Cleveland Clinic
Akron General
Lodi Hospital

Community Health Needs Assessment

2022

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Executive Summary

This Community Health Needs Assessment (CHNA) was conducted by Cleveland Clinic Lodi Hospital (the Lodi Hospital or "the hospital") to identify significant community health needs and to inform development of an Implementation Strategy to address current needs in accordance with the Affordable Care Act[1].

Lodi Hospital, a member of Cleveland Clinic Akron General, has proudly provided community-based healthcare to people of southwest Medina County and portions of Lorain, Ashland and Wayne Counties since 1920. Lodi Hospital is a designated 20 staffed bed[2] Critical Access Hospital and offers a comprehensive range of services: Acute and skilled care; Full range of outpatient diagnostic, rehabilitation and physical therapy services; Occupational healthcare; Outpatient and general, minimally invasive surgery; Radiology services and a state-of-the-art 24-hour emergency room. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/lodi-hospital

The hospital is part of the Cleveland Clinic health system, which includes an academic medical center near downtown Cleveland, fourteen regional hospitals in northeast Ohio, a children's hospital, a children's rehabilitation hospital, five southeast Florida hospitals, and several other facilities and services across Ohio, Florida, and Nevada.

Cleveland Clinic is a global leader and model of healthcare for the future. We work as a team with the patient at the center of care. As a truly integrated healthcare delivery system, we take on the most complex cases and provide collaborative, multidisciplinary care supported with cutting-edge research and technology. We treat patients and fellow caregivers as family and Cleveland Clinic as our home. Our vision is to become the best place to receive healthcare anywhere, and the best place to work in healthcare. Our goals for achieving that are bold, but reachable: To serve more patients, create more value and improve the well-being of all caregivers. As we grow and double the number of patients served by 2024, everything we do and every place we are located will bear the unmistakable stamp of One Cleveland Clinic –with the same quality, experience and Care Priorities at every location.

Cleveland Clinic's ability to provide world-class patient care and best-in-class clinicians is the product of our commitment to research and education, which has also contributed significant advancements toward the diagnosis and treatment of complex medical challenges. Figure 1 shows Our Care Priorities, which are to:[3]

- Care for Patients as if they are our own family
- Treat fellow caregivers as if they are our own family
- Be committed to the communities we serve

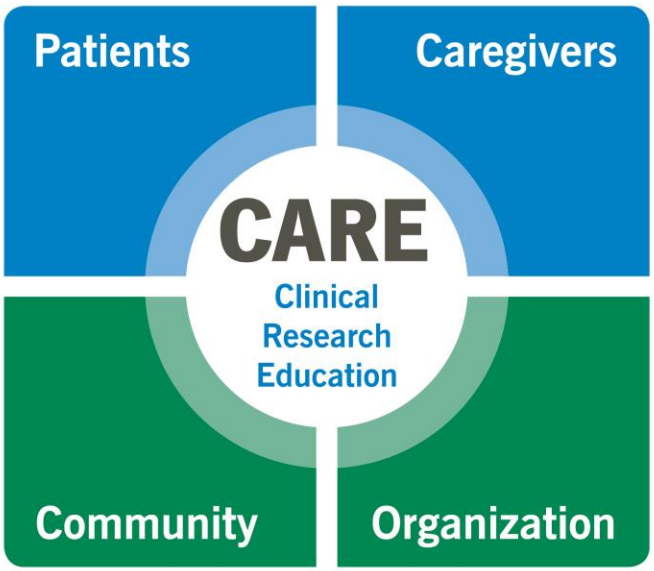
[1] Internal Revenue Service, Community Health Needs Assessment for Charitable Hospital Organizations – Section 501 (c) (3), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[2] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) 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.

[3] The Cleveland Clinic Mission, Vision and Values https://my.clevelandclinic.org/about/overview/who-we-are/mission-vision-values

- Treat the organization as our home

Figure 1: The Cleveland Clinic Care Priorities



Caring for the Community

Caring for the community is a long-standing priority at Cleveland Clinic. As an anchor institution –a major employer and provider of services in the community –our goal is to create the healthiest community for everyone. We do this through actions and programs to heal, hire and invest for the future.

Cleveland Clinic is much more than a healthcare organization. We are part of the social fabric of the community, creating opportunities for those around us and making the communities we serve healthier. We are listening to our neighbors to understand their needs, now and in the future. The health of every individual affects the broader community.

According to the National Academy of Medicine, only 20% of a person's health is related to the medical care they receive. There are other factors that have a lifelong impact, accounting for 80% of a person's overall health.[4] These social determinants of health are conditions in which people grow, work and live –including employment, education, food security, housing and several others.[5]

In order to address health disparities, we lead efforts in clinical and non-clinical programming, advocacy, partnerships, sponsorship and community investment. We are

[4] Magnan, S. Social Determinants of Health 101 for Healthcare: Five Plus Five, National Academy of Medicine. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
[5] Social Determinants of Health, World Health Organization. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

actively partnering with leaders to help strengthen community resources and mitigate the impact of disparities in social determinants of health. By engaging with partners who share our commitment, we can make a difference in creating a better, healthier community for everyone.[6]

Additional information about Cleveland Clinic is available at: https://my.clevelandclinic.org/.

Each Cleveland Clinic hospital is dedicated to the communities it serves. Each Cleveland Clinic hospital conducts a CHNA to understand and plan for the current and future health needs of residents and patients in the communities it serves. The CHNAs inform the development of strategies designed to improve community health, including initiatives designed to address social determinants of health.

These assessments are conducted using widely accepted methodologies to identify the significant health needs of a specific community. The assessments also are conducted to comply with federal and state laws and regulations including IRS requirements for 501(c)(3) Hospitals under the Affordable Care Act[7].

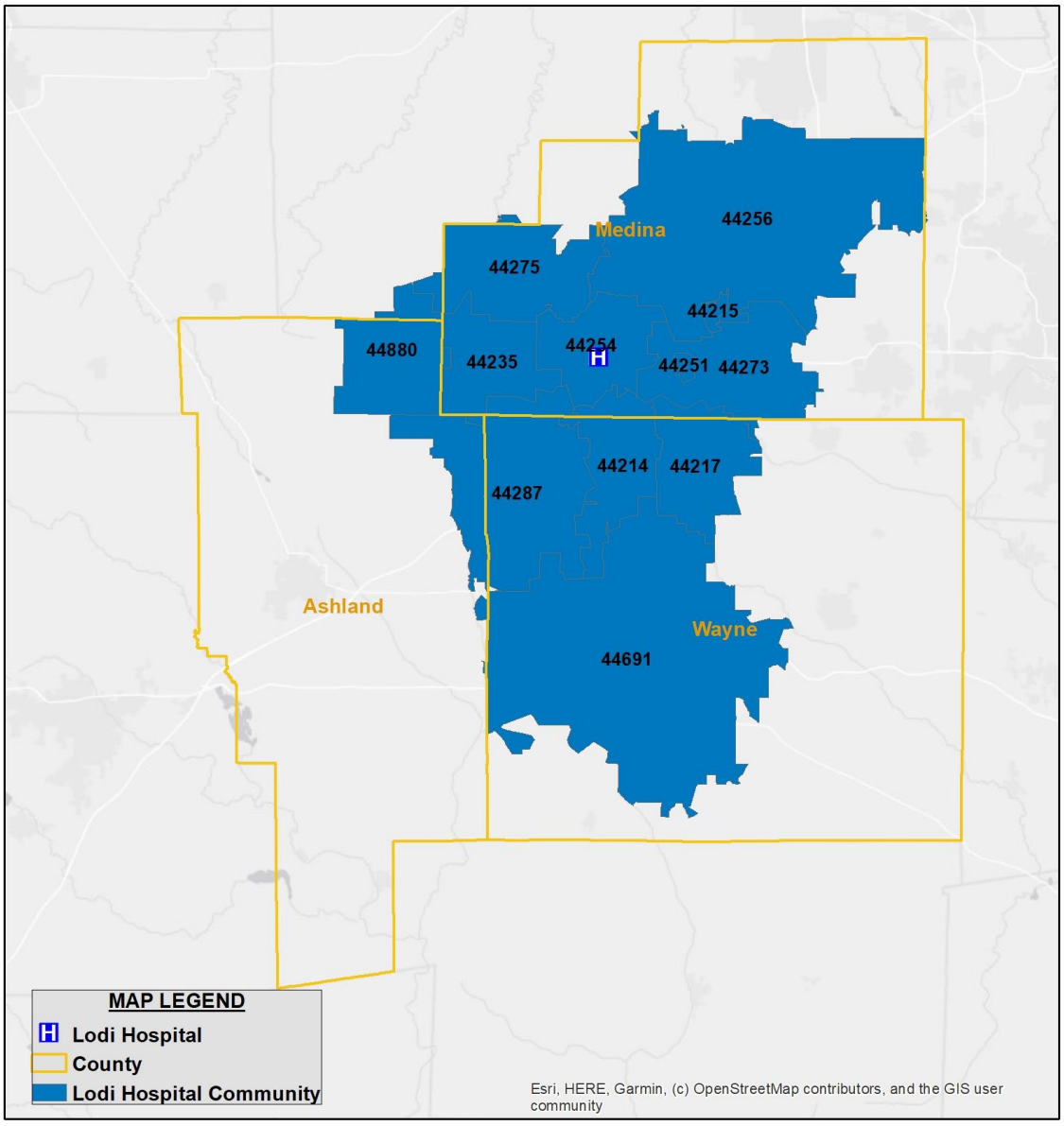
Community Definition

The community definition describes the zip codes where approximately 75% of Lodi Hospital patients reside. Figure 2 shows the service area for the Lodi Hospital Community. A table with zip codes and the associated postal names that comprise the community definition is located in Appendix C.

[6] Cleveland Clinic, Community Commitment, https://my.clevelandclinic.org/about/community#:~:text=Caring%20for%20the%20community%20is,and%20invest%20for%20the%20future.

[7] Internal Revenue Service, Requirements for 501 (c) (3) Hospitals Under the Affordable Care Act – Section 501 (r), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

Figure 2: Lodi Hospital Community Definition



Secondary Data Summary

Secondary data used for this assessment were collected and analyzed from Conduent Healthy Communities Institute's (HCI) community indicator database. The database, maintained by researchers and analysts at HCI, includes 300 community indicators covering at least 28 topics in the areas of health, social determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, nationally set targets and to previous time periods.

Due to variability in which public health data sets are available, data within this report may be presented at various geographic levels:

- The Lodi Hospital Community Definition—an aggregate of the 12 zip codes described in the Community Definition.
- Medina, Wayne and Ashland Counties—the three counties comprising the Lodi Hospital Community Definition

Primary Data Summary

Qualitative data collected from community members through key stakeholder interviews and a community engagement session comprised the primary data component of the CHNA and helped to inform selection of the significant health needs.

Conduent Healthy Communities Institute interviewed 20 key stakeholders from a diverse spectrum of community-based organizations and public health departments. To provide additional support and corroboration of vital community input, The Cleveland Clinic Foundation and Conduent Healthy Communities Institute facilitated a community engagement session featuring the Medina Hospital Community Advisory Council (CAC) members. Due to the overlapping Community Definitions and community concerns, Community Engagement Session data for the Lodi Hospital Community was derived from the Medina Hospital Community Advisory Council's Community Engagement Session. During the session, CAC members offered perspectives on the most important health problems in the community, barriers and challenges to improving health, identified the most underserved populations, discussed potential solutions to health challenges faced and offered success stories from existing program implementation.

Prioritized Health Needs

Following a comprehensive review of the significant community health needs throughout the Cleveland Clinic Health System, analysis of local county and state needs assessments and emerging trends, the following priority health needs were identified:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Socioeconomic Issues

Access to Healthcare

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

Behavioral Health

Behavioral Health encompasses two subtopics—Mental Health and Substance Use Disorder—into a single health need. Mental health secondary data indicators define suicide, Alzheimer's disease, depression and self-reported poor mental health rates. Similarly, Substance Use Disorder data outline rates related to alcohol and drug use including mortality rates due to drug overdoses. Primary data links the two together as community members and key stakeholders describe mental health challenges in the community, exacerbated by COVID-19 related stressors, resulting in increased alcohol and drug use starting in adolescence as a means of coping.

Chronic Disease Prevention and Management

This health topic encompasses several subtopics where information is available including Older Adult Health; Nutrition and Healthy Eating; Cancer; Chronic Diseases; Diabetes; Heart Disease and Stroke; and COVID-19. By addressing these issues in concert, the Cleveland Clinic Foundation hopes to impact chronic disease rates including those described in the Synthesis and Prioritization section of this report (page 33).

Socioeconomic Issues

Socioeconomic Issues for this report are defined as a subset of social determinants of health (SDOH). Prevention & Safety, Affordable Housing, Violence, Falls and Environmental Issues were the prioritized health needs described by primary and secondary data.

Additional Community Health Themes

In addition to the Prioritized Health Needs, other themes were prevalent in considering community health. These themes are intertwined in all community health components and impact multiple areas of community health strategies and delivery.

Health Equity

Health Equity issues in our communities were illuminated by COVID-19. They focus on the fair distribution of health determinants, outcomes and resources across communities.[8] Health Equity and reduction of health disparities are indicated as overarching themes in all our prioritized needs. It is described in detail and specifically as it relates to the Lodi Hospital Community in both the Disparities and Health Equity section (page 25) of the

[8] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative.National Center for Health Statistics.Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

report as well as in the Synthesis and Prioritization section (page 33). Special consideration will be given to addressing prioritized health needs through a health equity lens in the Lodi Hospital implementation strategy report.

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. Social determinants of health (SDOH) are major drivers of behaviors that impact individual and community health outcomes. For a full description of social determinants of health (SDOH) see the highlighted demographic section entitled Social & Economic Determinants of Health.

Medical Research and Health Professions Education

Cleveland Clinic has a tripartite mission to care for the sick and to improve patient care through research and education. Through research we discover cures and treatment of diseases affecting our communities. This cross-cutting issue was evident in addressing the emergent pandemic of COVID 19. Our education programs train qualified healthcare providers to support the needs of our patients and communities, reducing healthcare access issues. This has been of historical importance to the work, care and mission of Cleveland Clinic and will continue to be incorporated as Lodi Hospital moves toward development of the implementation strategy report.

COMMUNITY HEALTH NEEDS ASSESSMENT
Lodi Hospital

Prioritized Health Needs

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention & Management
- Socioeconomic Issues

Process

Additional Community Health Themes

Health Equity

Health Equity focuses on the fair and just distribution of health determinants, outcomes, and resources across communities.

Systemic racism
Poverty
Gender discrimination

Poorer health outcomes for groups such as Black persons, Hispanic or Latino persons, Indigenous communities, people experiencing poverty and LGBTQ+ communities.

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion

Medical Research and Health Professions Education

Cleveland Clinic has a tripartite mission to care for the sick and to improve patient care through research and education.

Through research we discover cures and treatment of diseases affecting our communities.

Our education programs train qualified healthcare providers to support the needs of our patients and communities, reducing healthcare access issues.

Demographics of the Lodi Hospital Community

The demographics of a community significantly impact its health profile.[9] Different racial, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community residing in the Lodi Hospital Community Definition.

