Ever Misused Prescription Pain Medication	*percent*	9.5	*2023*	23
1.35	High School Students who Feel Like They Matter to People in Their Community	*percent*	48.4	*2023*	23
1.35	High School Students who had a Check-up or Physical Exam	*percent*	73.4	*2023*	23
1.35	High School Students who had Been Stopped, Questioned, or Searched by Police	*percent*	15.3	*2021*	23
1.35	High School Students who had Mostly Negative or Negative Encounters With Police	*percent*	20.4	*2021*	23
1.35	High School Students Who Have Attempted Suicide: Past Year	*percent*	7.6	*2023*	23
1.35	High School Students who Obtained 8+ Hours of Sleep	*percent*	23.5	*2023*	23

1.35	High School Students who Used Birth Control to Prevent Pregnancy at Last Intercourse with Opposite-Sex Partner	*percent*	26.4	*2023*	23
1.35	High School Students who Usually Used Marijuana by Smoking it as a Blunt	*percent*	54.8	*2023*	23
1.35	High School Students who Went Hungry Because There Was Not Enough Food in the Home	*percent*	3.5	*2023*	23
1.35	High School Students who were Bullied on School Property	*percent*	13.6	*2023*	23
1.35	High School Students who were Ever Physically Forced to have Sexual Intercourse	*percent*	5.3	*2023*	23
1.35	High School Students who were in a Physical Fight	*percent*	23.3	*2023*	23
1.35	High School Students who were Physically Forced to Do Sexual Things by Someone They were Dating or Going Out With	*percent*	10.6	*2023*	23
1.35	High School Students who were Physically Injured by Someone They were Dating or Going Out With	*percent*	8.0	*2023*	23
1.35	High School Students who were Threatened or Injured with a Weapon on School Property	*percent*	7.4	*2023*	23
1.06	High School Students who Did Not Always Wear a Seatbelt	*percent*	50.7	*2023*	23
1.06	High School Students who Ever Drank Alcohol	*percent*	31.3	*2023*	23

1.06	High School Students who Ever Used an Illicit Drug	*percent*	2.1				*2023*	23
1.06	High School Students who Ever Used Marijuana	*percent*	24.7				*2023*	23
1.06	High School Students who have Been Pregnant or Gotten Someone Pregnant	*percent*	1.3				*2023*	23
1.06	High School Students who Rode with a Driver who had been Drinking Alcohol	*percent*	14.4				*2023*	23
1.06	High School Students who Seriously Considered Attempting Suicide	*percent*	13.3				*2023*	23
1.06	High School Students who Smoked Cigarettes: Past 30 Days	*percent*	1.3				*2023*	23
1.06	High School Students who Texted or E-mailed While Driving	*percent*	30.7				*2023*	23
1.06	High School Students who Use a Cigar Product	*percent*	3.1				*2023*	23
1.06	High School Students who Use Alcohol	*percent*	14.9				*2023*	23
1.06	High School Students who Use an Electronic Vapor Product	*percent*	7.0				*2023*	23
1.06	High School Students who Use Hookah or Waterpipe	*percent*	1.7				*2023*	23
1.06	High School Students who Use Marijuana	*percent*	15.4				*2023*	23
1.06	High School Students who were Electronically Bullied	*percent*	11.9				*2023*	23

SCORE	**ALCOHOL & DRUG USE**	**UNITS**	**CUYAHOGA COUNTY**	**HP2030**	**OH**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5		32.1		*2018-2022*	10
2.03	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	39.2		40.4	23.5	*2018-2020*	6
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*	21.0		21.2		*2022*	10
1.35	High School Students who Ever Misused Prescription Pain Medication	*percent*	9.5				*2023*	23
1.35	High School Students who Usually Used Marijuana by Smoking it as a Blunt	*percent*	54.8				*2023*	23
1.06	High School Students who Ever Drank Alcohol	*percent*	31.3				*2023*	23
1.06	High School Students who Ever Used an Illicit Drug	*percent*	2.1				*2023*	23
1.06	High School Students who Ever Used Marijuana	*percent*	24.7				*2023*	23
1.06	High School Students who Use Alcohol	*percent*	14.9				*2023*	23
1.06	High School Students who Use Marijuana	*percent*	15.4				*2023*	23
0.82	Liquor Store Density	*stores/ 100,000 population*	6.1		5.6	10.9	*2022*	27
0.62	Mothers who Smoked During Pregnancy	*percent*	3.8	4.3	7.9	3.7	*2022*	18

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

3.00	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	139.3		118.1	113.2	*2017-2021*	13
2.24	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	23.2	16.9	19.3	19.0	*2018-2022*	13
2.21	Cancer: Medicare Population	*percent*	13.0		12.0	12.0	*2023*	7
2.00	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.1		132.3	129.8	*2017-2021*	13
1.76	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.9	15.3	20.2	19.3	*2018-2022*	13
1.71	All Cancer Incidence Rate	*cases/ 100,000 population*	476.4		470.0	444.4	*2017-2021*	13
1.41	Colon Cancer Screening: USPSTF Recommendation	*percent*	66.2			66.3	*2022*	5
1.41	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	40.2		38.9	36.4	*2017-2021*	13
1.24	Adults with Cancer (Non-Skin) or Melanoma	*percent*	8.3			8.2	*2022*	5
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.7		64.3	53.1	*2017-2021*	13
0.88	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	159.5	122.7	161.1	146.0	*2018-2022*	13
0.88	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	13.8	8.9	13.9	12.9	*2018-2022*	13
0.88	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	36.6	25.1	39.8	32.4	*2018-2022*	13
0.88	Cervical Cancer Screening: 21-65	*Percent*	83.2			82.8	*2020*	5
0.88	Mammogram in Past 2 Years: 50-74	*percent*	78.7	80.3		76.5	*2022*	5
0.85	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.5		7.8	7.5	*2017-2021*	13
0.76	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.8	12.0	*2017-2021*	13

0.62	Mammography Screening: Medicare Population	*percent*	52.0		51.0	39.0	*2023*	7

SCORE	CHILDREN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.71	Child Food Insecurity Rate	*percent*	26.7		19.8	18.5	*2022*	12
2.38	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	70.8		58.5	50.6	*2018-2021*	10
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8		3.3	3.4	*2024*	9
1.65	Children Served by Designated Ohio Healthy Programs (Count)	*children*	4,611				*2021*	11
1.65	Designated Ohio Healthy Programs (Count)	*programs*	73				*2021*	11
1.65	Families Served by Designated Ohio Healthy Programs (Count)	*families*	2,423				*2021*	11
1.65	Family Engagement Activities Supported by Designated Ohio Healthy Programs (Count)	*activities*	2,640				*2021*	11
1.65	Healthy Policies Adopted by Designated Ohio Healthy Programs (Count)	*policies*	264				*2021*	11
1.62	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.6		0.6		*2021*	19
1.41	Substantiated Child Abuse Rate	*cases/ 1,000 children*	9.3	8.7	6.9		*2021*	4
1.38	Children with Health Insurance	*percent*	96.4		95.1	94.6	*2023*	1
1.35	Blood Lead Levels in Children (>=10 micrograms per deciliter; Count)	*children*	312				*2021*	19

1.35	Blood Lead Levels in Children (>=5 micrograms per deciliter; Count)	*children*	1,056				*2021*	19
1.32	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.5		2.0		*2021*	19
0.71	Child Care Centers	*per 1,000 population under age 5*	10.3		8.0	7.0	*2022*	10

SCORE	COMMUNITY	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
3.00	People 65+ Living Alone	*percent*	36.1		30.2	26.5	*2019-2023*	2
2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	654		570	612	*2019-2023*	2
2.56	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	8.7		7.5	7.4	*2024*	9
2.44	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	20.2	10.7	13.5	12.0	*2018-2020*	6
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5		32.1		*2018-2022*	10
2.41	Children in Single-Parent Households	*percent*	37.3		26.1	24.8	*2019-2023*	2
2.41	Youth not in School or Working	*percent*	2.7		1.7	1.7	*2019-2023*	2
2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4		11.3	12.3	*2024*	9
2.35	Adults with Internet Access	*percent*	78.6		80.9	81.3	*2024*	8
2.26	Residential Segregation - Black/White	*Score*	71.5		69.6		*2025*	10

2.26	Social Associations	*membership associations/ 10,000 population*	8.9		10.8		*2022*	10
2.21	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	83.4		84.9	85.1	*2024*	8
2.21	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	20.7	5.5	9.0		*2020-2022*	21
2.18	Linguistic Isolation	*percent*	2.7		1.5	4.2	*2019-2023*	2
2.12	Median Household Gross Rent	*dollars*	1,005		988	1,348	*2019-2023*	2
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,529		1,472	1,902	*2019-2023*	2
2.00	Voter Turnout: Presidential Election	*percent*	65.7	58.4	71.7		*2024*	22
1.94	Children Living Below Poverty Level	*percent*	23.2		18.0	16.3	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	85,788				*2019-2023*	2
1.94	People Living Below Poverty Level	*percent*	16.2	8.0	13.2	12.4	*2019-2023*	2
1.88	Violent Crime Rate	*crimes/ 100,000 population*	856.5		359.0		*2023*	20
1.85	Households with a Computer	*percent*	83.3		85.2	86.0	*2024*	8
1.76	Young Children Living Below Poverty Level	*percent*	24.9		20.0	17.6	*2019-2023*	2
1.74	Grandparents Who Are Responsible for Their Grandchildren	*percent*	38.9		41.3	32.0	*2019-2023*	2
1.68	Adults With Group Health Insurance	*percent*	36.0		37.4	39.8	*2024*	8
1.68	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.5		3.4	3.2	*2024*	9
1.59	Median Household Income	*dollars*	62,823		69,680	78,538	*2019-2023*	2

