Cleveland Clinic
Akron General
Lodi Hospital

Community Health Needs Assessment

2025



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Lodi Hospital 2025 Community Health Needs Assessment

Introduction

Lodi Hospital, a 20-bed[1] Critical Access Hospital and member of Cleveland Clinic Akron General, has served southwest Medina County and portions of Lorain, Ashland, and Wayne Counties since 1920. The hospital provides acute and skilled care, a full range of outpatient diagnostic, rehabilitation and physical therapy services, infusion services, outpatient and minimally invasive surgery, radiology, and a state-of-the-art 24-hour emergency department that has earned numerous patient satisfaction awards.

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

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

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

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

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

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

CHNA Background

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

Lodi Hospital Community Definition

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

Figure 1: Lodi Hospital Community Definition

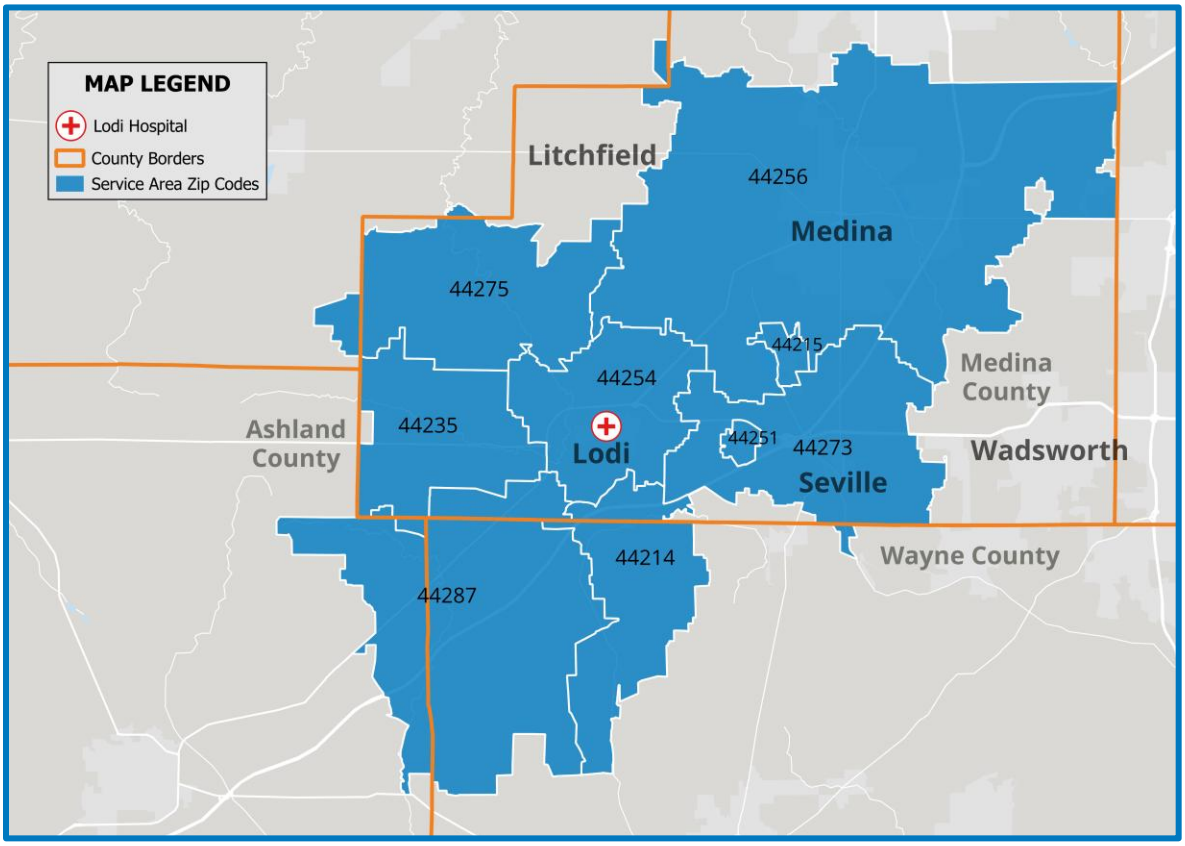


Table 1: Lodi Hospital Community Definition

Zip Code	Postal Name
44214	Burbank
44215	Chippewa Lake
44235	Homerville
44251	Westfield Center
44254	Lodi
44256	Medina
44273	Seville
44275	Spencer
44287	West Salem

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 9-zip-code Lodi Hospital community area. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced four key health priorities, Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, and Health-Related Social Needs, highlighting differences in outcomes by distinct groups.

Other Community Assessment and Improvement Plans

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

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

Primary Data Methodology and Key Findings

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

Summary

2025 Prioritized Health Needs

Lodi Hospital's 2025 Community Health Needs Assessment reaffirms its commitment to addressing four 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 four prioritized health needs will help shape the hospital's Implementation Strategy Reports (ISR) for the subsequent three years:

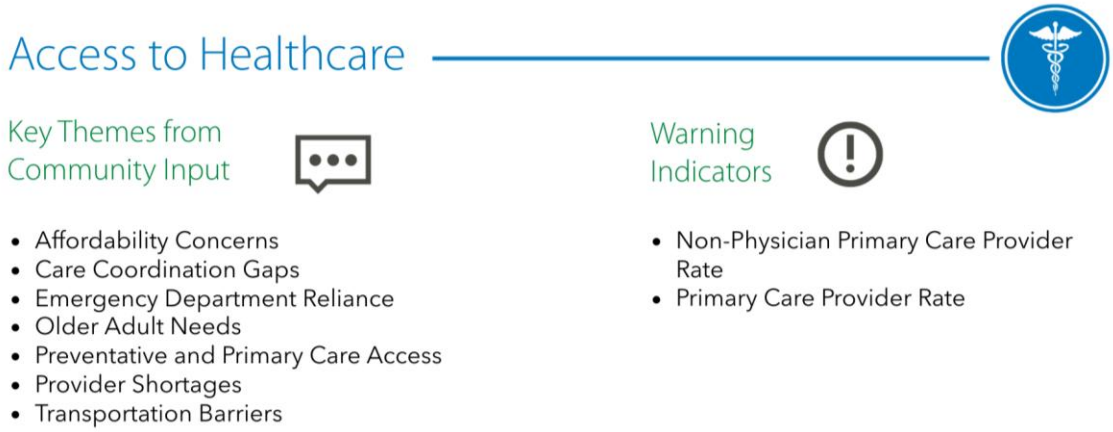


These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that the hospital's defined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

The four prioritized community health needs identified in this 2025 Lodi Hospital CHNA are summarized below. Within each summary, pertinent information pertaining to

secondary data findings, primary data findings and relevant demographics, social drivers of health, and differences in health outcomes are highlighted. Full data details are included in the appendices section at the end of this report.

Prioritized Health Need #1: Access to Healthcare



Access to Healthcare was identified as a pressing challenge for the Lodi Hospital community for the 2025 CHNA. Stakeholder interviews consistently emphasized that access to healthcare remains one of the most pressing challenges for residents in the Lodi Hospital community. Participants described how affordability, transportation barriers, and limited local service options make it difficult for individuals to obtain timely and consistent care. Even when health insurance is available, high deductibles, copays, and medication costs often discourage residents from seeking needed treatment or following up with specialists. These financial pressures particularly affect older adults, low-income households, and those living with chronic conditions.

Another recurrent theme was the shortage of providers and long wait times for both primary and specialty care. Stakeholders noted that residents often must travel outside the community for certain services, creating additional obstacles for those without reliable transportation. This challenge is compounded by gaps in awareness of available resources and difficulties navigating an often-fragmented healthcare system. Interviewees emphasized the need for models of care that bring services closer to residents, such as mobile clinics, expanded telehealth, and integration of primary, behavioral health, and social support within the same setting.

Stakeholders also highlighted the importance of culturally and linguistically appropriate care to better serve the growing diversity of the population. Many described instances of healthcare system mistrust and mistreatment that further limit engagement with health services. To overcome these barriers, interviewees suggested strengthening partnerships between hospitals, community-based organizations, and social service providers. They stressed that access solutions must go beyond clinical care alone, addressing underlying health-related social needs and ensuring continuity, trust, and improved service delivery.

Some of the greatest healthcare access challenges identified by secondary data concern provider availability. Despite improvements in recent years, the availability of primary care providers across Medina County remains lower than that of Ohio and the country.

The rate of preventable hospital stays in Medina County is relatively low, county-wide, but this rate is higher among the county's Black/African American population (8,310 vs. 2,377 per 100,000 Medicare enrollees).

Geospatial data from Conduent HCI's Community Health Index (CHI) can help to estimate health risk based on health-related social needs, thus identifying where health needs are especially high. Across the Lodi Hospital community, the zip code with the highest CHI value, and greatest healthcare needs, is 44287 (West Salem). In fact, despite low levels of uninsured persons across Medina County (4.1%), the zip code 44287 (located in Wayne County) has one of the highest uninsured rates across Ohio (15.8%). 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: Behavioral Health



Behavioral Health emerged as one of the priorities for the Lodi Hospital community in the 2025 CHNA. Stakeholder interviews for the Lodi Hospital consistently identified behavioral health as one of the most urgent and complex needs in the community. Participants described persistent challenges with mental health conditions such as depression, anxiety, trauma, and stress, which are widespread and often compounded by poverty, social isolation, and limited access to care. The availability of services remains a critical issue, with shortages of mental health providers, lengthy wait times, and limited crisis care resources cited as ongoing barriers. Many stakeholders noted that stigma continues to discourage individuals from seeking care, particularly in smaller communities where privacy concerns are heightened.

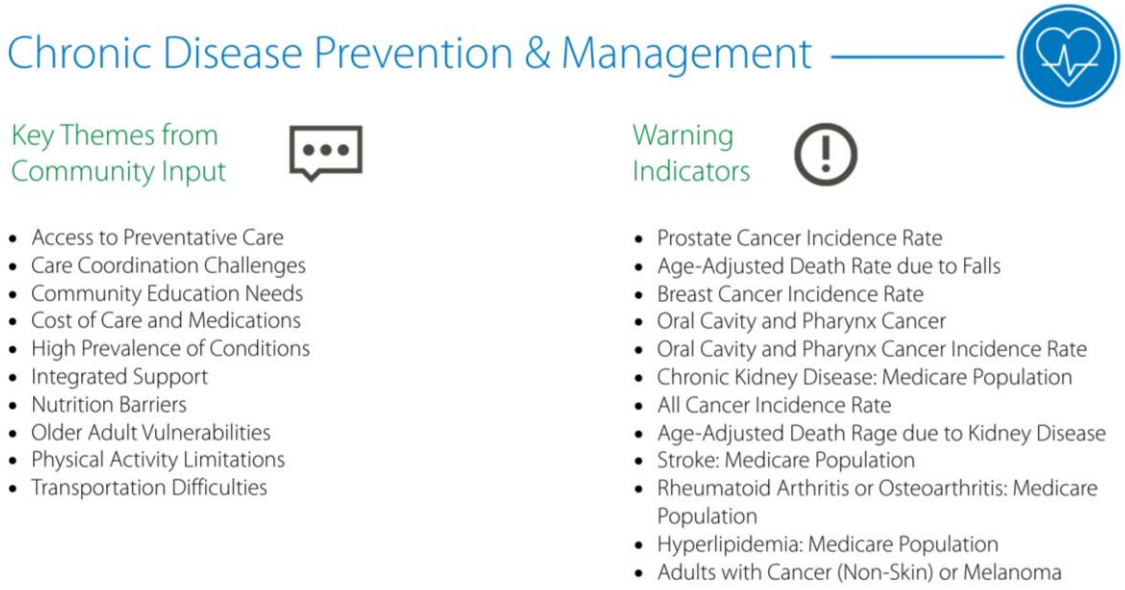
Substance use disorder was described as an escalating concern, particularly related to opioids and fentanyl. Stakeholders emphasized the need for more accessible, evidence-based treatment and recovery resources, including harm reduction programs and integrated behavioral health services. The lack of culturally responsive and affordable options was highlighted as a barrier, especially for low-income residents and older adults who face transportation challenges. Participants also stressed the importance of prevention and early intervention, including school-based programs, trauma-informed

care, and broader collaboration between healthcare providers, schools, and community organizations.

Stakeholders called for coordinated, community-driven solutions that address both mental health and substance use in a holistic manner. This includes expanding local treatment capacity, strengthening partnerships across sectors, and ensuring that services are tailored, accessible, and sustainable to meet the diverse needs of the community.

Secondary data indicate high rates of alcohol use across Medina County that exceed nearly all other Ohio counties. About one in four adults in Medina County have been diagnosed with depression (24.8%). Conduent HCI's Mental Health Index (MHI) can further pinpoint areas of elevated mental health risk based on local health-related social needs indicators. In the Lodi Hospital community, the zip code with the highest MHI value is 44287 (West Salem).

Prioritized Health Need #3: Chronic Disease Prevention and Management



Stakeholder interviews for the Lodi Hospital 2025 CHNA highlighted chronic disease prevention and management as a significant health concern for the community. Conditions such as diabetes, hypertension, heart disease, and respiratory illnesses were frequently mentioned, with participants noting that these diseases often go undetected or are poorly managed due to barriers in access, cost, and continuity of care. Many residents rely on episodic care from emergency rooms or health fairs rather than maintaining consistent relationships with primary care providers, which leads to late diagnoses and difficulties with long-term management.

Nutrition, lifestyle, and social and economic influences of health were consistently cited as factors contributing to the prevalence of chronic disease. Interviewees described limited access to healthy foods, reliance on convenience stores, and a lack of safe and

appealing spaces for physical activity. These challenges are particularly acute for older adults and low-income families, who face financial constraints, transportation limitations, and difficulty affording prescriptions or supplies necessary for disease control.

Stakeholders emphasized the need for holistic, community-based strategies that integrate early screening, health education, and culturally responsive self-management programs. They also pointed to opportunities for expanded partnerships with schools, workplaces, and community organizations to promote healthy living and support prevention. For high-risk populations, targeted outreach and patient navigation services were viewed as essential to improve adherence to treatment, reduce preventable hospitalizations, and lessen the overall burden of chronic disease in the Lodi Hospital community.

Primary and secondary data findings across topics such as nutrition, cancer, cardiovascular health, and aging consistently revealed differences in health outcomes influenced by income, race, location, and barriers in care delivery.

Nutrition, Healthy Eating, and Wellness
Participants highlighted limited access to affordable, fresh foods, noting reliance on convenience stores and fast-food options as contributing to poor dietary habits. These challenges were compounded by barriers such as transportation limitations, financial constraints, and the lack of consistent local resources like farmers markets or community gardens. Stakeholders emphasized that poor nutrition not only increases risks for obesity, diabetes, and hypertension but also makes it difficult for residents to effectively manage existing conditions. They also underscored the need for wellness initiatives that include culturally relevant nutrition education, accessible fitness opportunities, and expanded partnerships with schools and community organizations to promote healthier lifestyles. Together, these findings point to the importance of pairing clinical care with community-based prevention efforts to reduce the burden of chronic disease in the Lodi Hospital community.

Consumer data demonstrate that Medina County residents are more likely to cook meals at home and less likely to rely on fast food than state-wide and national rates. The county-wide food insecurity rate is also relatively low (12.1%), although food insecurity is more common among the Black/African American and Hispanic/Latino county residents (32.0% and 21.0%, respectively). Conduent HCI's Food Insecurity Index (FII) can help to identify geographic differences in food access across the entire Lodi Hospital community. The zip code with the highest FII value, and greatest estimated need, is 44254 (Lodi) with a value of 52.9.

Cancer
Stakeholder feedback for the Lodi Hospital community highlighted that prevention and early detection for cancer remain critical challenges, as residents often face barriers to routine screenings due to cost, transportation difficulties, and limited awareness of available services. Participants emphasized the importance of expanding outreach and education efforts to encourage timely screenings. Stakeholders also pointed to differences in outcomes across groups, underscoring the need for culturally tailored education, mobile or community-based screening opportunities, and stronger patient navigation services to help individuals access diagnostic and treatment resources.

Collectively, these insights reflect a clear need for more accessible and proactive cancer prevention strategies in the Lodi Hospital community.

In Medina County, residents face some elevated risk of developing cancer but also experience relatively better cancer outcomes. Rates of prostate cancer (136.4 per 100,000 males), breast cancer (139.2 per 100,000 females), and oral cancer (14.3 per 100,000 population) all exceed both state-wide and national rates and are also rising. In contrast, however, mortality data indicate that the Medina County has some of the lowest death rates across the nation with regard to breast cancer and prostate cancer, as well as colorectal cancer and lung cancer.

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions

Stakeholders in the Lodi Hospital community identified diabetes, heart disease, stroke, and other chronic conditions as widespread and deeply concerning health challenges. These illnesses were often described as preventable or manageable with early detection and consistent care, yet residents face persistent barriers that limit effective management. Participants pointed to poor nutrition, limited access to preventive care, and financial constraints around medications and follow-up visits as key drivers of poor outcomes. Many noted that residents frequently discover these conditions only during community screenings or urgent visits, rather than through continuous engagement with a primary care provider, which limits timely intervention. The high prevalence of these chronic diseases was also linked to lifestyle factors, food insecurity, and transportation barriers that make it difficult to maintain regular appointments. Stakeholders stressed the importance of expanding community-based education, chronic disease self-management programs, and integrated care approaches that connect medical treatment with nutrition, fitness, and behavioral health supports to improve long-term outcomes for residents in the community served by Lodi Hospital.

