Cleveland Clinic
Medina Hospital

Community Health Needs Assessment

2025

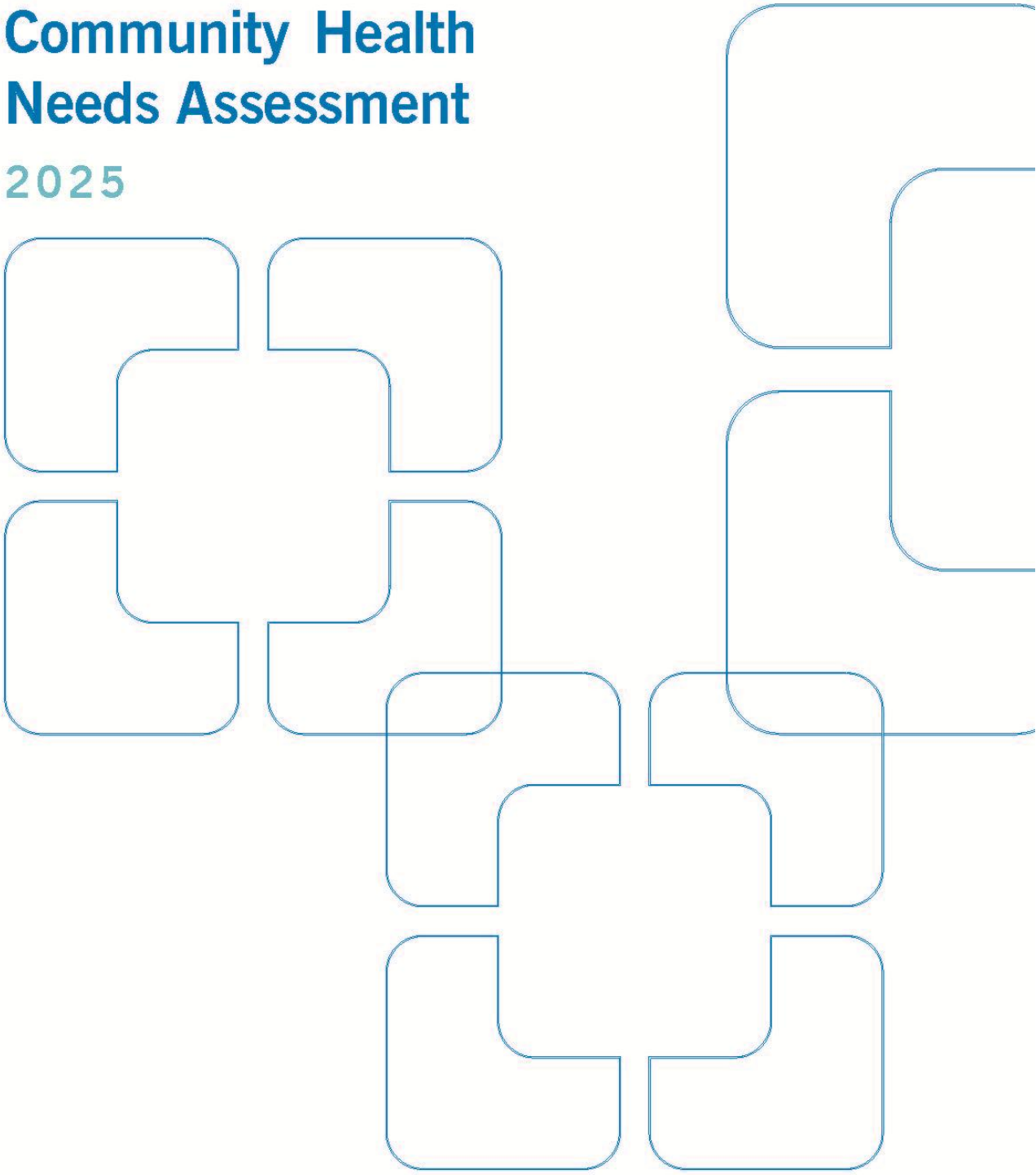


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Medina Hospital 2025 Community Health Needs Assessment

Introduction

Medina Hospital is a modern, 148-bed[1] hospital that serves the Medina community with advanced technology, more than 300 physicians, and over 30 areas of specialization. Since affiliating with Cleveland Clinic in 2009, the hospital has provided local access to world-class care while maintaining trusted community connections. It is especially recognized for its expanded orthopedic program, offering advanced treatments and excellent outcomes delivered by highly experienced physicians. Medina Hospital has also supported the community with expert emergency care since 1944, with a state-of-the-art Emergency Department equipped to treat everything from minor problems to critical injuries and illnesses, ensuring seamless access to inpatient and specialty services when needed.

As part of the broader Cleveland Clinic health system, Medina 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 Medina, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Medina Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Medina 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 more equal access to care. 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, Medina 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.

Medina 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/medina-hospital.

CHNA Background

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

Medina Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Medina Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Medina 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: Medina Hospital Community Definition

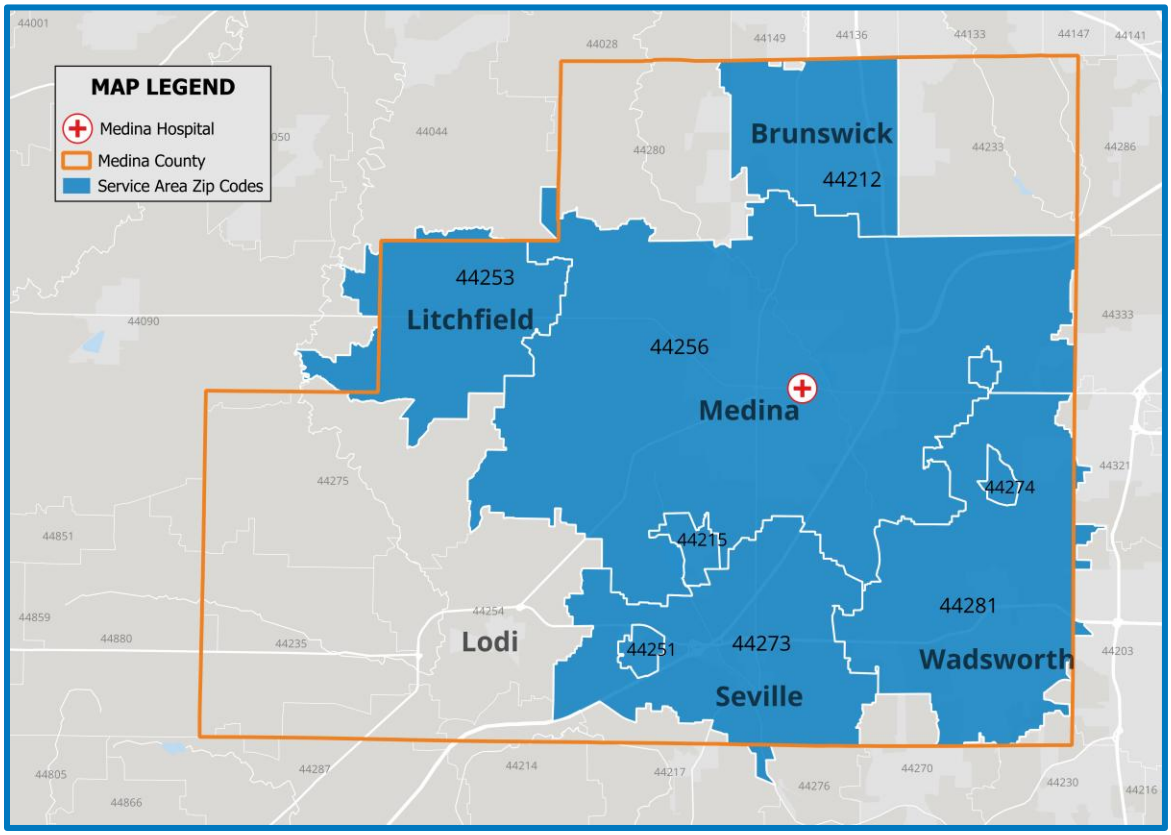


Table 1: Medina Hospital Community Definition

Zip Code	Postal Code
44212	Brunswick
44215	Chippewa Lake
44251	Westfield Center
44253	Litchfield
44256	Medina
44273	Seville
44274	Sharon Center
44281	Wadsworth

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 and health-related social needs. 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 8-zip-code Medina 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.

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 Medina 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 Cleveland Clinic service region. Community stakeholders from 10 organizations provided feedback specifically for the Medina 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

Medina 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:

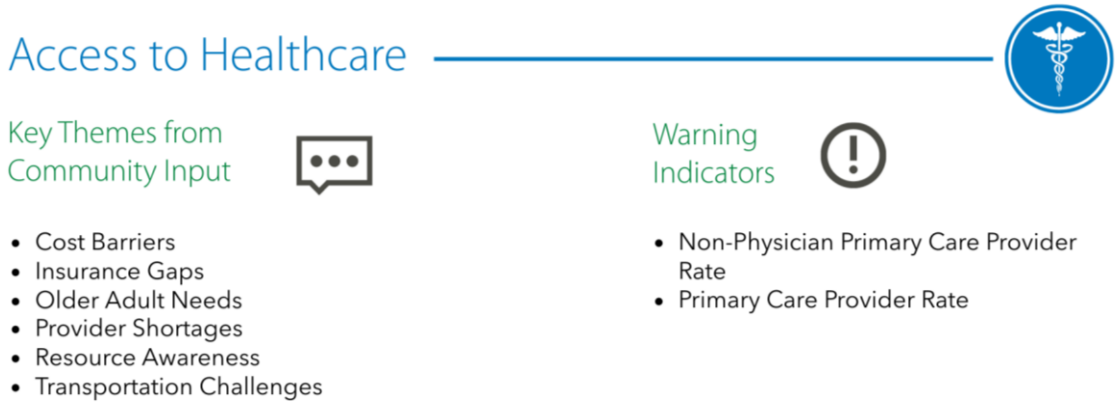


These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that the hospital's defined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

The four prioritized community health needs identified in this 2025 Medina 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



Stakeholder feedback from the 2025 CHNA highlighted that access to healthcare remains a persistent concern in Medina County, particularly for low-income residents, older adults, and those living in rural or under resourced areas. Participants described financial barriers such as high out-of-pocket costs, insurance gaps, and the affordability of prescriptions as major deterrents to seeking timely care. Even for those with insurance, copays and deductibles were viewed as prohibitive, creating delays in preventive care and ongoing treatment. Transportation challenges were also consistently identified, with limited public transit options restricting access to appointments and specialized services, especially for residents in more remote parts of the county.

In addition to financial and geographic barriers, stakeholders noted gaps in availability and navigation of healthcare resources. Long wait times, shortages of primary care and specialty providers, and limited access to behavioral health services were all cited as ongoing obstacles. Participants emphasized that many residents are unaware of available services or struggle to navigate complex systems, suggesting the need for better coordination, patient navigation, and expanded outreach. Culturally and linguistically responsive care was also seen as essential to building trust and addressing the needs of different populations.

Overall, stakeholder input reinforced that improving access requires a multifaceted approach that addresses affordability, provider capacity, transportation, and system navigation. Expanding integrated care models, investing in mobile and community-based services, and strengthening patient education and outreach were identified as key strategies to ensure residents can obtain timely and consistent healthcare in the Medina Hospital community.

Secondary data indicate that some of the greatest challenges regarding healthcare access in Medina County concern provider availability. The rate of non-physician primary care providers, specifically, is about half that of Ohio's state-wide rate (75.5 vs. 148.7 providers per 100,000), and lower than most other Ohio counties. The county-wide rate for preventable hospital stays is relatively low, although the rate of avoidable hospital

visits is significantly higher for 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 Medina Hospital community, the zip codes with the highest CHI values, and greatest healthcare needs, are 44253 (Litchfield) and 44251 (Westfield Center). Additional details including charts, maps, and additional findings from primary and secondary data for this health need can be found in the appendices section of this report.