1.41	Substantiated Child Abuse Rate	*cases/ 1,000 children*	9.3	8.7	6.9		*2021*	4
1.35	High School Students who Did Not Go to School Because They Felt Unsafe at School or on Their Way To or From School	*percent*	9.1				*2023*	23
1.35	High School Students who were Threatened or Injured with a Weapon on School Property	*percent*	7.4				*2023*	23
1.24	Households with a Smartphone	*percent*	86.1		87.5	88.2	*2024*	8
1.24	Workers Commuting by Public Transportation	*percent*	3.3	5.3	1.1	3.5	*2019-2023*	2
1.18	Total Employment Change	*percent*	5.0		2.9	5.8	*2021-2022*	27
1.09	Persons with Health Insurance	*percent*	93.0	92.4	92.9		*2022*	28
1.06	Households with an Internet Subscription	*percent*	87.5		89.0	89.9	*2019-2023*	2
1.06	Households with One or More Types of Computing Devices	*percent*	93.1		93.6	94.8	*2019-2023*	2
1.06	People 25+ with a High School Diploma or Higher	*percent*	91.2		91.6	89.4	*2019-2023*	2
1.06	Persons with an Internet Subscription	*percent*	90.3		91.3	92.0	*2019-2023*	2
1.06	Population 16+ in Civilian Labor Force	*percent*	59.3		60.1	59.8	*2019-2023*	2
0.97	Digital Distress		1.0				*2022*	24
0.79	Adults With Individual Health Insurance	*percent*	21.8		20.5	20.2	*2024*	8
0.79	Digital Divide Index	*DDI Score*	19.4		40.1	50.0	*2022*	24
0.79	Solo Drivers with a Long Commute	*percent*	30.3		30.5		*2019-2023*	10

0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	8.6		11.1		*2016-2022*	10
0.65	Female Population 16+ in Civilian Labor Force	*percent*	60.5		59.2	58.7	*2019-2023*	2
0.53	Mean Travel Time to Work	*minutes*	23.6		23.6	26.6	*2019-2023*	2
0.53	Per Capita Income	*dollars*	41,559		39,455	43,289	*2019-2023*	2
0.53	Workers who Drive Alone to Work	*percent*	71.7		76.6	70.2	*2019-2023*	2
0.47	Workers who Walk to Work	*percent*	2.7		2.0	2.4	*2019-2023*	2
0.44	Broadband Quality Score	*BQS Score*	69.9		53.4	50.0	*2022*	24
0.18	People 25+ with a Bachelor's Degree or Higher	*percent*	35.9		30.9	35.0	*2019-2023*	2

SCORE	DIABETES	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.00	Adults 20+ with Diabetes	*percent*	9.9				*2021*	6
1.41	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	24.3		28.4		*2020-2022*	21
0.97	Diabetes: Medicare Population	*percent*	23.0		25.0	24.0	*2023*	7

SCORE	ECONOMY	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	654		570	612	*2019-2023*	2
2.82	People 65+ Living Below Poverty Level	*percent*	12.3		9.5	10.4	*2019-2023*	2
2.71	Child Food Insecurity Rate	*percent*	26.7		19.8	18.5	*2022*	12
2.56	College Tuition Spending-to-Income Ratio	*percent*	14.7		12.9	12.4	*2024*	9

2.56	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	8.7	7.5	7.4	*2024*	9
2.56	Homeowner Spending-to-Income Ratio	*percent*	16.7	14.6	14.0	*2024*	9
2.53	Veterans Living Below Poverty Level	*percent*	9.7	7.4	7.2	*2019-2023*	2
2.41	Youth not in School or Working	*percent*	2.7	1.7	1.7	*2019-2023*	2
2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4	11.3	12.3	*2024*	9
2.38	Home Renter Spending-to-Income Ratio	*percent*	19.3	16.8	17.7	*2024*	9
2.38	Student Loan Spending-to-Income Ratio	*percent*	5.5	4.8	4.7	*2024*	9
2.26	People 65+ Living Below 200% of Poverty Level	*percent*	31.9	28.4	28.1	*2023*	1
2.26	Residential Segregation - Black/White	*Score*	71.5	69.6		*2025*	10
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8	3.3	3.4	*2024*	9
2.21	Income Inequality		0.5	0.5	0.5	*2019-2023*	2
2.21	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.8	1.6	1.6	*2024*	9
2.18	Food Insecurity Rate	*percent*	15.1	14.1	13.5	*2022*	12
2.12	Adults with Disability Living in Poverty	*percent*	33.1	28.2	24.6	*2019-2023*	2
2.12	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	2.3	2.0	2.0	*2024*	8
2.12	Median Household Gross Rent	*dollars*	1,005	988	1,348	*2019-2023*	2
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,529	1,472	1,902	*2019-2023*	2

2.03	Households Living Below Poverty Level	*percent*	16.7		14.0		*2022*	30
2.03	Utilities Spending-to-Income Ratio	*percent*	6.7		6.2	5.8	*2024*	9
2.00	Renters Spending 30% or More of Household Income on Rent	*percent*	47.5	25.5	45.1	50.4	*2019-2023*	2
1.97	Children Living Below 200% of Poverty Level	*percent*	42.8		38.3	36.1	*2023*	1
1.97	Families Living Below 200% of Poverty Level	*Percent*	25.6		22.8	22.3	*2023*	1
1.94	Children Living Below Poverty Level	*percent*	23.2		18.0	16.3	*2019-2023*	2
1.94	Families Living Below Poverty Level	*percent*	11.5		9.2	8.7	*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	28,068				*2019-2023*	2
1.94	People Living Below Poverty Level	*percent*	16.2	8.0	13.2	12.4	*2019-2023*	2
1.88	Homeowner Vacancy Rate	*percent*	1.1		0.9	1.0	*2019-2023*	2
1.88	Households with Cash Public Assistance Income	*percent*	2.8		2.5	2.7	*2019-2023*	2
1.85	Health Insurance Spending-to-Income Ratio	*percent*	7.1		6.8	6.1	*2024*	9
1.85	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	25.2	25.5	21.2	28.5	*2023*	1
1.85	Severe Housing Problems	*percent*	15.7		12.7		*2017-2021*	10
1.82	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	58.0		61.0		*2022*	30
1.79	People Living Below 200% of Poverty Level	*percent*	32.2		29.6	28.2	*2023*	1

1.76	Young Children Living Below Poverty Level	*percent*	24.9	20.0	17.6	*2019-2023*	2
1.71	Households with a Savings Account	*percent*	69.4	70.9	72.0	*2024*	8
1.71	Unemployed Veterans	*percent*	3.1	2.8	3.2	*2019-2023*	2
1.68	Cigarette Spending-to-Income Ratio	*percent*	2.2	2.2	1.9	*2024*	9
1.68	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.5	3.4	3.2	*2024*	9
1.65	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	25.3	25.0		*2022*	30
1.65	Size of Labor Force	*persons*	615,492			*January 2025*	26
1.59	Households with Student Loan Debt	*percent*	9.4	9.1	9.8	*2024*	8
1.59	Median Household Income	*dollars*	62,823	69,680	78,538	*2019-2023*	2
1.50	Adults who Feel Overwhelmed by Financial Burdens	*percent*	34.2	34.0	33.6	*2024*	8
1.35	Households with a 401k Plan	*percent*	37.4	38.4	40.8	*2024*	8
1.29	Unemployed Workers in Civilian Labor Force	*percent*	4.5	5.3	4.4	*January 2025*	26
1.24	Gender Pay Gap	*cents on the dollar*	0.8	0.7	0.8	*2023*	1
1.24	Median Household Income: Householders 65+	*dollars*	48,911	51,608	57,108	*2019-2023*	2
1.18	Total Employment Change	*percent*	5.0	2.9	5.8	*2021-2022*	27
1.06	Population 16+ in Civilian Labor Force	*percent*	59.3	60.1	59.8	*2019-2023*	2
0.65	Female Population 16+ in Civilian Labor Force	*percent*	60.5	59.2	58.7	*2019-2023*	2
0.53	Per Capita Income	*dollars*	41,559	39,455	43,289	*2019-2023*	2
0.47	Overcrowded Households	*percent*	1.1	1.4	3.4	*2019-2023*	2