Geography and Data Sources

Data are presented in this section at the geographic level of the Community Definition. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey[10] one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

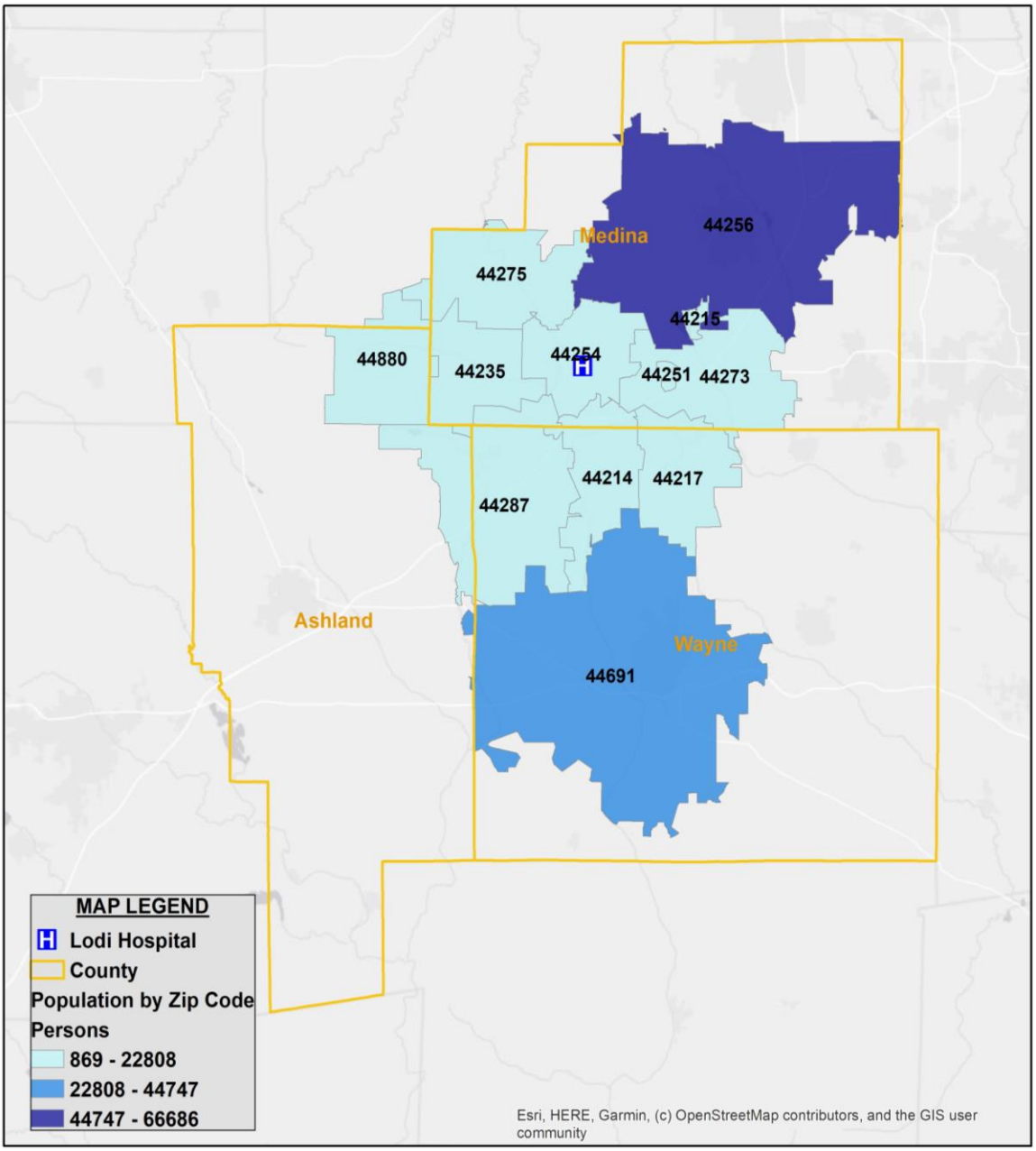
Population

According to the 2022 Claritas Pop-Facts® population estimates, the Lodi Hospital community has an estimated population of 148,283 persons. Figure 3 shows the population size by each zip code, with the darkest blue representing the zip codes with the largest population. Appendix C provides the actual population estimates for each zip code. The most populated zip code area within the Lodi Hospital Community is zip code 44256 (Medina) with a population of 66,686.

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

[10] American Community Survey. https://www.census.gov/programs-surveys/acs

Figure 3: Population by Zip Code

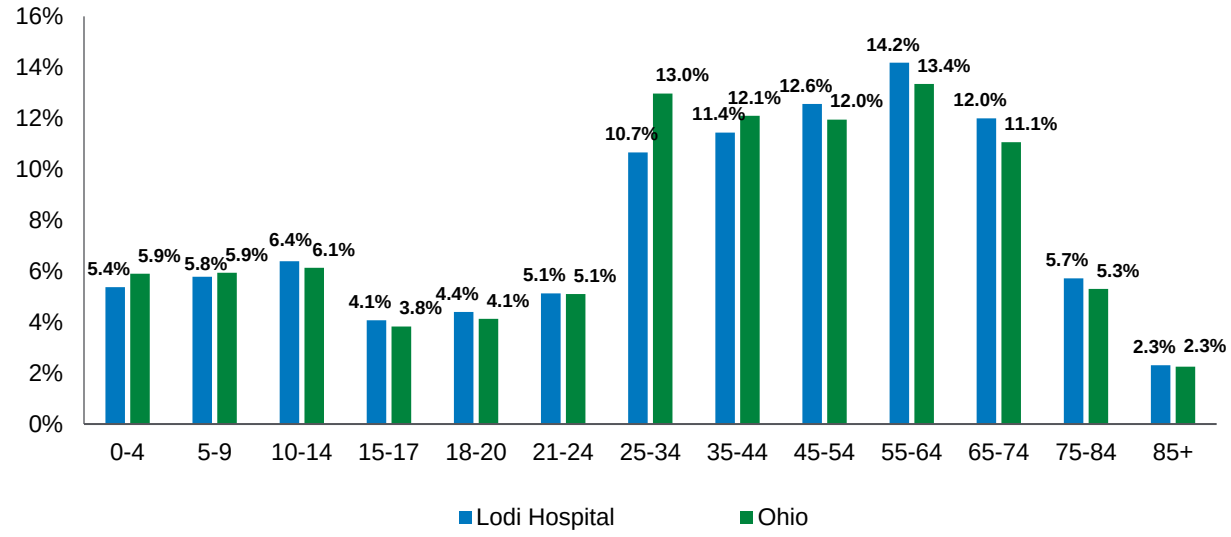


County values· Claritas Pop-Facts® (2022 population estimates)

Age

Children (0-17) comprised 21.6% of the population in the Lodi Hospital Community which is slightly less when compared to the state of Ohio (21.8%). The Lodi Hospital Community has a higher proportion of residents aged 65+ (20.0%) when compared with the state of Ohio at 18.6%. Figure 4 shows further breakdown of age categories.

Figure 4: Population by Age: Hospital and State Comparisons

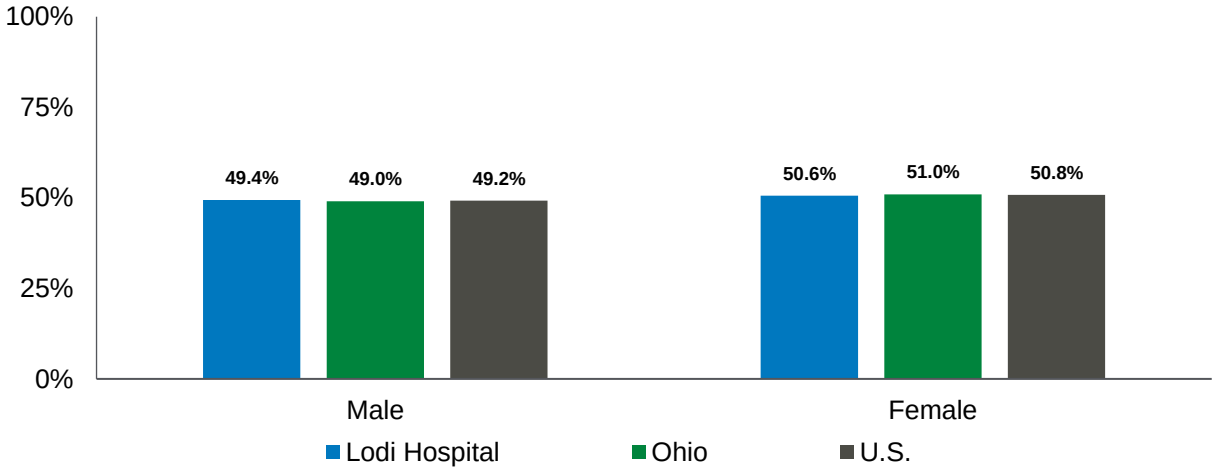


County and state values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 5 shows the population of the Lodi Hospital Community by sex. Males comprise 49.4% of the population in the Lodi Hospital Community, which is higher than both the Ohio (49.0%) and U.S. (49.2%) values. While females comprise 50.6% of the population in the Lodi Hospital Community which is similar to Ohio (51.0%) and the U.S. (50.8%) values.

Figure 5: Population by Sex: Hospital, State, and U.S. Comparisons



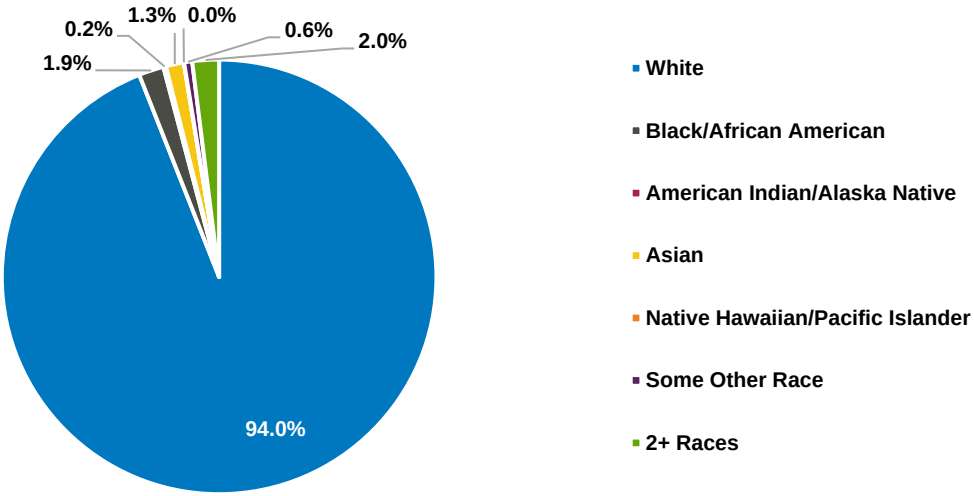
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2015-2019) estimates

Race and Ethnicity

Race and ethnicity contribute to the opportunities individuals and communities have to be healthy. The racial and ethnic composition of a population is also important in planning for future community needs, particularly for schools, businesses, community centers, healthcare, and childcare.

The racial makeup of Lodi Hospital area shows 94.0% of the population identifying as White, as indicated in Figure 6. The proportion of Black/African American community members is the second largest of all races in the Lodi Hospital Community at 1.9%.

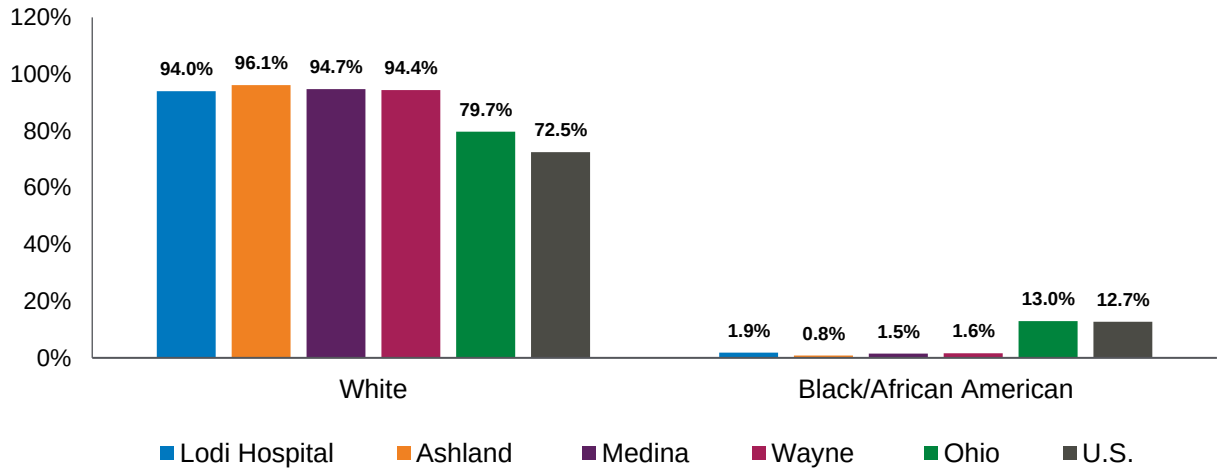
Figure 6: Population by Race: The Lodi Hospital Community



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

Those community members identifying as White represent a higher proportion of the population in the Lodi Hospital Community (94.0%) when compared to Ohio (79.7%) and the U.S. (72.5%), while Black/African American community members represent a lower proportion of population in the Lodi Hospital Community (1.9%) when compared to Ohio (13.0%) and the U.S. (12.7%). Wayne County has the largest percentage of community members identifying as Black/African American (1.6%) compared to the other counties included in the Lodi Hospital Community Definition. (Figure 7)

Figure 7: Population by Race: Hospital, County, State, and U.S. Comparisons

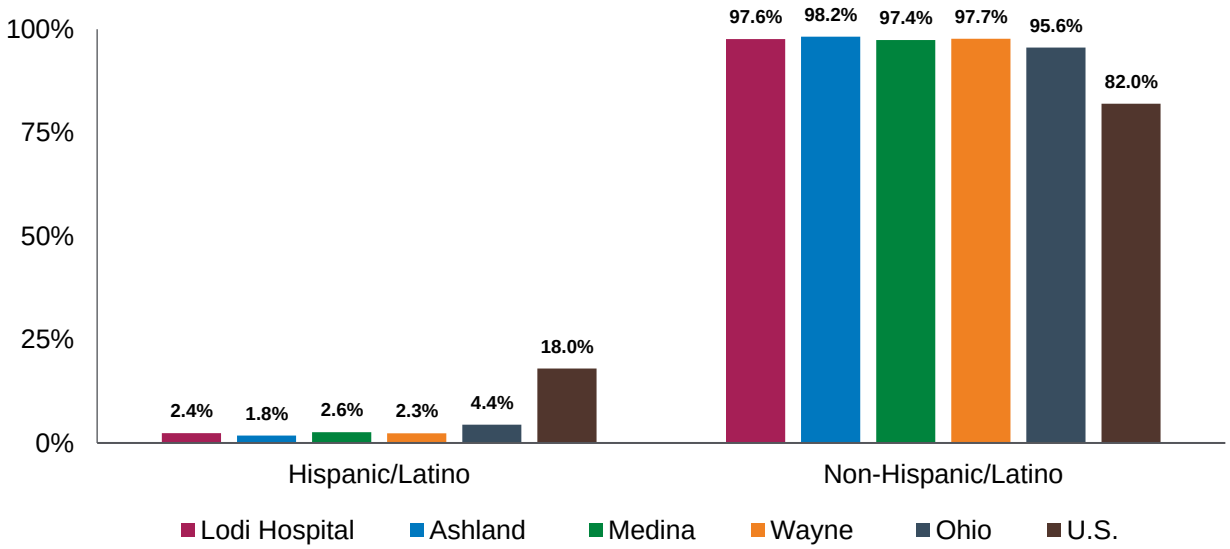


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

As shown in Figure 8, 2.4% of the population in the Lodi Hospital Community identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Ohio

(4.4%) and the U.S. (18.0%). Medina County has the largest percentage of community members who identify as Hispanic/Latino (2.6%).