Secondary data indicate that across Ohio, Medina County has some of the lowest rates of coronary heart disease, high blood pressure, and diabetes. Rates of kidney disease, however, are relatively high across the county, which is typically a result of untreated diabetes or high blood pressure. The prevalence of chronic kidney disease among the county's Medicare population (20.0%) exceeds both state-wide and national rates, and the county's death rate due to kidney disease (14.2 deaths per 100,000) has been increasing since 2016.

Older Adult Health

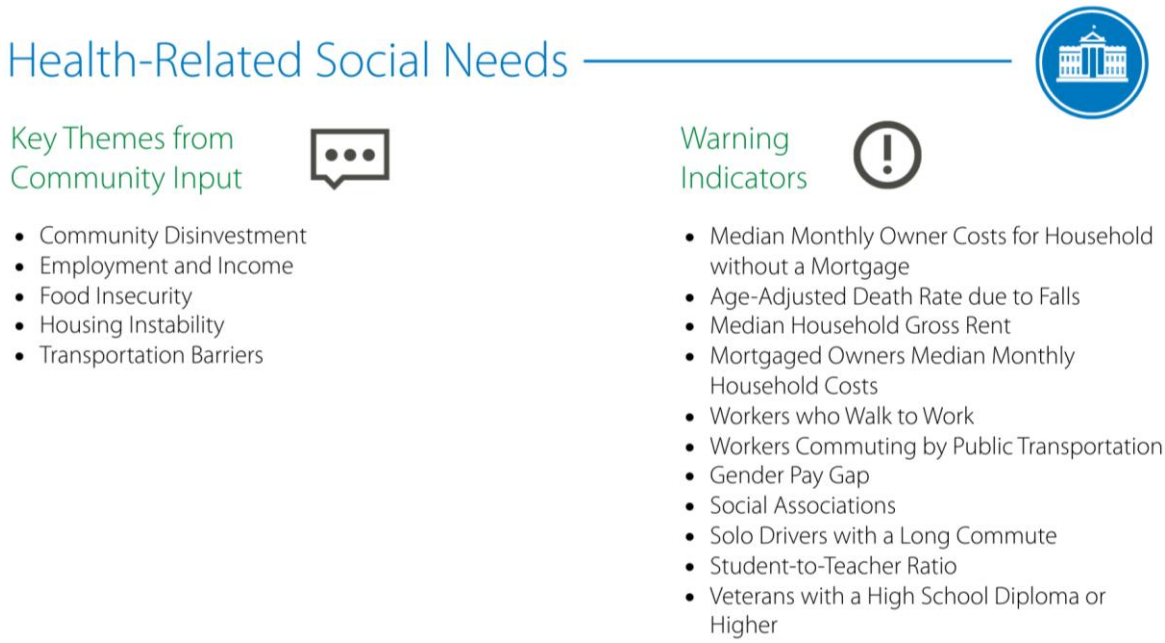
Stakeholders in the Lodi Hospital community emphasized that older adults face significant and growing challenges in maintaining their health and independence. Social isolation, mobility limitations, and the complexity of managing multiple chronic conditions were frequently highlighted as barriers to quality of life. Transportation difficulties, particularly in rural areas, often prevent seniors from attending regular appointments or accessing preventive services. The high cost of care, including medications and supportive services, was also described as a persistent burden for older residents on fixed incomes. Participants stressed the need for more community-based resources, such as senior centers, home health programs, and caregiver support, to help older adults age in place safely. They also underscored the importance of integrating physical, mental, and social support tailored to seniors, with the goal of reducing

preventable hospitalizations and promoting long-term wellness for this priority population.

The Lodi Hospital community is a relatively older population, with a larger percentage of individuals age 65 and above than either Ohio or the U.S. overall (21.6% vs. 19.8% and 16.8%, respectively). Many chronic disease outcomes, broadly, have an outsized impact on this population. Fall-related injuries and death are also health concerns that primarily impact older adults. Even after adjusting for the county's age distribution, Medina County has a high risk of fall-related deaths (17.2 per 100,000 persons), which falls in the top quartile of all Ohio counties, and has been increasing since 2015.

Adult day care is one possible solution to help prevent unintentional injuries and falls among older adults. In Medina County, the cost of adult day care is less expensive than most other counties (8.3% of household income), but this cost burden is higher for the county's Hispanic/Latino population (16.3% of household income).

Prioritized Health Need #4: Health-Related Social Needs



Stakeholders who participated in the 2025 CHNA process revealed that health-related social needs play a central role in shaping health outcomes for the Lodi Hospital community. Limited income, unstable employment, and persistent poverty create barriers to accessing health care, healthy foods, and safe housing. Participants emphasized that many families in the area live paycheck to paycheck, leaving little room to cover medical bills, prescriptions, or preventive care. Housing instability, including a lack of affordable rental options, was also identified as a pressing issue that increases stress and exacerbates poor health outcomes.

Transportation challenges further complicate these issues, particularly in more rural parts of the community where public transit is minimal or nonexistent. Residents without reliable vehicles are more likely to miss medical appointments, delay seeking care, or

struggle to reach employment opportunities and social services. Food insecurity was another recurring concern, with stakeholders pointing to high grocery costs and limited access to fresh, nutritious options, which contributes to diet-related chronic conditions such as diabetes and heart disease.

Underlying these challenges are broader factors, including limited social infrastructure, reduced investment in some neighborhoods, and differences in health outcomes based on demographic and economic characteristics. Stakeholders stressed the importance of addressing these upstream social and economic influencers through cross-sector collaboration, community investment, and initiatives that improve access to affordable housing, employment opportunities, and supportive social services. These approaches were seen as essential not only to improving individual health outcomes but also to building long-term resilience in the Lodi Hospital community.

Secondary data illustrate that the Lodi Hospital community population has relatively high levels of income and education, and relatively low levels of poverty and unemployment, compared to both Ohio and the U.S. overall. These outcomes, however, differ between demographic groups. For example, Black and African American residents have a median income that's lower than the community-wide median income ($58,845 vs. $95,277) and the gender pay gap in Medina County is one of the largest across the country, with women making $0.64 for every dollar earned by men. Access to education and childcare also differs by demographic groups. The typical cost burden of childcare is relatively low for Medina County (2.4% of household income), but this burden is higher for Hispanic/Latino households (4.4%).

Prioritized Health Needs in Context

Each of the four 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-based and needs-based approaches to improve health outcomes. The following sections provide an overview of the demographic and social factors influencing health in the Lodi Hospital community, offering additional context for understanding the differences and opportunities outlined in this report.

Secondary Data Overview

Demographics and Health-Related Social Needs

The demographics of a community significantly impact its health profile.[2] 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 Lodi Hospital, including the economic, environmental, and social drivers of health. The social drivers of health are the non-medical factors that influence health outcomes.

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

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.[3] In addition to these highlights, detailed findings from the secondary data analysis can be found in Appendix B.

Geography and Data Sources

Data are presented at various geographic levels (county, zip code, and/or census tract) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data may mask issues at the zip code level in many communities. While indicators may be strong when examined at a higher level, zip code level analysis can reveal differences in health outcomes.

All demographic and health-related social need 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 Lodi Hospital Community

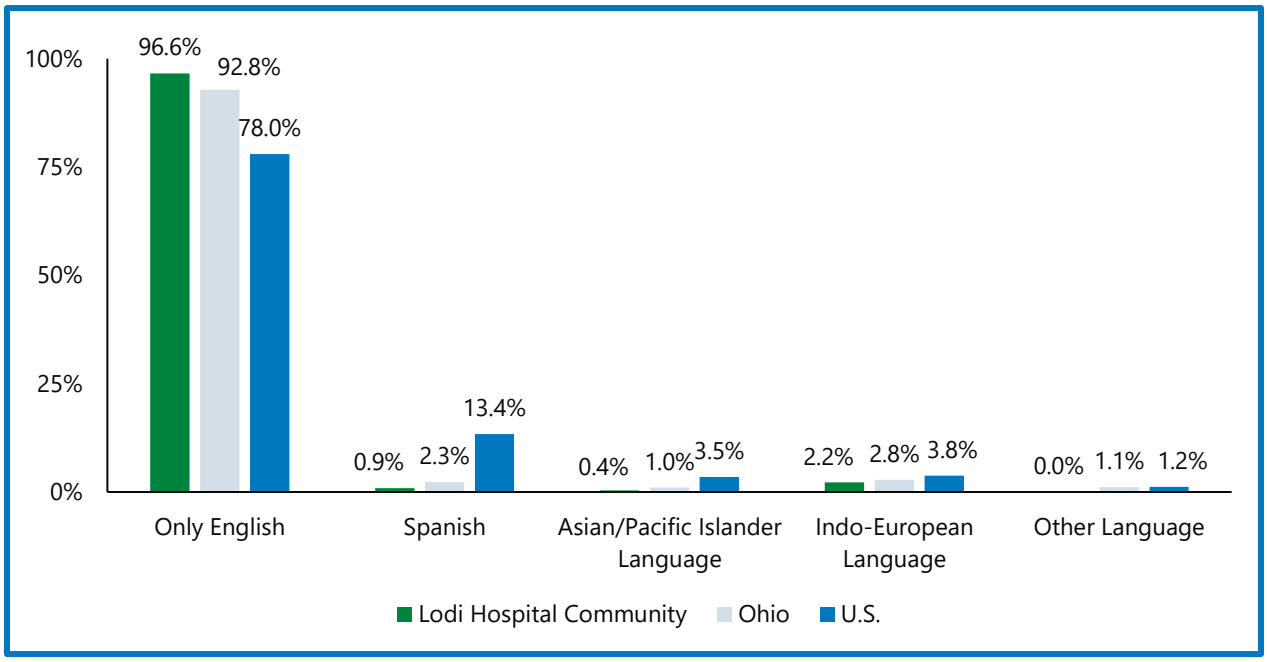
According to the 2024 Claritas Pop-Facts® population estimates, the Lodi Hospital community has an estimated population of 95,817 persons. The median age in the community is 44.0 years, which is older than that of Ohio (40.3 years). More than a quarter of the population (27.6%) is between 45-64 years old.

The majority of the population is White (90.9%), which is a substantially higher percentage than that of Ohio (75.7%) and the U.S. (63.4%). Compared to the Ohio population, the Lodi Hospital community population has a smaller percentage of Black/African American (1.6% vs. 12.8%), Asian (1.1% vs. 2.7%), and Hispanic/Latino (2.8% vs. 6.4%) residents.

As seen in Figure 2, the vast majority of the Lodi Hospital population aged five and above speaks primarily English at home (96.6%). Very few residents speak Spanish at home (0.9%), and 2.2% speak another Indo-European language. 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.

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

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



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

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

Income and Poverty

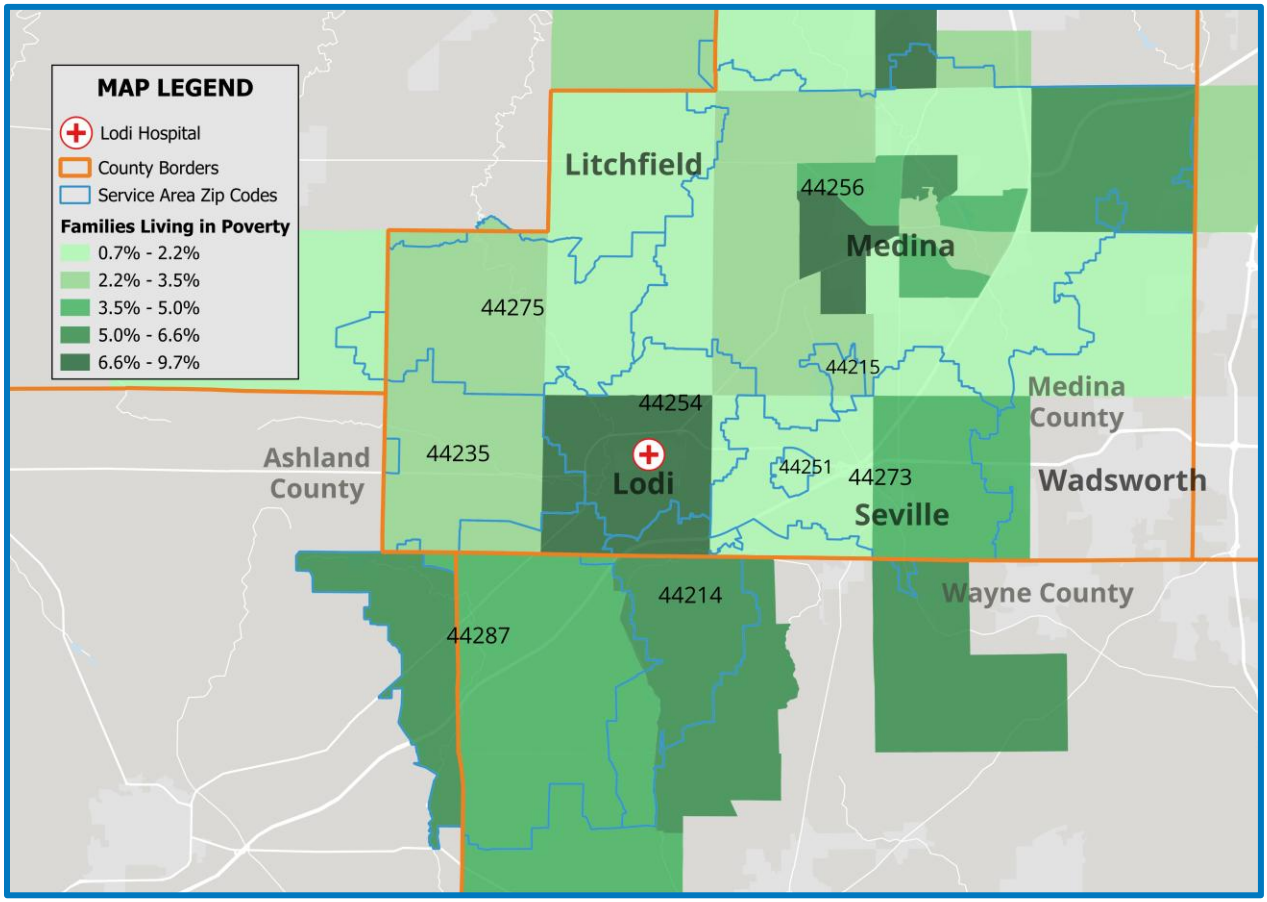
Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[4]

The median household income for the Lodi Hospital community is $95,277 which is more than a third higher than that of Ohio overall ($68,488).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. In the Lodi Hospital community, 4.4% of families live below the poverty level. This is approximately half the state-wide and national poverty rates (9.4% and 8.8%, respectively). Poverty levels differ geographically across the Lodi Hospital community (Figure 3), and poverty is most common in the zip code 44254 (Lodi), where 7.1% of families live in poverty, followed by 44214 (Burbank), where 6.7% of families live in poverty.

[4] Robert Wood Johnson Foundation. Health, Income, and Poverty. https://www.rwjf.org/en/library/research/2018/10/health--income-and-poverty-where-we-are-and-what-could-help.html

Figure 3: Families in Poverty by Census Tract, Lodi Hospital Community

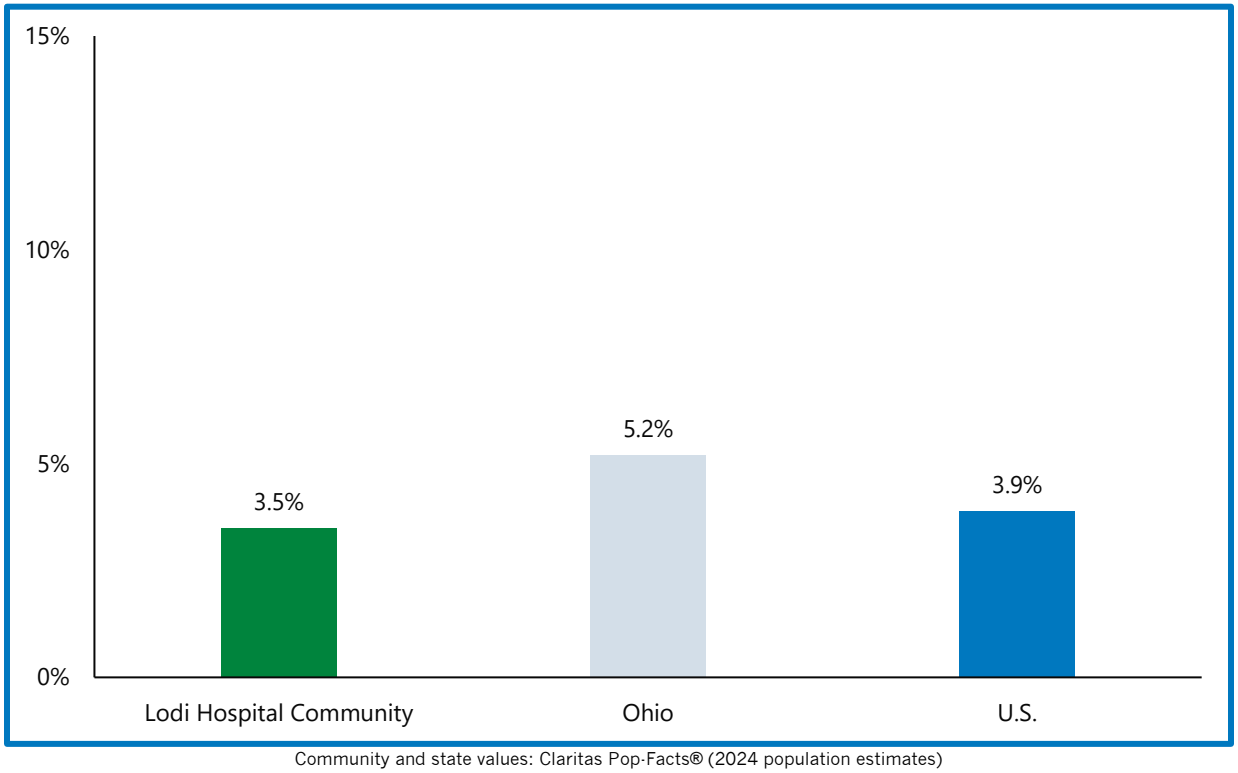


Claritas Pop-Facts® (2024 population estimates)

Education and Employment

The vast majority of the population within the Lodi Hospital community have a high school degree or higher (95.3%) and more than a third have a bachelor's degree or higher (36.4%). These rates are higher than state-wide and nation-wide rates. As seen in Figure 4, the unemployment rate is 3.5%, lower than the state-wide and national unemployment rates.