SCORE	EDUCATION	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	College Tuition Spending-to-Income Ratio	*percent*	14.7		12.9	12.4	*2024*	9
2.56	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	8.7		7.5	7.4	*2024*	9
2.38	Student Loan Spending-to-Income Ratio	*percent*	5.5		4.8	4.7	*2024*	9
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8		3.3	3.4	*2024*	9
2.21	Student-to-Teacher Ratio	*students/ teacher*	16.9		16.6	15.2	*2023-2024*	14
2.21	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.8		1.6	1.6	*2024*	9
1.85	High School Graduation	*percent*	89.1	90.7	92.5		*2022-2023*	16
1.71	4th Grade Students Proficient in English/Language Arts	*percent*	60.2		64.1		*2023-2024*	16
1.71	8th Grade Students Proficient in English/Language Arts	*percent*	45.6		49.4		*2023-2024*	16
1.71	Veterans with a High School Diploma or Higher	*percent*	93.5		94.4	95.2	*2019-2023*	2
1.65	Children Served by Designated Ohio Healthy Programs (Count)	*children*	4,611				*2021*	11
1.65	Designated Ohio Healthy Programs (Count)	*programs*	73				*2021*	11
1.65	Families Served by Designated Ohio Healthy Programs (Count)	*families*	2,423				*2021*	11
1.65	Family Engagement Activities Supported by Designated	*activities*	2,640				*2021*	11

	Ohio Healthy Programs (Count)							
1.65	Healthy Policies Adopted by Designated Ohio Healthy Programs (Count)	*policies*	264				*2021*	11
1.59	4th Grade Students Proficient in Math	*percent*	59.1		67.2		*2023-2024*	16
1.59	8th Grade Students Proficient in Math	*percent*	41.4		46.3		*2023-2024*	16
1.06	People 25+ with a High School Diploma or Higher	*percent*	91.2		91.6	89.4	*2019-2023*	2
0.71	Child Care Centers	*per 1,000 population under age 5*	10.3		8.0	7.0	*2022*	10
0.18	People 25+ with a Bachelor's Degree or Higher	*percent*	35.9		30.9	35.0	*2019-2023*	2

SCORE	ENVIRONMENTAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.41	Houses Built Prior to 1950	*percent*	37.4		24.9	16.4	*2019-2023*	2
2.29	Adults with Current Asthma	*percent*	11.8			9.9	*2022*	5
2.29	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	10.8		7.9		*2020*	10
2.29	Proximity to Highways	*percent*	12.5		7.2		*2020*	15
2.03	Utilities Spending-to-Income Ratio	*percent*	6.7		6.2	5.8	*2024*	9
2.00	Daily Dose of UV Irradiance	*Joule per square meter*	3,533.0		3,384.0		*2020*	15
1.85	Severe Housing Problems	*percent*	15.7		12.7		*2017-2021*	10
1.76	Annual Ozone Air Quality	*grade*	F				*2020-2022*	3
1.74	Annual Particle Pollution	*grade*	C				*2020-2022*	3

1.68	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.5	3.4	3.2	*2024*	9
1.65	Weeks of Moderate Drought or Worse	*weeks per year*	2			*2021*	15
1.62	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.6	0.6		*2021*	19
1.50	Asthma: Medicare Population	*percent*	7.0	7.0	7.0	*2023*	7
1.35	Blood Lead Levels in Children (>=10 micrograms per deciliter; Count)	*children*	312			*2021*	19
1.35	Blood Lead Levels in Children (>=5 micrograms per deciliter; Count)	*children*	1,056			*2021*	19
1.35	Number of Extreme Heat Days	*days*	11			*2023*	15
1.35	Number of Extreme Heat Events	*events*	9			*2023*	15
1.35	Number of Extreme Precipitation Days	*days*	4			*2023*	15
1.35	PBT Released	*pounds*	216100.3			*2023*	29
1.32	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.5	2.0		*2021*	19
0.91	Food Environment Index		7.8	7.0		*2025*	10
0.82	Liquor Store Density	*stores/ 100,000 population*	6.1	5.6	10.9	*2022*	27
0.79	Digital Divide Index	*DDI Score*	19.4	40.1	50.0	*2022*	24
0.71	Access to Exercise Opportunities	*percent*	97.9	84.2		*2025*	10
0.71	Access to Parks	*percent*	85.3	59.6		*2020*	15
0.47	Overcrowded Households	*percent*	1.1	1.4	3.4	*2019-2023*	2
0.44	Broadband Quality Score	*BQS Score*	69.9	53.4	50.0	*2022*	24

SCORE	FAMILY PLANNING	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.26	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.3		6.1	5.6	*2022*	18
1.35	High School Students who Used Birth Control to Prevent Pregnancy at Last Intercourse with Opposite-Sex Partner	*percent*	26.4				*2023*	23
1.06	High School Students who have Been Pregnant or Gotten Someone Pregnant	*percent*	1.3				*2023*	23

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.38	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3,677.0		3,269.0	2,769.0	*2023*	7
2.35	Adults with Health Insurance: 18+	*percent*	72.1		74.7	75.2	*2024*	8
2.21	Adults who go to the Doctor Regularly for Checkups	*percent*	63.3		65.2	65.1	*2024*	8
2.00	Adults who Visited a Dentist	*percent*	43.3		44.3	45.3	*2024*	8
1.85	Health Insurance Spending-to-Income Ratio	*percent*	7.1		6.8	6.1	*2024*	9
1.68	Adults With Group Health Insurance	*percent*	36.0		37.4	39.8	*2024*	8
1.65	High School Students who had a Dental Check-up, Exam, Cleaning or Other Dental Work	*percent*	69.6				*2023*	23
1.38	Children with Health Insurance	*percent*	96.4		95.1	94.6	*2023*	1

1.35	High School Students who had a Check-up or Physical Exam	*percent*	73.4				*2023*	23
1.29	Persons without Health Insurance	*percent*	5.5		6.1	7.9	*2023*	1
1.24	Adults with Health Insurance	*percent*	92.2		91.6	89.0	*2023*	1
1.24	Adults without Health Insurance	*percent*	6.4			10.8	*2022*	5
1.09	Persons with Health Insurance	*percent*	93.0	92.4	92.9		*2022*	28
0.88	Adults who have had a Routine Checkup	*percent*	80.0			76.1	*2022*	5
0.79	Adults With Individual Health Insurance	*percent*	21.8		20.5	20.2	*2024*	8
0.44	Primary Care Provider Rate	*providers/ 100,000 population*	111.3		75.3	74.9	*2021*	10
0.29	Dentist Rate	*dentists/ 100,000 population*	112.8		65.2	73.5	*2022*	10
0.26	Mental Health Provider Rate	*providers/ 100,000 population*	510.3		349.4		*2024*	10
0.26	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	251.3		148.7		*2024*	10

SCORE	HEART DISEASE & STROKE	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.85	Stroke: Medicare Population	*percent*	6.0		5.0	6.0	*2023*	7
1.76	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.8	33.4	46.0		*2020-2022*	21
1.59	High Blood Pressure Prevalence	*percent*	36.7	41.9		32.7	*2021*	5

1.41	Adults who Experienced a Stroke	*percent*	3.9			3.6	*2022*	5
1.41	Adults who Experienced Coronary Heart Disease	*percent*	7.5			6.8	*2022*	5
1.41	Adults who Have Taken Medications for High Blood Pressure	*percent*	80.6			78.2	*2021*	5
1.32	Heart Failure: Medicare Population	*percent*	12.0		12.0	11.0	*2023*	7
1.32	Hyperlipidemia: Medicare Population	*percent*	66.0		67.0	66.0	*2023*	7
1.15	Hypertension: Medicare Population	*percent*	66.0		67.0	65.0	*2023*	7
1.06	Cholesterol Test History	*percent*	86.1			86.4	*2021*	5
0.97	Atrial Fibrillation: Medicare Population	*percent*	14.0		15.0	14.0	*2023*	7
0.97	Ischemic Heart Disease: Medicare Population	*percent*	21.0		22.0	21.0	*2023*	7
0.88	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	101.3	71.1	101.6		*2020-2022*	21
0.88	High Cholesterol Prevalence	*percent*	34.6			35.5	*2021*	5
0.56	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.7		60.9		*2021*	15

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.44	Syphilis Incidence Rate	*cases/ 100,000 population*	21.4		16.4	15.8	*2023*	17
2.15	Chlamydia Incidence Rate	*cases/ 100,000 population*	779.4		464.2	492.2	*2023*	17
1.91	Age-Adjusted Death Rate due to HIV	*deaths/ 100,000 population*	1.5		0.9		*2020-2022*	21
1.91	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.9	1.4	1.6	2.9	*2023*	17

1.85	Gonorrhea Incidence Rate	*cases/ 100,000 population*	334.3		168.8	179.5	*2023*	17
0.97	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	60.4		59.8	60.4	*2024*	8
0.97	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	10.4	11.5	13.8		*2023*	17
0.85	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.5		7.8	7.5	*2017-2021*	13
0.82	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.5		12.3		*2020-2022*	21
0.47	Overcrowded Households	*percent*	1.1		1.4	3.4	*2019-2023*	2
0.44	Flu Vaccinations: Medicare Population	*percent*	55.0		50.0	3.0	*2023*	7
0.44	Pneumonia Vaccinations: Medicare Population	*percent*	10.0		9.0	9.0	*2023*	7

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.44	Babies with Low Birthweight	*percent*	10.8		8.7	8.6	*2022*	18
2.26	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.3		6.1	5.6	*2022*	18
2.18	Preterm Births	*percent*	12.0	9.4	10.8		*2022*	18
1.97	Infant Mortality Rate	*deaths/ 1,000 live births*	7.7	5.0	6.7	5.4	*2020*	18
1.91	Gestational Hypertension	*percent*	22.3		18.3		*2022*	25
1.91	Pre-Pregnancy Diabetes	*percent*	4.8		4.2		*2022*	25
1.91	Stopped Breastfeeding Due to Resuming Work	*percent*	26.6		17.5		*2022*	25
1.88	Babies with Very Low Birthweight	*percent*	1.9		1.5		*2022*	18
1.85	Ever Breastfed New Infant	*percent*	88.8		88.7		*2022*	25