Figure 8: Population by Ethnicity: Hospital, County, State, and U.S. Comparisons



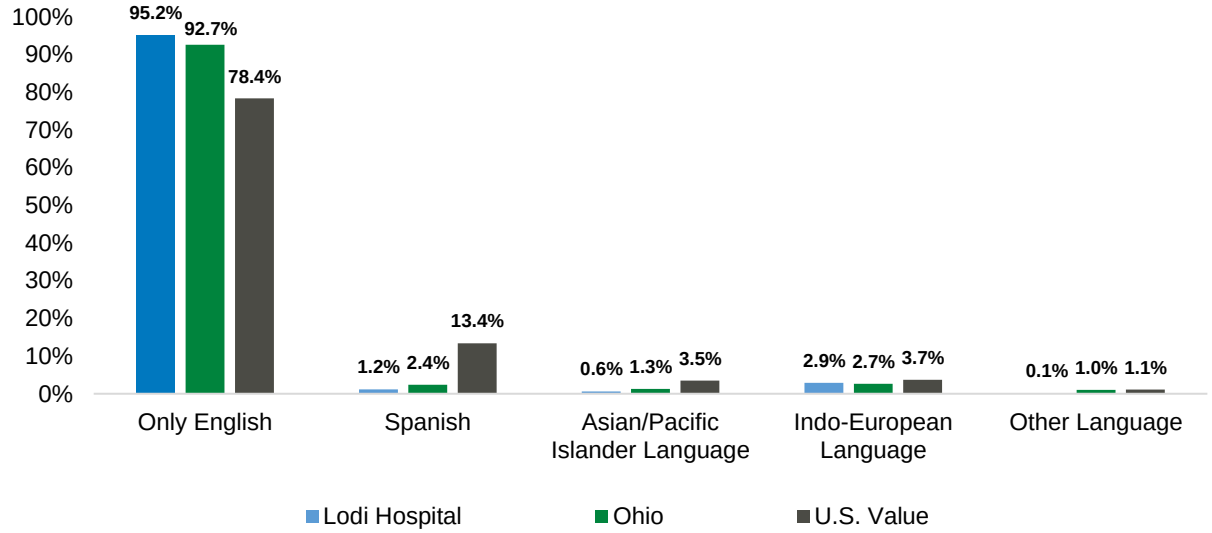
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system.

In the Lodi Hospital Community, 95.2% of the population age five and older speak only English at home, which is higher than both the state value of 92.7% and the national value of 78.4% (Figure 9). This data indicates that 1.2% of the population in the Lodi Hospital Community speak Spanish, 0.6% speak an Asian/Pacific Islander language, 2.9% speak an Indo-European Language, and 0.1% speak other languages at home.

Figure 9: Population 5+ by Language Spoken at Home: Hospital, State and U.S. Comparisons

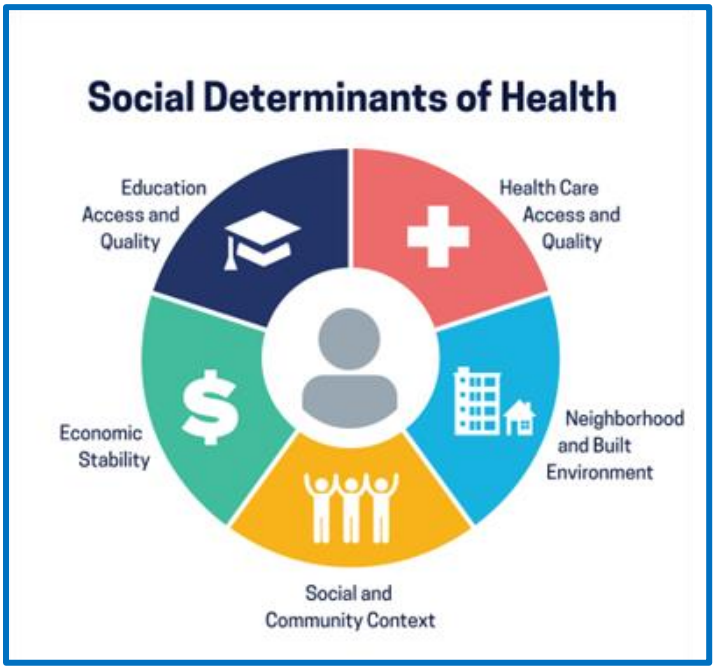


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Highlighted Demographics: Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Lodi Hospital Community. The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems[11]. The Social Determinants of Health (SDOH) can be grouped into five domains. Figure 10 shows the Healthy People 2030 Social Determinants of Health domains[12].

Figure 10: Healthy People 2030 Social Determinants of Health Domains



Geography and Data Sources

Data in this section are presented at various geographic levels (zip code and/or county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data can sometimes mask what could be going on at the zip code level in many communities. While indicators may be strong when examined at a higher level, zip code level analysis can reveal disparities.

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

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

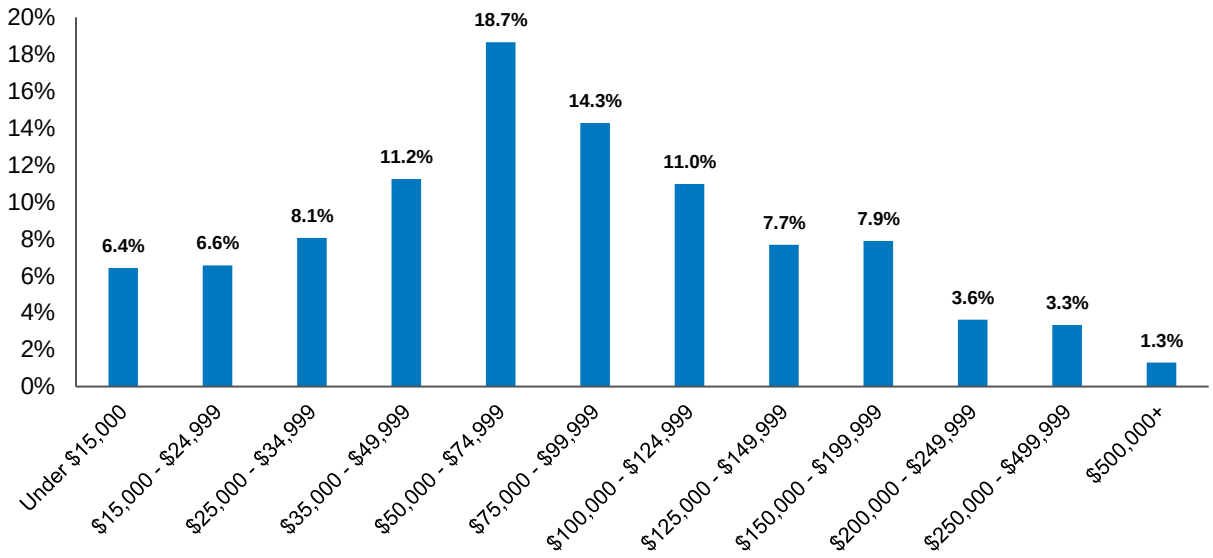
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[13]

Figure 11 provides a breakdown of households by income in the Lodi Hospital Community Definition. A household income of $50,000 - $74,999 is shared by the largest proportion of households in the Lodi Hospital Community (18.7%). Households with an income of less than $15,000 make up 6.4% of households in the Lodi Hospital Community.

Figure 11: Households by Income: The Lodi Hospital Community

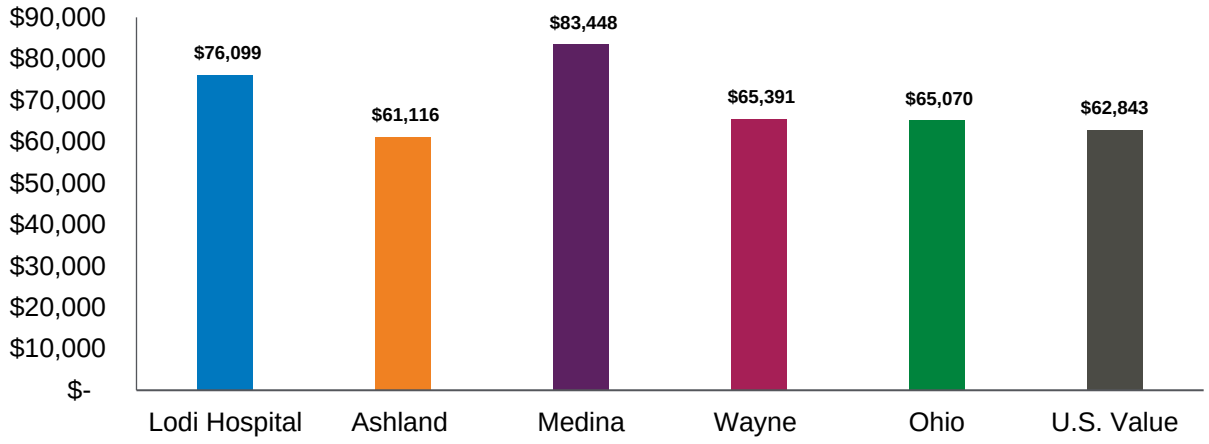


County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for the Lodi Hospital Community is $76,099, which is higher than the state value of $65,070 and national value of $62,843 (Figure 12).

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

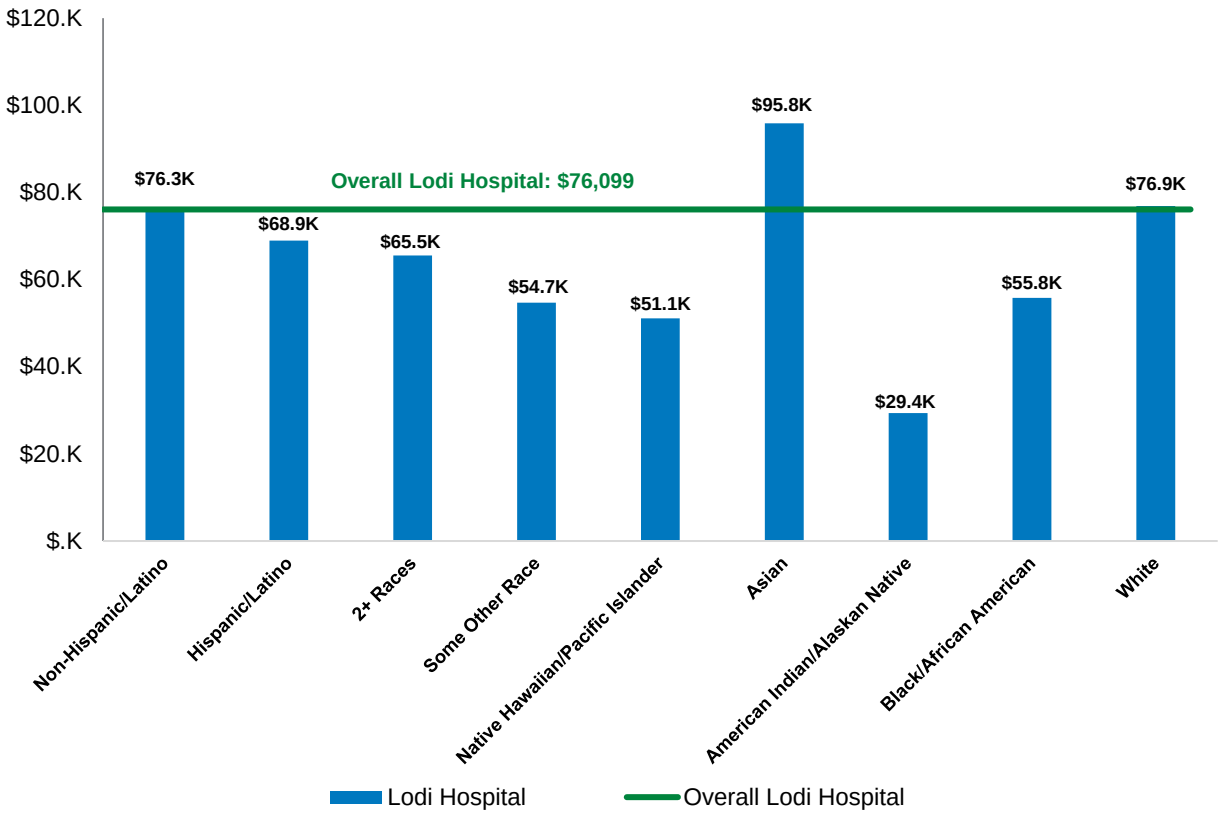
Figure 12: Household Income by: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Figure 13 shows the median household income by race and ethnicity. Three racial/ethnic groups – White, Asian, and Non-Hispanic/Latino– have median household incomes above the overall median value. All other races have incomes below the overall value, with the American Indian/Alaskan Native population having the lowest median household income at $29,365.