Prioritized Health Need #2: Behavioral Health



Behavioral Health emerged as one of the priorities for the Medina Hospital community in the 2025 CHNA. Stakeholder interviews highlighted Behavioral Health, including both mental health and substance use disorder, as one of the most pressing and complex needs. Participants described consistent challenges with access, citing long wait times, a shortage of providers, and gaps in affordable care as major obstacles. These barriers were felt most acutely by youth, older adults, and residents with low incomes, who often experience additional challenges such as transportation difficulties and limited insurance coverage. Stigma and a lack of culturally responsive services were also reported as key deterrents to care, discouraging residents from seeking treatment until crises emerge.

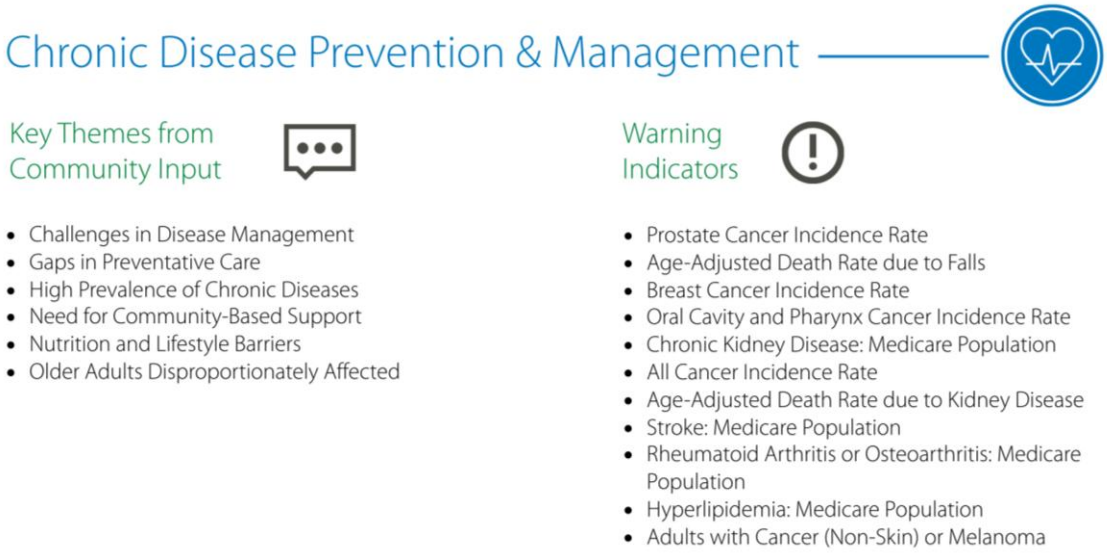
Substance use, particularly opioid, methamphetamine, and alcohol use, was repeatedly mentioned as a growing concern, with stakeholders noting the strain it places on families, schools, and the criminal justice system. Participants called for more integrated approaches that combine mental health and addiction services, as well as expansion of school-based interventions, crisis services, and peer support programs. The COVID-19 pandemic was described as having amplified existing challenges by increasing social isolation, anxiety, and depression, while simultaneously placing greater pressure on already strained behavioral health systems. Overall, stakeholders stressed the importance of building a more accessible, coordinated, and stigma-free system of care that engages community partners in prevention, treatment, and recovery efforts.

Secondary data indicate that rates of drug poisonings across Medina County are relatively low and meet the Healthy People 2030 target. Rates of alcohol use, however,

exceed nearly all other counties across the state, with nearly a quarter of adults reporting that they drink excessively (23.1%). Medina County residents also report high levels of depression. About one in four adults across the county have been diagnosed with depression (24.8%), including 18% of Medicare recipients, and both of these rates exceed most other counties across the nation.

Conduent HCI's Mental Health Index (MHI) assesses mental health risk based on local indicators related to health-related social needs and can help estimate where mental health needs are greatest across the community. In the Medina Hospital community, the zip code with the highest MHI value and greatest mental health needs is 44256 (Medina).

Prioritized Health Need #3: Chronic Disease Prevention and Management



Stakeholder interviews for the Medina 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 obesity were described as common and often detected late, leading to difficulties in long-term management. Participants emphasized that many residents struggle with maintaining consistent care due to barriers such as cost, transportation, and limited access to preventive services. These challenges contribute to higher rates of avoidable complications and hospital visits.

Stakeholders also noted the importance of addressing social and environmental factors that influence chronic conditions. Limited access to affordable healthy food, safe places to exercise, and reliable housing were frequently mentioned as underlying contributors to disease progression. Education and awareness gaps further hinder effective disease management, with residents often relying on episodic care, such as health fairs, rather than continuous engagement with a primary provider.

Moving forward, participants stressed the need for expanded prevention programs, better integration of care across providers, and patient-centered support such as navigation services and culturally tailored health education. Strengthening early detection, improving access to affordable specialty care, and creating supportive environments for healthy living were identified as critical strategies to reduce the burden of chronic disease in the Medina 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
Stakeholders emphasized that poor nutrition and limited access to affordable healthy foods are driving chronic disease rates in the Medina community. Residents in some areas rely heavily on fast food or convenience stores, while others face affordability challenges when trying to purchase fresh produce. Lack of consistent access to safe, inviting places for physical activity compounds the problem, contributing to obesity, diabetes, and cardiovascular disease. Participants highlighted the value of community gardens, farmers markets, and wellness programs to encourage healthier eating and active lifestyles.

Consumer data demonstrate promising trends regarding nutrition among the Medina County population. Compared to state-wide and national rates, adults are more likely to cook meals at home and less likely to rely on fast food. The county-wide food insecurity rate is also relatively low (12.1%), although this rate is higher for the county's Black/African American and Hispanic/Latino populations (32.0% and 21.0%, respectively). Conduent HCI's Food Insecurity Index (FII) can help to identify geographic differences in food access across the Medina Hospital community. The zip codes with the highest FII values, and greatest estimated need, are 44281 (Wadsworth) and 44256 (Medina).

Cancer
While not the most frequently discussed issue, cancer remains a pressing concern, with differences in both screening rates and access to specialty care. Stakeholders noted that many residents delay or miss screenings because of cost, transportation challenges, or lack of awareness of available resources. They also raised concerns about differences in outcomes across different demographic groups. Expanding outreach through mobile screening units, health fairs, and community-based education was identified as a way to improve early detection and reduce preventable deaths.

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 death rates due to breast cancer and prostate cancer are lower than most other U.S. counties and also meet the Healthy People 2030 targets.

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions
Diabetes, hypertension, and cardiovascular disease were consistently described as widespread health challenges in the Medina Hospital community. These conditions are often detected late and managed inconsistently due to cost barriers, transportation gaps, and limited access to primary or specialty care. Several participants noted that residents frequently learn of these conditions through screenings at health fairs or temporary clinics, rather than ongoing provider relationships. Stakeholders emphasized the importance of culturally relevant self-management programs, patient navigation support, and improved follow-up care to reduce complications and improve quality of life.

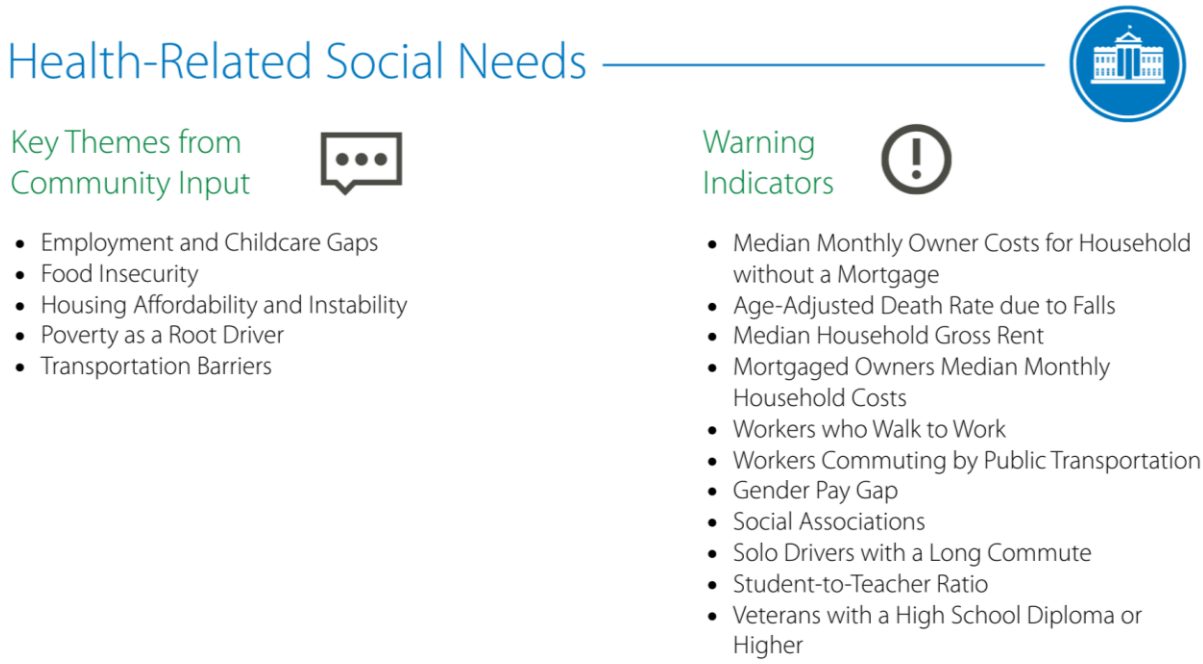
Secondary data indicate that across Ohio, Medina County has some of the lowest rates of coronary heart disease, high blood pressure, and diabetes. The county's Asian American and Pacific Islander population experiences a higher rate of diabetes than the overall county (47% vs. 23% of Medicare recipients). Further, rates of kidney disease 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 exceeds both state-wide and national rates, and the county's death rate due to kidney disease has been increasing since 2016.

Older Adult Health
Older adults were identified as a particularly important population for chronic disease management. Many face challenges related to transportation, the cost of medications, and limited caregiver support. Social isolation and mobility issues further complicate consistent engagement with healthcare services. Stakeholders stressed the need for programs that support aging in place, expanded access to preventive services, and integrated mental and physical health supports. Community-based resources such as senior centers, home health programs, and outreach services were viewed as essential to helping older adults maintain independence and avoid preventable hospitalizations.

Secondary data corroborate that most of the chronic disease outcomes discussed in this section have an outsized impact on older adults. Fall-related deaths are another significant health concern for Medina County's older adult population, with a death rate that is in the top quartile of all Ohio counties, and has been increasing since 2015. Most fall-related deaths occur among adults aged 65 and above and may be related to environmental hazards. The rate of housing problems in the county, however, is relatively low, as is the rate of older adults living alone.

Consumer data indicate that the typical cost of adult day care in Medina County (8.3% of household income) is also lower than most other counties. These costs are 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 Medina Hospital community. Participants emphasized that factors such as housing affordability, employment opportunities, transportation barriers, and income insecurity directly shape residents' ability to access care and maintain healthy lifestyles. These systemic challenges were seen as compounding stress for families, particularly those with limited resources, and were frequently linked to health disparities across the community.

Participants also highlighted food insecurity and unstable housing as pressing concerns that limit residents' ability to prioritize health and well-being. Older adults, low-income households, and families with children were described as populations of note because they often face choices between essential expenses such as housing, food, and healthcare. Transportation limitations furthered outcome differences by reducing access to both health and social services.

Stakeholders stressed that meaningful progress requires more than medical interventions, calling for stronger collaboration across healthcare, social services, and community organizations. They emphasized the importance of upstream strategies that address root causes of poor health, including poverty and educational opportunity, alongside improved navigation supports that connect residents to available resources. Addressing these issues holistically was seen as key to reducing disparities and creating healthier, more resilient communities in Medina County.