1.74	Chronic Health Condition(s) During Pregnancy	*percent*	50.6		49.6		*2022*	25
1.74	Postpartum Depression	*percent*	16.4		16.3		*2022*	25
1.74	Pre-Pregnancy Hypertension	*percent*	7.6		7.0		*2022*	25
1.56	Gestational Diabetes	*percent*	10.3		10.6		*2022*	25
1.44	Prevalence of Unintended Pregnancy	*percent*	22.4		21.1		*2022*	25
1.38	Pre-Pregnancy Depression	*percent*	19.9		22.5		*2022*	25
1.38	Pre-Pregnancy E-Cigarette Use	*percent*	6.8		8.6		*2022*	25
1.26	Breastfeeding at 8 Weeks	*percent*	73.7		70.9		*2022*	25
1.26	Infant Sleeps on Back	*percent*	87.0		86.2		*2022*	25
1.26	Mothers who Received Early Prenatal Care	*percent*	73.0		68.6	75.3	*2022*	18
1.15	Infant Sleeps Alone	*percent*	69.1		69.7		*2022*	25
1.15	Prevalence of Intended Pregnancy	*percent*	60.7		61.0		*2022*	25
1.09	Gestational Depression	*percent*	18.9		21.7		*2022*	25
0.97	Infant Sleeps Alone on Recommended Surface	*percent*	51.5		51.4		*2022*	25
0.97	Infant Sleeps in Crib, Bassinet, or Play Yard	*percent*	93.9		93.9		*2022*	25
0.97	Infant Sleeps Without Objects in Bed	*percent*	70.1		68.7		*2022*	25
0.79	Pre-Pregnancy Smoking	*percent*	10.2		12.2		*2022*	25
0.62	Mothers who Smoked During Pregnancy	*percent*	3.8	4.3	7.9	3.7	*2022*	18

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Self-Reported General Health Assessment: Good or Better	*percent*	84.2		85.4	86.0	*2024*	8

1.68	Poor Mental Health: Average Number of Days	*days*	6.0		6.1		*2022*	10
1.59	Poor Mental Health: 14+ Days	*percent*	17.5			15.8	*2022*	5
1.50	Adults who Feel Life is Slipping Out of Control	*Percent*	24.1		24.1	23.9	*2024*	8
1.41	Adults Ever Diagnosed with Depression	*percent*	23.2			20.7	*2022*	5
1.35	High School Students who Did Something to Purposefully Hurt Themselves Without Wanting to Die	*percent*	16.3				*2023*	23
1.35	High School Students Who Have Attempted Suicide: Past Year	*percent*	7.6				*2023*	23
1.35	High School Students who were Bullied on School Property	*percent*	13.6				*2023*	23
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6.0		6.0	6.0	*2023*	7
1.12	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	22.6		33.8		*2020-2022*	21
1.06	High School Students who Seriously Considered Attempting Suicide	*percent*	13.3				*2023*	23
1.06	High School Students who were Electronically Bullied	*percent*	11.9				*2023*	23
1.00	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	13.5	12.8	14.5		*2020-2022*	21
0.97	Depression: Medicare Population	*percent*	16.0		18.0	17.0	*2023*	7
0.26	Mental Health Provider Rate	*providers/ 100,000 population*	510.3		349.4		*2024*	10

SCORE	NUTRITION & HEALTHY EATING	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	Adults who Frequently Cook Meals at Home	*Percent*	66.2		67.6	67.7	*2024*	8
1.94	High School Students who Did Not Eat Any Fruit in the Past 7 Days	*percent*	6.7				*2023*	23
1.76	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	39.6		38.1	38.2	*2024*	8
1.35	High School Students who Did Not Eat Breakfast Every Day	*percent*	74.7				*2023*	23
1.35	High School Students who Went Hungry Because There Was Not Enough Food in the Home	*percent*	3.5				*2023*	23
0.91	Food Environment Index		7.8		7.0		*2025*	10
0.79	Adults who Drank Soft Drinks: Past 7 Days	*percent*	46.6		48.6	47.5	*2024*	8

SCORE	OLDER ADULTS	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
3.00	People 65+ Living Alone	*percent*	36.1		30.2	26.5	*2019-2023*	2
3.00	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	139.3		118.1	113.2	*2017-2021*	13
2.82	People 65+ Living Below Poverty Level	*percent*	12.3		9.5	10.4	*2019-2023*	2
2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4		11.3	12.3	*2024*	9
2.21	Cancer: Medicare Population	*percent*	13.0		12.0	12.0	*2023*	7
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20.0		19.0	18.0	*2023*	7
1.94	People 65+ Living Alone (Count)	*people*	85,788				*2019-2023*	2

1.94	People 65+ Living Below Poverty Level (Count)	*people*	28,068			*2019-2023*	2
1.85	Osteoporosis: Medicare Population	*percent*	12.0	11.0	12.0	*2023*	7
1.85	Stroke: Medicare Population	*percent*	6.0	5.0	6.0	*2023*	7
1.59	Adults 65+ with Total Tooth Loss	*percent*	13.9		12.2	*2022*	5
1.50	Asthma: Medicare Population	*percent*	7.0	7.0	7.0	*2023*	7
1.50	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	38.0	39.0	36.0	*2023*	7
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6.0	6.0	6.0	*2023*	7
1.32	Heart Failure: Medicare Population	*percent*	12.0	12.0	11.0	*2023*	7
1.32	Hyperlipidemia: Medicare Population	*percent*	66.0	67.0	66.0	*2023*	7
1.24	Median Household Income: Householders 65+	*dollars*	48,911	51,608	57,108	*2019-2023*	2
1.18	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	10.9	12.1		*2020-2022*	21
1.15	Hypertension: Medicare Population	*percent*	66.0	67.0	65.0	*2023*	7
1.12	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	22.6	33.8		*2020-2022*	21
0.97	Atrial Fibrillation: Medicare Population	*percent*	14.0	15.0	14.0	*2023*	7
0.97	Depression: Medicare Population	*percent*	16.0	18.0	17.0	*2023*	7
0.97	Diabetes: Medicare Population	*percent*	23.0	25.0	24.0	*2023*	7
0.97	Ischemic Heart Disease: Medicare Population	*percent*	21.0	22.0	21.0	*2023*	7
0.79	COPD: Medicare Population	*percent*	11.0	13.0	11.0	*2023*	7

0.62	Mammography Screening: Medicare Population	*percent*	52.0		51.0	39.0	*2023*	7

SCORE	ORAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.00	Adults who Visited a Dentist	*percent*	43.3		44.3	45.3	*2024*	8
1.59	Adults 65+ with Total Tooth Loss	*percent*	13.9			12.2	*2022*	5
0.76	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.8	12.0	*2017-2021*	13
0.29	Dentist Rate	*dentists/ 100,000 population*	112.8		65.2	73.5	*2022*	10

SCORE	OTHER CHRONIC CONDITIONS	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.47	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	18.0		15.1		*2020-2022*	21
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20.0		19.0	18.0	*2023*	7
1.85	Osteoporosis: Medicare Population	*percent*	12.0		11.0	12.0	*2023*	7
1.50	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	38.0		39.0	36.0	*2023*	7
1.41	Adults with Arthritis	*percent*	30.4			26.6	*2022*	5

SCORE	PHYSICAL ACTIVITY	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.35	High School Students who Engage in Regular Physical Activity	*percent*	42.8				*2023*	23
1.32	Adults 20+ Who Are Obese	*percent*	32.5	36.0			*2021*	6
1.18	Adults 20+ who are Sedentary	*percent*	20.0				*2021*	6

0.71	Access to Exercise Opportunities	*percent*	97.9		84.2		*2025*	10
0.71	Access to Parks	*percent*	85.3		59.6		*2020*	15
0.47	Workers who Walk to Work	*percent*	2.7		2.0	2.4	*2019-2023*	2

SCORE	PREVENTION & SAFETY	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.44	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	20.2	10.7	13.5	12.0	*2018-2020*	6
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7		*2020-2022*	10
1.94	Death Rate due to Injuries	*deaths/ 100,000 population*	111.0		100.7		*2018-2022*	10
1.85	Severe Housing Problems	*percent*	15.7		12.7		*2017-2021*	10
1.65	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	45.2		46.5		*2020-2022*	21
1.35	High School Students who Carried a Weapon on School Property	*percent*	2.0				*2023*	23
1.35	High School Students who Did Not Go to School Because They Felt Unsafe at School or on Their Way To or From School	*percent*	9.1				*2023*	23
1.35	High School Students who Drove After Drinking Alcohol	*percent*	3.2				*2023*	23
1.35	High School Students who Feel Like They Matter to People in Their Community	*percent*	48.4				*2023*	23
1.35	High School Students who had Been Stopped, Questioned, or Searched by Police	*percent*	15.3				*2021*	23