Figure 13: Median Household Income by Race/Ethnicity, The Lodi Hospital Community



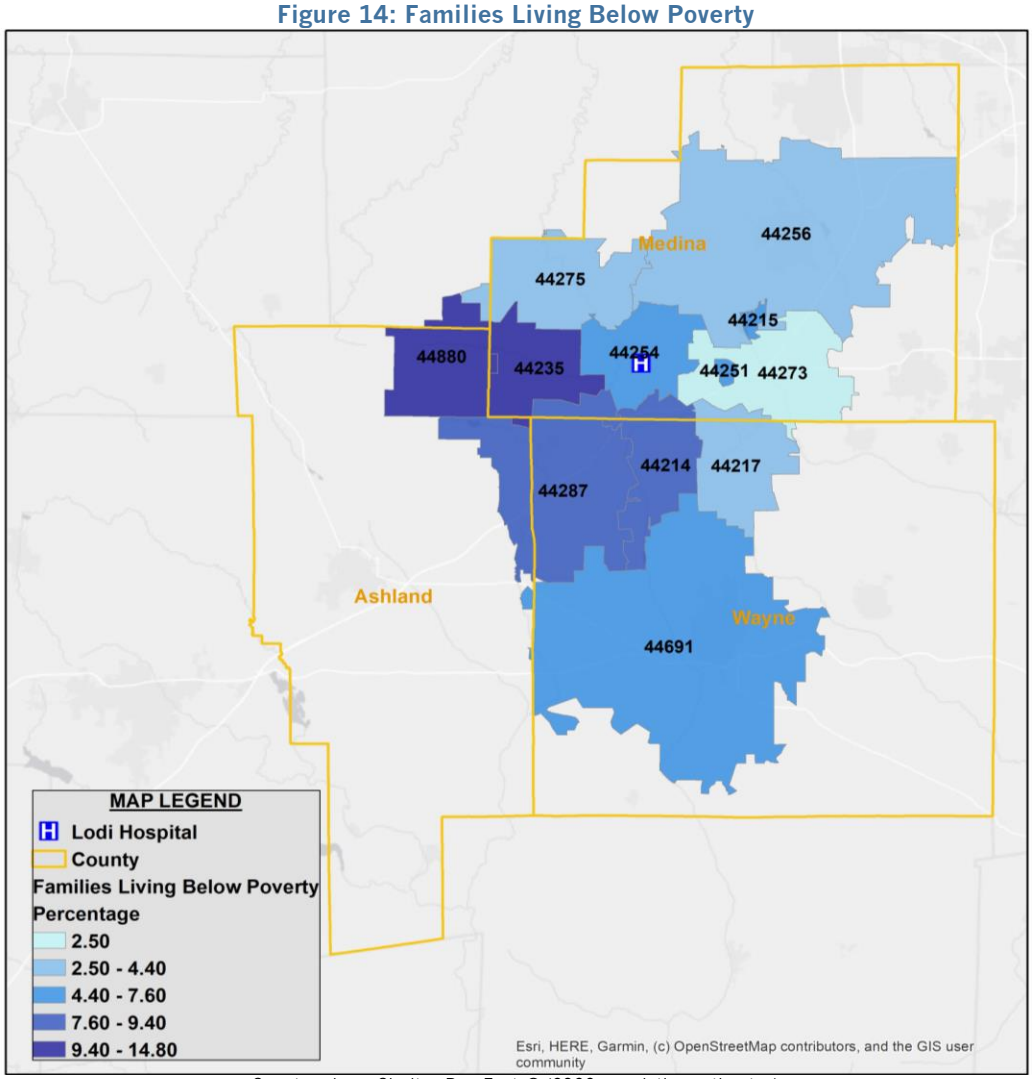
County values- Claritas Pop-Facts® (2022 population estimates)

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[14]

Figure 14 shows the percentage of families living below the poverty level by zip code. The darker blue colors represent a higher percentage of families living below the poverty level, with zip codes 44880 (Sullivan) and 44235 (Homerville) having the highest percentages at 12.2% and 9.6%, respectively. Overall, 5.4% of families in the Lodi Hospital Community live below the poverty level, which is lower than both the state value of 9.6% and the national value of 9.5%. The percentage of families living below poverty for each zip code in the Lodi Hospital Community is provided in Appendix C

Figure 14: Families Living Below Poverty



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

[14] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

Employment

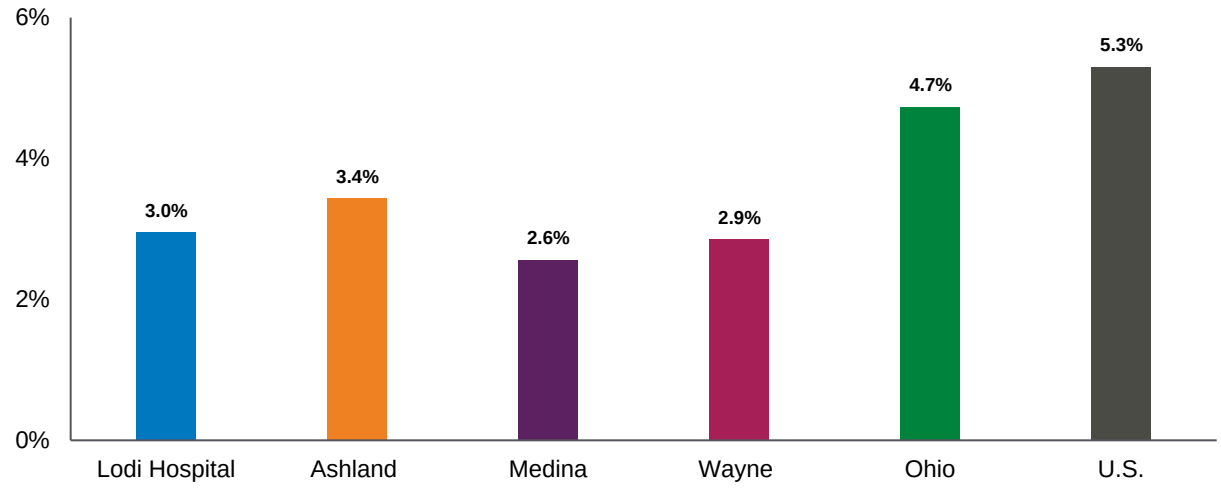
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[15]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[15]

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[15]

Figure 15 shows the population aged 16 and over who are unemployed. The unemployment rate for the Lodi Hospital Community is 3.0%, which is lower than the state value of 4.7% and lower than the national value of 5.3%.

Figure 15: Population 16+ Unemployed: Hospital, County, State, U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Education

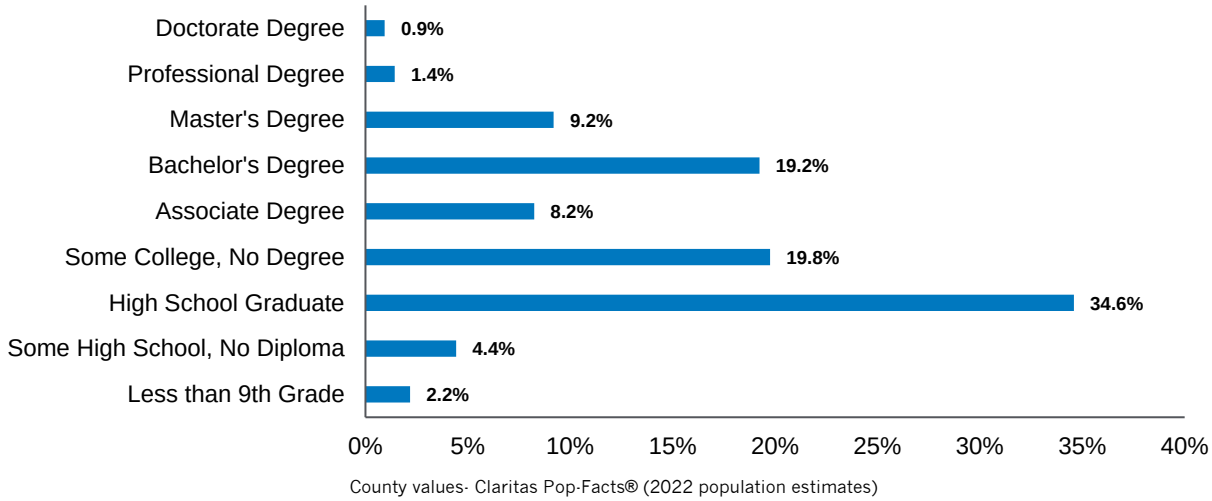
Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[16]

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

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

Figure 16 shows the percentage of the population 25 years or older by educational attainment.

Figure 16: Population 25+ by Education Attainment: The Lodi Hospital Community Definition

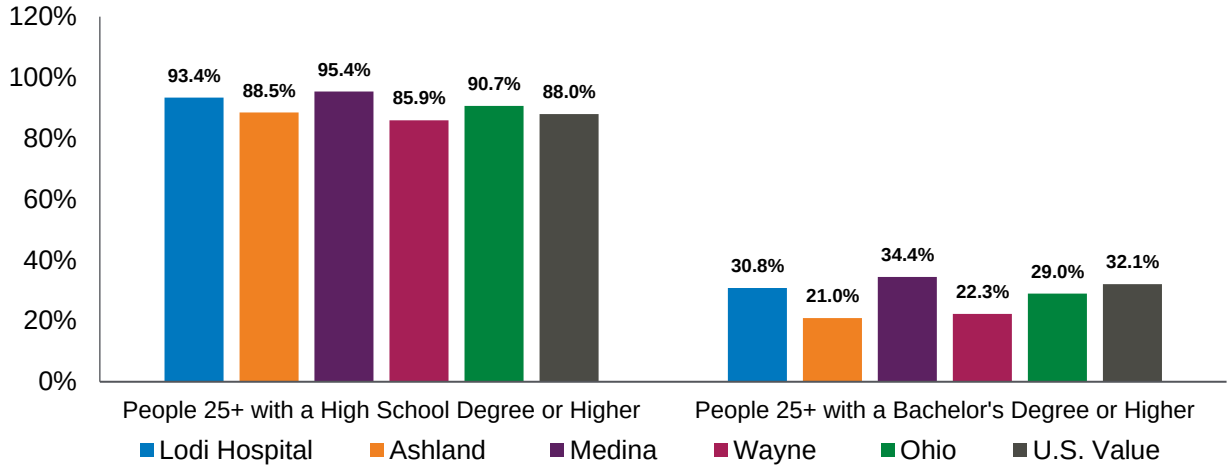


County values- Claritas Pop-Facts® (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[17]

Figure 17 shows that the Lodi Hospital Community has a higher percentage of residents with a high school degree or higher (93.4%) when compared to the state of Ohio value (90.7%) and the U.S. value (88.0%). Furthermore, the percentage of residents in Lodi with bachelor's degree or higher (30.8%) is higher when compared to the state of Ohio value (29.0%) and lower when compared to the U.S. value (32.1%).

Figure 17: Population 25+ by Education Attainment: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

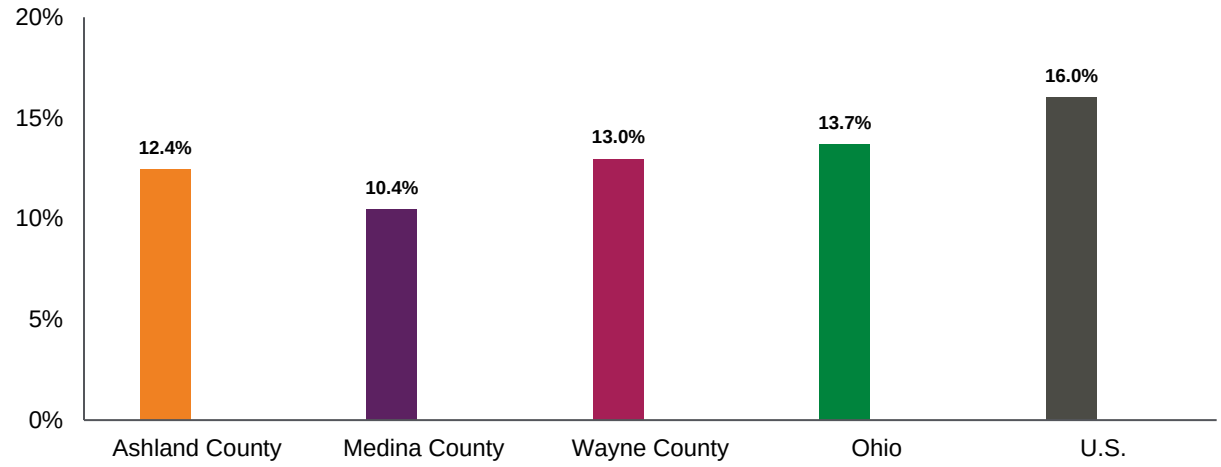
[17] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[18]

Figure 18 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Wayne County has the highest percentage of houses with severe housing problems.

Figure 18: Severe Housing Problems: County, State, And U.S. Comparisons



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

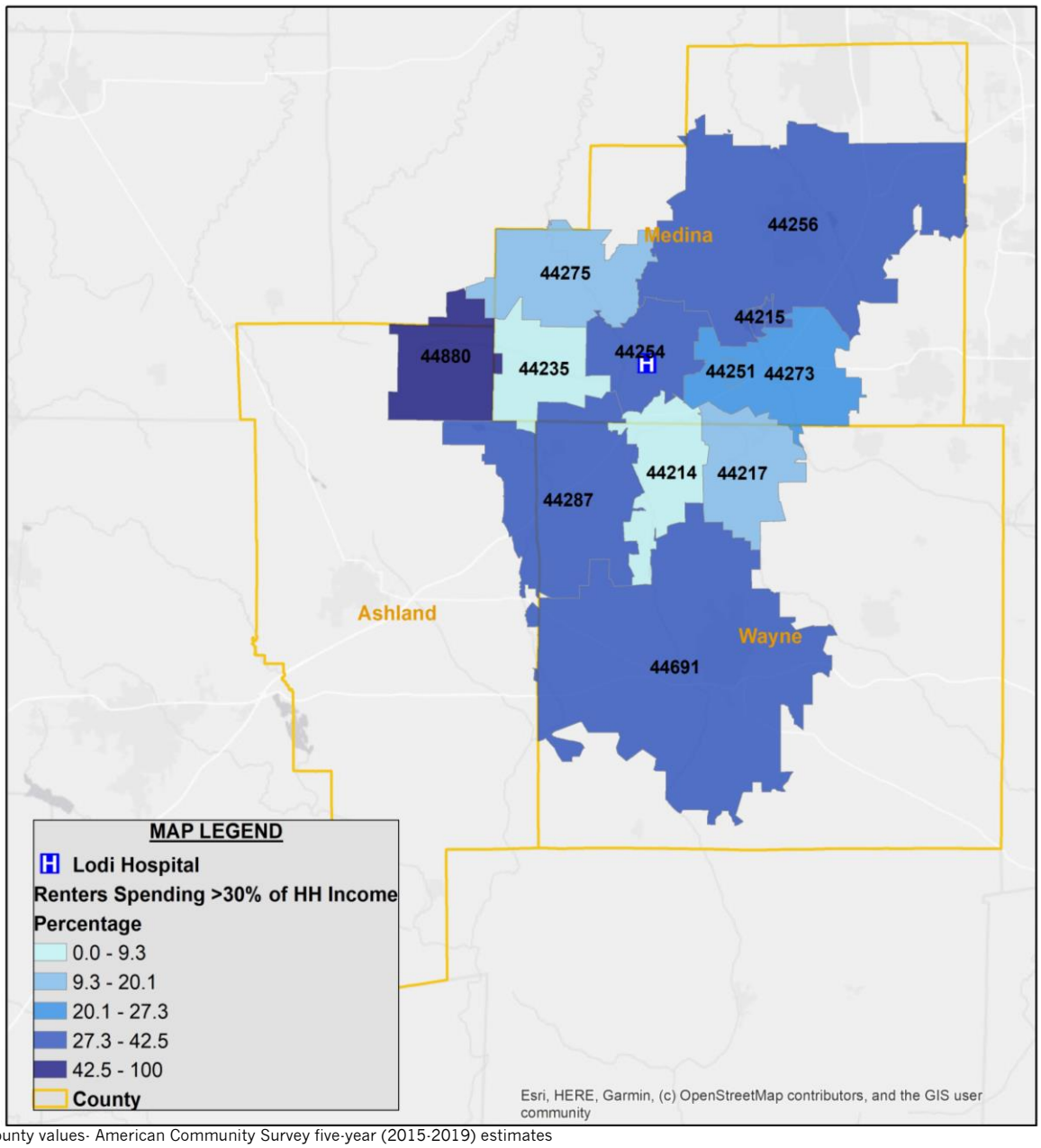
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.[19]

Figure 19 shows the percentage of renters who are spending 30% or more of their household income on rent.