The Medina Hospital community has higher levels of income and education, and lower levels of poverty and unemployment, than the state of Ohio and the U.S. overall. These health-related social needs, however, differ between demographic groups. For example, Hispanic/Latino residents have a median income that is lower than the county-wide median income ($61,855 vs. $93,433). The gender pay gap in Medina County is one of

the largest across all U.S. counties, with women making $0.64 for every dollar earned by men.

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 Medina 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 Medina Hospital, including the economic, environmental, and social drivers of health. The social drivers of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, 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 data estimates are sourced from Claritas Pop-Facts® (2024 population estimates) and American Community Survey one-year (2023) or five-year (2019-2023) estimates unless otherwise indicated.

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

[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

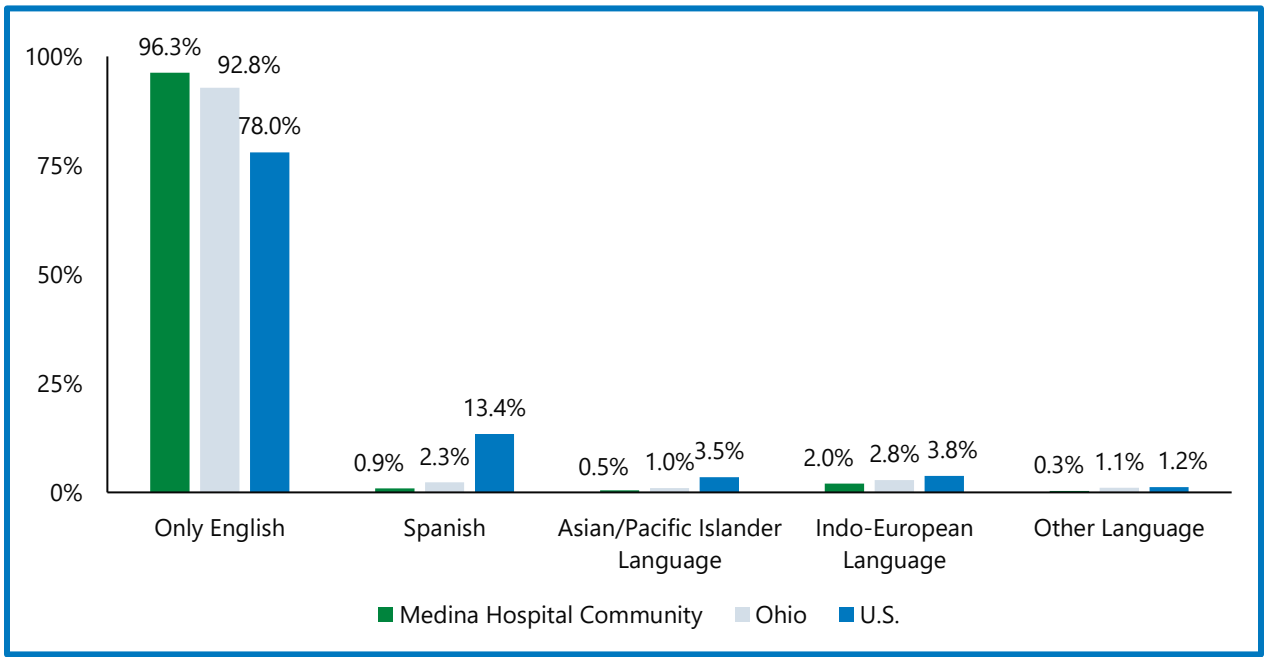
Population Demographics of the Medina Hospital Community

According to the 2024 Claritas Pop-Facts® population estimates, the Medina Hospital community has an estimated population of 159,397 persons, making up approximately 86.3% of the Medina County population. The median age in the community is 43.4 years, which is older than that of Ohio (40.3 years). About a quarter of the population (27.1%) is between 45-64 years old.

The majority of the population is White (90.2%). Residents are less likely than the overall Ohio population to be Black/African American (1.6% vs. 12.8%), Asian (1.4% vs. 2.7%), or Hispanic/Latino (5.6% vs. 6.4%).

As shown in Figure 2, the vast majority of the Medina Hospital population aged five and above speaks primarily English at home (95.7%). Very few residents speak Spanish at home (0.9%), and 2.0% 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.

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

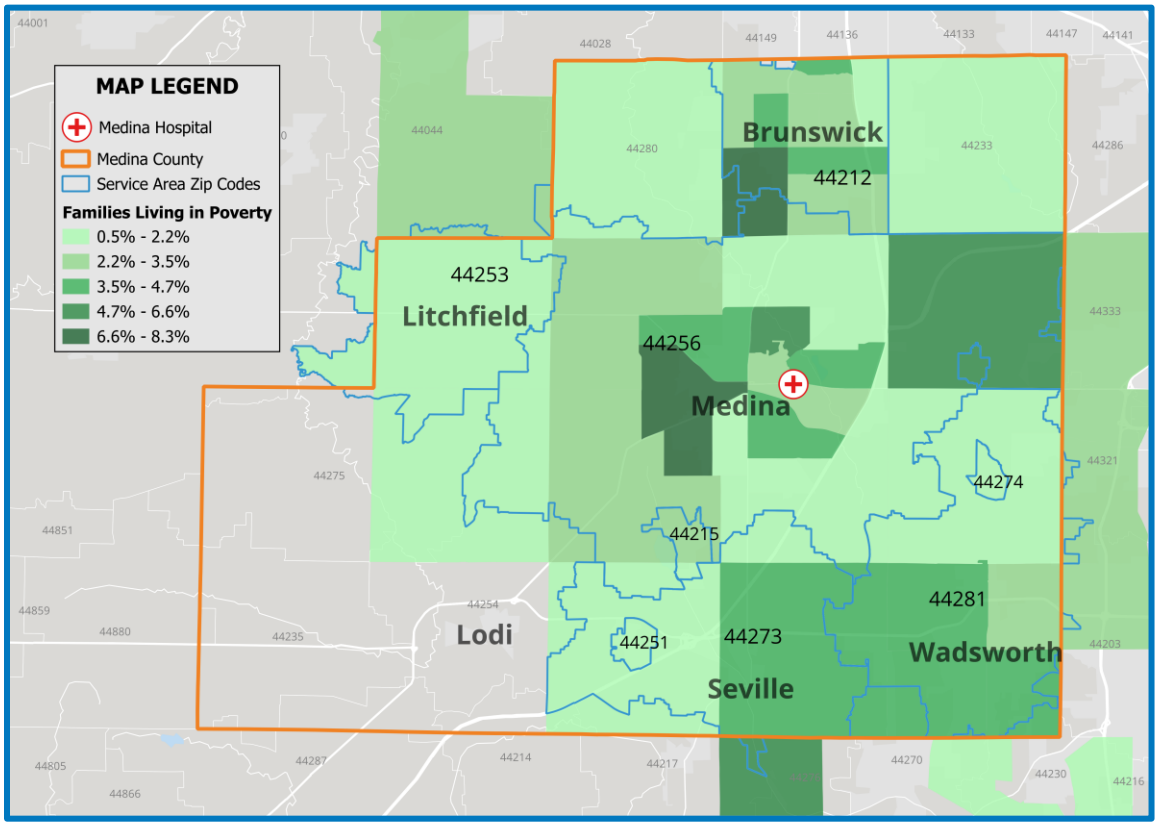
of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[4]

The median household income for the Medina Hospital community is $93,433 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 Medina Hospital community, 3.7% of families live below the poverty level. This is less than half the state-wide and national poverty rates (9.4% and 8.8%, respectively). Poverty levels differ geographically across the Medina Hospital community (Figure 3), and poverty is most common in the zip code 44215 (Chippewa Lake), where 5.0% of families live in poverty, followed by 44256 (Medina), where 4.2% of families live in poverty.

The map in Figure 3 offers greater detail by describing poverty rates by census tract, with darker green census tracts indicating a higher concentration of poverty. Examining neighborhood-level data is particularly valuable, especially in more densely populated zip codes, where broader data may obscure important local differences or trends.

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



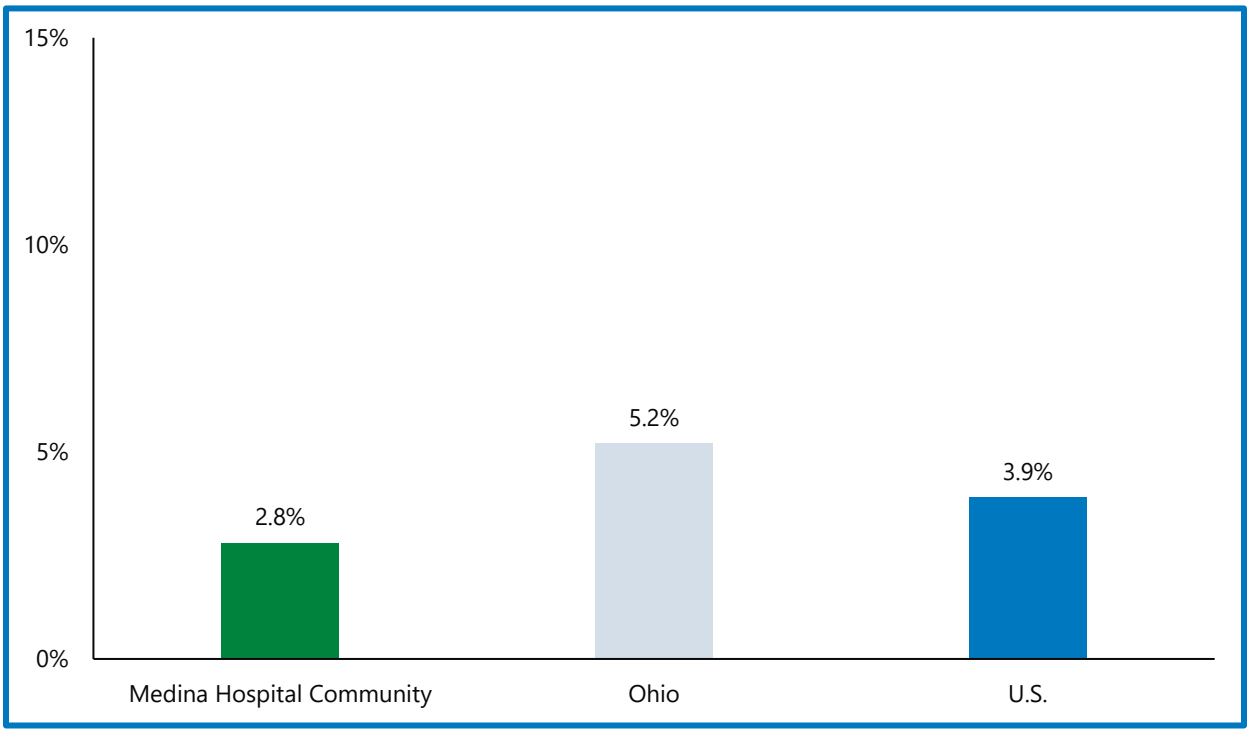
Claritas Pop-Facts® (2024 population estimates)

[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

Education and Employment

The vast majority of the population within the Medina Hospital community have a high school degree or higher (95.9%) and more than a third have a bachelor's degree or higher (37.2%). These rates are higher than state-wide and nation-wide rates. As seen in Figure 4, the unemployment rate is about half that of Ohio (2.8% vs. 5.2%).