1.35	High School Students who had Mostly Negative or Negative Encounters With Police	*percent*	20.4		*2021*	23
1.35	High School Students who were Bullied on School Property	*percent*	13.6		*2023*	23
1.35	High School Students who were Ever Physically Forced to have Sexual Intercourse	*percent*	5.3		*2023*	23
1.35	High School Students who were in a Physical Fight	*percent*	23.3		*2023*	23
1.35	High School Students who were Physically Forced to Do Sexual Things by Someone They were Dating or Going Out With	*percent*	10.6		*2023*	23
1.35	High School Students who were Physically Injured by Someone They were Dating or Going Out With	*percent*	8.0		*2023*	23
1.35	High School Students who were Threatened or Injured with a Weapon on School Property	*percent*	7.4		*2023*	23
1.18	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	10.9	12.1	*2020-2022*	21
1.06	High School Students who Did Not Always Wear a Seatbelt	*percent*	50.7		*2023*	23
1.06	High School Students who Rode with a Driver who had been Drinking Alcohol	*percent*	14.4		*2023*	23
1.06	High School Students who Texted or E-mailed While Driving	*percent*	30.7		*2023*	23

1.06	High School Students who were Electronically Bullied	*percent*	11.9				*2023*	23
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	8.6		11.1		*2016-2022*	10

SCORE	RESPIRATORY DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Adults with Current Asthma	*percent*	11.8			9.9	*2022*	5
2.29	Proximity to Highways	*percent*	12.5		7.2		*2020*	15
1.91	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.9	1.4	1.6	2.9	*2023*	17
1.50	Asthma: Medicare Population	*percent*	7.0		7.0	7.0	*2023*	7
1.41	Adults who Smoke	*percent*	16.6	6.1		12.9	*2022*	5
1.41	Adults with COPD	*Percent of adults*	8.2			6.8	*2022*	5
1.06	High School Students who Smoked Cigarettes: Past 30 Days	*percent*	1.3				*2023*	23
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.7		64.3	53.1	*2017-2021*	13
0.97	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.6		6.9	6.8	*2024*	8
0.88	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	36.6	25.1	39.8	32.4	*2018-2022*	13
0.82	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.5		12.3		*2020-2022*	21
0.79	COPD: Medicare Population	*percent*	11.0		13.0	11.0	*2023*	7
0.53	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	33.2		42.8		*2020-2022*	21
0.29	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.0		1.7	1.6	*2024*	8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.44	Syphilis Incidence Rate	*cases/ 100,000 population*	21.4		16.4	15.8	*2023*	17
2.15	Chlamydia Incidence Rate	*cases/ 100,000 population*	779.4		464.2	492.2	*2023*	17
1.94	High School Students who have Ever Been Taught About AIDS or HIV Infection in School	*percent*	64.4				*2023*	23
1.94	High School Students who were Ever Tested for HIV	*percent*	6.2				*2023*	23
1.91	Age-Adjusted Death Rate due to HIV	*deaths/ 100,000 population*	1.5		0.9		*2020-2022*	21
1.85	Gonorrhea Incidence Rate	*cases/ 100,000 population*	334.3		168.8	179.5	*2023*	17

SCORE	TOBACCO USE	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.68	Cigarette Spending-to-Income Ratio	*percent*	2.2		2.2	1.9	*2024*	9
1.41	Adults who Smoke	*percent*	16.6	6.1		12.9	*2022*	5
1.06	High School Students who Smoked Cigarettes: Past 30 Days	*percent*	1.3				*2023*	23
1.06	High School Students who Use a Cigar Product	*percent*	3.1				*2023*	23
1.06	High School Students who Use an Electronic Vapor Product	*percent*	7.0				*2023*	23
1.06	High School Students who Use Hookah or Waterpipe	*percent*	1.7				*2023*	23
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.7		64.3	53.1	*2017-2021*	13

0.97	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.6		6.9	6.8	*2024*	8
0.88	Tobacco Use: Medicare Population	*percent*	6.0		7.0	6.0	*2023*	7
0.29	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.0		1.7	1.6	*2024*	8

SCORE	WEIGHT STATUS	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.94	Obesity: Medicare Population	*percent*	26.0		25.0	20.0	*2023*	7
1.65	High School Students who are Obese	*percent*	17.3				*2023*	23
1.35	High School Students who are Overweight	*percent*	15.7				*2023*	23
1.32	Adults 20+ Who Are Obese	*percent*	32.5	36.0			*2021*	6
1.32	Adults Happy with Weight	*Percent*	42.2		42.1	42.6	*2024*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Self-Reported General Health Assessment: Good or Better	*percent*	84.2		85.4	86.0	*2024*	8
2.21	Adults who Frequently Cook Meals at Home	*Percent*	66.2		67.6	67.7	*2024*	8
1.76	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	39.6		38.1	38.2	*2024*	8
1.59	High Blood Pressure Prevalence	*percent*	36.7	41.9		32.7	*2021*	5
1.59	Insufficient Sleep	*percent*	37.7	26.7		36.0	*2022*	5
1.59	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.1			17.9	*2022*	5
1.56	Poor Physical Health: Average Number of Days	*days*	4.4		4.3		*2022*	10

1.50	Adults who Feel Life is Slipping Out of Control	*Percent*	24.1		24.1	23.9	*2024*	8
1.35	High School Students who Obtained 8+ Hours of Sleep	*percent*	23.5				*2023*	23
1.32	Adults Happy with Weight	*Percent*	42.2		42.1	42.6	*2024*	8
1.24	Life Expectancy	*years*	75.4		75.2		*2020-2022*	10
1.24	Poor Physical Health: 14+ Days	*percent*	13.1			12.7	*2022*	5
0.97	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	60.4		59.8	60.4	*2024*	8

SCORE	WOMEN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.00	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.1		132.3	129.8	*2017-2021*	13
1.76	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.9	15.3	20.2	19.3	*2018-2022*	13
0.88	Cervical Cancer Screening: 21-65	*Percent*	83.2			82.8	*2020*	5
0.88	Mammogram in Past 2 Years: 50-74	*percent*	78.7	80.3		76.5	*2022*	5
0.85	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.5		7.8	7.5	*2017-2021*	13
0.62	Mammography Screening: Medicare Population	*percent*	52.0		51.0	39.0	*2023*	7

Lorain County 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		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			..

Lorain County Indicators of Concern: Adult Health

The prioritized health topic of *Adult Health* includes 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	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			

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				
1.50	Asthma: Medicare Population	*Percent*	7	7	7			..
1.50	Cancer: Medicare Population	*Percent*	12	12	12			..

Lorain County Indicators of Concern: Community Safety

The prioritized health topic *Community Safety* was captured under the two health topics *Prevention and Safety*, with a score of 1.68, and *Alcohol and Drug Use*, with a score of 1.76. Indicators from these two health 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			
2.35	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42.1	--	40.5	23.5			
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				
2.09	Severe Housing Problems	*percent*	12.9	--	12.7	--			
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	Death Rate due to Injuries	*deaths/ 100,000 population*	101.7	--	100.7				--
1.74	Adults who Drink Excessively	*percent*	20.9		21.2				
1.71	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.9	43.2	69.9	51.6			

Lorain County 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 15 below as a reference key for indicator data sources.

Table 15: 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 16: 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 CCRH Avon Community described in the body of this CHNA report. All data are sourced from Claritas Pop-Facts® (2024 population estimates), unless otherwise noted.

Table 17: Population Size of CCRH Avon Community

Zip Code	Population
44001	21,057
44011	25,690
44012	25,714
44017	17,872
44035	62,843
44039	37,266
44044	14,273
44052	29,360
44053	21,336
44054	12,624
44055	19,552
44070	31,764
44074	11,764
44090	11,157
44102	41,880
44107	49,191
44109	37,444
44111	39,791
44116	21,278
44126	16,603
44130	49,467
44133	30,594
44135	25,792
44136	25,526
44138	22,582
44140	15,561
44142	18,043
44144	20,879
44145	33,573
CCRH Avon Community (Total)	790,476

Table 18: Age Profile of CCRH Avon Community and Surrounding Geographies

Age Category	CCRH Avon Community	Ohio
0-4	5.2%	5.6%
5-9	5.4%	5.7%
10-14	5.7%	6.1%
15-17	3.5%	3.8%
18-20	3.7%	4.4%
21-24	4.7%	5.3%
25-34	12.9%	12.4%
35-44	12.8%	12.2%
45-54	11.9%	11.7%
55-64	13.4%	13.0%
65-74	12.1%	11.6%
75-84	6.3%	6.1%
85+	2.4%	2.2%
Median Age	42.2 years	40.5 years

Table 19: Racial/Ethnic Profile of CCRH Avon Community and Surrounding Geographies

	CCRH Avon Community	Ohio	U.S.
White	75.6%	75.7%	63.4%
Black/African American	8.4%	12.8%	12.4%
American Indian/Alaskan Native	0.3%	0.3%	0.9%
Asian	2.7%	2.7%	5.8%
Native Hawaiian/Pacific Islander	<0.1%	0.1%	0.2%
Another Race	4.5%	2.1%	6.6%
Two or More Races	8.5%	6.4%	10.7%
Hispanic or Latino (any race)	11.8%	5.0%	19.0%

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

Table 20: Population Age 5+ by Language Spoken at Home, CCRH Avon Community and Surrounding Geographies