[18] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

[19] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Figure 19: Renters Spending 30% Or More Of Household Income on Rent



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

Neighborhood and Built Environment

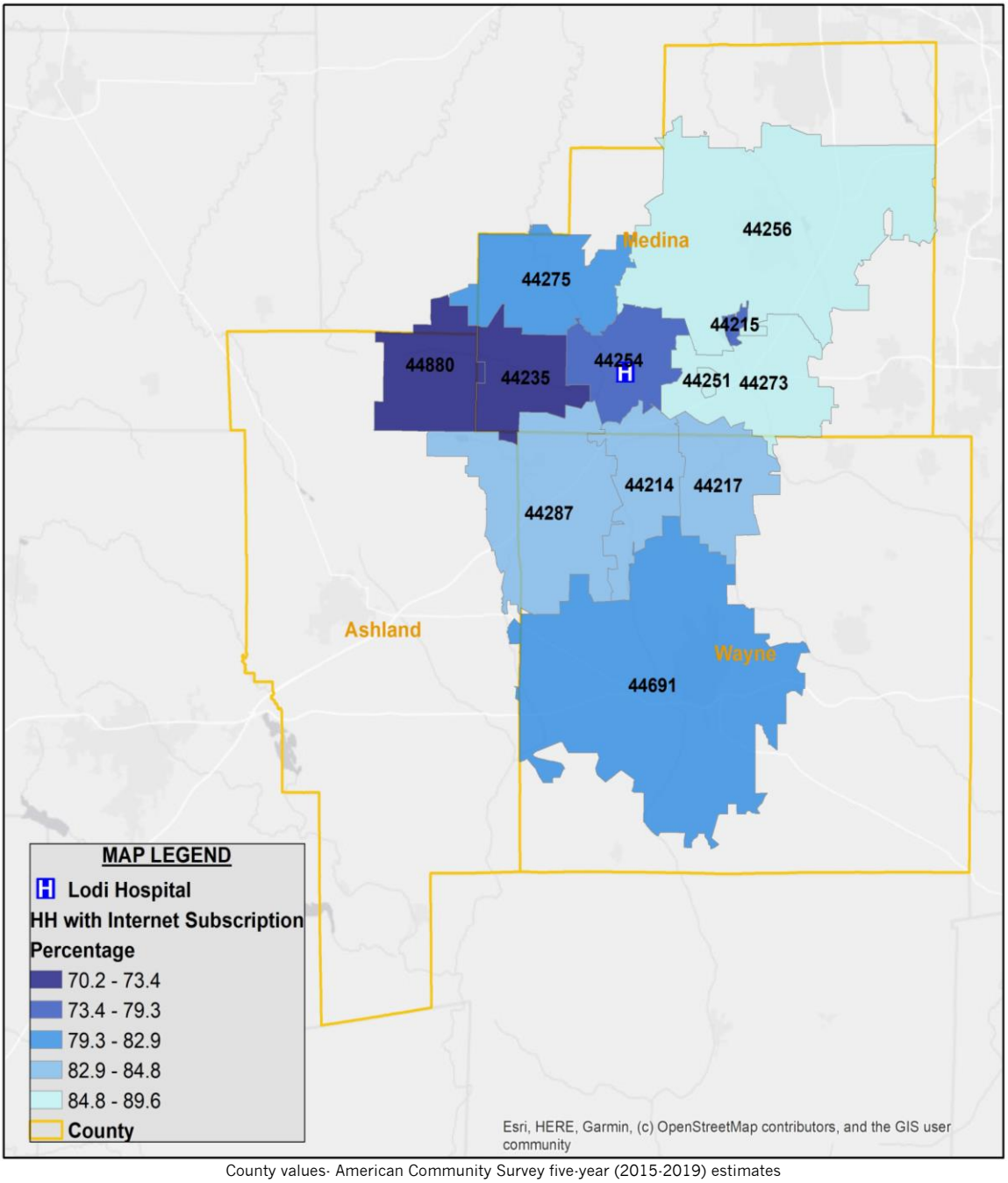
Internet access is essential for basic healthcare access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.[20]

Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[20]

[20] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Figure 20 shows the percentage of households that have an internet subscription. 44235 (Homerville) has the least percentage of households with internet connection, represented by darkest shade of blue on the map.

Figure 20: Households with an Internet Subscription



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

Highlighted Demographics: Disparities and Health Equity

Identifying disparities by population groups and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity.

Health Equity

Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities.[21] National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American, Hispanic/Latino, Indigenous, communities with incomes below the federal poverty level, and LGBTQ+ communities.[22]

Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, gender, and age. It is important to note that the data is presented to show differences and distinctions by population groups. And a data variation within each population group may be as great as that between different groups. For instance, Asian or Asian and Pacific Islander persons encompasses individuals from over 40 different countries with very different languages, cultures, and histories in the U.S. Information and themes captured through key informant interviews and community engagement session discussions have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[23] analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or gender) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix A.

Table 1 below identifies secondary data indicators with a statistically significant race or ethnic disparity for the Lodi Hospital Community, based on the Index of Disparity.

[21] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

[22] Baciu A, Negussie Y, Geller A, et al (2017). Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/

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

Table 1: Indictors with Significant Race or Ethnic Disparities

Health Indicator	Group(s) Negatively Impacted
Children Living Below Poverty Level	Black/African American Hispanic/Latino, Other Race
Families Living Below Poverty Level	Black/African American, Asian, Hispanic/Latino, Other Race
HIV/AIDS Prevalence Rate	Black/African American, Hispanic/Latino
People 65+ Living Below Poverty Level	Black/African American, Hispanic/Latino
Persons without Health Insurance	Hispanic/Latino
Workers who Walk to Work	Other Race, White (Non-Hispanic)
Young Children Living Below Poverty Level	Black/African American, Other Race, Two or More Races

The Index of Disparity analysis for Ashland, Medina, and Wayne counties reveals that the Black/African American, Hispanic/Latino, Asian, Two or More Races, and Other Race group populations are disproportionately impacted by various measures of poverty, which is often associated with poorer health outcomes. These indicators include Families Living Below Poverty Level, Children Living Below Poverty Level, People 65+ Living Below Poverty Level, and Young Children Living Below Poverty Level. Furthermore, Black/African American, and Hispanic/Latino populations are disproportionately impacted in HIV/AIDS Prevalence Rate. Hispanic/Latino groups also have the highest rates of Persons without Health Insurance, compared to other races/ethnicities in the region.

Finally, White (Non-Hispanic) and Other Race populations are disproportionately impacted across measures of public transportation (Table 1).

Geographic Disparities

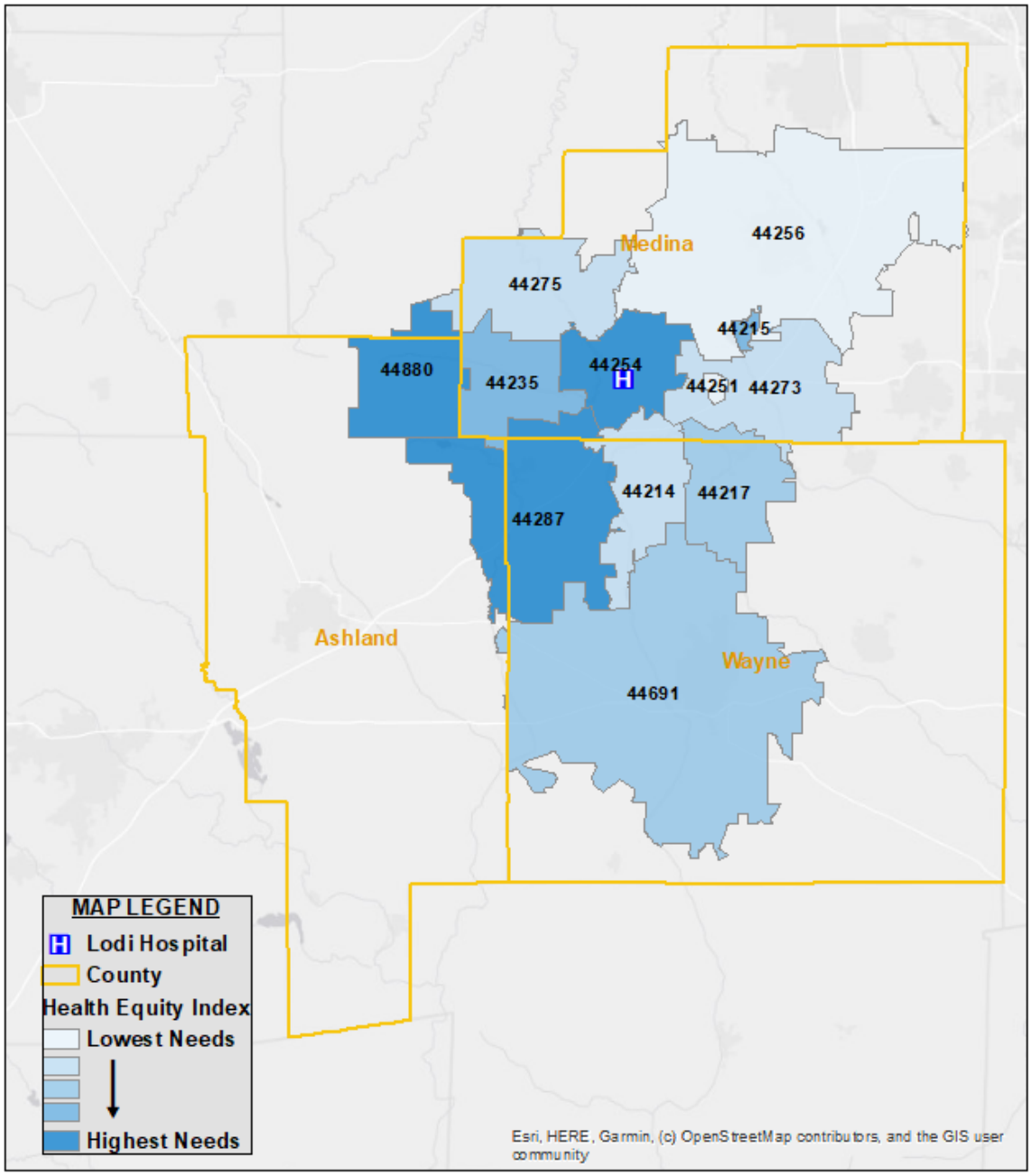
In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific zip codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity and poor mental health. For all indices, counties, zip codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index (HEI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index

value to identify relative levels of need, as illustrated by the map in Figure 21. The following zip codes in the Lodi Hospital Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44880 in Ashland County, 44287 in Wayne County, and 44254 in Medina County. Appendix A provides the index values for each zip code.

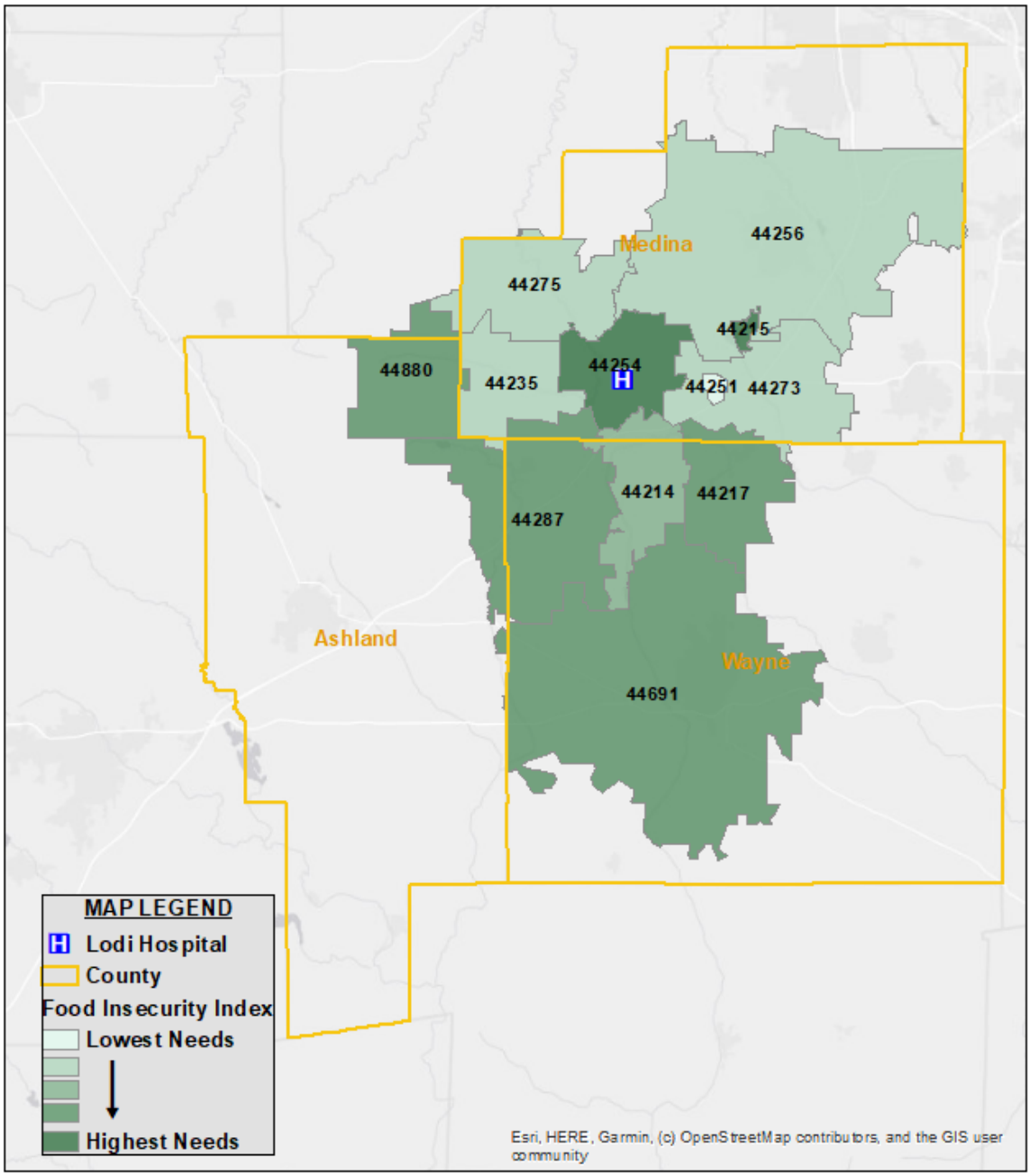
Figure 21: Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 44215 and 44254 in Medina County. Appendix A provides the index values for each zip code.