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]

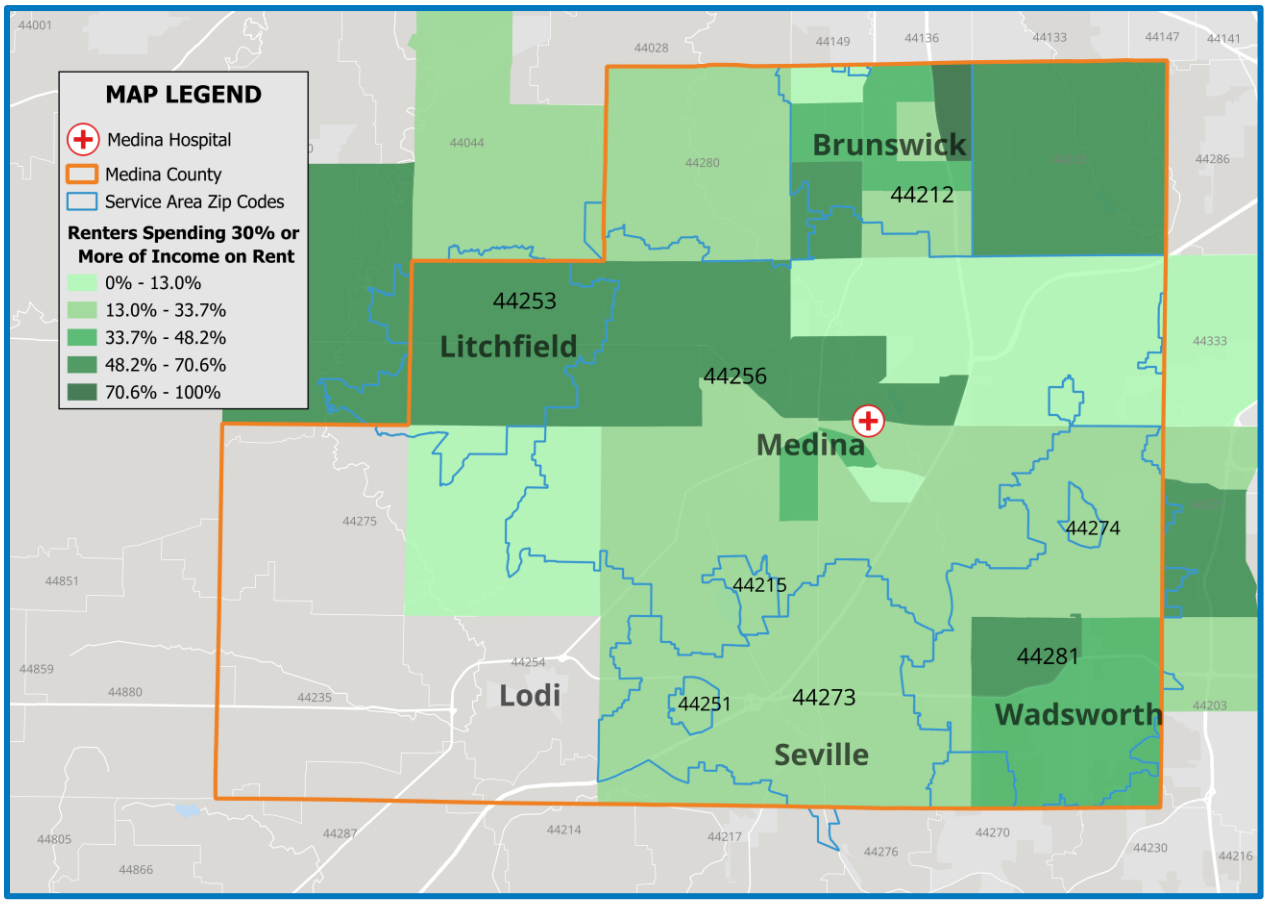
[5] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

[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

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).

Figure 5: High Rent Burden by Census Tract, Medina 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 Medina Hospital community are in the zip codes 44251 (Westfield), with 88.4% of households, and 44215 (Chippewa Lake), with 88.9% 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.

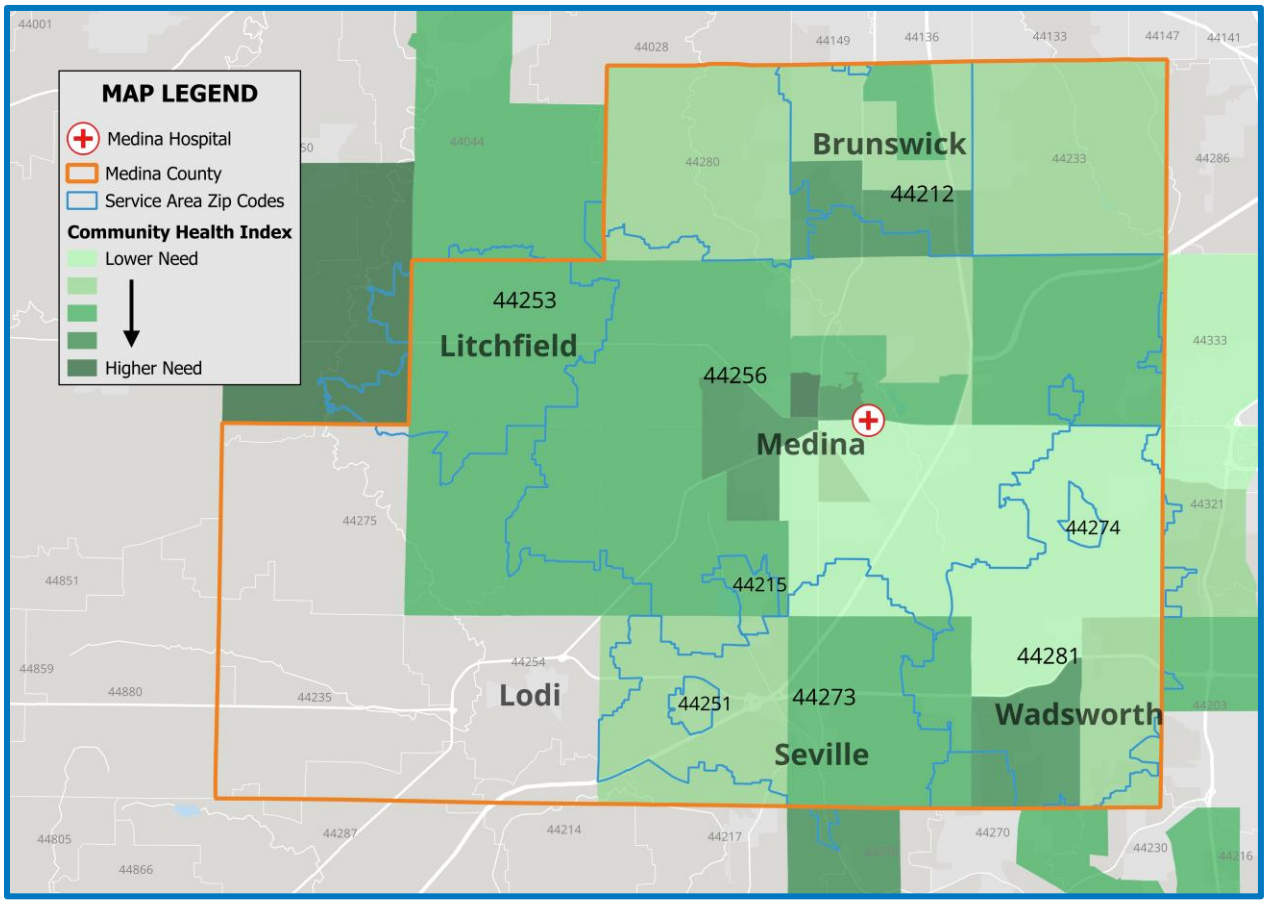
The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the Medina Hospital community at the zip code level.

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 Medina Hospital community, as indicated by the darkest shade of green. At the zip code level, 44253 (Litchfield) and 44251 (Westfield Center) have the highest index values, at 23.9 and 23.7, respectively. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the Medina Hospital community.

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

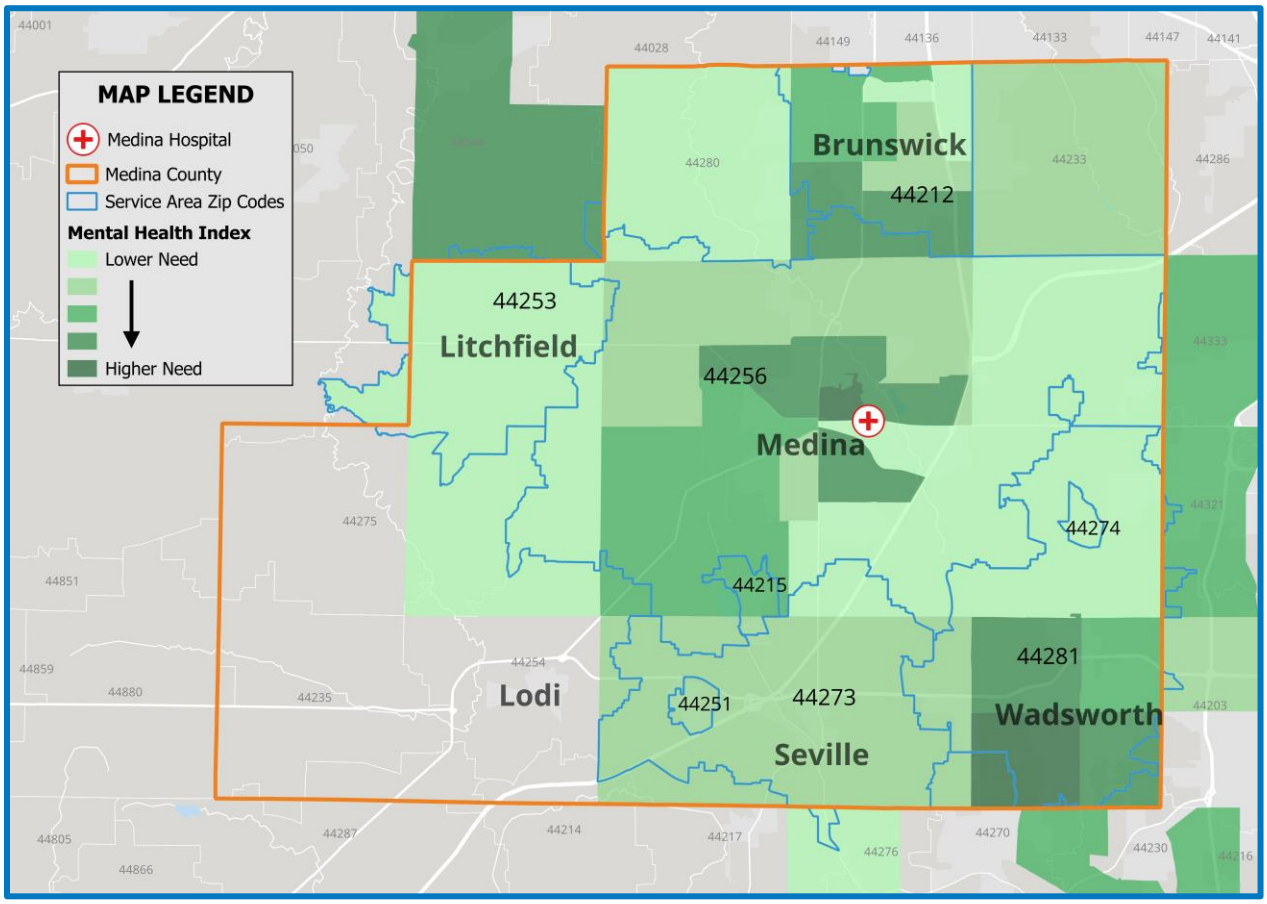


Mental Health Index

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 Medina Hospital Community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44256 (Medina) with an MHI value of 50.6. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Medina Hospital community.