	CCRH Avon Community	Ohio	U.S.
Only English	88.2%	92.8%	78.0%
Spanish	5.9%	2.3%	13.4%
Asian/Pacific Islander Language	1.0%	1.0%	3.5%
Indo-European Language	3.4%	2.8%	3.8%
Other Language	1.6%	1.1%	1.2%

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

Table 21: Household Income of CCRH Avon Community and Surrounding Geographies

Income Category	CCRH Avon Community	Ohio
Under $15,000	9.5%	9.5%
$15,000 - $24,999	8.1%	7.8%
$25,000 - $34,999	8.6%	8.0%
$35,000 - $49,999	12.8%	12.2%
$50,000 - $74,999	17.2%	17.0%
$75,000 - $99,999	13.0%	13.0%
$100,000 - $124,999	9.5%	9.9%
$125,000 - $149,999	6.3%	7.0%
$150,000 - $199,999	6.9%	7.2%
$200,000 - $249,999	3.4%	3.5%
$250,000 - $499,999	3.3%	3.4%
$500,000+	1.5%	1.6%
Median Household Income	$68,837	$68,488

Table 22: Families Living Below Federal Poverty Level, CCRH Avon Community and Surrounding Geographies

Zip Code	Families Below Poverty
44001	3.0%
44011	3.6%
44012	3.1%
44017	5.9%
44035	14.9%
44039	4.5%
44044	4.4%
44052	25.3%
44053	12.2%
44054	4.8%
44055	25.7%
44070	7.0%
44074	5.9%
44090	3.0%
44102	25.7%
44107	8.4%
44109	21.0%
44111	16.8%
44116	2.9%
44126	6.3%
44130	7.4%
44133	2.5%
44135	19.6%
44136	3.0%
44138	1.9%
44140	2.6%
44142	6.5%
44144	11.5%
44145	4.8%
CCRH Avon Community (Overall)	10.0%
Ohio	9.4%
U.S.	8.8%

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

Table 23: Educational Attainment, CCRH Avon Community and Surrounding Geographies

	CCRH Avon Community	Ohio	U.S.
Less than High School Graduate	8.9%	8.6%	10.6%
High School Graduate	29.3%	32.8%	26.2%
Some College, No Degree	20.9%	19.6%	19.4%
Associate Degree	9.0%	8.9%	8.8%
Bachelor's Degree	20.2%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	11.8%	11.5%	13.7%

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

Table 24: Renters Spending at Least 30% of Household Income on Rent, CCRH Avon Community and Surrounding Geographies

Zip Code	Renters Spending 30% or More of Income on Rent
44001	49.5%
44011	31.8%
44012	37.0%
44017	41.9%
44035	44.1%
44039	35.6%
44044	38.7%
44052	53.7%
44053	50.0%
44054	29.2%
44055	56.0%
44070	44.1%
44074	50.5%
44090	45.7%
44102	50.1%
44107	37.0%
44109	50.6%
44111	46.3%
44116	41.6%
44126	42.0%
44130	48.1%
44133	32.2%
44135	53.0%
44136	41.9%
44138	29.8%
44140	40.0%
44142	46.2%
44144	40.7%
44145	49.5%
Cuyahoga County	47.5%
Lorain County	46.3%
Ohio	45.1%
U.S.	50.4%

All values: American Community Survey (2019-2023)

Table 25: Households with an Internet Subscription, CCRH Avon Community and Surrounding Geographies

Zip Code	Households with Internet
44001	91.0%
44011	94.0%
44012	90.7%
44017	94.3%
44035	83.8%
44039	93.4%
44044	87.0%
44052	79.0%
44053	81.8%
44054	91.3%
44055	79.1%
44070	91.3%
44074	90.0%
44090	89.9%
44102	83.7%
44107	91.6%
44109	85.0%
44111	87.8%
44116	91.1%
44126	93.2%
44130	89.8%
44133	93.7%
44135	85.2%
44136	92.0%
44138	89.9%
44140	92.0%
44142	87.9%
44144	86.6%
44145	93.3%
Cuyahoga County	87.5%
Lorain County	86.9%
Ohio	89.0%
U.S.	89.9%

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 the CCRH Avon 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 community organizations, hospital systems, and regional health collaboratives, corroborated the relevance of the three prioritized needs in this 2025 CHNA process.

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 health-related social needs, particularly poverty, housing insecurity, and gun violence, impact all other areas of health.

- 2023 Ohio State Health Assessment[13]
- 2023 City of Cleveland Parks and Recreation Community Needs Assessment[14]
- 2024 Cuyahoga County ADAMHS Board Needs Assessment[15]
- 2023 Cuyahoga County Planning Commission Data Book[16]
- 2022 Greater Cleveland LGBTQ+ Community Needs Assessment[17]
- Joint 2022 Cuyahoga County CHNA (Collaborating Organizations: University Hospital, Cuyahoga County Board of Health, and the City of Cleveland Department of Health)[18]

[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] Cleveland Parks & Recreation Plan Team. (2024). *Community needs assessment report* [PDF]. City of Cleveland Department of Parks & Recreation. https://cleparksrecplan.com/wp-content/uploads/240102_Community-Needs-Assessment-Report_web.pdf
[15] Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County (2024). *Community health needs assessment* [PDF]. https://www.adamhscc.org/about-us/budgets-reports/needs-assessments
[16] Cuyahoga County Planning Commission. (December 2023). *Our County: The 2023 data book* [PDF]. Cuyahoga County Planning Commission. https://s3.countyplanning.us/wp-content/uploads/2023/12/Our-County-2023-reduced.pdf?
[17] 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
[18] Cuyahoga County CHNA Steering Committee. (2022). *2022 Cuyahoga County community health needs assessment* [PDF]. Conduent Healthy Communities Institute & Cuyahoga County Community Partners. https://www.healthyneo.org/content/sites/cuyahoga/Resources/CHNA-Cuy-Cty-11.22.pdf

- 2023 Livable Cuyahoga Needs Assessment[19]
- 2023 United Way of Greater Cleveland Community Needs Assessment[20]
- 2025 Lorain County Community Health Needs Assessment[21]

[19] Cuyahoga County Department of Health and Human Services, Division of Senior & Adult Services. (2023). *Livable Cuyahoga needs assessment report*. Cuyahoga County. Retrieved June 2025, from https://hhs.cuyahogacounty.gov/docs/default-source/default-document-library/reports/livable-cuyahoga-needs-assessment-report.pdf?sfvrsn=b1f65b31_1

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

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

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 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? (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

A total of nine organizations provided feedback for the CCRH Avon 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:

- Cuyahoga County Board of Health
- El Centro
- Greater CLE/Akron LGBTQ+ CHA
- Lorain County Commissioners
- Lorain County Public Health
- Lorain County Veteran Services 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 three prioritized health needs identified in the 2025 Community Health Needs Assessment.

Access to Healthcare

The following highlights key insights from stakeholder interviews regarding Access to Healthcare in the community. Access to Healthcare was described by nearly all stakeholders as one of the most persistent and complex challenges facing residents within the CCRH Avon community. Participants emphasized that while the region benefits from a strong network of hospitals and community partners, significant barriers remain related to affordability, system navigation, and culturally responsive care. Stakeholders described a disconnect between available services and the populations most in need, often citing transportation limitations, coverage lapses, and lack of awareness of available resources as key factors reducing access to consistent and preventive care.

The following are highlights of participant feedback regarding Access to Healthcare:

- Insurance gaps and re-enrollment issues leave many residents without continuous coverage.
- Limited awareness of safety-net clinics and available community resources contributes to underutilization.
- Long wait times and provider shortages, particularly in specialty and behavioral health care, delay treatment.
- Transportation barriers, especially in rural and southern areas of the county, limit access to appointments.
- Distrust of healthcare institutions and lack of culturally or linguistically relevant care discourage engagement.

- Navigation and outreach programs led by community health workers are seen as effective solutions to improve access and health literacy.

The following are a few select quotes illustrating feedback about Access to Healthcare by key informants:

"We don't do enough to educate people about Medicaid. So many are eligible and haven't even applied, and we don't use presumptive eligibility enough to keep them covered."

"People don't always know where to go. We have safety-net clinics, but not everyone trusts them or understands how to get care without insurance."

"Transportation is a real problem once you get outside of the cities. If you don't have a car, it's almost impossible to get to an appointment on time."

"The system is intimidating for a lot of people. We need more navigators and community health workers who can walk people through the process and help them stay connected to care."

Overall, the interviews reveal that Access to Healthcare in the CCRH Avon community is shaped by intertwined economic, geographic, and cultural factors. Even as clinical resources expand, many residents continue to face practical and perceptual barriers that prevent timely, preventive, and ongoing care. Stakeholders consistently called for strategies that strengthen outreach, integrate behavioral and physical health services, and support culturally responsive models of care that meet residents where they are. Strengthening of these connections between healthcare providers and community systems was viewed as critical to improving access and health outcomes across the region.

Adult Health

Adult Health was a recurring concern across stakeholder interviews, with participants emphasizing the widespread burden of chronic disease and its connection to social and behavioral factors. Stakeholders described diabetes, hypertension, heart disease, and cancer as ongoing challenges, often linked to unhealthy dietary patterns, limited access to nutritious foods, and low levels of physical activity. These conditions were reported to increasingly affect adults at younger ages, reflecting both lifestyle factors and environmental influences. Many participants also discussed the role of social isolation, economic stress, and the rising cost of living in shaping the overall health and well-being of adults in the community.