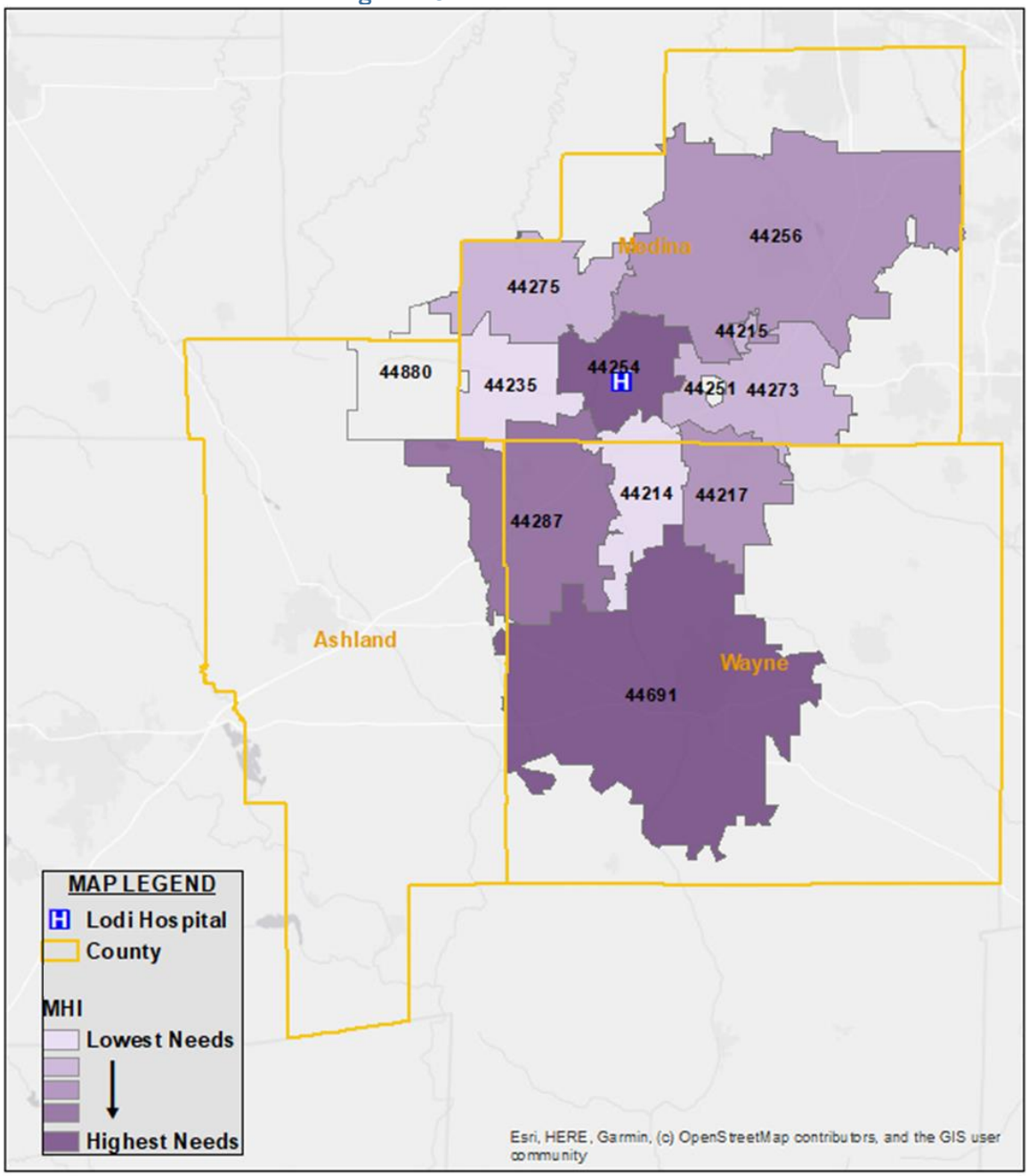
Figure 22: Food Insecurity Index



Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Zip codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 44254 in Medina County and 44691 in Wayne County. Appendix A provides the index values for all zip codes within the Lodi Hospital Community.

Figure 23: Mental Health Index



Highlighted Demographics: COVID-19 Impacts Snapshot

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Province of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Later that month, stay-at-home orders were placed by the Ohio Governor and unemployment rates soared as companies were impacted and mass layoffs began.

At the time that the Lodi Hospital Community began its collaborative CHNA process, the community and the state of Ohio were in a period of the pandemic that was hoped to be in its final phases. Primary data was collected virtually to ensure the health and safety of those participating.

COVID-19 Pandemic

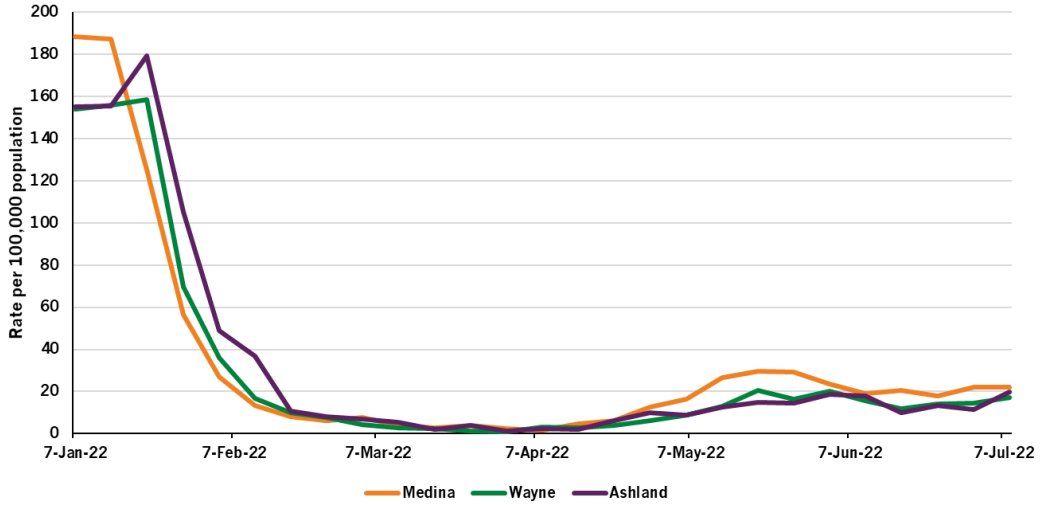
Community Input

Key stakeholder interviews and the Lodi Hospital Community Engagement Session served to assess the impact of the COVID-19 pandemic by asking respondents to describe how the pandemic has impacted community health outputs. Top responses focused on mental health challenges that spanned all age groups. Widespread workforce attrition during the pandemic placed additional burdens on those who continued to work—placing them both at greater risk for disease and higher stress levels. Furthermore, inflation and other economic forces increased food insecurity among low-income populations and exacerbated existing challenges with finding safe and affordable housing.

The COVID-19 Daily Average Case Incidence Rate by County

Figure 24 shows the daily average COVID-19 case incidence rate for Ashland, Medina, and Wayne counties from January 2022 through early July 2022. As shown, the incidence rate has declined since the beginning of 2022, although some small spikes in incidence rates have occurred.

Figure 24: Daily Average COVID-19 Case Incidence Rate by County



County values· Centers for Disease Control and Prevention (2022)

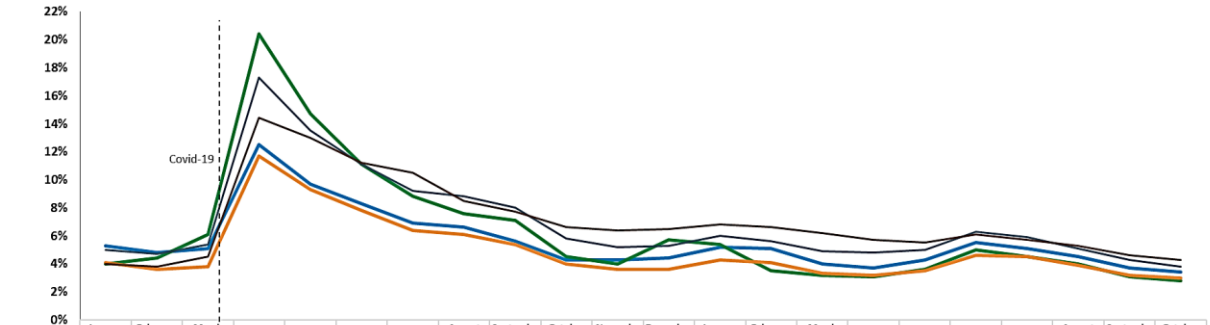
Vaccination Rates

As of June 2022, at least 43% of the population residing in counties within the Lodi Hospital Community Definition are fully vaccinated against COVID-19. Medina County has the highest vaccination rates (64.6%), followed by Wayne County (46.1%) and Ashland (43.8%).

Unemployment Rates

Unemployment rates rose between March and April 2020 for Ashland, Medina, and Wayne counties when stay-at-home orders were first announced. Illustrated in Figure 25 below, as counties began slowly reopening some businesses in late-2020, the unemployment rate gradually began to go down. As of late 2021, unemployment rates have stabilized but still exceed pre-pandemic rates. When unemployment rates rise, there is a potential impact on health insurance coverage and healthcare access if jobs lost include employer-sponsored healthcare.

Figure 25: Unemployment Rate After the Start of the COVID-19 Pandemic



	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021
Ashland	5.3%	4.8%	5.1%	12.5%	9.7%	8.3%	6.9%	6.6%	5.6%	4.3%	4.3%	4.4%	5.2%	5.1%	4.0%	3.7%	4.3%	5.5%	5.1%	4.5%	3.7%	3.4%
Medina	4.0%	4.4%	6.1%	20.4%	14.7%	11.1%	8.8%	7.6%	7.1%	4.5%	4.0%	5.7%	5.4%	3.5%	3.2%	3.1%	3.6%	5.0%	4.5%	4.0%	3.1%	2.8%
Wayne	4.1%	3.6%	3.8%	11.7%	9.3%	7.8%	6.4%	6.1%	5.4%	4.0%	3.6%	3.6%	4.3%	4.1%	3.3%	3.2%	3.5%	4.6%	4.5%	3.9%	3.2%	3.0%
Ohio	5.0%	4.7%	5.4%	17.3%	13.5%	11.1%	9.2%	8.8%	8.0%	5.8%	5.2%	5.3%	6.0%	5.6%	4.9%	4.8%	5.0%	6.3%	5.9%	5.1%	4.3%	3.8%
U.S.	4.0%	3.8%	4.5%	14.4%	13.0%	11.2%	10.5%	8.5%	7.7%	6.6%	6.4%	6.5%	6.8%	6.6%	6.2%	5.7%	5.5%	6.1%	5.7%	5.3%	4.6%	4.3%

County, State, and National Values- Bureau of Labor Statistics (2020-2021)

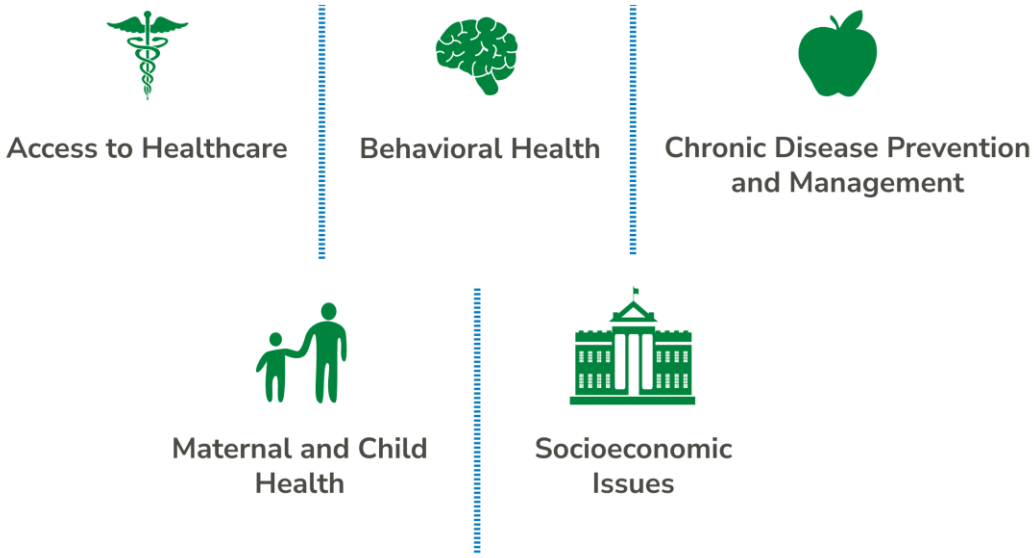
Synthesis and Prioritization

All forms of data may present strengths and limitations. Each data source used in this CHNA process was evaluated based on strengths and limitations and should be kept in mind when reviewing this report. Each health topic presented a varying scope and depth of quantitative data indicators and qualitative findings. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, community engagement session participants, and key stakeholders as possible. A full list of contributors can be found in the Primary Data Collection and Analysis description in Appendix A.

To gain a comprehensive understanding of the significant health needs for the Lodi Hospital Community, the findings from all three data sets were compared and studied simultaneously. The secondary data scores, community engagement session themes, and key stakeholder responses were considered equally important in understanding the health issues of the community. The top health needs identified from each of these data sources were analyzed for areas of overlap. Five health issues were identified as significant health needs across all three data sources and were used for further prioritization. To ensure alignment with state and local health department objectives, a working group analyzed these significant health needs alongside the Ohio State Health Improvement Plan (SHIP) as well as the Ashland, Medina and Wayne County Community Health Improvement Plans (CHIP) most recent findings. The prioritization process distilled the significant needs into five categories.

The five prioritized health needs are summarized in Figure 26. Each prioritized health topic includes the key findings from secondary data, the community engagement session discussions and key stakeholder interviews.

Figure 26: 2022 Prioritized Health Needs



Prioritized Health Topic #1: Access to Healthcare

Access to Healthcare

Secondary Data Score: 1.50

Key Themes from Community Input

- Access or access-related topics (resources, transportation and access) were top 3 barriers to improving health
- Cultural beliefs within Amish communities effects health behaviors and outcomes
- Difficulties navigating health care system due to lack of broadband access/computer knowledge, no prior experience as a healthcare consumer/history of accessing the system
- Dentists that accept Medicaid is a large need in Wayne County
- Health literacy barriers: not knowing what insurance covers/what parts to pay, making appointments at Cleveland Clinic is difficult for those not computer savvy i.e. older populations
- Lack of investment in local primary care and preventive care
- Racial, economical, geographical, educational, environmental inequities all affect access to care, disproportionately impacting communities of color
- Gentrification/Built Environment reduces accessibility to services

Warning Indicators

- Adults with Health Insurance
- Children with Health Insurance
- Clinical Care Ranking
- Consumer Expenditures: Health Insurance
- Consumer Expenditures: Medical Services
- Consumer Expenditures: Medical Supplies
- Consumer Expenditures: Prescription and Non-Prescription Drugs
- Persons without Health Insurance
- Primary Care Provider Rate

Primary Data: Key Stakeholder Interviews and Community Engagement Session

The Cleveland Clinic Foundation and Conduent Healthy Communities Institute facilitated a community engagement session featuring the Medina Hospital Community Advisory Council (CAC) members. Due to the overlapping Community Definitions and community concerns, Community Engagement Session data for the Lodi Hospital Community was derived from the Medina Hospital Community Advisory Council's Community Engagement Session. During the session, CAC members offered perspectives on the most important health problems in the community, barriers and challenges to improving health, identified the most underserved populations, discussed potential solutions to health challenges faced and offered success stories from existing program implementation.