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



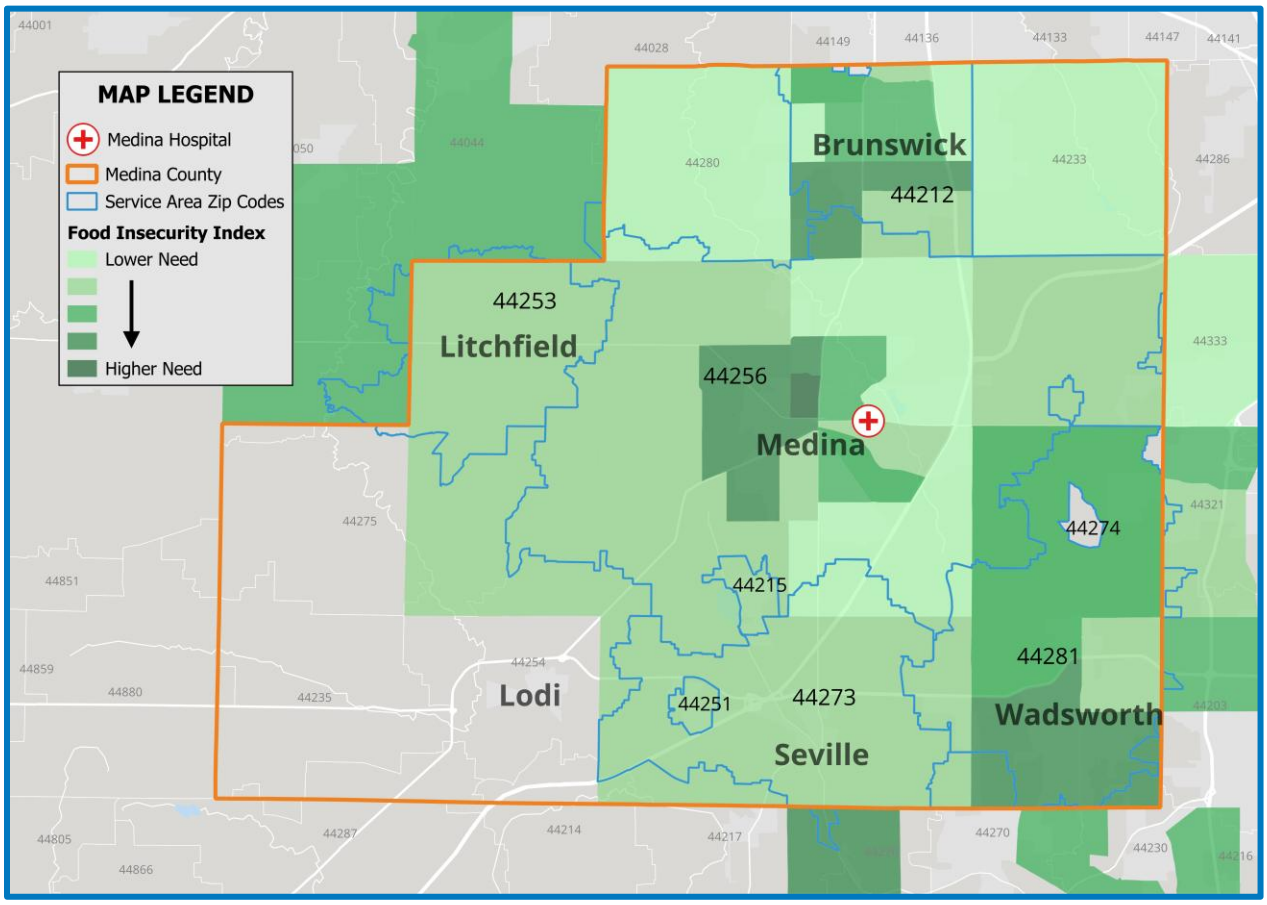
Food Insecurity Index

Conduent HCI's Food Insecurity Index (FII) can help to identify geographic differences in food access across the county, down to the census tract level. The FII uses health-related

social needs data that are strongly associated with poor food access to estimate which geographic regions have the greatest needs regarding food insecurity. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the Medina Hospital Community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44281 (Wadsworth), with a FII value of 34.5. See Appendix B for additional details about the FII and a table of FII values for each zip code in the Medina Hospital community.

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



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the Medina Hospital community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the four prioritized health needs identified in Medina 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 Medina Hospital's prioritized health needs:

- Access to Healthcare:
  - 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.

[7] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[8] Akron Children's Hospital. (2022). *Community Health Needs Assessment.* Retrieved from https://www.akronchildrens.org/pages/Community_Health_Needs_Assessment.html?tab=sctabtwo

2022 Greater Akron LGBTQ+ Community Needs Assessment[9]

Healthcare Access

- Need for more accessible and LGBTQ+ affirming healthcare providers.
- Gaps in availability of primary care and preventative services.

Mental Health

- Strong demand for culturally aware therapists and mental health providers.
- Emphasis on reducing stigma and increasing access to mental health support.

Wellness & Prevention

- HIV prevention and sexual health education remain critical areas of focus.
- Broader wellness programs are recommended to promote holistic health.

Nutrition & Food Security

- Food insecurity is a barrier to well-being, particularly for LGBTQ+ youth.
- More supportive food programs are needed to ensure access to healthy nutrition

2023 Medina County Community Development Needs Assessment[10]

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.
- Opportunities for Improvement: Despite the presence of healthcare services, participants emphasized the need for enhanced access points for some 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.

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[9] Snyder, A. M., Roufael, J. S., DiDonato, A. E., Maikranz, N. E., & Alemagno, S. (2022). *Greater Akron LGBTQ+ community needs assessment.* Kent State University College of Public Health. Retrieved from https://www.lgbtqohio.org/news/lgbtq-community-needs-assessment-greater-akron

[10] 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

2024 Medina County Community Health Assessment[11]

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[12]

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

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

[12] 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/

Primary Data Overview

Community Stakeholder Conversations

Community stakeholders from 10 organizations provided feedback specifically for the Medina 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 Medina Hospital community:

- Alternative Paths
- Cleveland Clinic Children's
- Educational Service Center of Medina County
- Hope Recovery Community
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Medina County Health Department
- Medina County Mental Health and Recovery Board
- Medina County Sheriff's Department
- Ohio Guidestone
- Second Baptist Church

Stakeholder discussions for the Medina Hospital 2025 Community Health Needs Assessment affirmed Behavioral Health as a top priority for the local community. Gaps in availability, affordability, and access to care were described as urgent challenges, especially for youth, older adults, and low-income residents. Provider shortages, long wait times, and limited crisis response options continue to restrict timely care. Stigma and the lack of culturally responsive services were also identified as barriers that prevent individuals from seeking support. Youth mental health, including depression, anxiety, and trauma, was repeatedly emphasized as an area of growing concern, often linked to family stress and the lingering effects of the COVID-19 pandemic.

Access to Healthcare and Chronic Disease Prevention and Management also emerged as pressing concerns. Residents noted significant obstacles related to transportation, service availability, and financial constraints that limit both preventive and ongoing care. Chronic diseases such as diabetes, hypertension, obesity, heart disease, and stroke remain prevalent in Medina County, with stakeholders pointing to poor nutrition, physical inactivity, and environmental stressors as contributing factors. Participants emphasized the importance of expanding mobile health services, telehealth options, and integrated care models to improve access, while also strengthening nutrition and wellness supports that encourage prevention and healthier lifestyles.

Challenges specific to Older Adults were also raised in the context of chronic disease management. Many seniors struggle with access to specialty care, medication affordability, and coordination of services, while also facing barriers from fixed incomes, social isolation, and transportation gaps. Stakeholders underscored the need for better

alignment of senior services, affordable care options, and community-based support that promote independence and reduce preventable hospitalizations.

Finally, health-related social needs were consistently described as underlying drivers of the differences in health outcomes present in the Medina Hospital community. Poverty, food insecurity, housing instability, unemployment, and financial stress affect residents across neighborhoods and age groups, limiting their ability to prioritize health and well-being. Stakeholders noted that reduced investment in some parts of the county, combined with gaps in social services, continue to widen differences in health outcomes. They stressed that progress would require coordinated cross-sector strategies that address both clinical and social needs through sustainable, community-driven, and culturally responsive solutions.

The following quotes highlight key themes highlighted in community feedback:

Priority Area	Key Quote	Additional Context
Access to Healthcare	"People often have to travel far or wait months to see a specialist, and many give up because of the cost and difficulty."	Highlights transportation and cost barriers that prevent timely access, especially in rural areas of Medina County.
Behavioral Health	"Mental health services are either full or too expensive, and families don't know where to turn when their kids are struggling."	Reflects the shortage of providers and affordability concerns, especially affecting youth mental health and family stress.
Chronic Disease Prevention and Management	"So many people are dealing with diabetes and heart problems, but they don't have the resources or education to manage them consistently."	Illustrates the widespread prevalence of chronic conditions and the importance of preventive education and support.
Health-Related Social Needs	"If you can't afford rent or food, healthcare becomes the last thing on the list."	Underscores how poverty, housing instability, and food insecurity drive differences in health outcomes for residents.

Prioritization Methodology

Medina 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, Medina 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. Medina 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 Medina Hospital available to address community health needs.

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[13] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services in medically 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, and supports access to care through federal funding and enhanced Medicaid and Medicare reimbursement. Within the Medina Hospital community, community health services are further supported by local public health agencies, including the Medina County Health Department. The following FQHC clinics and networks operate in the Medina Hospital Community:

- Medina County Health Department
- MetroHealth Community Health Centers (MHCHC)

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

Hospitals

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

- MetroHealth Medical Centers (Multiple Locations)
- University Hospitals (Multiple Locations)

Other Community Resources

A network of agencies, coalitions, and organizations provides a broad array of health and social services within the region served by Medina 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 Ohio contains information on organizations and resources in the following categories:

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

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

Comments Received on Previous CHNA

Community Health Needs Assessment reports from 2022 were published on the Medina 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. Medina 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

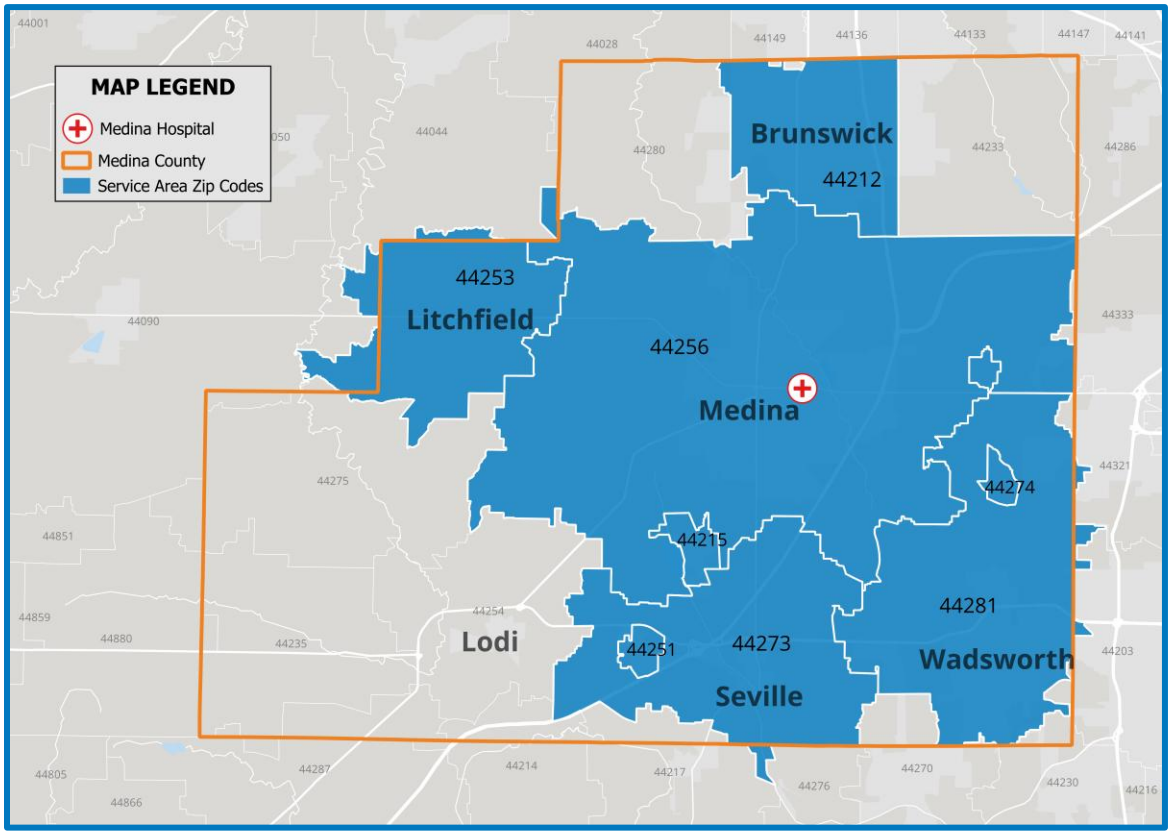
E. Impact Evaluation

F. Acknowledgements

Appendix A: Medina Hospital Community Definition

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

Figure 9: Medina 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.