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

- Diabetes, hypertension, heart disease, and cancer are consistently cited as top adult health issues.
- Rising rates of obesity and sedentary lifestyles contribute to worsening chronic disease outcomes.
- Food insecurity and limited access to affordable, healthy foods are key drivers of poor nutrition and diet-related illness.

- Screening rates for cancer and other preventive services have declined, leading to delayed detection and treatment.
- Adults are increasingly diagnosed with chronic conditions at younger ages.
- Older adults face compounding barriers including social isolation, transportation challenges, and high costs of care.
- Community-based programs that promote physical activity, healthy eating, and social connection were identified as effective prevention strategies.

The following are a few select quotes illustrating feedback about Adult Health key informants:

> *"We hear about the same health problems over and over—diabetes, hypertension, heart disease. People are developing these conditions earlier, and it's tied to how and what we eat."*
>
> *"Food insecurity and diet are huge issues. People rely on fast food because it's convenient and cheaper, but it drives chronic disease in the long run."*
>
> *"We're seeing cancer being diagnosed later because people skipped screenings during the pandemic and still haven't returned to regular preventive care."*
>
> *"Social isolation and the lack of affordable services make it hard for older adults to stay healthy. Many don't have transportation or support systems."*

Overall, findings from the stakeholder interviews point to a complex picture of Adult Health in the CCRH Avon community, shaped by chronic disease, health behaviors, and social conditions. Stakeholders emphasized that without consistent access to affordable and nutritious food, opportunities for exercise, and preventive care, health differences will continue to grow. Strengthening community partnerships to support chronic disease prevention, increasing participation in screenings, and expanding outreach to isolated and aging populations were identified as key priorities for improving adult health and quality of life across the region.

Community Safety

Community Safety was identified as a pressing concern across stakeholder interviews, reflecting the interconnection between safety, behavioral health, housing stability, and social well-being. Participants emphasized that experiences of violence, unsafe housing, and substance use contribute to chronic stress and poor health outcomes across the community. Stakeholders noted that while progress has been made in reducing overdose deaths through stronger collaboration and harm reduction efforts, significant challenges remain in ensuring stable housing, mental health support, and long-term recovery services. Many described safety as a foundational determinant of health that influences whether individuals can maintain employment, manage chronic conditions, and engage in community life.

The following are highlights of participant feedback regarding Community Safety:

- Substance use and addiction, particularly opioid and alcohol misuse, remain major community safety concerns.
- Overdose prevention efforts have shown success, but recovery and treatment supports are still insufficient.
- Unsafe or unstable housing environments contribute to both physical and emotional insecurity.
- Rising homelessness among older adults and individuals with disabilities increases vulnerability to poor health and victimization.
- Violence and neighborhood conditions contribute to stress, fear, and mistrust among residents.
- Stakeholders emphasized that prevention, recovery, and safety require cross-sector collaboration among behavioral health, housing, and social service agencies.

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

"We have a growing number of people over 60 who are homeless or disabled. They're staying in shelters longer because they can't get the help they need or afford housing and medical care."

"The community has made progress reducing overdoses, but it takes constant coordination. We still need more recovery supports and places for people to go after treatment."

"Safety is about more than crime. It's about whether people have stable housing, feel secure, and can live in neighborhoods where they're not constantly worried."

"We need everyone at the table…housing, mental health, healthcare, and law enforcement…to make our communities safer and healthier."

Overall, the interviews underscored that Community Safety in the CCRH Avon community is deeply linked to behavioral health, housing, and social conditions. Stakeholders described how instability, substance use, and exposure to violence undermine both individual and neighborhood well-being. Participants called for continued investment in prevention, trauma-informed care, and housing stability efforts to address these root causes. Strengthening cross-sector partnerships and ensuring culturally relevant, community-led solutions were viewed as essential to creating safer, healthier environments for all residents.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

CCRH Avon's previous Implementation Strategy outlined a plan for addressing the following priorities identified in the 2022 CHNA. Access to Healthcare, Adult Health, and Community Safety were identified as needs within the 2022 CHNA for CCRH Avon. The table below describes the strategies completed and modifications made to the action plans for each health priority area.

Access to Healthcare

Actions:

- Access to affordable healthcare was identified as a significant need in the 2022 CHNA for CCRH Avon. Access barriers include cost, poverty, inadequate transportation, a lack of awareness regarding available services, and an undersupply of providers.

Highlighted Impacts:

- Financial Assistance – CCRH Avon 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 provides free or discounted care based on financial need.
- Awareness - CCRH Avon developed and shared educational materials with patients, families, and providers to broaden community awareness and improve patients' ability to choose the most appropriate care setting.
- How to Access Care - Clinical staff serving the Brain Injury and Stroke Program teams at CCRH Avon offered support groups and educational sessions for families and community residents. As part of this education and outreach, the hospital provided information on post-acute care settings, how to access different levels of care, and community-based resources.
- Transportation resources are distributed by case managers during discharge planning and reviewed with the therapy team to determine most appropriate option to meet individualized needs.

Adult Health

Actions:

- Adult health, as chronic diseases and management was identified as a priority need within the 2022 CHNA for CCRH Avon. Chronic diseases include behavioral health, heart disease, hypertension, obesity, diabetes, and COPD.

Highlighted Impacts:

- Physicians educate patients on their overall healthcare and on potential risk factors that may affect their recovery.
- Physical and functional impairments may be exacerbated by obesity. To encourage weight loss, the clinical team provided education and training to patients to increase mobility and activity. Discussions regarding healthy eating and interpretation of food labels were included as part of the therapy care plan.
- Depression and emotional changes, common following illness or injury, were addressed by a variety of modes of treatment and professionals including:

therapists, nursing staff, psychologists, psychiatrists, non-pharmacological techniques, pharmacological treatment and recreation therapy.
- CCRH Avon developed a large network of clinical liaisons throughout the community to assist elderly consumers in understanding their post-acute care options.
- Continuing education was provided to nursing and pharmacy staff specific to diabetes medication and diabetic management.
- The Care Partner program provided comprehensive caregiver/family training prior to the patient's discharge focusing on level of assistance and supervision needed to support a safe home discharge.
- The *Stride On* event brings together current and former patients, their families, staff, and members of the community to celebrate stroke survivors and raise stroke prevention awareness.—The event is hosted on a triennial basis and rotates between each CCRH site to allow greater community involvement based upon geography.
- CCRH Avon continued to participate as a member of the Avon Hospital Community Advisory Council. This group meets quarterly to provide updates and opportunities surrounding healthcare in Lorain County.

Community Safety

Actions:

- The hospital provides patient education and resources to enhance knowledge, skills, and behaviors related to fall prevention and safety, alcohol, tobacco and drug use.

Highlighted Impacts:

- CCRH Avon developed evidence-based falls prevention education for internal and external stakeholders including information on environmental modifications, balance exercises, and home safety assessments. The hospital also provided educational materials detailing how to reduce the likelihood of injury should a fall occur.
- A formalized smoking cessation program was developed including resources and education that were provided to patients during an inpatient rehabilitation stay. Patients were also connected with organizations in the community for ongoing follow up and support.
- The hospital formalized an internal opioid management process for reviewing healthcare prescribing, data collection, and the use of non-pharmacologic treatment for pain.
- Healthcare providers screened all patients for pain on admission and developed a pain management plan based on the patient's input, history, and desired goals.
- Appropriate referrals to community programs, such as AA, NA, or mental health resources were provided by case management and psychology staff.

Appendix F: Acknowledgements

Conduent Healthy Communities Institute (HCI) supported report preparation. HCI collaborates 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 conduent.com/community-population-health.

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Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Avon

Implementation Strategy Report

2025

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

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Cleveland Clinic Rehabilitation Hospital Avon
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 Cleveland Clinic Rehabilitation Hospital Avon (CCRH Avon or "the 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 CCRH Avon. This report includes strategies for years 2026 through 2028.

A. Description of Hospital

CCRH Avon is a 60-bed rehabilitation hospital, offering sophisticated technology and advanced medical care in intensive, specialized rehabilitation setting for neurological, orthopedic, and complex spinal injuries. Additional information on the hospital and its services is available at: my.clevelandclinic.org/locations/rehabilitation-hospital.

The hospital is a joint venture between Cleveland Clinic health system and Select Medical. As part of the broader Cleveland Clinic health system, CCRH Avon upholds the tripartite mission of clinical care, research, and education. Cleveland Clinic 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 CCRH Avon, contributes to the system-wide advancement of clinical research and medical innovation. Patients at CCRH Avon benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Select Medical is one of the largest providers of post-acute care encompassing three areas of expertise: critical illness recovery, inpatient medical rehabilitation, and outpatient physical therapy, all of which are delivered and supported by talented healthcare professionals across the U.S. Additional information about Select Medical is available at https:www.selectmedical.com/.