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]

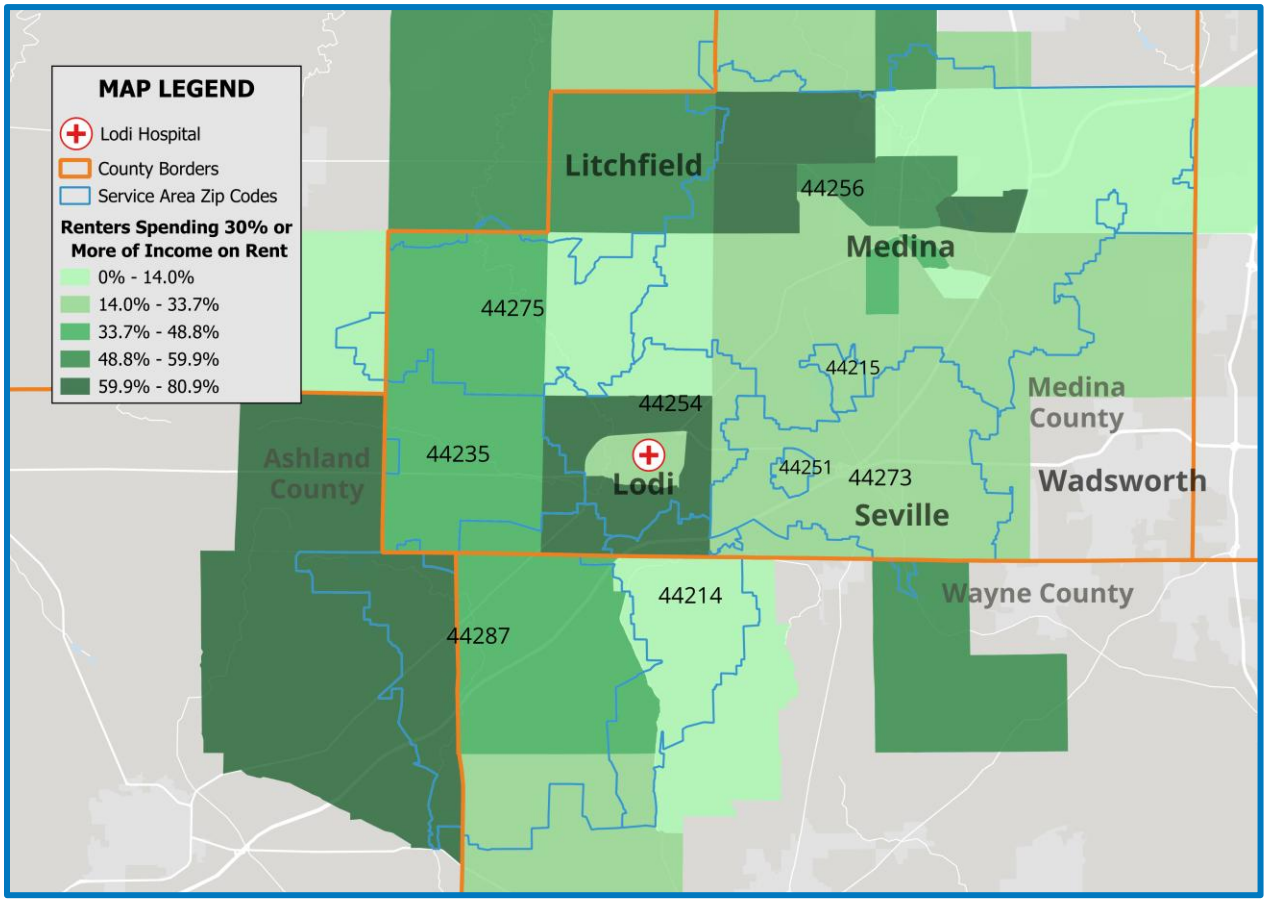
Housing and Built Environment

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Across Medina County, 9.4% of households have severe housing problems, such as: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Additionally, 43.7% of renters in the county spend at least 30% of their income on rent (Figure 5).

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

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

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



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

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. The vast majority of Medina County households have internet access (91.8%). At the zip code level, the lowest levels of internet access in the Lodi Hospital community are in the zip codes 44235 (Homerville), with 77.5% of households, and 44254 (Lodi), with 80.2% of households.

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 Lodi Hospital community at the zip code level.

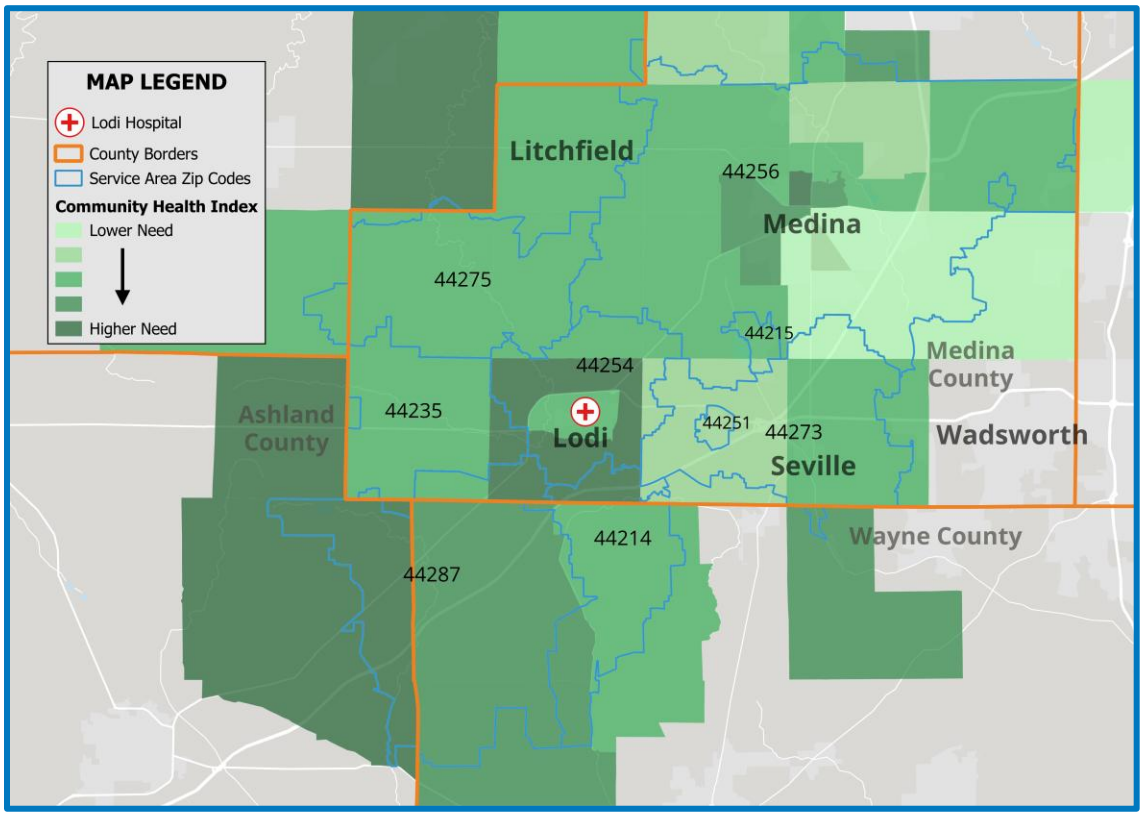
Community Health Index

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 need 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 Lodi Hospital community, as indicated by the darkest shade of green. At the zip code level, 44287 (West Salem) and 44235 (Homerville) have the highest index values, at 67.9 and 57.5, respectively. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the Lodi Hospital community.

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



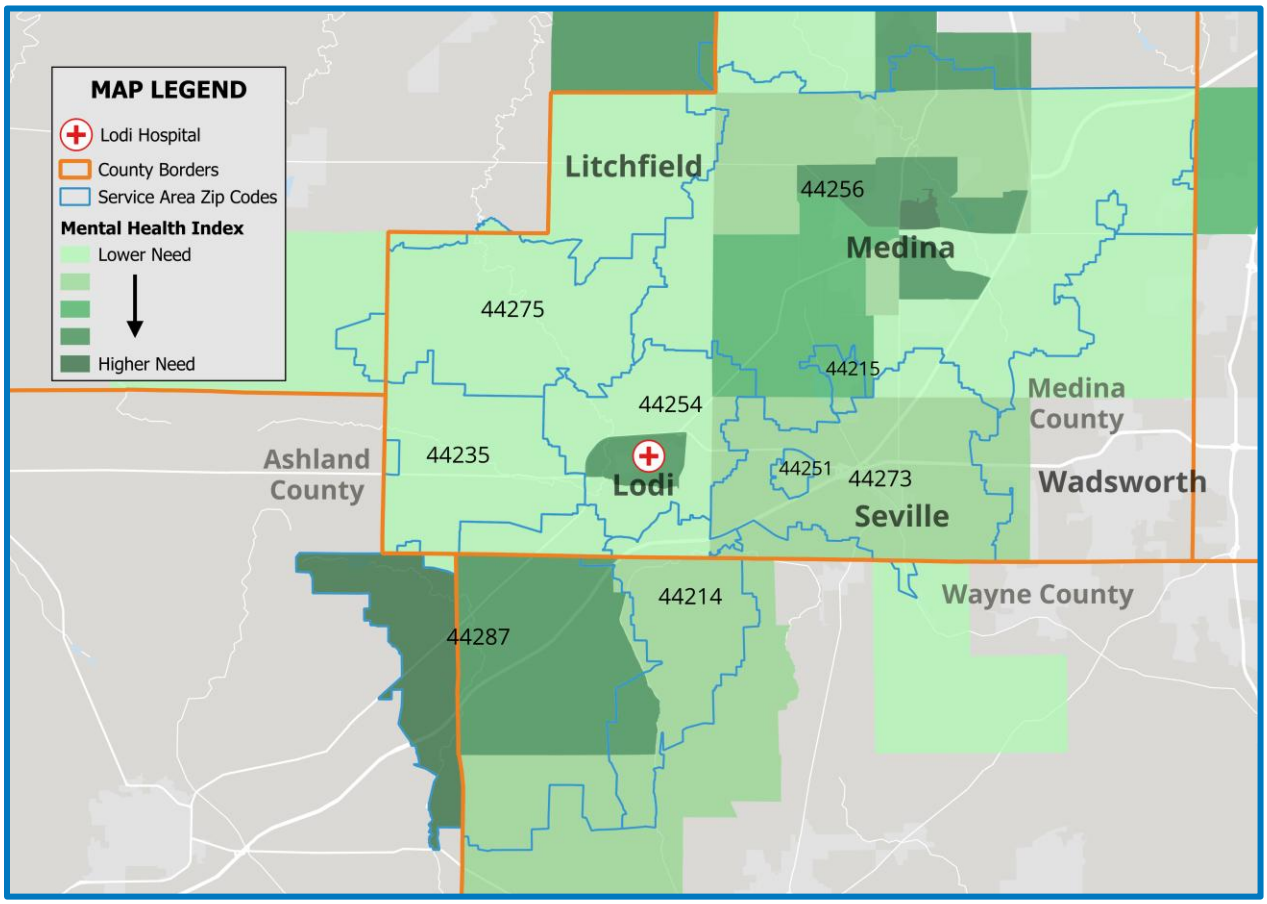
Mental Health Index

Conduent HCI's Mental Health Index (MHI) can help to identify geographic differences in mental health outcomes across the county, down to the census tract level. The MHI uses health-related social need 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 Lodi Hospital Community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44287 (West Salem) with an

MHI value of 68.9, followed by 44256 (Medina) and 44254 (Lodi), with values of 50.6 and 49.9, respectively. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Lodi Hospital community.

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

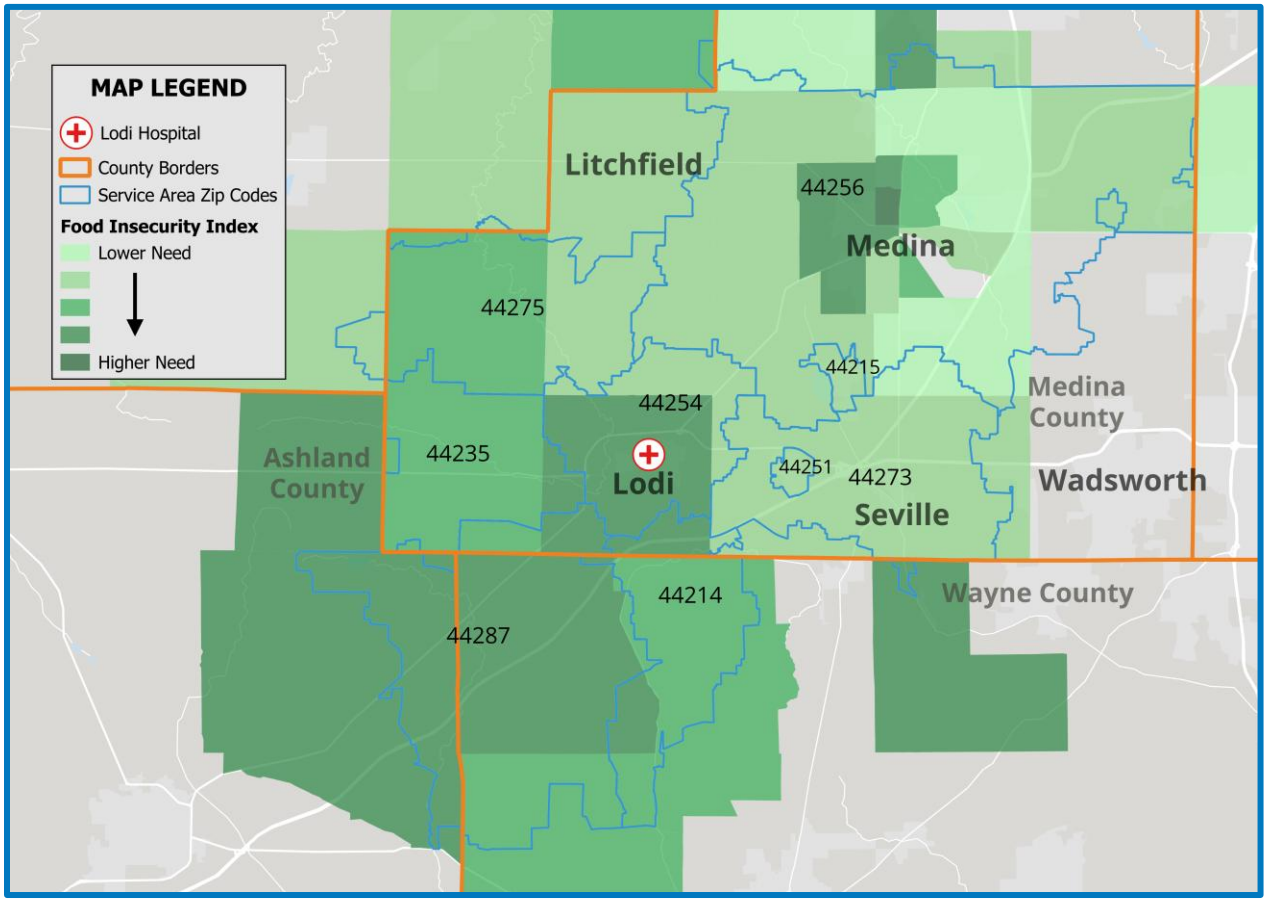


Food Insecurity Index

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

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the Lodi Hospital Community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44254 (Lodi), with a FII value of 52.9. See Appendix B for additional details about the FII and a table of FII values for each zip code in the Lodi Hospital community.

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



Other Community Assessment and Improvement Plans

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

2023 Ohio State Health Assessment[7]

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

- Access to Healthcare:

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

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

2022 Akron Children's Hospital CHNA[8]

Priority Areas Identified:

- Mental and Behavioral Health (children's social and emotional health is urgent and critical need exacerbated by the COVID-19 pandemic and response, parents not satisfied with mental health services in the community for their child).
- Community Based Health and Wellness (encompasses basic health services, such as well visits and regular health screenings tailored to the needs of the community and in some cases located within it).
- Overarching commitments: Improving Health Access and Fostering Resiliency.

2023 Medina County Community Development Needs Assessment[9]

Health Areas Identified:

- Strengths in Community Amenities: Stakeholders recognized that healthcare services, along with parks, shopping, and restaurants, are among the above-average community amenities available to residents. These resources were viewed as valuable supports to overall quality of life and community well-being.