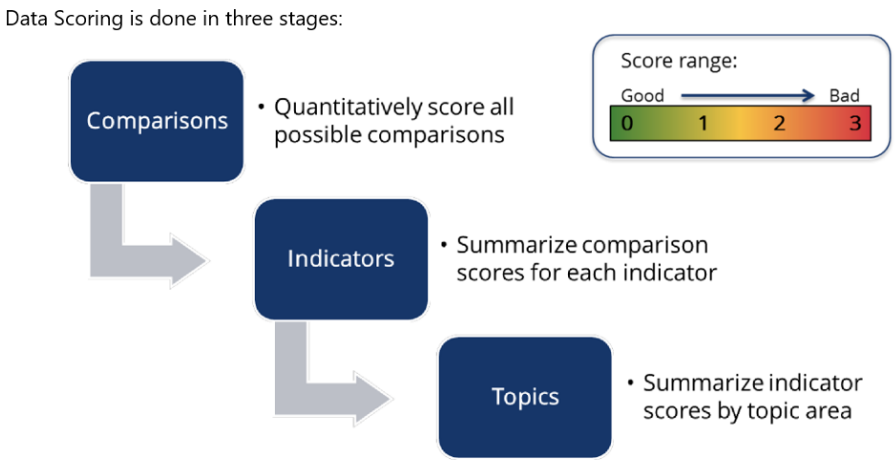
The following is a list of both local and national sources used in the Medina Hospital Community Health Needs Assessment:

- 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 Medina 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 4: 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 Medina Hospital community.

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

Zip Code	CHI Value	FII Value	MHI Value
44212	15.5	30.5	38.8
44215	22.7	15.4	29.9
44251	23.7	6.9	17.9
44253	23.9	18.6	8.4
44256	13.3	32.3	50.6
44273	17.2	13.9	22.4
44274	--	--	--
44281	12.8	34.5	46.7

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 Medina Hospital Community.

Figure 12: Census Tract Key (Medina Hospital)

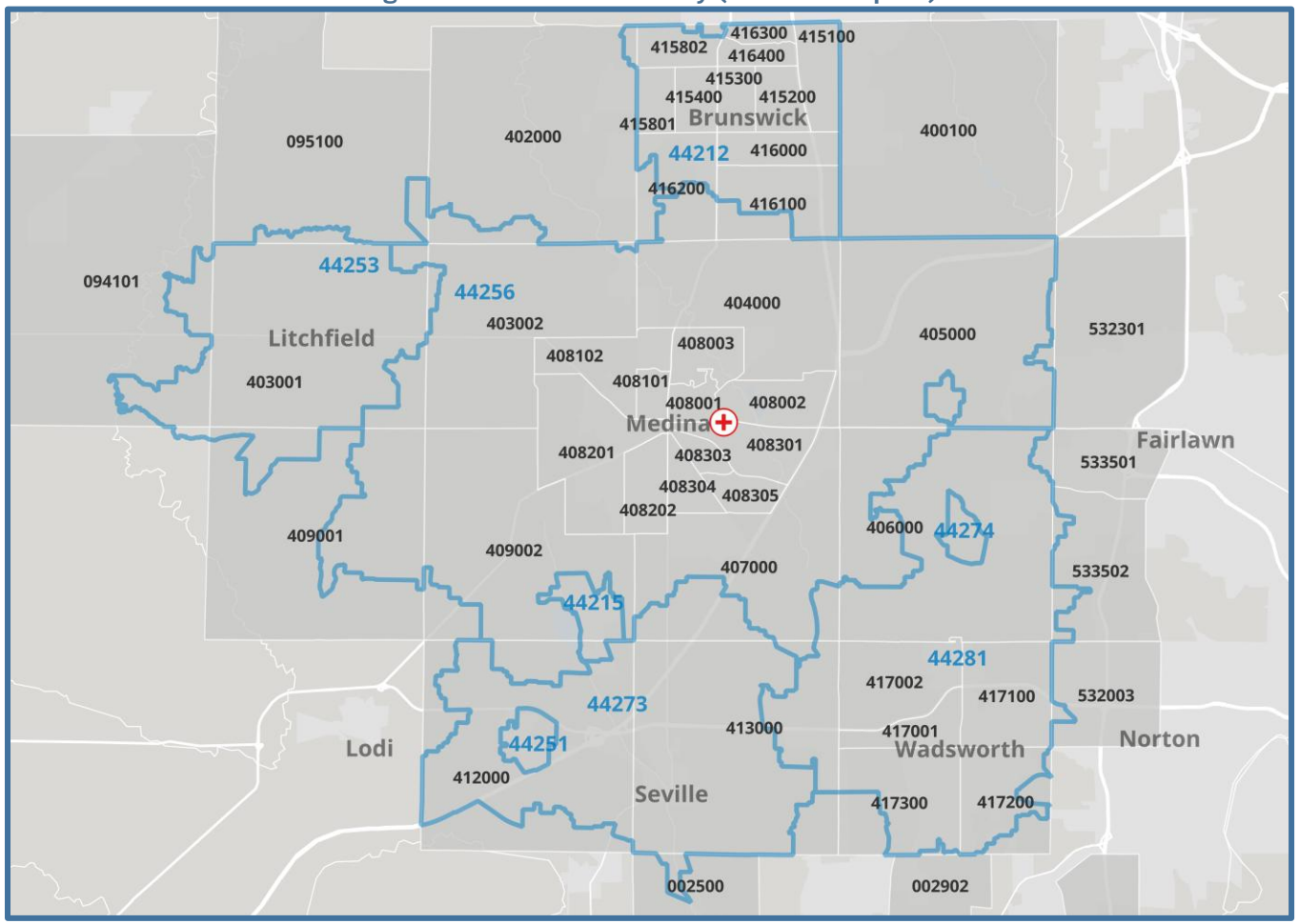


Table 5: Census Tracts by Zip Code (Medina Hospital)

44212	44215	44253	44256	44273	44251	44274	44281
400100	409002	94101	095100	002500	412000	406000	002902
402000	412000	95100	402000	407000			405000
415100		403001	403001	412000			406000
415200		403002	403002	413000			407000
415300		409001	404000				413000
415400			405000				417001
415801			406000				417002
415802			407000				417100
416000			408001				417200
416100			408002				417300
416200			408003				532003
416300			408101				533501
416400			408102				533502
			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 (CHI) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing concerning health outcomes.

HOW IS THE INDEX VALUE CALCULATED?

The national index value (ranging from 0 to 100) is calculated for each zip code, census tract, and county in the nation. Communities with the highest index values are estimated to have the highest health-related social needs correlated with preventable hospitalizations and premature death.

WHAT DO THE RANKS AND COLORS MEAN?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the CHI, with darker coloring associated with higher relative need.

Food Insecurity Index (FII)

Every community can be described by various demographic and economic factors that can contribute to differences in health outcomes. Conduent HCI's Food Insecurity Index 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 is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to 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 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 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 Medina 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
44212	45,872
44215	2,187
44251	879
44253	3,382
44256	66,016
44273	7,021
44274	--
44281	34,040
44212	45,872
Medina Hospital Community (Total)	159,397

Table 10: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Medina Hospital Community	Ohio
0-4	5.1%	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	10.2%	12.4%
35-44	12.0%	12.2%
45-54	13.0%	11.7%
55-64	14.1%	13.0%
65-74	12.1%	11.6%
75-84	6.7%	6.1%
85+	2.2%	2.2%
Median Age	43.4 years	40.5 years

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

	Medina Hospital Community	Ohio	U.S.
White	90.2%	75.7%	63.4%
Black/African American	1.6%	12.8%	12.4%
American Indian/Alaskan Native	0.1%	0.3%	0.9%
Asian	1.4%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.1%	0.2%
Another Race	1.0%	2.1%	6.6%
Two or More Races	5.6%	6.4%	10.7%
Hispanic or Latino (any race)	3.1%	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

	Medina Hospital Community	Ohio	U.S.
Only English	96.3%	92.8%	78.0%
Spanish	0.9%	2.3%	13.4%
Asian/Pacific Islander Language	0.5%	1.0%	3.5%
Indo-European Language	2.0%	2.8%	3.8%
Other Language	0.3%	1.1%	1.2%

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

Table 13: Household Income of Hospital Community and Surrounding Geographies

Income Category	Medina Hospital Community	Ohio
Under $15,000	4.6%	9.5%
$15,000 - $24,999	4.6%	7.8%
$25,000 - $34,999	5.2%	8.0%
$35,000 - $49,999	9.4%	12.2%
$50,000 - $74,999	15.8%	17.0%
$75,000 - $99,999	14.3%	13.0%
$100,000 - $124,999	12.3%	9.9%
$125,000 - $149,999	9.9%	7.0%
$150,000 - $199,999	11.3%	7.2%
$200,000 - $249,999	5.5%	3.5%
$250,000 - $499,999	5.0%	3.4%
$500,000+	2.1%	1.6%
Median Household Income	$93,433	$68,488

Table 14: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Medina Hospital Community	3.7%
Ohio	9.4%
U.S.	8.8%
Medina Hospital Zip Codes	-
44212	3.1%
44215	5.0%
44251	1.4%
44253	1.7%
44256	4.2%
44273	3.4%
44274	--
44281	4.1%

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

Table 15: Educational Attainment of Hospital Community and Surrounding Geographies

	Medina Hospital Community	Ohio	U.S.
Less than High School Graduate	4.1%	8.6%	10.6%
High School Graduate	29.3%	32.8%	26.2%
Some College, No Degree	19.7%	19.6%	19.4%
Associate Degree	9.6%	8.9%	8.8%
Bachelor's Degree	24.2%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	13.1%	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%
Medina Hospital Zip Codes	-
44212	46.8
44215	46.6
44251	5.1
44253	74.3
44256	43.8
44273	26.4
44274	--
44281	43.1

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%
Medina Hospital Zip Codes	-
44212	91.7%
44215	88.9%
44251	88.4%
44253	93.0%
44256	92.8%
44273	93.1%
44274	100%
44281	91.8%

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 Medina 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[14]
- 2022 Akron Children's Hospital CHNA[15]
- 2022 Greater Akron LGBTQ+ Community Needs Assessment[16]
- 2023 Medina County Community Development Needs Assessment[17]
- 2024 Medina County Community Health Assessment[18]
- United Way Community Needs Assessment: Summit & Medina Counties[19]

[14] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[15] Akron Children's Hospital. (2022). *Community Health Needs Assessment.* Retrieved from https://www.akronchildrens.org/pages/Community_Health_Needs_Assessment.html?tab=sctabtwo
[16] Snyder, A. M., Roufael, J. S., DiDonato, A. E., Maikranz, N. E., & Alemagno, S. (2022). *Greater Akron LGBTQ+ community needs assessment.* Kent State University College of Public Health. Retrieved from https://www.lgbtqohio.org/news/lgbtq-community-needs-assessment-greater-akron
[17] 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
[18] Medina County Health Department. (2024). *Community Health Assessment.* Medina County Health Department. Retrieved from https://medinahealth.org/community/data-reports/community-health-assessment/
[19] 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/

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 10 organizations provided feedback specifically for the Medina 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 Medina Hospital community:

- Alternative Paths
- Cleveland Clinic Children's
- Educational Service Center of Medina County
- Hope Recovery Community
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Medina County Health Department
- Medina County Mental Health and Recovery Board
- Medina County Sheriff's Department
- Ohio Guidestone
- Second Baptist Church

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 Medina Hospital's 2025 CHNA highlighted ongoing challenges in ensuring timely access to healthcare. Residents reported barriers such as high out-of-pocket costs, insurance gaps, and limited provider availability, which disproportionately affect low-income families, older adults, and rural residents. Transportation was frequently cited as a challenge, with limited public options making it difficult to attend appointments. Long wait times for specialty care, particularly in behavioral health, were described as a persistent obstacle. Many participants also stressed the importance of culturally responsive care and clearer communication to help residents navigate complex systems of insurance, referrals, and available services.