II. CCRH Avon Community Definition

The community definition describes the zip codes where approximately 75% of CCRH Avon Hospital discharges originated in 2024. Figure 1 shows the specific geography for this 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: CCRH Avon Community Definition

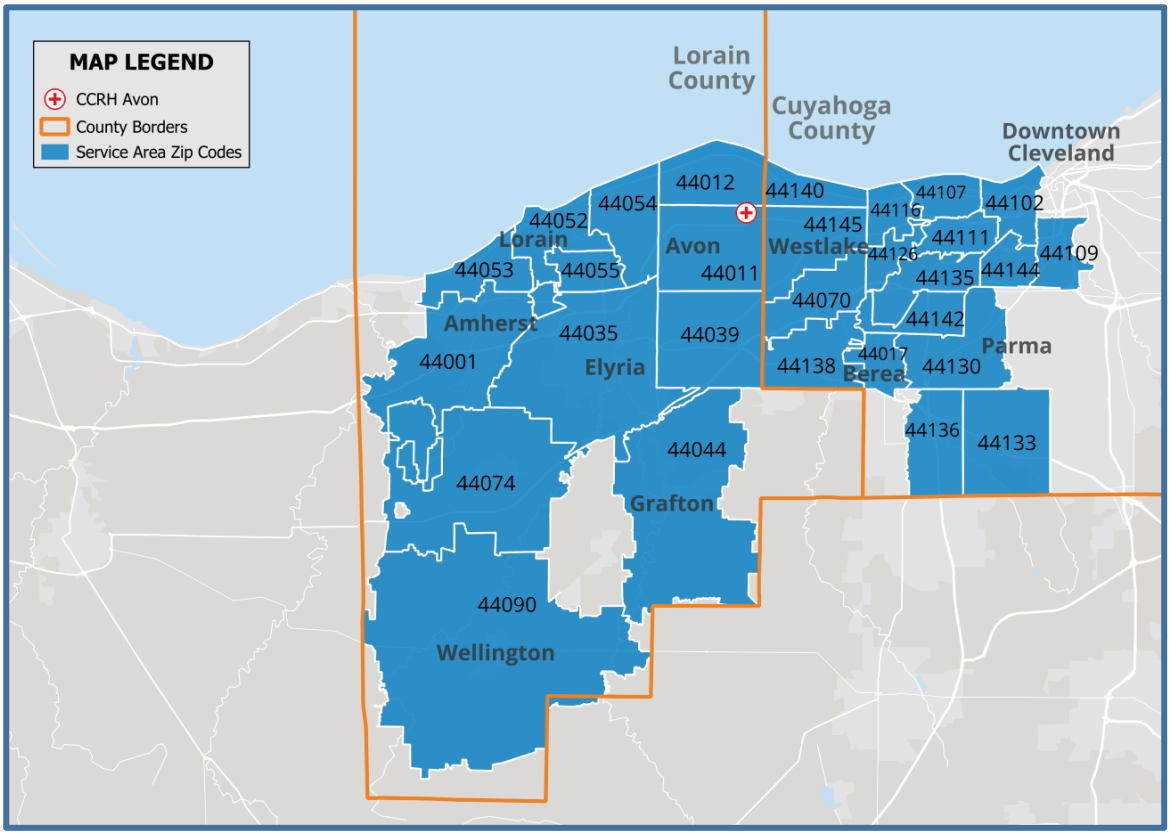


Table 1: CCRH Avon Community Definition

Zip Code	Municipality	Zip Code	Municipality
44102	Cleveland (Detroit-Shoreway)	44145	Westlake
44055	Lorain	44054	Sheffield
44052	Lorain	44039	North Ridgeville
44109	Cleveland (Brooklyn-Centre)	44011	Avon
44135	Cleveland	44012	Avon Lake
44111	Cleveland (Jefferson)	44001	Amherst
44035	Elyria	44136	Strongsville
44053	Lorain	44116	Rocky River
44144	Cleveland	44140	Bay Village
44107	Lakewood	44133	North Royalton
44130	Cleveland	44138	Olmsted Falls
44070	North Olmsted	44145	Westlake
44142	Brookpark		
44126	Cleveland		
44017	Berea		

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of senior leadership at Avon Rehabilitation and Cleveland Clinic representing several departments of these organizations. Leadership at Avon Rehabilitation will utilize this Implementation Strategy to determine whether changes should be made to better address the health needs of its communities.

IV. Summary of the Community Health Needs Identified

CCRH Avon's 2025 Community Health Needs Assessment reaffirms its commitment to addressing three core health priorities based on a 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 three prioritized health needs will help shape the hospital's Implementation Strategy Reports (ISR) for the subsequent three years:

- Access to Healthcare

- Adult Health
- Community Safety

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

V. Needs Hospital Will Address

Each Cleveland Clinic hospital provides numerous services and programs in efforts to address the health needs of the community. Implementation of our services focuses on addressing structural factors important for community health, strengthening trust with residents and stakeholders, ensuring community voice in developing strategies, and evaluating our strategies and programs. Strategies within the ISRs are included according to the prioritized list of needs developed during the 2025 CHNA.

- Access to Healthcare
- Adult Health
- Community Safety

A. Access to Healthcare

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

Access to Healthcare Initiatives for 2026-2028 include:

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

Injury and Stroke Program teams at Avon Rehabilitation will develop support groups and educational sessions for families and community residents. As part of this education and outreach, the hospital will provide information on post-acute care settings, how to access different levels of care, and community based resources.

B. Adult Health

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

Adult Health Initiatives for 2026-2028 include:

1. Each patient is followed by a physician's service throughout their stay at the rehabilitation hospital. Physicians educate patients on their overall healthcare and on potential risk factors that may affect their recovery. They also educate patients on their past medical history and how their existing conditions may be impacted by their new injury. There are consulting physicians including but not limited to internal medicine, cardiologists, pulmonologists, and nephrologists that are available for consultation regarding secondary diagnoses or complications related to the new injury/illness. Additionally, through Avon Rehabilitation's linkage with Cleveland Clinic, patients have access to comprehensive diagnostic, medical, and surgical services.
2. Provide education and training to patients to increase mobility and activity. Discussions regarding healthy eating and interpretation of food labels may be initiated as part of the therapy care plan.
3. Continuing education is routinely provided to nursing and pharmacy staff specific to diabetes medication and diabetic management.
4. Depression and emotional changes are common following illness or injury. These occur as primary effects of the illness, as in the case of stroke, or as secondary reactions to new disabilities that may have commonly pre-existed the event.
    a. Psychologists are capable of evaluation and psychotherapeutic treatment of a variety of disorders. They may recommend starting pharmacological intervention with antidepressant medications, mood stabilizers, and anxiolytics. It is important to use medications that can improve recovery and to avoid and/or discontinue those medications that have been shown or hypothesized to impede recovery.
    b. Therapists, case managers, and nursing staff also provide emotional support, encouragement, and hope. It is also essential to use non-pharmacological techniques to help with these psychological disorders.
    c. Recreational therapy is essential to help add some "downtime" to the rigors of the therapy schedule as well as to provide information on

community resources, spiritual care, and participation in leisure activities.

5. Avon Rehabilitation will leverage relationships with providers across the continuum of post-acute care in order to cross-refer, provide patient education, and support self-advocacy. Recognizing the health literacy needs of the community and the wide array of post-acute care options available, Avon Rehabilitation has developed a large network of clinical liaisons throughout the community to assist elderly consumers in understanding their post-acute care options. The hospital offers facility tours and coordinates with our acute care case management partners.
6. As part Avon Rehabilitation's inpatient care for individuals recovering from stroke, brain injury, spinal cord injury, limb loss and other conditions, the Care Partner program is utilized to provide comprehensive caregiver/family training prior to the patient's discharge focusing on level of assistance and supervision needed to support a safe home discharge.
7. Avon Rehabilitation hosts a Stride On event. This event brings together current and former patients, their families, staff, and members of the community to celebrate stroke survivors and raise stroke prevention awareness.
8. Avon Rehabilitation is a member of the Avon Hospital Community Advisory Council. This group meets quarterly to provide updates and opportunities surrounding healthcare in Lorain County.

C. Community Safety

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

Community Safety Initiatives for 2026-2028 include:

1. Falls represent a particular concern for our elderly populations. Avon Rehabilitation has developed evidence-based falls prevention education for internal and external stakeholders including information on environmental modifications, balance exercises, and home safety assessments. In addition to focusing on falls prevention, the hospital also provides educational materials detailing how to reduce the likelihood of injury should a fall occur.
2. Tobacco use is a risk factor for several medical conditions commonly treated in the inpatient rehabilitation setting. Smoking can also increase the risk of disease recurrence and presents a significant barrier to healthy living. A formalized smoking cessation program will be available including resources and education that can be provided to patients during an inpatient rehabilitation stay. Patients will also be connected with organizations in the community for ongoing follow up and support. Low-cost or free smoking cessation resources will also be investigated.
3. Avon Rehabilitation is committed to preventing deaths from opioid overdose by improving opioid prescribing practices, reducing exposure to opioids, and

preventing misuse. The hospital has formalized an internal opioid management process for reviewing healthcare prescribing, data collection, and the use of non-pharmacologic treatment for pain.

4. Healthcare providers screen all patients for pain on admission and develop a pain management plan based on the patient's input, history, and desired goals.
5. Appropriate referrals to community programs, such as AA, NA, or mental health resources are delivered by case management and psychology staff.

While this ISR outlines specific strategies and programs identified to address the 2025 CHNA prioritized areas of Access to Healthcare, Adult Health, and Community Safety, it does not reflect all the work being done by CCRH Avon 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 CCRH Avon to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

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

clevelandclinic.org/**CHNAreports**

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