[8] Akron Children's Hospital. (2022). *Community Health Needs Assessment.* Retrieved from https://www.akronchildrens.org/pages/Community_Health_Needs_Assessment.html?tab=sctabtwo

[9] Ohio State University Extension Medina County. (2023). *Community Development Needs Assessment Report.* The Ohio State University. Retrieved from https://medina.osu.edu/program-areas/community-development/community-initiatives

- Opportunities for Improvement: Despite the presence of healthcare services, participants emphasized the need for enhanced access points for under resourced populations. Specifically, they called out the importance of expanding low- or no-cost clinic services, particularly for working residents who may not qualify for public assistance but struggle to afford regular care.
- Nutrition and Preventive Health: Suggestions to increase the number of farmers markets that accept EBT cards reflect a broader emphasis on improving access to affordable, healthy foods, which are critical for chronic disease prevention and long-term community health.
- Wellness Infrastructure: Calls for more biking, walking, and hiking trails highlight the community's interest in expanding opportunities for physical activity. These infrastructure investments were viewed as important for supporting wellness, preventing chronic disease, and encouraging healthy lifestyles.

2024 Medina County Community Health Assessment[10]

Priority Areas Identified:

- Mental Health and Addiction including:
    - Adverse Childhood Experiences (ACEs)
    - Mental Health and Access to Mental Healthcare
    - Housing and Homelessness
    - Substance Use / Drug Use
- Chronic Disease Prevention including:
    - Preventive Care and Practices
    - Access to Healthcare
    - Food Insecurity
    - Tobacco and Nicotine Use

United Way Community Needs Assessment: Summit & Medina Counties[11]

Priority Areas Identified (Medina County):

- Addiction/Substance Use: Gaps in treatment access and stigma around seeking help.
- Food Insecurity: Struggles with affordability and access to healthy food options.
- Housing: Difficulty finding affordable and available rental options.
- Mental Health: Limited accessibility, high costs, and stigma remain major barriers.

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[10] Medina County Health Department. (2024). *Community Health Assessment.* Medina County Health Department. Retrieved from https://medinahealth.org/community/data-reports/community-health-assessment/

[11] United Way of Summit & Medina County. *Understanding community needs in Summit & Medina counties.* United Way of Summit & Medina County. Retrieved from https://www.uwsummitmedina.org/united-way-of-summit-medina-names-in-summit-medina/

- Transit: Transportation access and affordability limit mobility and access to services.

Primary Data Overview

Community Stakeholder Conversations

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

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

- Alternative Paths
- Cloverleaf High School
- Cleveland Clinic Children's
- Lodi Community Library
- Lodi Family Center
- Lodi Police Department
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Medina BirthCare
- Medina County Health Department

Stakeholder discussions for the Lodi Hospital 2025 Community Health Needs Assessment identified Behavioral Health as one of the most urgent community concerns. Residents described significant barriers to care, including limited availability of behavioral health providers, long wait times, affordability challenges, and a shortage of crisis services. These barriers were viewed as particularly harmful for youth and older adults. Stakeholders emphasized that stigma, lack of culturally responsive care, and limited language access further prevent individuals from seeking support. Youth mental health, including anxiety, depression, and trauma, was consistently raised as an area of increasing concern, reflecting family stress, isolation, and lasting impacts from the COVID-19 pandemic.

Access to Healthcare emerged as another major theme. Participants described financial barriers, transportation challenges, and gaps in service availability that make it difficult for residents to obtain timely, affordable, and continuous care. Even insured residents often struggle with out-of-pocket costs for prescriptions, specialty care, and follow-up visits. Stakeholders noted that reliance on emergency services in place of preventive or primary care remains common, while rural isolation limits options for many residents. Expanded mobile care, telehealth, and co-located service models were suggested as ways to close gaps and better connect people to needed resources.

Chronic Disease Prevention and Management also stood out as a priority. Conditions such as diabetes, heart disease, hypertension, obesity, and cancer remain widespread in the community and are often diagnosed late or managed inconsistently. Stakeholders attributed these outcomes to poor nutrition, limited preventive care, and difficulties maintaining regular follow-up. Older adults and under resourced populations were

highlighted in relation to the long-term impacts of chronic conditions. Participants emphasized the importance of holistic strategies, such as nutrition education, wellness initiatives, chronic disease self-management programs, and accessible screenings to reduce disease burden and improve quality of life.

Within this category, Older Adult Health was frequently raised as a specific concern. Many seniors face unique challenges, including managing multiple chronic illnesses, accessing specialists, and navigating fragmented systems of care. Transportation limitations, fixed incomes, and social isolation exacerbate these issues. Stakeholders called for stronger coordination of senior services, improved access to affordable care, and community-based supports to promote independence, reduce preventable hospitalizations, and enable aging in place.

Finally, stakeholders underscored the role of health-related social needs as underlying drivers of health differences. Poverty, unstable housing, food insecurity, and limited employment opportunities were described as persistent barriers that affect health across the lifespan. Lack of reliable transportation and gaps in community investment were linked to limited access to care and social supports. Participants stressed that lasting improvements require cross-sector collaboration and strategies that address both clinical needs and upstream social and economic conditions. Community-driven and sustainable approaches were seen as essential to building resilience and reducing differences in health outcomes.

The following quotes highlight key themes highlighted in community feedback:

Priority Area	Key Quote	Additional Context
Access to Healthcare	"Transportation is a big issue. If people don't drive, there are very few options for getting to appointments."	Highlights limited transportation as a barrier preventing residents from accessing needed care.
Behavioral Health	"We have a lot of depression, anxiety, and addiction, but people do not always know where to go for help."	Reflects the high need for accessible mental health and substance use disorder services.
Chronic Disease Prevention and Management	"People often wait until it is an emergency before seeking care for diabetes or blood pressure."	Demonstrates delayed care and poor chronic disease management due to barriers in preventive and ongoing care.

Health-Related Social Needs	"Housing is so expensive now, and without stable housing it is hard to focus on health."	Illustrates how economic pressures directly impact the ability to maintain health and access care.

Prioritization Methodology

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

Collaborating Organizations

The fifteen regional hospitals within the Cleveland Clinic health system in Northeast Ohio collaborate to share community health data and resources throughout the CHNA and implementation strategy processes. Lodi Hospital is part of the Cleveland Clinic Southern Submarket which includes Akron General, Lodi, Medina, Mercy, and Union hospitals.

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[12] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services in under resourced areas. In Ohio, the Ohio Association of Community Health Centers (OACHC) represents 57 Community Health Centers operating at over 400 locations, including mobile units,

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

and supports access to care through federal funding and enhanced Medicaid and Medicare reimbursement. Within the Lodi Hospital community, community health services are further supported by local public health agencies, including the Medina County Health Department.

Hospitals

In addition to several Cleveland Clinic hospitals in Northeast Ohio, the University Hospitals Medina facility is also situated within the Lodi Hospital community.

Other Community Resources

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

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

Additional information is available at www.211oh.org.

Comments Received on Previous CHNA

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

Request for Public Comment

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

Appendices Summary

A. Lodi Hospital Community Definition

B. Secondary Data Sources and Analysis

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

C. Environmental Scan and Key Findings

Environmental scan findings from the region comparing significant and prioritized health needs and 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

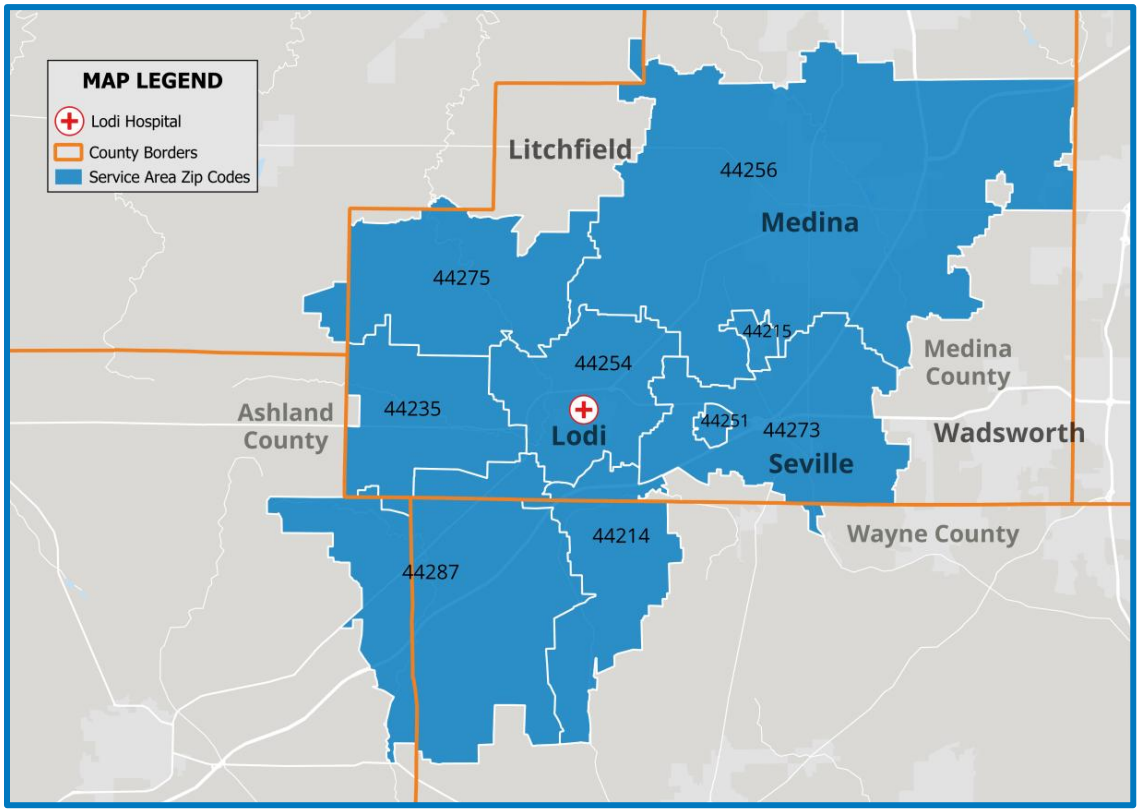
E. Impact Evaluation

F. Acknowledgements

Appendix A: Lodi Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Lodi Hospital Emergency Department discharges originated in 2023. Figure 9 shows the specific geography for the Lodi Hospital community that served as a guide for data collection and analysis for this CHNA.

Figure 9: Lodi Hospital Community Definition



Appendix B: Secondary Data Sources and Analysis

Secondary Data Sources & Analysis

The main source for the secondary data, or data that have been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute (HCI). This database includes more than 300 community indicators from at least 25 state and national data sources. HCI carefully evaluates sources based on the following three criteria: the source has a validated methodology for data collection and analysis; the source has scheduled, regular publication of findings; and the source has data values for small geographic areas or populations.

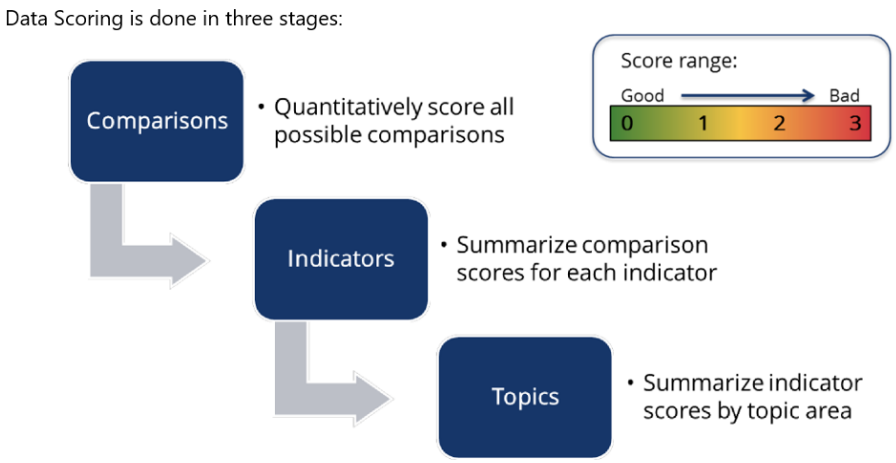
The following is a list of both local and national sources used in the Lodi Hospital Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Feeding America
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Ohio Department of Education
- Ohio Department of Health, Infectious Diseases
- Ohio Department of Health, Vital Statistics
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- Purdue Center for Regional Development
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Census Bureau – Small Area Health Insurance Estimates
- U.S. Environmental Protection Agency
- United for ALICE

Secondary Data Scoring

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

Figure 10: Summary of Topic Scoring Analysis



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

Comparison to a Distribution of County Values: State and Nation

For ease of interpretation and analysis, distribution data for each indicator is visually represented as a green-yellow-red gauge illustrating how the county fares against a distribution of counties across either the state or across the nation. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, and red) based on their order. Counties with the most concerning scores are "in the red" and those with the least concerning scores are "in the green."

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and the target value. Target values are defined by nation-wide Healthy People 2030 (HP2030) goals. HP2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is more or less concerning than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results. A full list of indicators and their scores can be found below.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0 to 3, where a higher score indicates more concerning outcomes. A topic score is only calculated if it includes at least three indicators.

Figure 11: Health and Quality of Life Topic Areas



Topics that received a score of 1.50 or higher were considered a significant health need. Three topics scored at or above this threshold in Medina County (see Tables 2 and 3). The highest scoring health topic was *Other Chronic Conditions* with a score of 1.75.

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 2 and 3 below. The highest scoring health need in Medina County was *Other Chronic Conditions* with a score of 1.75.

Table 2: Health Topic Scores: Medina County

Health Topic	Score
Other Chronic Conditions	1.75
Weight Status	1.62
Physical Activity	1.56
Older Adults	1.32
Mental Health & Mental Disorders	1.24
Oral Health	1.22
Heart Disease & Stroke	1.21
Alcohol & Drug Use	1.17
Maternal, Fetal & Infant Health	1.13
Cancer	1.12
Children's Health	1.06
Women's Health	1.05
Health Care Access & Quality	1.03
Respiratory Diseases	1.01
Diabetes	0.97
Nutrition & Healthy Eating	0.96
Wellness & Lifestyle	0.96
Tobacco Use	0.90

Prevention & Safety	0.87
Mortality Data	0.78
Immunizations & Infectious Diseases	0.77
Sexually Transmitted Infections	0.46

Table 3: Quality of Life Topic Scores: Medina County

Quality of Life Topic	Score
Environmental Health	1.02
Community	1.02
Economy	0.84
Education	0.83

Conduent's SocioNeeds Index Suite®

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

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

Zip Code	CHI Value	FII Value	MHI Value
44214	44.1	30.3	2.5
44215	22.7	15.4	29.9
44235	57.5	28.8	7.4
44251	23.7	6.9	17.9
44254	43.9	52.9	49.9
44256	13.3	32.3	50.6
44273	17.2	13.9	22.4
44275	19.2	11.0	2.1
44287	67.9	31.5	68.9

Census Tract Key

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

Figure 12: Census Tract Key (Lodi Hospital)

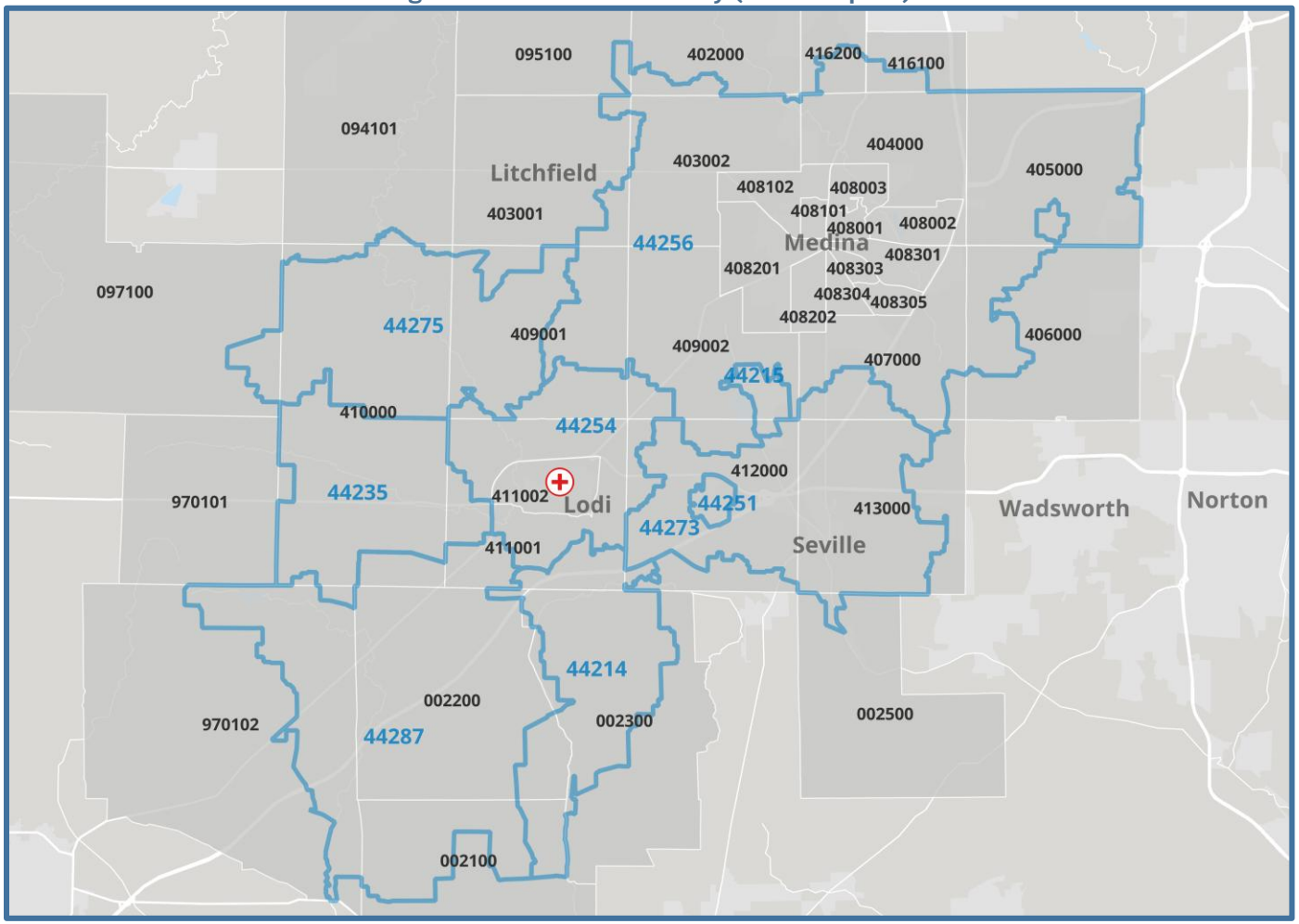


Table 5: Census Tracts by Zip Code (Lodi Hospital)

44214	44215	44235	44251	44254	44256	44273
002100	409002	410000	412000	409001	095100	002500
002200	412000	411001		409002	402000	407000
002300		970102		410000	403001	412000
411001				411001	403002	413000
412000				411002	404000	
				412000	405000	
					406000	
					407000	
					408001	
					408002	
					408003	
					408101	
					408102	
					408201	
					408202	
					408301	
					408303	
					408304	
					408305	
					409001	
					409002	
					412000	
					413000	
					416100	
					416200	
					532301	

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.