Access to Health Care was described as a top health need by the Medina Hospital Community Advisory Council members participating in the Community Engagement Session. Access, and access-related topics including transportation, affordability of care and health disparities were described as among the top barriers to improving health. Participants noted that there were no public transportation options for Lodi residents to use when accessing services in Medina or other neighboring areas. The City of Lodi provides transportation vouchers to qualifying residents to increase access to schools,

medical services and employment opportunities. Further, affordable prescriptions and coverage for hospice or other high-cost medical services were discussed as barriers to improving health in the community.

> Certainly the people who are living with Long COVID have very direct health care issues that they're dealing with. The pandemic has definitely led to significant delays in care early on, so a lot of that preventative stuff got pushed off and I don't think we've caught up with all that.
>
> - Key Stakeholder

Key stakeholders noted a lack of investment in prevention practices including accessibility of primary services at a local level. Racial, economic, geographic, educational and environmental inequities all impact access to care and disproportionately affect communities of color. Three key themes surfaced from community discussions including systemic inequities in healthcare, the need to focus on preventative care, and barriers to healthcare.

Systemic inequities in healthcare included issues of discrimination and bias from providers which ultimately creates mistrust from communities experiencing this discrimination. Key informants suggested hiring providers that look like the people they are caring for, building a sustainable presence in the community, and ensuring providers are trained in trauma-informed care and gender-affirming care.

Preventative care included high utilization rates of the ER for minor health issues due to lack of primary care physician, and the need to strengthen the public health infrastructure. In Wayne County, stakeholders noted there are not many Dentists that accept Medicaid, especially for adults. Furthermore, COVID-19 allowed for the expansion of telehealth which increased access to healthcare for many. However, it also exposed the inequities in broadband support due to infrastructure issues leaving residents unable to access telehealth.

Barriers to healthcare included transportation, navigating the difficulties of a fragmented healthcare system, ability to pay for services/insurance (lack of insurance, high co-pays/deductibles), and health literacy for providers to communicate with patients.

Secondary Data

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

The average dollar amount per consumer unit for health insurance in Medina County is $5, 410.8, which is higher than the average dollar amount spent on health insurance in the state of Ohio, where that amount is $4,371.7 dollars per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. For this indicator, Medina County fell in the worst 25% of all counties in the nation. Medical costs in the United States are high. Therefore, people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. [24]Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.[25]

In Ashland County, the rate of dentists per 100,000 population is an area of concern where there are 43 dentists per 100,000 residents (compared to 64.2 in Ohio). The primary care provider rate is also concerning at 44.7 primary care providers per 100,000 population in Ashland County (compared to 76.7 in Ohio).

Consumer Expenditures: Medical Services also ranked poorly in Medina and Wayne counties. This indicator measures the average dollar amount spent on medical services per consumer unit. This includes expenditures on eye care, dental care, physician care, non-physician care (e.g., chiropractors, naturopaths, psychologists, midwives), lab and blood tests, x-rays, hospital rooms and related services, nursing homes/convalescent care, and other medical services. In 2021, Medina County residents spent $1,419.1 per consumer unit on medical services

[24] Kaiser Family Foundation, 2020 and 2015
[25] The Commonwealth Fund, 2019

Prioritized Health Topic #2: Behavioral Health

Behavioral Health: Mental Health

Secondary Data Score: **1.61**

Key Themes from Community Input

- Closely linked with substance use as self-medication
- Lack of meaningful investment in true community health programming
- Lack of providers to meet the increasing mental health/behavioral health needs
- Need to expand provider network as the justice system works to divert folks with low-level violations to treatment and mental health care
- Reported as increasing in both teachers and school-aged children as a result of COVID-19 isolation
- Second leading cause of death in kids 10-14 is suicide

Warning Indicators

- Adults Ever Diagnosed with Depression
- Age-Adjusted Death Rate due to Alzheimer's Disease
- Age-Adjusted Death Rate due to Suicide
- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Poor Mental Health: 14+ Days
- Poor Mental Health: Average Number of Days

Primary Data: Key Stakeholder Interviews and Community Engagement Sessions (Mental Health)

Members of the Medina Hospital Community Advisory Council, representing a range of organizations within the community, who attended the Community Engagement session described mental health the most important health problem in the community. They also reported a strong association between mental health and substance use suggesting that community members increasingly use and abuse alcohol, illicit drugs and prescription drugs as a form of self-medication to cope with stress. Notable stressors included inflation impacts on low-income populations and work-related stressors resulting from workforce attrition during the COVID-19 pandemic. Further, attendees reported an increase in mental health concerns and the difficulty of finding mental health providers to meet the rising demand for services.

Mental health resources, and the availability of mental health providers were frequently cited as disproportionate to community need. Overall, lack of mental health providers and resources, and navigation and/or knowledge about available services were all mentioned as barriers. Participants emphasized the need to examine the root causes leading to mental health issues within the community including poverty and an unequal playing field in terms of investment in education in low-income communities. Furthermore, LGBTQ+ community members experience disproportionate mental health issues. Stakeholders recommended an increase in meaningful investment in community health programming.

Secondary Data: Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders had the second highest data score of all topic areas, with a score of 1.61. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Age-Adjusted Death Rate due to Alzheimer's Disease is ranked poorly in both Wayne and Ashland counties where the death rate is 38.1 and 47.4 per 100,000 population, respectively.

Additionally, the Age-Adjusted Death Rate due to Suicide is a top area of concern in Wayne County. Wayne County has a rate of 16.7 deaths per 100,000 population and the trend over the last four years is increasing for both indicators.

Age-Adjusted Death Rate due to Suicide is also an area of concern in Medina County with a data value of 15.7 deaths due to suicide per 100,000 population. Depression in the Medicare Population is also of concern with 19% of Medicare beneficiaries in Medina County treated for depression. Both indicators are increasing significantly.

Substance Use

Behavioral Health: Substance Use

Secondary Data Score: **1.32**

Key Themes from Community Input

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

Warning Indicators

- Adults who Binge Drink
- Alcohol-Impaired Driving Deaths
- Consumer Expenditures: Alcoholic Beverages

Primary Data: Key Stakeholder Interviews and Community Engagement Sessions (Substance Use)

Members of the Medina Hospital Community Advisory Council attending the Community Engagement session recognized Alcohol and Drug Use as one of the most important health problems in the community. They described addiction as an outcome of mental health challenges and mental disorders wherein substances are used as a means of easing stress. Furthermore, they suggested that adolescents abusing substances did not have access to treatments and considered the adolescent population, therefore, to be among the most underserved populations in the community.

Key stakeholders noted an overall increase in alcohol intake and opioid use during the COVID-19 pandemic. They asserted that there was a lack of space in treatment sites and low access to outpatient provider services to meet the needs of those suffering from substance use disorder further exacerbating a worsening issue. They asserted that lack of access to outpatient providers and treatment sites further exacerbated the issue of needs not being met for those suffering from substance use disorder.

> "I think substance abuse treatment is one of the places hit the hardest during COVID and really had a difficult time moving to a virtual kind of visit system, because so much of the recovery from substance use disorder is about relationships and being connected."
>
> - Key Stakeholder

Secondary Data

Substance Use is a health topic that is analyzed through the Alcohol and Drug Use topic area. From the secondary data scoring results, Alcohol & Drug Use had the 14th highest data score of all topic areas, with a score of 1.32. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Alcohol-Impaired Driving Deaths was the worst performing indicator in Medina and Ashland. Both counties score in the worst 25% of both Ohio counties and counties across the nation.

According to the secondary data, Liquor Store Density in Wayne County is an area of concern. There are 11.2 liquor stores per 100,000 population which puts Wayne County in the lowest 25% of counties in Ohio.

Prioritized Health Topic #3: Chronic Disease Prevention and Management

Chronic Disease Prevention and Management is a health topic that is analyzed from four secondary data topics – Nutrition and Healthy Eating, Chronic Diseases, Older Adult Health and Cancer. An overview snapshot of each relevant subtopic is provided below.

Primary Data: Key Stakeholder Interviews and Community Engagement Session

NUTRITION & HEALTHY EATING

Nutrition & Healthy Eating

Secondary Data Score: **1.46**

Key Themes from Community Input

- Access to healthy food limited by transportation, minimal grocery stores nearby, built environment
- Conditions such as hypertension asthma, diabetes, COPD, coronary heart disease, all related to the quality of food one has access to
- Effects of redlining are still seen—these are the neighborhoods that do not always have grocery stores in a close mile radius
- Food banks are seeing employees from medical institutions that are food insecure: institutions have really impactful voices and need to start advocating for things that affect so many of their employees and their patients i.e. paying employees wages & having benefits that allow them to be healthy/eat healthy
- Heart disease, diabetes, obesity, cancer—all inherently tied to healthy food accessibility, built environment/walkability, safety, access to care
- More focus on expanding access to federal SNAP benefits as money is available but can't always get income eligible people as a community approved for benefits and get a SNAP card into their hands to use to access healthy food at the supermarket, also affects supermarket's ability to operate in a low income neighborhood

Warning Indicators

- Consumer Expenditures: Fast Food Restaurants
- Consumer Expenditures: Fruits and Vegetables
- Consumer Expenditures: High Sugar Foods

Participants in the Medina Hospital Community Engagement Session described rates of food insecurity in the community that increased proportionately with unemployment rates during the pandemic. Participants mentioned that low-income community members were the population most impacted by inflation and housing prices. Shifting economic forces impacting the ability to purchase healthy foods, stigmas associated with accessing food assistance and unstable employment were described as the top barriers to improving health.

Key stakeholders revealed that access to healthy food was often limited by a lack of either public or private transportation. There are only a few grocery stores in the community and

few community members can access those by walking. The effects of redlining are evident as these neighborhoods do not always have grocery stores and therefore are limited to corner stores which often do not have fresh fruits and vegetables. Furthermore, key informants advised medical institutions to advocate for better pay for employees, as food banks are seeing employees from these very institutions show up at their doors. Thus, these institutions are poised to prevent food insecurity within the walls of their hospital. Conditions such as hypertension, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease are all related to the quality of food community members have access to[26].

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

Secondary Data

Nutrition & Healthy Eating had the sixth highest data score of all topic areas with a score of 1.46. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Consumer Expenditures: Fruits and Vegetables ranked highly in Ashland and Wayne counties. In Wayne County, the average dollar amount per consumer unit spent on fruits and vegetables is $818.0, which is lower than the Ohio state value of $864.60 and the United States value of $1,002.1. In Ashland County, the average dollar amount spent on fruits and vegetables is $785.8.

In Medina County, consumer expenditures related to fast food restaurants and high sugar foods were identified as areas of concern. The average dollar spent per consumer unit on high sugar foods (cookies, ice cream, candy, gum, jams/jelly, etc.) in Medina County is $627.0. This is higher than the Ohio value ($519) and U.S. value ($530.2). In addition, the average dollar amount spent per consumer unit on fast food restaurants is $1,814.2 (compared to $1,461 in Ohio and $1,638.9 in the U.S.).

[26] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion.
https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm

Prioritized Health Topic #4: Socioeconomic Issues

Prevention and Safety

Secondary Data Score: **1.07**

Key Themes from Community Input

- Affordable, accessible housing is s a resource issue as there's not enough appropriate housing
  - home modifications to make it easier for people to stay in home i.e. ramp installations, walk-in shower instead of bathtubs
  - reduces fall risk, increases accessibility
- Food insecurity increased with unemployment during the pandemic
- Generational poverty, poor housing and lack of resources available to create healthy conditions for people to live, work, and play in
- Gun violence was a top community concern
- People without safe and affordable housing are an underserved population
- Urgent need for SANE nurses in Medina County for victims and survivors of sexual assault

Warning Indicators

- Age-Adjusted Death Rate due to Falls
- Access to Exercise Opportunities
- Adults with Current Asthma
- Age-Adjusted Death Rate due to Motor Vehicle Collisions
- Fast Food Restaurant Density
- Households with No Car and Low Access to a Grocery Store
- Overcrowded Households
- SNAP Certified Stores
- WIC Certified Stores

Primary Data: Key Stakeholder Interviews and Community Engagement Session

The Prevention and Safety health topic includes a variety of subtopics namely affordable housing, violence, unintentional injuries and falls. During the Medina Hospital Community Engagement Session affordable housing was a key concern for participants. Low-income persons—particularly those living in southern Medina County, subsidized housing or mobile housing parks were described as among the most underserved populations in the community. Further, some of the ways to improve health in the community that participants suggested included addressing social determinants of health; stigmatizations surrounding mental health, substance abuse and unemployment; focusing on disease prevention in the community; improving housing and healthcare affordability; and collaborating with underserved populations to identify solutions.

Key stakeholders couched discussions around specific health needs in the context of generational poverty, poor housing and historical red lining. Generally, there is a lack of resources individually and as a community to create healthy conditions for people to live, work and play. Finally, transgender patients have higher rates of victimization and murder.

> The biggest disparities that we are working on right now are infant mortality, lead poisoning, community violence and behavioral health. There is inequity imbedded into our economic and educational system that so greatly impact health outcomes.
>
> - Key Stakeholder

Secondary Data

Prevention & Safety ranked 20th among all health topics with a score of 1.07. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Age-Adjusted Death Rate due to Falls is an area of concern in the prevention & safety topic area for both Ashland and Wayne counties where the death rate is 9.5 and 16 per 100,000 population, respectively.

Age-Adjusted Death Rate due to Motor Vehicle Collisions is also an area of concern for Wayne County where the rate of deaths per 100,000 residents is 3.8, higher than the Ohio state value (2.8) and U.S. value (2.5).

2022 Lodi Hospital CHNA Alignment

The final prioritized health needs from this 2022 Lodi Hospital CHNA are in alignment with some of the top priorities and factors influencing health outcomes from the 2019 Ohio State Health Assessment/State Health Improvement Plan. They continue alignment with the 2019 Lodi CHNA priority areas. The check mark icon in Figure 27 indicates areas of alignment.

Figure 27. Lodi Hospital CHNA Alignment

2019 Ohio SHA/SHIP	2019 Lodi Hospital CHNA	2022 Lodi Hospital CHNA
Top Health Priorities: ☑ • Mental Health & Addiction ☑ • Chronic Disease • Maternal and Infant Health Top Priority Factors Influencing Health Outcomes: ☑ • Community Conditions ☑ • Health Behaviors ☑ • Access to Care	Priority Health Areas: ☑ • Access to Affordable Healthcare ☑ • Addiction and Mental Health ☑ • Chronic Disease Prevention and Management • Infant Mortality ☑ • Socioeconomic Concerns • Medical Research and Health Professions Education	Prioritized Health Needs: ☑ • Access to Healthcare ☑ • Behavioral health (Mental health and Substance Use Disorder) ☑ • Chronic disease prevention and management ☑ • Socioeconomic issues

Appendices Summary

A. Methodology

An overview of methods used to collect and analyze data from both secondary and primary sources.

B. Impact Evaluation

A detailed overview of progress made on the Implementation Strategy planning, development and roll-out as well as email and web contacts for more information on the 2022 CHNA.

C. Secondary Data Methodology and Scoring Tables

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

D. Community Input Assessment Tools

Quantitative and qualitative community feedback data collection tools, stakeholders and organizations that were vital in capturing community feedback during this collaborative CHNA:

- Community Engagement Session Questions
- Key Stakeholder Interview Questions
- Key Stakeholder and Community Organizations

E. Community Partners and Resources

The tables in this section acknowledge community partners and organizations who supported the CHNA process.