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

- Cost barriers: High deductibles and copays deter routine and follow-up care.
- Insurance gaps: Residents fall into a "working poor" gap, earning too much for assistance but unable to afford care.
- Provider shortages: Long waits for specialists, especially in behavioral health.
- Transportation challenges: Lack of reliable public transit limits access to care in rural areas.

- Resource awareness: Community members are often unaware of available services or how to access them.
- Older adult needs: Older residents face difficulties affording prescriptions, accessing preventive care, and finding age-appropriate supports.

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

"People with insurance still can't afford their deductibles, so they put off going to the doctor until it's an emergency."

"The public transportation system is not reliable. If you miss a bus, you might not get to your appointment on time."

"There are very few providers that take Medicaid, especially for mental health, which makes it really tough for families."

"Residents do not know where to turn for help, even though we have resources in the county."

Overall, stakeholders emphasized that access to healthcare in Medina remains shaped by affordability, availability, and awareness. Financial barriers, provider shortages, and transportation challenges limit residents' ability to receive preventive and consistent care. Older adults and low-income households were consistently described as populations most susceptible to these gaps. Participants stressed the need for integrated service models, better outreach, and stronger collaboration between healthcare, social services, and community organizations to ensure that care is accessible.

Behavioral Health: Mental Health and Substance Use Disorder

Stakeholders emphasized that behavioral health, including both mental health and substance use disorder, is one of the most urgent and persistent concerns in the Medina Hospital community. Participants described increasing demand for services, particularly for youth, older adults, and families facing financial and social stressors. Depression, anxiety, and trauma were identified as common mental health challenges, while substance use, especially opioids, alcohol, and vaping among youth, was described as a continuing crisis. Access to care is hindered by provider shortages, long wait times, stigma, and the lack of culturally responsive or affordable services, leaving many residents without timely or appropriate support. Stakeholders stressed the need for early intervention, integrated care models, and stronger community collaborations to address these complex behavioral health needs.

The following are highlights of participant feedback regarding behavioral health:

- Rising youth mental health needs: Depression, anxiety, and trauma linked to stress, family instability, and social pressures.
- Substance use concerns: Ongoing opioid and alcohol misuse, with growing concerns about youth vaping.

- Provider shortages and long waits: Difficulty accessing timely behavioral health care due to workforce shortages.
- Stigma limiting treatment: Stigma continues to prevent individuals from seeking help, particularly in smaller communities.
- Need for integrated care: Calls for behavioral health services embedded within schools, primary care, and community-based settings.
- Gaps in affordability and accessibility: Insurance barriers, out-of-pocket costs, and limited local service availability.

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

"We see more kids struggling with anxiety and depression, but the resources to support them are very limited."

"There are still long wait times to see a counselor, and for many people the cost makes it impossible."

"Stigma is huge in smaller communities, and people are reluctant to get help because of how they will be viewed."

"Substance use is still a major problem, and vaping among young people has become another issue that needs attention."

Behavioral health remains a critical area of need in Medina County, with stakeholders underscoring the urgency of addressing both mental health and substance use disorders. The shortage of providers, long wait times, and persistent stigma create significant barriers to care, while the affordability and accessibility of services continue to be major concerns. Expanding integrated care models, supporting youth and families with prevention and early intervention, and reducing stigma through education and community engagement were identified as essential steps toward improving behavioral health outcomes.

Chronic Disease Prevention & Management

Stakeholder conversations for the Medina Hospital community highlighted chronic disease prevention and management as a critical area of concern, with conditions such as diabetes, hypertension, heart disease, and cancer affecting residents across demographics. Participants linked these illnesses to persistent barriers in access to preventive services, delayed detection, and inconsistent care management, particularly among older adults and lower-income households. Poor nutrition, limited opportunities for physical activity, and financial strain from medications and supplies were frequently cited as underlying drivers of disease burden.

Community members emphasized the importance of proactive and coordinated approaches to reduce the prevalence of chronic conditions. Recommendations included increasing education and outreach around lifestyle changes, expanding access to early screening programs, and ensuring follow-up care is reliable and affordable. Stakeholders also pointed to the need for culturally responsive disease self-management programs and

stronger integration between clinical care and community resources such as nutrition assistance, fitness opportunities, and behavioral health supports. Addressing these needs was viewed as essential to improving health outcomes, reducing preventable hospitalizations, and strengthening the long-term wellbeing of the 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 & Lifestyle
The following are highlights of participant feedback regarding nutrition and healthy eating and wellness and lifestyle:

- Food Access Gaps: Limited affordable, healthy food options in some neighborhoods.
- Nutrition Education: Need for culturally relevant nutrition and cooking education programs.
- Wellness Infrastructure: Lack of affordable gyms, safe walking/biking trails, and recreational spaces.
- Community-Based Solutions: Strong support for farmers markets, community gardens, and local wellness initiatives.
- Prevention Connection: Stakeholders consistently tied better nutrition and wellness opportunities to chronic disease prevention.

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

"There are parts of the county where families have to rely on convenience stores, which do not offer the kind of food needed to prevent chronic health conditions."

"People need more affordable and accessible places to exercise, especially seniors who want to stay active but do not have transportation."

"If we could increase farmers markets that take EBT, it would help families access healthier food options."

Cancer
The following are highlights of participant feedback regarding cancer:

- Screening Access: Regular screenings and early detection were described as critical but underutilized.
- Financial Barriers: High costs and insurance gaps prevent timely diagnosis and treatment.
- Transportation Challenges: Limited access to reliable transportation contributes to delayed care.

- Awareness and Education: Residents are not always aware of available resources or the importance of preventive screenings.
- Disparities in Outcomes: Cancer disproportionately affects low-income residents and communities of color.
- Supportive Services: Navigation, education, and culturally tailored programs are needed to reduce gaps in care.

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

"People avoid screenings because they cannot afford the copay or do not have insurance."

"Transportation is a huge issue. Even if people want to get screened, they cannot always get to the appointment."

"We see worse outcomes for certain populations because they are not being reached with the right education or support."

Diabetes, Heart Disease, & Stroke

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

- High prevalence: Diabetes, hypertension, and heart disease remain common across the community.
- Delayed detection: Many residents only discover these conditions through screenings at events rather than through regular preventive care.
- Care management challenges: Consistent follow-up and adherence to treatment are limited by transportation, costs, and provider access.
- Lifestyle contributors: Poor nutrition, stress, and physical inactivity were frequently mentioned as drivers of chronic illness.
- Education and support needs: Residents would benefit from culturally relevant disease management programs and accessible health education.
- Older adults at risk: Stakeholders noted that seniors face greater barriers in managing multiple chronic conditions simultaneously.

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

"People often do not know they have high blood pressure or diabetes until they go to a health fair or screening."

"Even if they get diagnosed, follow-up is hard because of transportation or cost issues."

"Lifestyle is a big part of the problem. People are stressed, not eating well, and not moving enough."

"Older adults really struggle to manage multiple conditions at once without consistent support."

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:

- Social isolation limits access to both social and health support.
- Transportation barriers prevent older adults from attending regular appointments.
- Multiple chronic conditions create complex management challenges.
- High healthcare costs restrict the affordability of preventive and ongoing care.
- Limited caregiver support increases strain on families and seniors themselves.
- Need for aging-in-place programs and home health services.
- Integration of mental and physical health resources is a growing priority.

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

"Many older adults in this community live alone and simply cannot get to the doctor even if they want to."

"The cost of prescriptions and ongoing care is overwhelming for seniors on a fixed income."

"Transportation is a huge barrier, especially for those outside the city who cannot drive anymore."

Health-Related Social Needs

Stakeholders emphasized that health-related social needs remain a critical driver of health outcomes in the Medina Hospital community. Poverty, unstable housing, limited transportation, and financial insecurity were described as persistent barriers that shape residents' ability to access care, maintain healthy lifestyles, and achieve stability. Employment opportunities and access to affordable childcare were also raised as pressing concerns, particularly for low-income families who often face difficult trade-offs between work, health, and basic needs. Food insecurity and the affordability of healthy options further complicate chronic disease management and wellness for susceptible households. These health-related social needs intersect with other priority health needs, reinforcing the importance of upstream investments and coordinated cross-sector strategies.

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

- Housing affordability and instability: Limited affordable housing options create stress and instability for low-income families.
- Food insecurity: Access to affordable, nutritious food is an ongoing challenge in parts of the community.
- Transportation barriers: Limited transit options hinder residents' access to healthcare, jobs, and other essential services.
- Employment and childcare gaps: Lack of stable employment opportunities and affordable childcare create financial strain for working families.
- Poverty as a root driver: Financial insecurity underlies many health disparities, impacting residents' ability to prioritize care and wellness.

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

"Families are having to choose between paying for rent, food, or healthcare. Those trade-offs create real health challenges."

"We hear from people all the time that they cannot find affordable childcare, which makes it hard to keep steady employment."

"Healthy food is too expensive for some families. They rely on cheaper options that contribute to health issues like diabetes and obesity."

"Transportation continues to be a major barrier, especially for people living outside the city center."

Health-related social needs, particularly related to housing, food security, transportation, and financial stability, were consistently highlighted as critical influences on community health in Medina. These issues contribute directly to disparities in healthcare access, chronic disease management, and overall well-being. Stakeholders stressed that addressing these upstream factors requires strong collaboration among healthcare providers, community organizations, employers, and local government. Investing in affordable housing, food access initiatives, transportation solutions, and family support such as childcare will be essential for creating equal health outcomes across Medina County.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

Medina 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, Medina 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. Medina Hospital continued to provide training and supplies of Naloxone nasal spray to law enforcement colleagues in the county who are often first on scene of opioid overdoses.

D. Medina Hospital supported Alternative Paths with probate and indigent funding to ensure patients have access to needed care and outpatient treatment care.

E. The hospital offered central intake procedures to streamline the process related to additional levels of care for patients with behavioral health concerns.

F. Medina Hospital provided a representative on the Medina County Coalition for Suicide Prevention Team to enable continued conversations related to reducing stigma and assistance with the identification of early onset behavioral health conditions. The hospital provided caregiver representation on county LOSS team that provides support and resources during mental health crisis situations.

G. Working with *Hope Recovery Community*, Medina Hospital supported workforce development opportunities for those in active recovery from substance use disorder.

H. The hospital participated in the Medina County First Responder Support Team, a collaboration between Cleveland Clinic and Alternative Paths to provide peer support for first responders. Peers were trained in support and education as well as offered connection to a licensed clinician. Established in 2023, the goal is to support our first responders.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. Through the Healthy Medina initiative, the hospital provided health and wellness programs related to nutrition and physical activity. Medina Community Recreation Center provided programming on mindful eating, heart health, mental health, and movement.

B. Medina Hospital launched a collaboration with the Main Street Medina Farmers Market to provide health and wellness education during the market. Monthly health and wellness topics were presented to the community and reached 300-500 people a month. Topics included heart health, alternative medicine, eating well and mental health.

C. Medina Hospital provided free health screenings for the surrounding communities at the Medina Community Recreation Center, Cloverleaf Recreation Center, local schools, and other community-based locations. They provided blood pressure, height, weight and BMI screenings and information relating to risk factors/benefits to healthy lifestyle.

D. The hospital partnered with the Medina County Health Department as a member of the Living Well Medina County to provide education related to chronic disease. The hospital provided leadership on the action team addressing initiatives related to chronic disease self-management, heart health, vaping, food insecurity, diabetes, access to care, and access to routine screenings.