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

Indicators of Concern for Prioritized Health Needs

Below are details regarding indicators of concern for all prioritized health needs discussed in this report. Each indicator includes a county-level value and standardized score, as well as the following comparison data, where available: state value, national value, state county distribution, national county distribution, and over-time trend. Table 6 describes how to interpret the icons used to describe county distributions and trend data.

Table 6: Icon Legend

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

Indicators of Concern: Access to Healthcare

The topic *Health Care Access and Quality* was ranked as the thirteenth highest scoring health need, with a score of 1.03 out of 3. Those indicators scoring at or above 1.00 were categorized as indicators of concern and are listed in below.

SCORE	INDICATOR	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
1.79	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	75.5	--	148.7	--			
1.53	Primary Care Provider Rate	*providers/ 100,000 population*	62.3	--	75.3	74.9			
1.32	Adults With Individual Health Insurance	*percent*	20.5	--	20.5	20.2			--
1.32	Mental Health Provider Rate	*providers/ 100,000 population*	190.7	--	349.4	--			
1.24	Dentist Rate	*dentists/ 100,000 population*	55.6	--	65.2	73.5			
1.21	Adults with Health Insurance	*percent*	93.6	--	91.6	89	--		
1.12	Persons without Health Insurance	*percent*	4.4	--	6.1	7.9	--	--	
1.09	Children with Health Insurance	*percent*	96.8	--	95.1	94.6	--		
1.06	Adults who have had a Routine Checkup	*percent*	79	--	--	76.1			--

Indicators of Concern: Behavioral Health

The prioritized health topic *Behavioral Health* was captured under three health topic areas: *Mental Health and Mental Disorders*, *Alcohol and Drug Use*, and *Tobacco Use*. The most concerning of these topics was *Mental Health and Mental Disorders* (1.24), followed by *Alcohol and Drug Use* (Score: 1.17), and the least concerning was *Tobacco Use* (0.90). Indicators from these three topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed below.

SCORE	INDICATOR	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.29	Adults who Binge Drink	*percent*	19.8	--	--	16.6			--
2.26	Adults who Drink Excessively	*percent*	23.1	--	21.2	--			
1.68	Depression: Medicare Population	*percent*	18	--	18	17			--
1.65	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	34.6	--	33.8	--		--	
1.59	Adults Ever Diagnosed with Depression	*percent*	24.8	--	--	20.7			--
1.41	Adults who Smoke	*percent*	17	6.1	--	12.9			--
1.41	Tobacco Use: Medicare Population	*percent*	7	--	7	6		--	--
1.38	Poor Mental Health: Average Number of Days	*days*	5.7	--	6.1	--			
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6	--	6	6			--
1.32	Mental Health Provider Rate	*providers/ 100,000 population*	190.7	--	349.4	--			
1.24	Poor Mental Health: 14+ Days	*percent*	16.9	--	--	15.8			--
1.09	Mothers who Smoked During Pregnancy	*percent*	4.1	4.3	7.9	3.7		--	

Indicators of Concern: Chronic Disease Prevention and Management

The prioritized health topic *Chronic Disease Prevention and Management* was captured under the following health topics: *Nutrition and Healthy Eating*, *Wellness and Lifestyle*, *Cancer*, *Diabetes*, *Heart Disease and Stroke*, *Other Chronic Conditions*, and *Older Adults*. The most concerning of these topics was *Other Chronic Conditions* (Score: 1.75), followed by *Older Adults* (1.32), *Heart Disease and Stroke* (1.21), *Cancer* (1.12), *Diabetes* (0.97), *and* the least concerning topics were *Wellness and Lifestyle* (0.96) and *Nutrition and Healthy Eating* (0.96). Indicators from these seven topic areas which scored at or above 1.70 were categorized as indicators of concern and are listed below.

SCORE	INDICATOR	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.56	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	136.4	--	118.1	113.2			
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	17.2	--	12.1	--		--	
2.35	Breast Cancer Incidence Rate	*cases/ 100,000 females*	139.2	--	132.3	129.8			
2.35	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.3	--	12.8	12			
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20	--	19	18			--
2.03	All Cancer Incidence Rate	*cases/ 100,000 population*	489.1	--	470	444.4			
1.94	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.2	--	15.1	--		--	
1.85	Stroke: Medicare Population	*percent*	6	--	5	6			--
1.85	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	39	--	39	36			--
1.85	Hyperlipidemia: Medicare Population	*percent*	69	--	67	66			--
1.76	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.3	--	--	8.2			--

1.76	Adults who Have Taken Medications for High Blood Pressure	*percent*	79.3	--	--	78.2			--
1.68	Depression: Medicare Population	*percent*	18	--	18	17			--
1.65	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	34.6	--	33.8	--		--	
1.65	People 65+ Living Alone (Count)	*people*	8358	--	--	--	--	--	
1.65	People 65+ Living Below Poverty Level (Count)	*people*	1986	--	--	--	--	--	
1.59	Adults who Experienced Coronary Heart Disease	*percent*	8.4	--	--	6.8			--
1.50	Osteoporosis: Medicare Population	*percent*	11	--	11	12			--
1.50	Asthma: Medicare Population	*percent*	7	--	7	7			--
1.50	Cancer: Medicare Population	*percent*	12	--	12	12			--

Indicators of Concern: Health-Related Social Needs

The prioritized health topic *Health-Related Social Needs* was captured under the quality of life topics *Community, Economy,* and Education, as well as the health topic *Prevention and Safety*. The topic *Prevention and Safety* was the nineteenth highest scoring health topic with a score of 0.87. The most concerning quality of life topic was *Community* (Score: 1.02), followed by *Economy* (0.84), and the least concerning topic was *Education* (0.83). Indicators from these four health and quality of life topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed below.

SCORE	INDICATOR	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	638	--	570	612			
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	17.2	--	12.1	--		--	
2.47	Median Household Gross Rent	*dollars*	1090	--	988	1348			
2.47	Mortgaged Owners Median Monthly Household Costs	*dollars*	1681	--	1472	1902			
2.41	Workers who Walk to Work	*percent*	1	--	2	2.4			
2.35	Workers Commuting by Public Transportation	*percent*	0.1	5.3	1.1	3.5		--	
2.29	Gender Pay Gap	*cents on the dollar*	0.6	--	0.7	0.8	--		
2.26	Social Associations	*membership associations/ 10,000 population*	8.4	--	10.8	--			
2.15	Solo Drivers with a Long Commute	*percent*	42.9	--	30.5	--			
2.06	Student-to-Teacher Ratio	*students/ teacher*	17.8	--	16.6	15.2			

2.00	Veterans with a High School Diploma or Higher	*percent*	92.9	--	94.4	95.2			
2.00	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.8	8.7	6.9	--		--	
1.88	Mean Travel Time to Work	*minutes*	26.8	--	23.6	26.6			
1.88	Households with Student Loan Debt	*percent*	9.5	--	9.1	9.8			
1.74	Grandparents Who Are Responsible for Their Grandchildren	*percent*	39.8	--	41.3	32		--	
1.65	People 65+ Living Alone (Count)	*people*	8358	--	--	--	--	--	
1.65	People 65+ Living Below Poverty Level (Count)	*people*	1986	--	--	--	--	--	
1.59	Renters Spending 30% or More of Household Income on Rent	*percent*	43.7	25.5	45.1	50.4			
1.59	Child Care Centers	*per 1,000 population under age 5*	7.6	--	8	7		--	--
1.50	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	24.5	--	25	29.4		--	

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 7 below as a reference key for indicator data sources.

Table 7: 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 8: All Medina County Secondary Data Indicators

SCORE	ALCOHOL & DRUG USE	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Adults who Binge Drink	*percent*	19.8			16.6	*2022*	5
2.26	Adults who Drink Excessively	*percent*	23.1		21.2		*2022*	10
1.09	Mothers who Smoked During Pregnancy	*percent*	4.1	4.3	7.9	3.7	*2022*	17
0.79	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	21.3		40.4	23.5	*2018-2020*	6
0.71	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	19	20.7	44.7		*2020-2022*	10
0.59	Liquor Store Density	*stores/ 100,000 population*	2.7		5.6	10.9	*2022*	23
0.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	23.6		32.1		*2018-2022*	10

SCORE	CANCER	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	136.4		118.1	113.2	*2017-2021*	12
2.35	Breast Cancer Incidence Rate	*cases/ 100,000 females*	139.2		132.3	129.8	*2017-2021*	12
2.35	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.3		12.8	12	*2017-2021*	12
2.03	All Cancer Incidence Rate	*cases/ 100,000 population*	489.1		470	444.4	*2017-2021*	12

1.76	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.3			8.2	*2022*	5
1.50	Cancer: Medicare Population	*percent*	12		12	12	*2023*	7
1.38	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7.1		7.8	7.5	*2017-2021*	12
1.06	Mammogram in Past 2 Years: 50-74	*percent*	76.6	80.3		76.5	*2022*	5
1.00	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	36.9		38.9	36.4	*2017-2021*	12
0.88	Cervical Cancer Screening: 21-65	*Percent*	84.8			82.8	*2020*	5
0.88	Colon Cancer Screening: USPSTF Recommendation	*percent*	68.4			66.3	*2022*	5
0.82	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	56.8		64.3	53.1	*2017-2021*	12
0.62	Mammography Screening: Medicare Population	*percent*	52		51	39	*2023*	7
0.53	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	32.8	25.1	39.8	32.4	*2018-2022*	12
0.29	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	16.7	16.9	19.3	19	*2018-2022*	12
0.18	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	139.9	122.7	161.1	146	*2018-2022*	12
0.00	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	14.3	15.3	20.2	19.3	*2018-2022*	12

SCORE	CHILDREN'S HEALTH	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.00	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.8	8.7	6.9		*2021*	4

1.59	Child Care Centers	*per 1,000 population under age 5*	7.6		8	7	*2022*	10
1.12	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.3		1.9		*2022*	19
1.09	Children with Health Insurance	*percent*	96.8		95.1	94.6	*2023*	1
0.71	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	32.4		59.2		*2019-2022*	10
0.59	Child Food Insecurity Rate	*percent*	12.3		20.1	18.4	*2023*	11
0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.4		3.2	3.3	*2025*	9

SCORE	COMMUNITY	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	638		570	612	*2019-2023*	2
2.47	Median Household Gross Rent	*dollars*	1090		988	1348	*2019-2023*	2
2.47	Mortgaged Owners Median Monthly Household Costs	*dollars*	1681		1472	1902	*2019-2023*	2
2.41	Workers who Walk to Work	*percent*	1		2	2.4	*2019-2023*	2
2.35	Workers Commuting by Public Transportation	*percent*	0.1	5.3	1.1	3.5	*2019-2023*	2
2.26	Social Associations	*membership associations/ 10,000 population*	8.4		10.8		*2022*	10

2.15	Solo Drivers with a Long Commute	*percent*	42.9		30.5		*2019-2023*	10
2.00	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.8	8.7	6.9		*2021*	4
1.88	Mean Travel Time to Work	*minutes*	26.8		23.6	26.6	*2019-2023*	2
1.74	Grandparents Who Are Responsible for Their Grandchildren	*percent*	39.8		41.3	32	*2019-2023*	2
1.65	People 65+ Living Alone (Count)	*people*	8358				*2019-2023*	2
1.41	Linguistic Isolation	*percent*	0.8		1.5	4.2	*2019-2023*	2
1.41	Workers who Drive Alone to Work	*percent*	78.5		76.6	70.2	*2019-2023*	2
1.32	Adults With Individual Health Insurance	*percent*	20.5		20.5	20.2	*2024*	8
1.24	Residential Segregation - Black/White	*Score*	56.1		69.6		*2025*	10
1.18	Total Employment Change	*percent*	4.1		2.9	5.8	*2021-2022*	23
1.12	Violent Crime Rate	*crimes/ 100,000 population*	79		331		*2024*	18
0.97	Digital Distress		1				*2022*	21
0.97	Social Vulnerability Index	*Score*	0				*2022*	6
0.94	Adults with Internet Access	*percent*	84.1		80.9	81.3	*2024*	8
0.94	Female Population 16+ in Civilian Labor Force	*percent*	61.2		59.2	58.7	*2019-2023*	2
0.94	People 25+ with a High School Diploma or Higher	*percent*	94.5		91.6	89.4	*2019-2023*	2
0.94	Population 16+ in Civilian Labor Force	*percent*	64.6		60.1	59.8	*2019-2023*	2

0.88	Persons with Health Insurance	*percent*	94	92.4	92.9		*2022*	24
0.82	Voter Turnout: Presidential Election	*percent*	80.5	58.4	71.7		*2024*	20
0.79	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	88.2		84.9	85.1	*2024*	8
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	7.5		11.1		*2016-2022*	10
0.65	Households with a Computer	*percent*	89.1		85.2	86	*2024*	8
0.65	Households with One or More Types of Computing Devices	*percent*	95.7		93.6	94.8	*2019-2023*	2
0.65	Persons with an Internet Subscription	*percent*	93.7		91.3	92	*2019-2023*	2
0.59	People Living Below Poverty Level	*percent*	6.1	8	13.2	12.4	*2019-2023*	2
0.59	Young Children Living Below Poverty Level	*percent*	8.9		20	17.6	*2019-2023*	2
0.47	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	5.8		7.4	7.1	*2025*	9
0.47	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	2.8		3.3	3.1	*2025*	9
0.44	Adults With Group Health Insurance	*percent*	44.5		37.4	39.8	*2024*	8
0.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	23.6		32.1		*2018-2022*	10
0.44	Broadband Quality Score	*BQS Score*	64.9		53.4	50	*2022*	21

0.44	Children in Single-Parent Households	*percent*	15.1		26.1	24.8	*2019-2023*	2
0.44	Children Living Below Poverty Level	*percent*	7.4		18	16.3	*2019-2023*	2
0.44	Digital Divide Index	*DDI Score*	11.1		40.1	50	*2022*	21
0.44	People 65+ Living Alone	*percent*	23.7		30.2	26.5	*2019-2023*	2
0.35	Households with a Smartphone	*percent*	89.5		87.5	88.2	*2024*	8
0.35	Households with an Internet Subscription	*percent*	91.8		89	89.9	*2019-2023*	2
0.35	Youth not in School or Working	*percent*	0.9		1.7	1.7	*2019-2023*	2
0.29	Adult Day Care Spending-to-Income Ratio	*percent*	8.3		11.1	11.9	*2025*	9
0.26	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	8.2	10.7	13.5	12	*2018-2020*	6
0.18	People 25+ with a Bachelor's Degree or Higher	*percent*	36.2		30.9	35	*2019-2023*	2
0.18	Per Capita Income	*dollars*	46652		39455	43289	*2019-2023*	2
0.00	Median Household Income	*dollars*	92660		69680	78538	*2019-2023*	2

SCORE	DIABETES	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.12	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	19.8		28.4		*2020-2022*	19
0.97	Diabetes: Medicare Population	*percent*	23		25	24	*2023*	7
0.82	Adults 20+ with Diabetes	*percent*	7.4				*2021*	6

SCORE	ECONOMY	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source

2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	638		570	612	*2019-2023*	2
2.47	Median Household Gross Rent	*dollars*	1090		988	1348	*2019-2023*	2
2.47	Mortgaged Owners Median Monthly Household Costs	*dollars*	1681		1472	1902	*2019-2023*	2
2.29	Gender Pay Gap	*cents on the dollar*	0.6		0.7	0.8	*2023*	1
1.88	Households with Student Loan Debt	*percent*	9.5		9.1	9.8	*2024*	8
1.65	People 65+ Living Below Poverty Level (Count)	*people*	1986				*2019-2023*	2
1.59	Renters Spending 30% or More of Household Income on Rent	*percent*	43.7	25.5	45.1	50.4	*2019-2023*	2
1.50	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	24.5		25	29.4	*2023*	26
1.35	Size of Labor Force	*persons*	98842				*45748*	22
1.29	Unemployed Veterans	*percent*	2.5		2.8	3.2	*2019-2023*	2
1.24	Residential Segregation - Black/White	*Score*	56.1		69.6		*2025*	10
1.18	Homeowner Spending-to-Income Ratio	*percent*	12.4		14.3	13.5	*2025*	9
1.18	Total Employment Change	*percent*	4.1		2.9	5.8	*2021-2022*	23
1.15	Households Living Below Poverty Level	*percent*	7.6		13.5	12.7	*2023*	26
1.15	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	67.9		61.5	58	*2023*	26

1.03	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.9	25.5	21.2	28.5	*2023*	1
0.94	Female Population 16+ in Civilian Labor Force	*percent*	61.2		59.2	58.7	*2019-2023*	2
0.94	Population 16+ in Civilian Labor Force	*percent*	64.6		60.1	59.8	*2019-2023*	2
0.94	Unemployed Workers in Civilian Labor Force	*percent*	4.3		5.4	4.5	*April 2025*	22
0.88	Children Living Below 200% of Poverty Level	*percent*	28.3		38.3	36.1	*2023*	1
0.85	Families Living Below 200% of Poverty Level	*Percent*	14.1		22.8	22.3	*2023*	1
0.85	People 65+ Living Below 200% of Poverty Level	*percent*	19.8		28.4	28.1	*2023*	1
0.85	People Living Below 200% of Poverty Level	*percent*	20.5		29.6	28.2	*2023*	1
0.82	Health Insurance Spending-to-Income Ratio	*percent*	6		6.6	5.9	*2025*	9
0.79	Adults who Feel Overwhelmed by Financial Burdens	*percent*	31.2		34	33.6	*2024*	8
0.79	Income Inequality		0.4		0.5	0.5	*2019-2023*	2
0.76	Households with Cash Public Assistance Income	*percent*	1.5		2.5	2.7	*2019-2023*	2
0.65	Households with a Savings Account	*percent*	76.7		70.9	72	*2024*	8
0.62	Students Eligible for the Free Lunch Program	*percent*	21.3		23.6	43.6	*2023-2024*	13
0.59	Child Food Insecurity Rate	*percent*	12.3		20.1	18.4	*2023*	11
0.59	Families Living Below Poverty Level	*percent*	4		9.2	8.7	*2019-2023*	2
0.59	Food Insecurity Rate	*percent*	12.1		15.3	14.5	*2023*	11

0.59	People 65+ Living Below Poverty Level	*percent*	5.8		9.5	10.4	*2019-2023*	2
0.59	People Living Below Poverty Level	*percent*	6.1	8	13.2	12.4	*2019-2023*	2
0.59	Veterans Living Below Poverty Level	*percent*	4.3		7.4	7.2	*2019-2023*	2
0.59	Young Children Living Below Poverty Level	*percent*	8.9		20	17.6	*2019-2023*	2
0.47	Cigarette Spending-to-Income Ratio	*percent*	1.8		2.1	1.9	*2025*	9
0.47	College Tuition Spending-to-Income Ratio	*percent*	9.9		12.6	11.9	*2025*	9
0.47	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	5.8		7.4	7.1	*2025*	9
0.47	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	2.8		3.3	3.1	*2025*	9
0.47	Home Renter Spending-to-Income Ratio	*percent*	12.5		16.3	17	*2025*	9
0.47	Utilities Spending-to-Income Ratio	*percent*	5.2		6.1	5.6	*2025*	9
0.44	Children Living Below Poverty Level	*percent*	7.4		18	16.3	*2019-2023*	2
0.44	Severe Housing Problems	*percent*	9.4		12.7		*2017-2021*	10
0.35	Youth not in School or Working	*percent*	0.9		1.7	1.7	*2019-2023*	2
0.29	Adult Day Care Spending-to-Income Ratio	*percent*	8.3		11.1	11.9	*2025*	9
0.29	Adults with Disability Living in Poverty	*percent*	13.2		28.2	24.6	*2019-2023*	2
0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.4		3.2	3.3	*2025*	9

0.29	Homeowner Vacancy Rate	*percent*	0.3		0.9	1	*2019-2023*	2
0.29	Households with a 401k Plan	*percent*	45.1		38.4	40.8	*2024*	8
0.29	Overcrowded Households	*percent*	0.8		1.4	3.4	*2019-2023*	2
0.29	Student Loan Spending-to-Income Ratio	*percent*	3.5		4.6	4.5	*2025*	9
0.29	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.2		1.6	1.5	*2025*	9
0.18	Median Household Income: Householders 65+	*dollars*	60602		51608	57108	*2019-2023*	2
0.18	Per Capita Income	*dollars*	46652		39455	43289	*2019-2023*	2
0.00	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	1.6		2	2	*2024*	8
0.00	Median Household Income	*dollars*	92660		69680	78538	*2019-2023*	2

SCORE	EDUCATION	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.06	Student-to-Teacher Ratio	*students/ teacher*	17.8		16.6	15.2	*2023-2024*	13
2.00	Veterans with a High School Diploma or Higher	*percent*	92.9		94.4	95.2	*2019-2023*	2
1.59	Child Care Centers	*per 1,000 population under age 5*	7.6		8	7	*2022*	10
1.00	High School Graduation	*percent*	97.5	90.7	92.5		*2022-2023*	15
0.97	8th Grade Students Proficient in English/Language Arts	*percent*	68.6		49.4		*2023-2024*	15
0.94	People 25+ with a High School Diploma or Higher	*percent*	94.5		91.6	89.4	*2019-2023*	2

0.82	4th Grade Students Proficient in English/Language Arts	*percent*	79.1		64.1		*2023-2024*	15
0.53	4th Grade Students Proficient in Math	*percent*	83.9		67.2		*2023-2024*	15
0.53	8th Grade Students Proficient in Math	*percent*	65		46.3		*2023-2024*	15
0.47	College Tuition Spending-to-Income Ratio	*percent*	9.9		12.6	11.9	*2025*	9
0.47	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	5.8		7.4	7.1	*2025*	9
0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.4		3.2	3.3	*2025*	9
0.29	Student Loan Spending-to-Income Ratio	*percent*	3.5		4.6	4.5	*2025*	9
0.29	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.2		1.6	1.5	*2025*	9
0.18	People 25+ with a Bachelor's Degree or Higher	*percent*	36.2		30.9	35	*2019-2023*	2

SCORE	ENVIRONMENTAL HEALTH	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Daily Dose of UV Irradiance	*Joule per square meter*	3665		3384		*2020*	14
1.74	Annual Particle Pollution	*grade*	D				*2021-2023*	3
1.65	Weeks of Moderate Drought or Worse	*weeks per year*	2				*2021*	14
1.59	Proximity to Highways	*percent*	5.5		7.2		*2020*	14
1.56	Annual Ozone Air Quality	*grade*	C				*2021-2023*	3
1.50	Asthma: Medicare Population	*percent*	7		7	7	*2023*	7
1.35	Number of Extreme Heat Days	*days*	15				*2023*	14

1.35	Number of Extreme Heat Events	*events*	11			*2023*	14
1.35	Recognized Carcinogens Released into Air	*pounds*	82			*2023*	25
1.24	Access to Parks	*percent*	53.5	59.6		*2020*	14
1.24	Adults with Current Asthma	*percent*	10.5		9.9	*2022*	5
1.12	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.3	1.9		*2022*	19
1.06	Number of Extreme Precipitation Days	*days*	3			*2023*	14
0.97	Social Vulnerability Index	*Score*	0			*2022*	6
0.85	Food Environment Index		8.6	7		*2025*	10
0.71	Access to Exercise Opportunities	*percent*	92.7	84.2		*2025*	10
0.71	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	6.5	7.9		*2020*	10
0.59	Liquor Store Density	*stores/ 100,000 population*	2.7	5.6	10.9	*2022*	23
0.47	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	2.8	3.3	3.1	*2025*	9
0.47	Utilities Spending-to-Income Ratio	*percent*	5.2	6.1	5.6	*2025*	9
0.44	Broadband Quality Score	*BQS Score*	64.9	53.4	50	*2022*	21
0.44	Digital Divide Index	*DDI Score*	11.1	40.1	50	*2022*	21
0.44	Severe Housing Problems	*percent*	9.4	12.7		*2017-2021*	10
0.29	Overcrowded Households	*percent*	0.8	1.4	3.4	*2019-2023*	2
0.18	Houses Built Prior to 1950	*percent*	10.5	24.9	16.4	*2019-2023*	2

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.79	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	75.5		148.7		*2024*	10
1.53	Primary Care Provider Rate	*providers/ 100,000 population*	62.3		75.3	74.9	*2021*	10
1.32	Adults With Individual Health Insurance	*percent*	20.5		20.5	20.2	*2024*	8
1.32	Mental Health Provider Rate	*providers/ 100,000 population*	190.7		349.4		*2024*	10
1.24	Dentist Rate	*dentists/ 100,000 population*	55.6		65.2	73.5	*2022*	10
1.21	Adults with Health Insurance	*percent*	93.6		91.6	89	*2023*	1
1.12	Persons without Health Insurance	*percent*	4.4		6.1	7.9	*2023*	1
1.09	Children with Health Insurance	*percent*	96.8		95.1	94.6	*2023*	1
1.06	Adults who have had a Routine Checkup	*percent*	79			76.1	*2022*	5
0.94	Adults with Health Insurance: 18+	*percent*	79.5		74.7	75.2	*2024*	8
0.88	Persons with Health Insurance	*percent*	94	92.4	92.9		*2022*	24
0.82	Health Insurance Spending-to-Income Ratio	*percent*	6		6.6	5.9	*2025*	9
0.79	Adults who go to the Doctor Regularly for Checkups	*percent*	69		65.2	65.1	*2024*	8
0.71	Adults without Health Insurance	*percent*	4.3			10.8	*2022*	5
0.62	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000*	2377		3269	2769	*2023*	7

		Medicare enrollees						
0.59	Adults who Visited a Dentist	*percent*	50.1		44.3	45.3	*2024*	8
0.44	Adults With Group Health Insurance	*percent*	44.5		37.4	39.8	*2024*	8

SCORE	HEART DISEASE & STROKE	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.85	Hyperlipidemia: Medicare Population	*percent*	69		67	66	*2023*	7
1.85	Stroke: Medicare Population	*percent*	6		5	6	*2023*	7
1.76	Adults who Have Taken Medications for High Blood Pressure	*percent*	79.3			78.2	*2021*	5
1.59	Adults who Experienced Coronary Heart Disease	*percent*	8.4			6.8	*2022*	5
1.32	Atrial Fibrillation: Medicare Population	*percent*	15		15	14	*2023*	7
1.24	Adults who Experienced a Stroke	*percent*	3.7			3.6	*2022*	5
1.15	Hypertension: Medicare Population	*percent*	66		67	65	*2023*	7
1.12	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	85.1	71.1	101.6		*2020-2022*	19
1.06	Cholesterol Test History	*percent*	86.1			86.4	*2021*	5
1.06	High Blood Pressure Prevalence	*percent*	33.2	41.9		32.7	*2021*	5
0.97	Heart Failure: Medicare Population	*percent*	11		12	11	*2023*	7
0.97	Ischemic Heart Disease: Medicare Population	*percent*	21		22	21	*2023*	7

0.88	High Cholesterol Prevalence	*percent*	33.7			35.5	*2021*	5
0.82	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	34.9	33.4	46		*2020-2022*	19
0.56	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	44.6		60.9		*2021*	14

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.00	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	16.3	11.5	13.8		*2023*	16
1.38	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7.1		7.8	7.5	*2017-2021*	12
0.97	Pneumonia Vaccinations: Medicare Population	*percent*	9		9	9	*2023*	7
0.85	Syphilis Incidence Rate	*cases/ 100,000 population*	2.7		16.4	15.8	*2023*	16
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	62.6		59.8	60.4	*2024*	8
0.62	Flu Vaccinations: Medicare Population	*percent*	53		50	3	*2023*	7
0.56	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.6	2.9	*2023*	16
0.53	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	6.5		12.3		*2020-2022*	19
0.29	Overcrowded Households	*percent*	0.8		1.4	3.4	*2019-2023*	2
0.26	Chlamydia Incidence Rate	*cases/ 100,000 population*	147.1		464.2	492.2	*2023*	16

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.56	Mothers who Received Early Prenatal Care	*percent*	70.8		68.6	75.3	*2022*	17
1.47	Preterm Births	*percent*	9.9	9.4	10.8		*2022*	17
1.29	Babies with Very Low Birthweight	*percent*	1.1		1.5		*2022*	17
1.09	Mothers who Smoked During Pregnancy	*percent*	4.1	4.3	7.9	3.7	*2022*	17
1.03	Infant Mortality Rate	*deaths/ 1,000 live births*	4.4	5	6.7	5.4	*2020*	17
0.88	Babies with Low Birthweight	*percent*	7.3		8.7	8.6	*2022*	17
0.56	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	0.3		6.1	5.6	*2022*	17

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.68	Depression: Medicare Population	*percent*	18		18	17	*2023*	7
1.65	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	34.6		33.8		*2020-2022*	19
1.59	Adults Ever Diagnosed with Depression	*percent*	24.8			20.7	*2022*	5
1.38	Poor Mental Health: Average Number of Days	*days*	5.7		6.1		*2022*	10
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6		6	6	*2023*	7
1.32	Mental Health Provider Rate	*providers/ 100,000 population*	190.7		349.4		*2024*	10
1.24	Poor Mental Health: 14+ Days	*percent*	16.9			15.8	*2022*	5

0.94	Self-Reported General Health Assessment: Good or Better	*percent*	88.2		85.4	86	*2024*	8
0.79	Adults who Feel Life is Slipping Out of Control	*Percent*	22.2		24.1	23.9	*2024*	8
0.53	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	11.5	12.8	14.5		*2020-2022*	19

SCORE	NUTRITION & HEALTHY EATING	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.15	Adults who Frequently Cook Meals at Home	*Percent*	69.7		67.6	67.7	*2024*	8
1.06	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	36.1		38.1	38.2	*2024*	8
0.85	Food Environment Index		8.6		7		*2025*	10
0.79	Adults who Drank Soft Drinks: Past 7 Days	*percent*	46.2		48.6	47.5	*2024*	8

SCORE	OLDER ADULTS	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	136.4		118.1	113.2	*2017-2021*	12
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	17.2		12.1		*2020-2022*	19
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20		19	18	*2023*	7
1.85	Hyperlipidemia: Medicare Population	*percent*	69		67	66	*2023*	7
1.85	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	39		39	36	*2023*	7

1.85	Stroke: Medicare Population	*percent*	6	5	6	*2023*	7
1.68	Depression: Medicare Population	*percent*	18	18	17	*2023*	7
1.65	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	34.6	33.8		*2020-2022*	19
1.65	People 65+ Living Alone (Count)	*people*	8358			*2019-2023*	2
1.65	People 65+ Living Below Poverty Level (Count)	*people*	1986			*2019-2023*	2
1.50	Asthma: Medicare Population	*percent*	7	7	7	*2023*	7
1.50	Cancer: Medicare Population	*percent*	12	12	12	*2023*	7
1.50	Osteoporosis: Medicare Population	*percent*	11	11	12	*2023*	7
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6	6	6	*2023*	7
1.32	Atrial Fibrillation: Medicare Population	*percent*	15	15	14	*2023*	7
1.15	COPD: Medicare Population	*percent*	12	13	11	*2023*	7
1.15	Hypertension: Medicare Population	*percent*	66	67	65	*2023*	7
0.97	Diabetes: Medicare Population	*percent*	23	25	24	*2023*	7
0.97	Heart Failure: Medicare Population	*percent*	11	12	11	*2023*	7
0.97	Ischemic Heart Disease: Medicare Population	*percent*	21	22	21	*2023*	7
0.71	Adults 65+ with Total Tooth Loss	*percent*	9.9		12.2	*2022*	5
0.62	Mammography Screening: Medicare Population	*percent*	52	51	39	*2023*	7
0.59	People 65+ Living Below Poverty Level	*percent*	5.8	9.5	10.4	*2019-2023*	2

0.44	People 65+ Living Alone	*percent*	23.7		30.2	26.5	*2019-2023*	2
0.29	Adult Day Care Spending-to-Income Ratio	*percent*	8.3		11.1	11.9	*2025*	9
0.18	Median Household Income: Householders 65+	*dollars*	60602		51608	57108	*2019-2023*	2

SCORE	ORAL HEALTH	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.3		12.8	12	*2017-2021*	12
1.24	Dentist Rate	*dentists/ 100,000 population*	55.6		65.2	73.5	*2022*	10
0.71	Adults 65+ with Total Tooth Loss	*percent*	9.9			12.2	*2022*	5
0.59	Adults who Visited a Dentist	*percent*	50.1		44.3	45.3	*2024*	8

SCORE	OTHER CHRONIC CONDITIONS	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.03	Chronic Kidney Disease: Medicare Population	*percent*	20		19	18	*2023*	7
1.94	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.2		15.1		*2020-2022*	19
1.85	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	39		39	36	*2023*	7
1.50	Osteoporosis: Medicare Population	*percent*	11		11	12	*2023*	7
1.41	Adults with Arthritis	*percent*	30.4			26.6	*2022*	5