Health-Related Social Needs

Actions and Highlighted Impacts:

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

B. Medina continued to partner with Medina County Police Activities League (MCPAL) and participate in youth engagement strategies. The hospital collaborated with SHARE Coalition, a local organization consisting of mental health professionals, law enforcement, school counselors and other partners within the community who actively work on programming to promote substance free initiatives and leadership opportunities for middle and high school students from all districts within the community.

C. Medina Hospital Emergency Management provided training to the community related to Code Silvers and all large-scale incidences. Medina Hospital partnered with the county Emergency Management Association (EMA) to offer training for local first responders and hospital personnel.

D. The hospital supported the Main Street Medina Farmers Market as the Health and Wellness Sponsor. Education materials and content expertise were provided weekly to community members.

E. Medina Hospital provided support for Feeding Medina County Weekend Backpack Program, nutritious food supplies for K_12 students.

F. Medina Hospital continued to sponsor the Medina County Recreation Center (MCR) to provide education and speakers on health and wellness topics. Programs designed to engage youth through the *Young Chef* program introduced the concept of healthy seasonal fruits/vegetables and recipes to promote healthy habits.

G. The hospital provided career exploration opportunities for youth involved in Junior Leadership Medina County. They provided field trips, and panel discussions regarding career development for clinical and non-clinical areas. Various caregivers completed outreach at local high schools to talk about their careers and educational paths providing for exposure to a multitude of vocations.

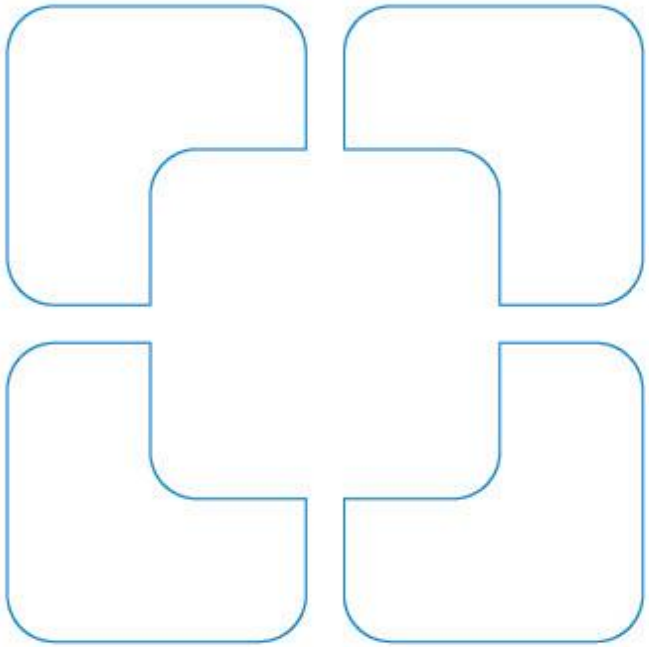
H. Cleveland Clinic's Center for Youth and College Education provided youth and college learners with career exploration opportunities in a healthcare environment, offering programming that prepares the next generation of caregivers to join the healthcare workforce.

Appendix F: Acknowledgements

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

Authors for this report include:

Ashley Wendt, MPH, Director of Public Health Consulting
Era Chaudry, MPH, Public Health Consultant
Adrian Zongrone, MPH, Senior Public Health Analyst
Sarah Jameson, MPH, Public Health Analyst
Dari Goldman, MPH Public Health Analyst



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Cleveland Clinic
Medina Hospital

Implementation Strategy Report

2025



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

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Medina 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 Medina 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 Medina 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

Medina Hospital is a modern, 148-bed[20] hospital that serves the Medina community with advanced technology, more than 300 physicians, and over 30 areas of specialization. Since affiliating with Cleveland Clinic in 2009, the hospital has provided local access to world-class care while maintaining trusted community connections. It is especially recognized for its expanded orthopedic program, offering advanced treatments and excellent outcomes delivered by highly experienced physicians. Medina Hospital has also supported the community with expert emergency care since 1944, with a state-of-the-art Emergency Department equipped to treat everything from minor problems to critical injuries and illnesses, ensuring seamless access to inpatient and specialty services when needed.

[20] 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.

As part of the broader Cleveland Clinic health system, Medina 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 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 Medina, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Medina Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Medina 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 more equal access to care. 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, Medina 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.

Medina 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: https://my.clevelandclinic.org/locations/medina-hospital.

II. Medina Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Medina Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Medina 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: Medina Hospital Community Definition

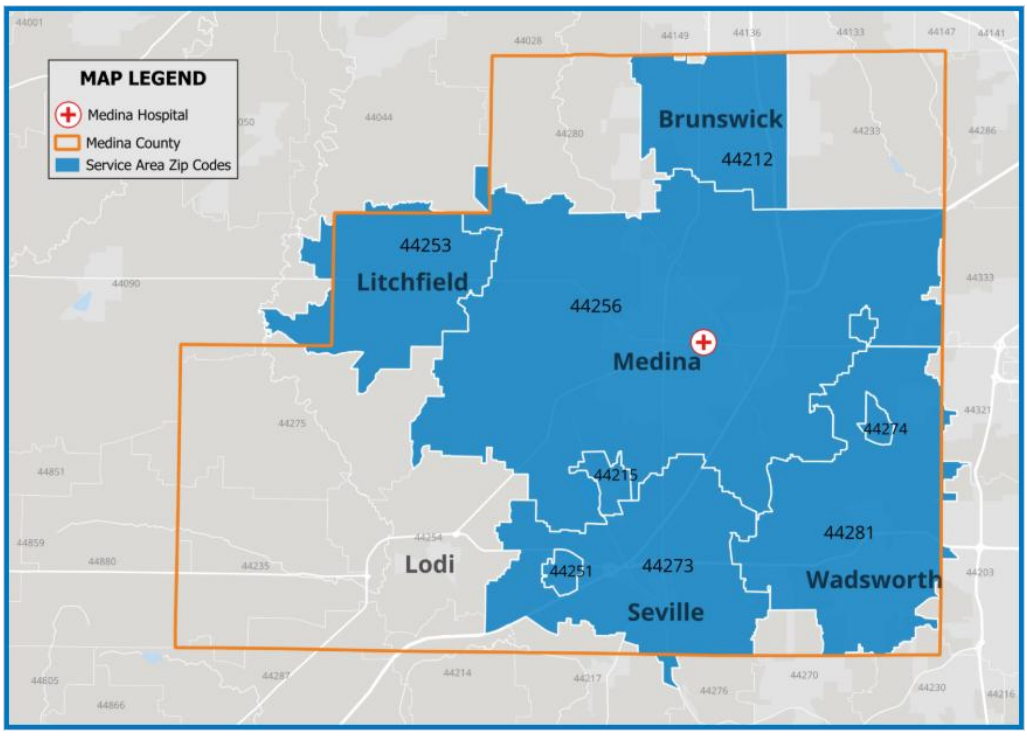


Table 1: Medina Hospital Community Definition

Zip Code	Postal Code
44212	Brunswick
44215	Chippewa Lake
44251	Westfield Center
44253	Litchfield
44256	Medina
44273	Seville
44274	Sharon Center
44281	Wadsworth

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of leadership at Medina 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 Medina 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

Medina 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 disparities and improve health outcomes across populations in the community served by Medina 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 Medina 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

Access to healthcare remains a significant concern in Medina County, as identified in the 2025 CHNA. Stakeholders cited financial barriers, including high out-of-pocket costs, copays, and prescription affordability, as major deterrents to preventive and ongoing care. Transportation limitations, especially in rural areas, further restrict access to appointments and specialized services. Additional challenges include provider shortages, long wait times, and limited behavioral health resources, compounded by residents'

difficulty navigating complex systems. Stakeholders emphasized the need for culturally responsive care, patient navigation, and integrated models that combine medical and social supports. Data reveal low availability of non-physician primary care providers and higher rates of avoidable hospital visits among some residents.

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

Behavioral Health, including mental health and substance use, is a top priority for the Medina Hospital community, as identified in the 2025 CHNA. Stakeholders reported significant access challenges, including provider shortages, long wait times, affordability issues, and lack of culturally responsive care. These barriers disproportionately affect youth, older adults, and low-income residents, with stigma further deterring treatment. Substance use, particularly opioids, methamphetamine, and alcohol, was highlighted as a growing concern, alongside rising anxiety and depression exacerbated by COVID-19. Recommended strategies include integrated mental health and addiction services, school-based interventions, crisis resources, and peer support programs. Data show high rates of excessive drinking and depression diagnoses, with certain neighborhoods experiencing greater mental 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 Alternative Paths, LLC to provide 24/7 crisis intervention and referral services.

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

B. **Initiative:** Through the hospital's Emergency Department, collaborate with Medina County Health Department to provide free naloxone medication via NaloxBox.

Anticipated Impacts: Reduce opioid overdose rates.

C. Chronic Disease Prevention and Management

Chronic Disease Prevention and Management is a major concern for the Medina Hospital community, as identified in the 2025 CHNA. Conditions such as diabetes, hypertension, heart disease, and obesity are common and often detected late, with barriers like cost, transportation, and limited preventive care contributing to poor outcomes. Stakeholders emphasized addressing social factors such as food access, safe spaces for exercise, and housing stability, alongside culturally tailored education and navigation support. Data show relatively low overall chronic disease rates but higher risks for certain populations, including elevated diabetes and rising kidney disease mortality. Food insecurity is concentrated in certain zip codes. Older adults face added challenges, including isolation and high fall-related death rates.

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

Health-related social needs were identified as a key priority in the Medina Hospital 2025 CHNA due to their strong influence on health outcomes. Stakeholders emphasized that housing affordability, transportation barriers, income insecurity, and employment gaps create systemic challenges that limit access to care and healthy lifestyles, particularly for older adults, low-income families, and households with children. Food insecurity and unstable housing were highlighted as pressing concerns, alongside the need for upstream strategies addressing poverty and education. While Medina County overall has higher income and education levels than state and national averages, differences persist for some residents who earn significantly less than the county median, and the gender

pay gap is among the largest nationally. Coordinated, cross-sector solutions were viewed as essential.

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

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

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

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

B. **Initiative:** Expand a multi-pronged strategy to address food security through education and healthy food access options. Support key partnership with Feeding Medina County.

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

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

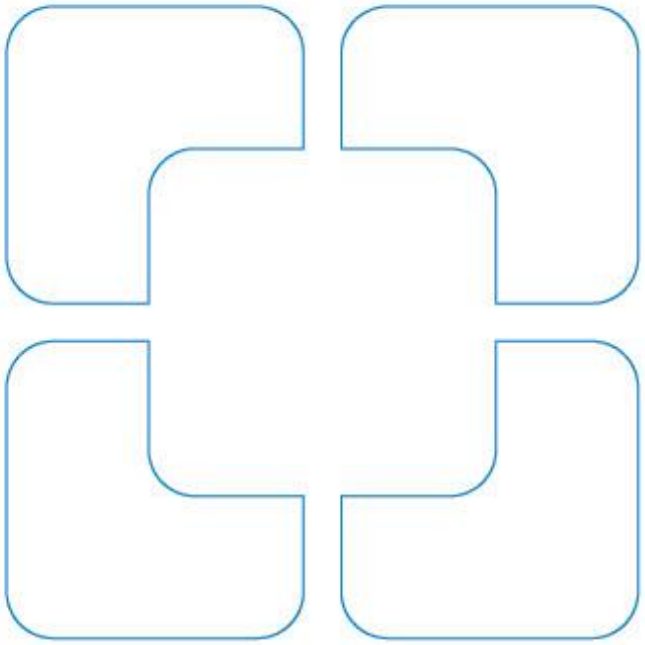
   Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives. Improve community awareness of available resources, develop a resource guide, and improve access to social supports.

D. **Initiative:** Provide workforce development and training opportunities for K-12 students, and adults, in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders. Continue to support Junior Leadership Medina County, introducing high school students to careers in healthcare.

   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 Medina 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 Medina 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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