SCORE	PHYSICAL ACTIVITY	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.41	Workers who Walk to Work	*percent*	1		2	2.4	*2019-2023*	2
2.12	Adults 20+ Who Are Obese	*percent*	34.4	36			*2021*	6
1.32	Adults 20+ who are Sedentary	*percent*	20.2				*2021*	6
1.24	Access to Parks	*percent*	53.5		59.6		*2020*	14
0.71	Access to Exercise Opportunities	*percent*	92.7		84.2		*2025*	10

SCORE	PREVENTION & SAFETY	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	17.2		12.1		*2020-2022*	19
0.82	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	21		46.5		*2020-2022*	19
0.71	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	19	20.7	44.7		*2020-2022*	10
0.71	Death Rate due to Injuries	*deaths/ 100,000 population*	68.6		100.7		*2018-2022*	10
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	7.5		11.1		*2016-2022*	10
0.44	Severe Housing Problems	*percent*	9.4		12.7		*2017-2021*	10
0.26	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	8.2	10.7	13.5	12	*2018-2020*	6

SCORE	RESPIRATORY DISEASES	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.76	Adults with COPD	*Percent of adults*	9.4			6.8	*2022*	5
1.59	Proximity to Highways	*percent*	5.5		7.2		*2020*	14
1.50	Asthma: Medicare Population	*percent*	7		7	7	*2023*	7
1.41	Adults who Smoke	*percent*	17	6.1		12.9	*2022*	5
1.24	Adults with Current Asthma	*percent*	10.5			9.9	*2022*	5
1.15	COPD: Medicare Population	*percent*	12		13	11	*2023*	7
0.82	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.7		1.7	1.6	*2024*	8
0.82	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	35.3		42.8		*2020-2022*	19
0.82	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	56.8		64.3	53.1	*2017-2021*	12
0.56	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.6	2.9	*2023*	16
0.53	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	6.5		12.3		*2020-2022*	19
0.53	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	32.8	25.1	39.8	32.4	*2018-2022*	12
0.44	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	5.8		6.9	6.8	*2024*	8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
0.85	Syphilis Incidence Rate	*cases/ 100,000 population*	2.7		16.4	15.8	*2023*	16
0.26	Chlamydia Incidence Rate	*cases/ 100,000 population*	147.1		464.2	492.2	*2023*	16

0.26	Gonorrhea Incidence Rate	*cases/ 100,000 population*	25.6		168.8	179.5	*2023*	16

SCORE	TOBACCO USE	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.41	Adults who Smoke	*percent*	17	6.1		12.9	*2022*	5
1.41	Tobacco Use: Medicare Population	*percent*	7		7	6	*2023*	7
0.82	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.7		1.7	1.6	*2024*	8
0.82	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	56.8		64.3	53.1	*2017-2021*	12
0.47	Cigarette Spending-to-Income Ratio	*percent*	1.8		2.1	1.9	*2025*	9
0.44	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	5.8		6.9	6.8	*2024*	8

SCORE	WEIGHT STATUS	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.12	Adults 20+ Who Are Obese	*percent*	34.4	36			*2021*	6
1.94	Obesity: Medicare Population	*percent*	27		25	20	*2023*	7
0.79	Adults Happy with Weight	*Percent*	43.5		42.1	42.6	*2024*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	MEDINA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.24	Poor Physical Health: 14+ Days	*percent*	13.4			12.7	*2022*	5
1.15	Adults who Frequently Cook Meals at Home	*Percent*	69.7		67.6	67.7	*2024*	8

1.06	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	36.1		38.1	38.2	*2024*	8
1.06	High Blood Pressure Prevalence	*percent*	33.2	41.9		32.7	*2021*	5
1.06	Insufficient Sleep	*percent*	35.1	26.7		36	*2022*	5
0.94	Self-Reported General Health Assessment: Good or Better	*percent*	88.2		85.4	86	*2024*	8
0.88	Life Expectancy	*years*	79		75.2		*2020-2022*	10
0.88	Self-Reported General Health Assessment: Poor or Fair	*percent*	17.3			17.9	*2022*	5
0.85	Poor Physical Health: Average Number of Days	*days*	3.8		4.3		*2022*	10
0.79	Adults Happy with Weight	*Percent*	43.5		42.1	42.6	*2024*	8
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	62.6		59.8	60.4	*2024*	8
0.79	Adults who Feel Life is Slipping Out of Control	*Percent*	22.2		24.1	23.9	*2024*	8

SCORE	**WOMEN'S HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**OH**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.35	Breast Cancer Incidence Rate	*cases/ 100,000 females*	139.2		132.3	129.8	*2017-2021*	12
1.38	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7.1		7.8	7.5	*2017-2021*	12
1.06	Mammogram in Past 2 Years: 50-74	*percent*	76.6	80.3		76.5	*2022*	5
0.88	Cervical Cancer Screening: 21-65	*Percent*	84.8			82.8	*2020*	5
0.62	Mammography Screening: Medicare Population	*percent*	52		51	39	*2023*	7

Additional Demographic Data

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

Table 9: Population Size of Hospital Community by Zip Code

Zip Code	Population
44214	2137
44215	2187
44235	1761
44251	879
44254	4739
44256	66016
44273	7021
44275	3163
44287	7914
44214	2137
Lodi Hospital Community (Total)	95817

Table 10: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Lodi Hospital Community	Ohio
0-4	5.2%	5.6%
5-9	5.4%	5.7%
10-14	6.3%	6.1%
15-17	4.1%	3.8%
18-20	4.0%	4.4%
21-24	5.0%	5.3%
25-34	9.9%	12.4%
35-44	11.3%	12.2%
45-54	12.9%	11.7%
55-64	14.7%	13.0%
65-74	12.6%	11.6%
75-84	6.7%	6.1%
85+	2.1%	2.2%
Median Age	44.0 years	40.5 years

Table 11: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	Lodi Hospital Community	Ohio	U.S.
White	90.9%	75.7%	63.4%
Black/African American	1.6%	12.8%	12.4%
American Indian/Alaskan Native	0.2%	0.3%	0.9%
Asian	1.1%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.1%	0.2%
Another Race	0.9%	2.1%	6.6%
Two or More Races	5.3%	6.4%	10.7%
Hispanic or Latino (any race)	2.8%	5.0%	19.0%

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

Table 12: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	Lodi Hospital Community	Ohio	U.S.
Only English	90.9%	92.8%	78.0%
Spanish	1.6%	2.3%	13.4%
Asian/Pacific Islander Language	0.2%	1.0%	3.5%
Indo-European Language	1.1%	2.8%	3.8%
Other Language	0.0%	1.1%	1.2%

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

Table 13: Household Income of Hospital Community and Surrounding Geographies

Income Category	Lodi Hospital Community	Ohio
Under $15,000	4.8%	9.5%
$15,000 - $24,999	4.9%	7.8%
$25,000 - $34,999	4.9%	8.0%
$35,000 - $49,999	9.3%	12.2%
$50,000 - $74,999	15.2%	17.0%
$75,000 - $99,999	14.2%	13.0%
$100,000 - $124,999	12.3%	9.9%
$125,000 - $149,999	9.8%	7.0%
$150,000 - $199,999	11.3%	7.2%
$200,000 - $249,999	5.7%	3.5%
$250,000 - $499,999	5.3%	3.4%
$500,000+	2.3%	1.6%
Median Household Income	$95,277	$68,488

Table 14: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Lodi Hospital Community	4.4%
Ohio	9.4%
U.S.	8.8%
Lodi Hospital Zip Codes	-
44214	6.7%
44215	5.0%
44235	4.9%
44251	1.4%
44254	7.1%
44256	4.2%
44273	3.4%
44275	2.9%
44287	5.3%

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

Table 15: Educational Attainment of Hospital Community and Surrounding Geographies

	Lodi Hospital Community	Ohio	U.S.
Less than High School Graduate	4.7%	8.6%	10.6%
High School Graduate	32.3%	32.8%	26.2%
Some College, No Degree	17.7%	19.6%	19.4%
Associate Degree	9.0%	8.9%	8.8%
Bachelor's Degree	23.8%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	12.6%	11.6%	13.7%

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

Table 16: High Rent Burden in Hospital Community and Surrounding Geographies

	Renters Spending 30% or More of Income on Rent
Medina County	43.7%
Ohio	45.1%
U.S.	50.4%
Lodi Hospital Zip Codes	-
44214	22.0%
44215	46.6%
44235	--
44251	5.1%
44254	25.2%
44256	43.8%
44273	26.4%
44275	41.5%
44287	57.0%

All values: American Community Survey (2019-2023)

Table 17: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Medina County	91.8%
Ohio	89.0%
U.S.	89.9%
Lodi Hospital Zip Codes	-
44214	92.2%
44215	88.9%
44235	77.5%
44251	88.4%
44254	80.2%
44256	92.8%
44273	93.1%
44275	90.9%
44287	87.2%

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 Medina County. 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 latest Ohio State Health Assessment and Medina County Community Health Assessment (CHA) corroborated the relevance of the four prioritized needs in this 2025 CHNA process for Lodi Hospital.

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

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

- 2023 Ohio State Health Assessment[13]
- 2022 Akron Children's Hospital CHNA[14]
- 2023 Medina County Community Development Needs Assessment[15]
- 2024 Medina County Community Health Assessment[16]
- United Way Community Needs Assessment: Summit & Medina Counties[17]

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Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

Cleveland Clinic

Building a healthy community together.

WELCOME: Cleveland Clinic is in the process of conducting our 2025 comprehensive Community Health Needs Assessment (CHNA) to understand and plan for the current and future health needs of our community.

You have been invited to take part in this interview because of your experience working in [XXXX] County. During this interview, we will ask a series of questions related to health issues in your community. Our goal is to gain various perspectives on the major issues affecting the population that your organization serves and how to improve health in your community. We hope to get through as many questions as possible and hear your perspective as much as time allows.

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

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

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

Section #1: Introduction

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

Section #2: Community Health Questions and Probes

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

- **What are the top health-related issues that residents are facing in your community that you would change or improve?**
    - What makes them the most important health issues?
    - What do you think is the cause of these problems in your community?

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

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

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

- **What are some possible solutions to the problems that we have discussed?**
    - How can organizations such as hospitals, health departments, government, and community-based organizations work together to address some of the problems that have been mentioned?
    - What specific community organizations or agencies can you see taking a strong leadership role in improving the health of your community?
    - What resources does your community have that can be used to improve community health?

- **How can we make sure that community voices are heard when decisions are made that affect their community?**
    - What would be the best way to communicate with community members about the progress organizations are making to improve health and quality of life?

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

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

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

Community Input Key Findings

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

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

- Alternative Paths
- Cloverleaf High School
- Cleveland Clinic Children's
- Lodi Community Library
- Lodi Family Center
- Lodi Police Department
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Medina BirthCare
- Medina County Health Department

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

Access to Healthcare

Stakeholder interviews for the Lodi Hospital 2025 CHNA consistently highlighted access to healthcare as one of the community's most pressing challenges. Residents face multiple barriers that limit their ability to obtain timely, affordable, and continuous care. Transportation difficulties, shortages of local providers, high out-of-pocket costs, and limited-service availability all emerged as central concerns. These issues disproportionately affect older adults, low-income households, and those with chronic health conditions. Stakeholders emphasized the importance of strengthening primary and preventive care locally, expanding specialty access, and improving coordination between hospital-based and community-based services.

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

- Transportation Barriers: Residents struggle with limited transit options, especially for appointments outside the immediate area.
- Provider Shortages: A lack of local primary care and specialty providers contributes to long wait times and delayed treatment.
- Affordability Concerns: High out-of-pocket costs, copays, and prescription expenses prevent many from seeking regular care.
- Emergency Department Reliance: Delayed preventive care results in greater dependence on emergency services.

- Care Coordination Gaps: Fragmented systems and lack of service integration complicate navigation and reduce continuity of care.
- Older Adult Needs: Seniors face unique challenges, including transportation difficulties and limited caregiver support.
- Preventive and Primary Care Access: Strong community need for local, affordable, and preventive services to reduce reliance on acute care.

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

"If people don't have reliable transportation, even a 20-minute drive for an appointment can mean they just skip it."

"The wait times to see a specialist are too long, and many just give up trying to get the care they need."

"Even people with insurance struggle with copays and deductibles, so they delay care until it becomes an emergency."

"Older adults in our community want to age in place, but they cannot keep up with regular appointments without local, affordable options."

"We need better coordination between hospital services and community providers, so residents do not fall through the cracks."

Overall, access to healthcare in the Lodi community is shaped by a combination of geographic, financial, and systemic barriers. Residents face difficulties in reaching appointments, affording care, and maintaining consistent engagement with providers. These challenges disproportionately affect under resourced populations and contribute to delayed diagnoses and preventable emergency visits. Stakeholders stressed that improving access requires targeted investment in local preventive and primary care services, stronger care coordination, and expanded transportation and affordability solutions. Addressing these barriers is critical to building a healthier, more resilient community.

Behavioral Health: Mental Health and Substance Use Disorder

Behavioral health, including both mental health and substance use disorder, was one of the most frequently identified priorities during stakeholder conversations for the Lodi Hospital CHNA. Participants described the increasing prevalence of depression, anxiety, trauma, and stress across all age groups, compounded by the lingering effects of the COVID-19 pandemic, financial hardship, and social isolation. Substance use, especially opioid and fentanyl misuse, was also highlighted as a pressing concern with devastating impacts on families and community stability. Stakeholders emphasized that while some services exist, limited availability of providers, high costs, long wait times, and a lack of culturally appropriate care create barriers to effective prevention, treatment, and recovery.

The following are highlights of participant feedback regarding behavioral health:

- High prevalence of mental health issues: Rising rates of depression, anxiety, and trauma across age groups.

- Substance use concerns: Increasing opioid and fentanyl misuse, with few recovery resources locally.

- Provider shortages: Lack of behavioral health specialists, particularly those accepting Medicaid or uninsured patients.

- Long wait times: Residents often wait weeks or months for mental health or addiction treatment.

- Access barriers: Financial constraints, stigma, and transportation challenges delay or prevent care.

- Youth and older adults at risk: Schools and seniors were noted as groups particularly affected by stress, isolation, and lack of support

- Need for integrated care: Strong calls for primary care, behavioral health, and social services to be coordinated in one place.

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

"We have people waiting months to see a counselor. By the time they get in, the crisis has often worsened."

"Addiction is everywhere right now. We need more treatment beds and long-term recovery support, not just detox."

"Mental health is a huge issue for kids and teens. They are struggling with anxiety and trauma, and the resources just are not there."

"Older adults are isolated, and many are facing depression without any real services nearby."

"People are afraid to seek help because of stigma, or they do not have insurance to cover what they need."

Stakeholders consistently emphasized that behavioral health remains a core community challenge in the Lodi Hospital community. The combination of rising mental health concerns, escalating substance use, and limited treatment infrastructure places a significant strain on families and community well-being. Addressing these issues requires targeted investments in behavioral health workforce capacity, expansion of affordable and culturally competent services, and integrated approaches that bring together medical, behavioral, and social supports. Efforts to reduce stigma, engage schools, and provide community-based prevention and recovery programs were seen as essential steps toward building a more resilient and healthier community.

Chronic Disease Prevention & Management

Based on the Lodi Hospital stakeholder interviews conducted as part of their 2025 CHNA, several pressing concerns around chronic disease prevention and management were identified by stakeholders. Participants noted that diabetes, hypertension, heart disease, and other long-term conditions remain widespread challenges for residents, with significant variation across groups. Barriers such as limited access to preventive screenings, inconsistent follow-up care, and cost-related challenges in maintaining treatment were cited as persistent drivers of poor outcomes. Stakeholders also emphasized that nutrition, physical inactivity, and lack of health education contribute to the onset and progression of chronic illness in the community.

Interviewees underscored the importance of a comprehensive approach to prevention and management. This includes improving access to early detection, increasing patient engagement in care plans, and expanding community-based wellness initiatives that address root causes such as food insecurity and lack of exercise opportunities. Older adults were identified as an important population to consider, as many face challenges affording medications, maintaining mobility, and navigating multiple comorbidities. Stakeholders also noted that culturally tailored outreach and education are needed to build trust and ensure equal participation in chronic disease programs.
Overall, the findings point to the need for coordinated strategies that integrate healthcare, social services, and community partners. Sustained focus on prevention, access, and tailored support for at-risk groups was described as essential to reducing the long-term burden of chronic disease and improving health outcomes across Medina County.

Primary and secondary data findings across topics such as nutrition, cancer, cardiovascular health, and aging consistently revealed differences in health outcomes influenced by income, race, location, and barriers in care delivery.

Nutrition & Healthy Eating and Wellness & Lifestyle
The following are highlights of participant feedback regarding nutrition and healthy eating and wellness and lifestyle:

- Food Access Barriers: Limited availability of affordable healthy foods, particularly in rural areas.
- Lifestyle Influences: Poor diet, inactivity, and stress contribute to chronic disease burden.
- Education Gaps: Need for culturally relevant nutrition education and awareness programs.
- Community Wellness Resources: Desire for more accessible and affordable wellness programs, including exercise classes, fitness trials, and community events.
- Prevention Emphasis: Strong interest in early intervention strategies that encourage healthier habits before conditions worsen.

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

"Families struggle to find affordable fresh foods nearby, and convenience foods become the default."

"People know they need to eat better or move more, but the resources to do that just are not there."

"Wellness programs that are culturally relevant and affordable could really make a difference here."

Cancer
The following are highlights of participant feedback regarding cancer:

- Early Detection Importance: Stakeholders stressed the need for regular screenings and outreach.
- Barriers to Screening: Financial cost, transportation, and lack of awareness limit participation.
- Equal Access Concerns: Differences in outcomes for low-income and rural residents.
- Community Outreach: Mobile screening units, health fairs, and non-traditional engagement seen as effective solutions.
- Navigation Support: Need for services that connect patients to diagnostic and treatment options quickly.

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

"People often put off cancer screenings because of the cost or because they do not know where to go."

"In rural areas, access to cancer care is very limited, and transportation is a big challenge."

"Health fairs and mobile units can really help bring screenings to the people who need them most.

Diabetes, Heart Disease, & Stroke
The following are highlights of participant feedback regarding diabetes, heart disease, stroke, and other chronic conditions:

- Prevalence of Chronic Conditions: Diabetes, hypertension, and heart disease were cited as highly common.
- Late Detection: Many residents only learn of conditions during health fairs or emergency visits.
- Care Barriers: Affordability, transportation, and lack of coordinated follow-up hinder effective management.

- Lifestyle Contributors: Poor diet, physical inactivity, and stress contribute to disease burden.
- Need for Support: Stakeholders emphasized chronic disease education, patient navigation, and culturally appropriate self-management programs.

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

"People are often diagnosed with diabetes or high blood pressure at screenings because they have not been to a doctor in years."

"We see a lot of residents who cannot afford their prescriptions, or the follow-up care they need to manage chronic conditions."

"Education and support programs are critical if we want people to make lifestyle changes and actually stick with them."

Older Adult Health

The themes related to the 65 and older population center around access to care, environmental supports, health behaviors, and social factors that directly impact older adults' ability to manage chronic conditions such as diabetes, hypertension, and dementia.

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

- Transportation challenges: Older adults have limited options to access care and services.
- Medication costs: High out-of-pocket costs create barriers to treatment adherence.
- Caregiver shortages: Limited formal and informal support increases isolation and stress.
- Chronic condition burden: Seniors often manage multiple health conditions simultaneously.
- Preventive care needs: Gaps in routine screenings and wellness services for aging populations.

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

"Many older adults cannot get to their appointments because transportation options in rural areas are almost nonexistent."

"The cost of prescriptions for seniors is overwhelming, especially for those on fixed incomes."

"We are seeing more people aging alone without the caregiver support they need to stay healthy and independent."

Health-Related Social Needs

Stakeholder conversations emphasized that health-related social needs are a foundational driver of health outcomes in the Lodi Hospital community. Participants described how persistent poverty, limited job opportunities, and housing instability place strain on families and prevent consistent access to medical care and healthy living conditions. Food insecurity and the high cost of daily necessities were also identified as ongoing concerns, creating difficult tradeoffs for many residents. Transportation gaps, especially for those without reliable vehicles, compound these issues by limiting access to employment, healthcare, and social support Together, these barriers create a cycle that not only impacts individual well-being but also affects the broader community's ability to thrive.

The following highlights key insights from stakeholder interviews regarding health-related social needs in the community Lodi Hospital serves.

- Housing Instability: Lack of affordable rental and homeownership options increases stress and impacts health.
- Transportation Barriers: Limited public transit and reliance on personal vehicles restrict access to care and jobs.
- Food Insecurity: High grocery costs and limited access to nutritious foods contribute to chronic health conditions.
- Employment and Income: Job instability and low wages leave many residents unable to cover healthcare and living costs.
- Community Disinvestment: Underfunded public services and fewer resources in some neighborhoods perpetuate differences in outcomes.

The following are a selection of quotes illustrating feedback about health-related social needs:

"Affordable housing is really difficult to find, and families are moving frequently which creates instability for both health and education."

"If you don't have a car, it is nearly impossible to get to appointments or even a grocery store from certain areas."

"Food costs are rising so quickly that people are skipping healthier options because they are more expensive."

"Many families are just scraping by, and medical bills or prescriptions fall to the bottom of the list of priorities."

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

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

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

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

Access to Affordable Health Care

Actions and Highlighted Impacts:

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

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

Behavioral Health

Actions and Highlighted Impacts:

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

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

help someone who is developing a mental health problem or experiencing a mental health crisis.

C. Lodi Community Hospital continued to provide space to Alternative Paths which offers behavioral health services including alcohol and substance use disorder counseling.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. Lodi Hospital implemented health promotion, health education, support groups, and outreach events related to heart disease and stroke, cancer, respiratory disease, women's health, obesity.

B. Lodi's community nurse partnered with local food distribution non-profit to provide nutrition health education to participants.

C. The hospital incorporated nutritional information into their community babysitting courses.

D. Lodi Hospital provided community diabetic education classes and free blood sugar screenings through community events.

E. The hospital collaborated with Medina County Health Department for *Lodi Health in Motion* to explore improved walkability opportunities in Lodi.

F. Lodi continued to offer CPR and AED training at the hospital and throughout the community.

Health-Related Social Needs

Actions and Highlighted Impacts:

A. Lodi Hospital continued to participate in the Community Meal Program and support of the Feeding Medina County initiative, provided free meals and distributed food to community members.

B. The hospital served more than 1,000 individuals through Lodi Hospital 's monthly Community Meals Program, in partnership with the Lodi United Methodist Church.

C. In partnership with *Medina Birth Care*, Lodi Community Hospital provided diapers and wipes onsite. Served women, infants and children up to age 5 with diapers, formula and nutrition support.

D. The hospital hosted Medina County Health Department's monthly USDA's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

E. Lodi sponsored the Free Clinic of Medina County to provide medical care for uninsured and underinsured community members.

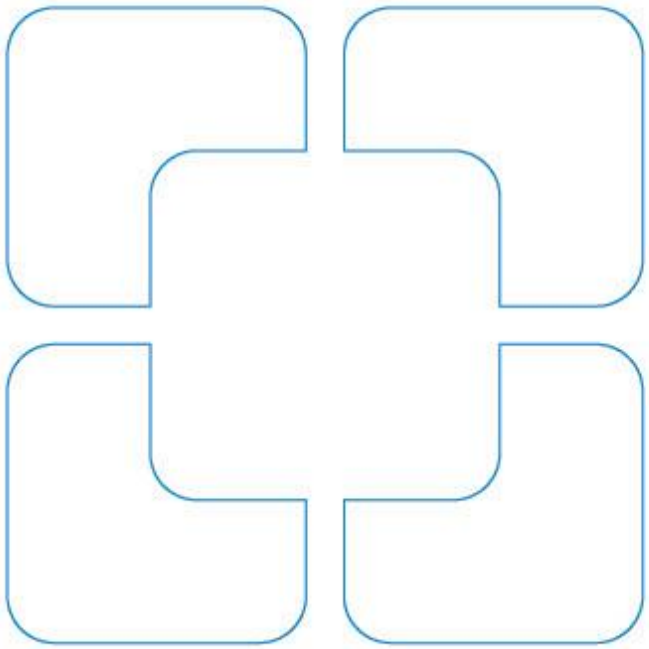
F. Lodi Hospital provided *Safe Sitter* classes to community members and *Safe at Home* classes to community youth with the goals of reducing injuries in child and adolescent populations.

Appendix F: Acknowledgements

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

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Lodi Hospital

Implementation Strategy Report

2025



LODI HOSPITAL
2025 Community Health Needs Assessment
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Lodi Hospital Implementation Strategy Report

I. Introduction and Purpose

This written plan is intended to satisfy the requirements set forth in Internal Revenue Code Section 501(r)(3) regarding community health needs assessments and implementation strategies. The overall purpose of the Implementation Strategy is to align the hospital's limited resources, program services, and activities with the Lodi 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 Lodi Hospital. This report includes strategies for years 2026 through 2028.

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

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

A. Description of Hospital

Lodi Hospital, a 20-bed[18] Critical Access Hospital and member of Cleveland Clinic Akron General, has served southwest Medina County and portions of Lorain, Ashland, and Wayne Counties since 1920. The hospital provides acute and skilled care, a full range of outpatient diagnostic, rehabilitation and physical therapy services, infusion services, outpatient and minimally invasive surgery, radiology, and a state-of-the-art 24-hour emergency department that has earned numerous patient satisfaction awards.

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

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

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

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

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

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

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

II. Lodi Hospital Community Definition

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

Figure 1: Lodi Hospital Community Definition

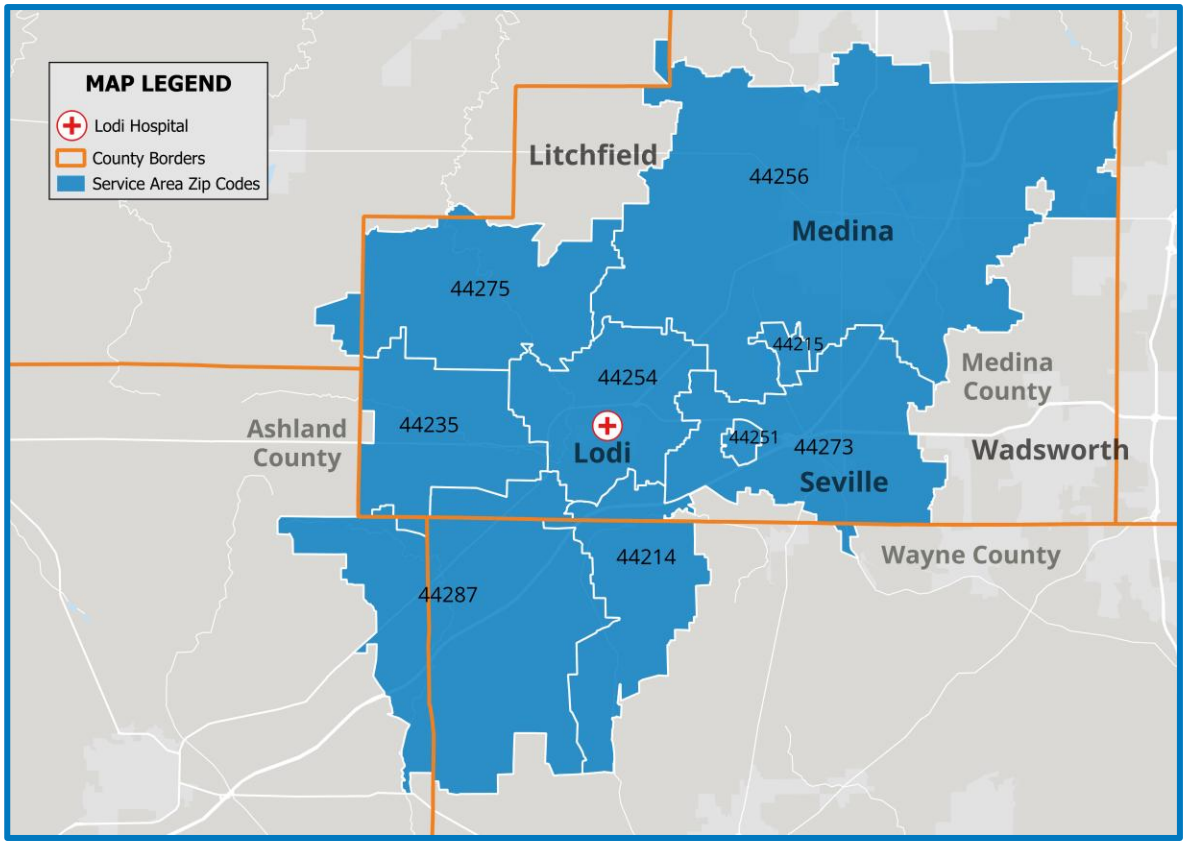


Table 1: Lodi Hospital Community Definition

Zip Code	Postal Name
44214	Burbank
44215	Chippewa Lake
44235	Homerville
44251	Westfield Center
44254	Lodi
44256	Medina
44273	Seville
44275	Spencer
44287	West Salem

III. How Implementation Strategy was Developed

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

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

IV. Summary of the Community Health Needs Identified

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

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

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

V. Needs Hospital Will Address

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

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

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

A. Access to Healthcare 

The 2025 CHNA for Lodi Hospital identifies Access to Healthcare as a major challenge, with stakeholders emphasizing affordability barriers, transportation limitations, and a shortage of local providers. High deductibles, copays, and medication costs often discourage residents, especially older adults, low-income households, and those with chronic conditions, from seeking timely care or following up with specialists. Long wait times and the need to travel outside the community further limit access, particularly for those without reliable transportation. Stakeholders also cited fragmented systems, gaps in resource awareness, and the need for culturally appropriate care. Secondary data highlight low provider availability, higher preventable hospitalization rates among Black residents, and elevated CHI scores in zip code 44287, where uninsured rates remain notably high.

Access to Healthcare Initiatives for 2026-2028 include:

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

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

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

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

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

B. Behavioral Health 

The 2025 CHNA for Lodi Hospital identifies Behavioral Health as a major priority, with stakeholders reporting widespread depression, anxiety, trauma, and stress compounded by poverty, social isolation, and limited access to care. Persistent shortages of mental health providers, long wait times, and minimal crisis services hinder timely support, while stigma, especially in small communities, discourages early intervention. Substance use disorder, particularly involving opioids and fentanyl, is an escalating concern, with residents needing more accessible, evidence-based treatment, harm-reduction services, and culturally responsive care. Stakeholders emphasized prevention, school-based programs, and stronger cross-sector collaboration. Secondary data reinforce these challenges, showing high alcohol use, elevated depression rates, and a high Mental Health Index score in certain neighborhoods, indicating significant unmet behavioral health needs.

Behavioral Health Initiatives for 2026-2028 include:

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

A. **Initiative:** Collaborate with community-based organizations, schools, and local healthcare providers to educate and understand behavioral health issues, available resources, and treatment options for mental health and substance misuse issues. Partner with and provide space for Alternative Paths, LLC to provide 24/7 services for behavioral health services including alcohol and substance use counseling.

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

C. Chronic Disease Prevention and Management 

The 2025 CHNA for Lodi Hospital identifies Chronic Disease Prevention and Management as a significant community concern, with high rates of diabetes, hypertension, heart disease, respiratory conditions, and cancer often going undetected or poorly managed due to cost, transportation barriers, and limited continuity of care. Stakeholders noted that many residents rely on episodic or emergency care rather than ongoing primary care, contributing to late diagnoses and preventable complications. Limited access to healthy foods, safe spaces for physical activity, and culturally relevant wellness resources further exacerbates chronic disease risks, particularly for older adults and low-income families. Participants emphasized the need for community-based prevention programs, improved screening access, nutrition and wellness supports, and integrated care models to strengthen management and reduce hospitalizations. Secondary data reflect elevated cancer risks, high kidney disease rates among Medicare recipients, and growing challenges for older adults facing mobility, transportation, and fall-related risks.

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

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

A. **Initiative:** Provide community health education and screenings regarding chronic diseases and conditions for community-based organizations, residents, and faith-based organizations.

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

D. Health-Related Social Needs

The 2025 CHNA for Lodi Hospital identifies health-related social needs as major drivers of health outcomes, with stakeholders emphasizing how limited income, unstable employment, and persistent poverty restrict access to healthcare, nutritious food, and safe housing. Families often struggle to afford medical bills or prescriptions, while housing instability and transportation barriers, especially in rural areas without public transit, lead to missed appointments and delayed care. Food insecurity and high grocery costs contribute to diet-related chronic conditions. Stakeholders stressed that these challenges are reinforced by limited social infrastructure and uneven community investment. Secondary data show overall higher income and education in the region, but significant differences among some groups remain, including lower median income for some residents and one of the nation's largest gender wage gaps in Medina County.

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

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

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

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

B. Initiative: Expand a multi-pronged strategy to address food security through education and healthy food access options. Integrate hospital's food distribution with community resources. Support key partnership with Feeding Medina County.

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

C. Initiative: Support Birthcare of Medina County by providing hospital space and connecting community members with services and resources supporting healthy family environments.

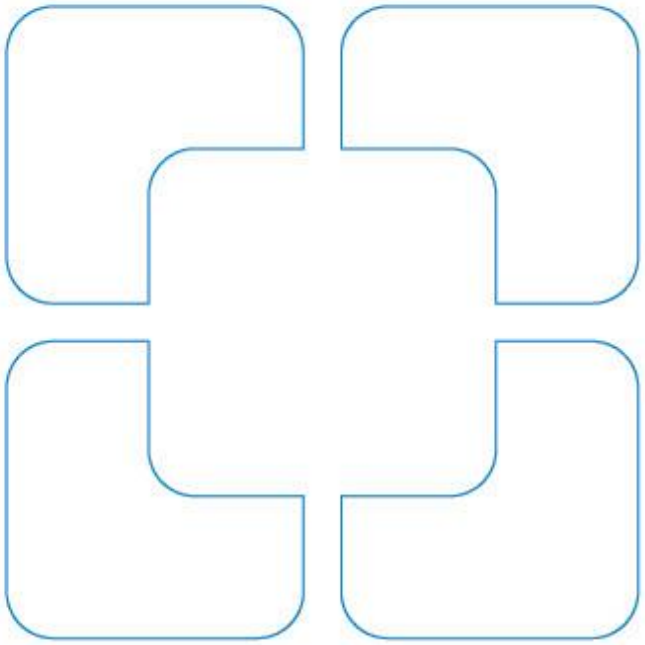
Anticipated Impacts: Increase family environmental safety, increase access to essential childcare supplies.

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

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

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

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



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