F. Acknowledgements

Appendix A: Methodology

Overview

Primary and secondary data were collected and analyzed to inform the 2022 CHNA. Primary data consisted of community engagement session discussions and key stakeholder interviews. The secondary data included indicators of health outcomes, health behaviors and social determinants of health. The methods used to analyze each type of data are outlined below. This analysis was conducted at the county-level and included data for Ashland, Medina, and Wayne counties. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of health needs in the Lodi Hospital Community.

Secondary Data Sources & Analysis

The main source for the secondary data, or data that have been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national sources used in the Lodi Hospital Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Buying Power
- Claritas Consumer Profiles
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Ohio Department of Education
- Ohio Department of Health, Infectious Diseases
- Ohio Department of Health, Vital Statistics

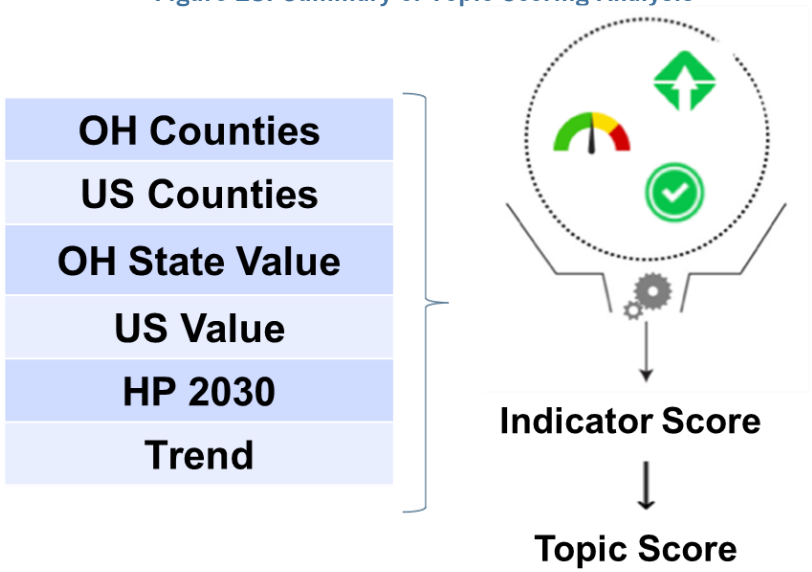
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food Environment Atlas
- U.S. Environmental Protection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

Secondary data used for this assessment were collected and analyzed from HCI's community indicator database. This database, maintained by researchers and analysts at HCI, includes 300 community indicators from at least 25 state and national data sources. HCI carefully evaluates sources based on the following three criteria: the source has a validated methodology for data collection and analysis; the source has scheduled, regular publication of findings; and the source has data values for small geographic areas or populations.

Secondary Data Scoring

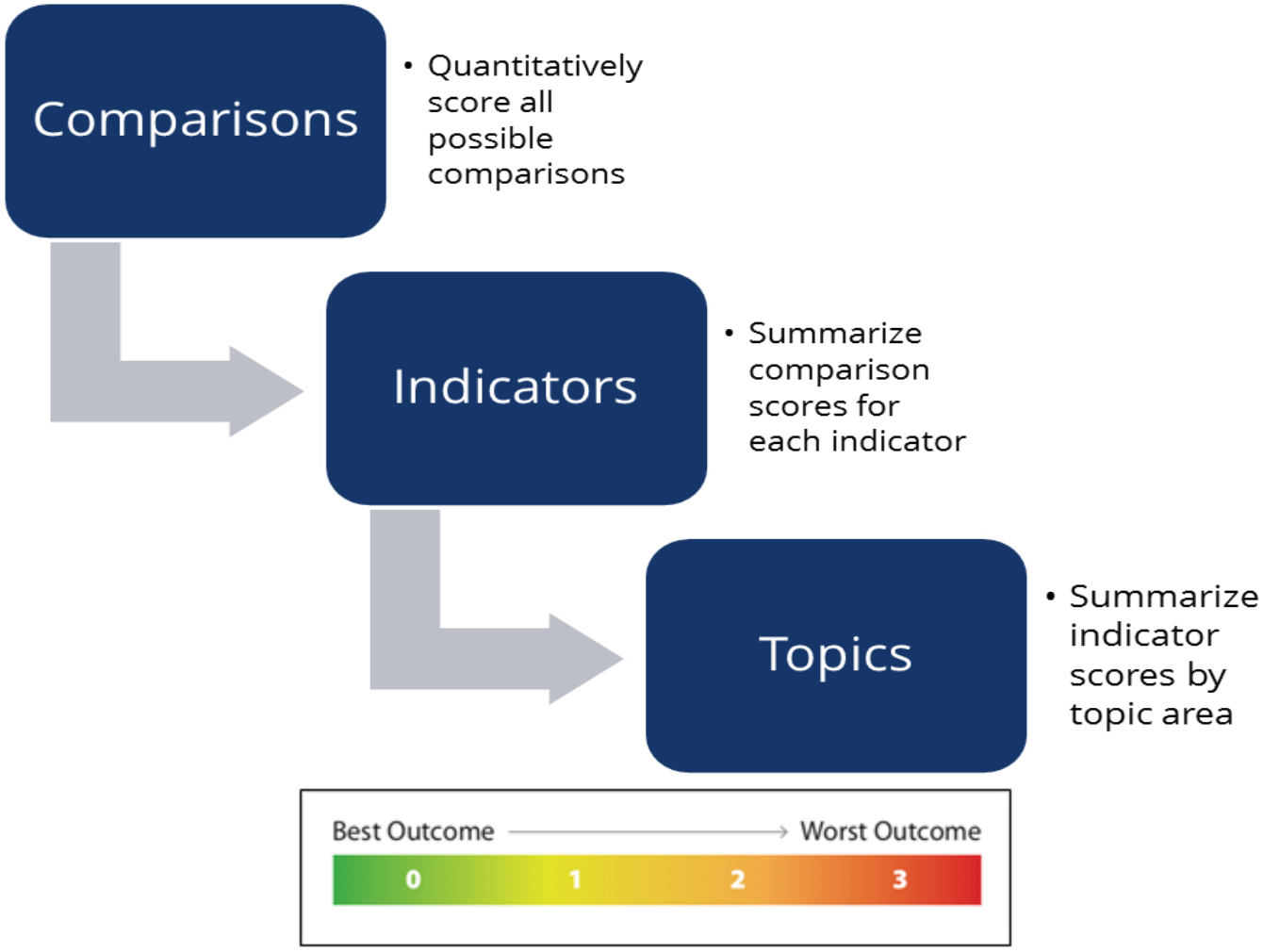
HCI's Data Scoring Tool (Figure 28) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs.

Figure 28: Summary of Topic Scoring Analysis



Secondary Data Scoring

Data scoring is done in three stages:



Each indicator available is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time.
Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.
This process was completed separately for the three counties within the Lodi Hospital Community: Ashland, Medina, and Wayne counties. To calculate the overall highest needs topic area scores, an average was taken for each topic area across the three counties. Each county's values were weighted the same. More details about topics scores and the average score for the Lodi Hospital Community, see Appendix C.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

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

Trend over Time

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

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with

a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

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

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.
Examples of the health and quality of life topic areas available through this analysis are described as follows:

Quality of Life	Health	
Community	Adolescent Health	Older Adults
Economy	Alcohol & Drug Use	Oral Health
Education	Cancer	Other Conditions
Environmental Health	Children's Health	Prevention & Safety
	Diabetes	Physical Activity
	Health Care Access and Quality	Respiratory Diseases
	Heart Disease & Stroke	Sexually Transmitted Infections
	Immunization & Infectious Diseases	Tobacco Use
	Maternal, Fetal & Infant Health	Women's Health
	Medications & Prescriptions	Wellness & Lifestyle
	Mental Health & Mental Disorders	Weight Status
	Nutrition & Healthy Eating	

Table 2 shows the health and quality of life topic scoring results for the Lodi Hospital Community, ranked in order of highest need. Medications & Prescriptions scored as the poorest performing topic area with a score of 1.89, followed by Mental Health & Mental Disorders with a score of 1.61. Topics that received a score of 1.50 or higher were considered a significant health need. Four topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 2: Top Secondary Data Health Needs

Top Secondary Data Health Needs
Medications & Prescriptions
Mental Health & Mental Disorders
Tobacco Use
Health Care Access & Quality

Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

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

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5)

locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (ranging from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

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

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (ranging from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

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

Table 3 below lists each zip code within the Lodi Hospital Community and their respective HEI, FII, and MHI values.

Table 3: HEI, FII and MHI Values for Zip Codes within the Lodi Hospital Community

Zip Code	HEI Value	FII Value	MHI Value
44214	28.1	39.3	4.7
44215	48.6	62.5	29
44217	38.6	49.5	41.8
44235	48.1	20.5	12.8
44251	6.7	7.4	N/A
44254	58.2	63.1	76.4
44256	11.7	19.9	43.3
44273	20	28.6	27.4
44275	29	26.3	28
44287	59.9	49.9	54.4
44691	42.8	42.6	75.4
44880	69.7	42.6	N/A

Data Considerations

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

Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

Primary Data Collection & Analysis

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

Community Engagement Session Methodology and Results

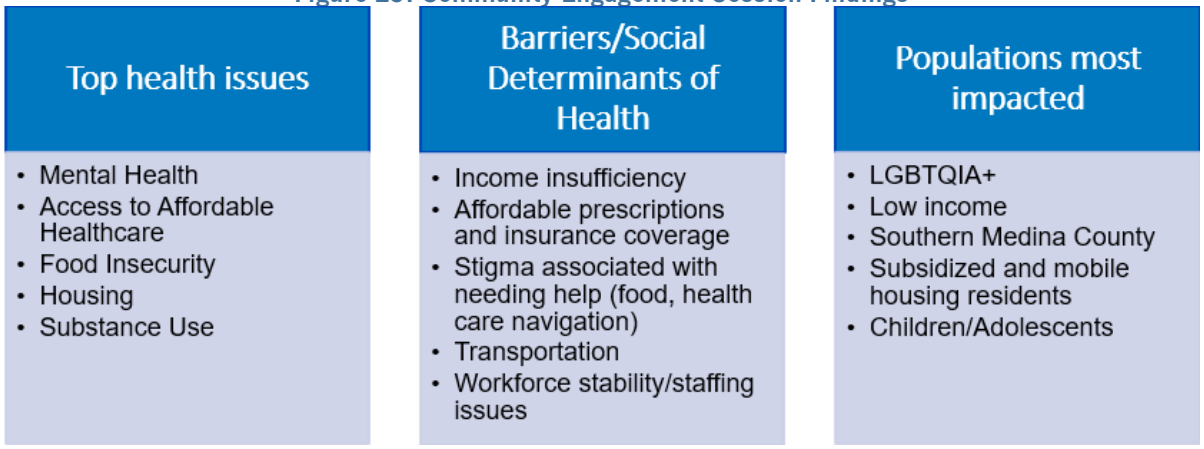
The Cleveland Clinic Foundation and Conduent Healthy Communities Institute facilitated a community engagement session featuring the Medina Hospital Community Advisory Council (CAC) members. Due to the overlapping Community Definitions and community concerns, Community Engagement Session data for the Lodi Hospital Community was derived from the Medina Hospital Community Advisory Council's Community Engagement Session held virtually on June 23, 2022. Participants answered four questions including:

1. What are the most important health problems in the community?
2. What barriers or challenges to improving health exist in your community?
3. What community groups, populations, or neighborhoods are underserved?
4. What can be done to improve the health in your community?

At the end of the session, participants were also asked to describe interventions or programs they are aware of that have been successful in improving health in the community.

The project team captured detailed records of the discussion through transcripts and a polling tool (Poll Everywhere®). Figure 29 shows the results from analysis of inputs collected from these tools.

Figure 29: Community Engagement Session Findings



Key Stakeholder Interviews Methodology and Results

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

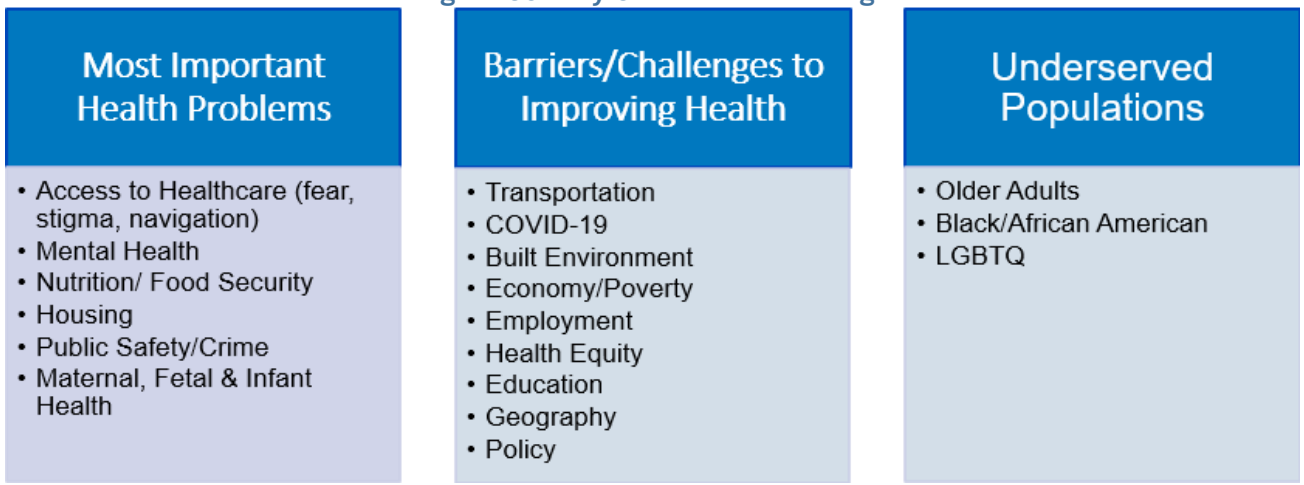
Table 4: Lodi Hospital Key Stakeholder Organizations

Key Stakeholder and Community Organizations	
• City of Cleveland Department of Public Health • Medina County Health Department • Wayne County Health Department • Medina Community Advisory Council	• Neighborhood Family Practice • Birthing Beautiful Communities • Lead Safe Cleveland Coalition • Better Health Partnerships • NAMI Greater Cleveland • Asian Services in Action (ASIA) • Cleveland Clinic LGBTQ+ Care • Benjamin Rose Institute on Aging • Greater Cleveland Food Bank

	• The Gathering Place • Cuyahoga Metropolitan Housing Authority • Esperanza • The Centers for Families and Children

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

Figure 30: Key Stakeholder Findings



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

Appendix B: Impact Evaluation

The CHNA process should be viewed as a three-year cycle to evaluate the impact of actions taken to address priority areas. This step affirms organizations focus and target efforts during the next CHNA cycle. The top health priorities for the Lodi Hospital Community from the 2019 CHNA were:

- Access to Affordable Healthcare
- Addiction and Mental Health
- Chronic Disease Prevention and Management
- Infant Mortality
- Socioeconomic Concerns
- Medical Research and Health Professions Education

Implementation strategies for these health topics shifted in response to the COVID-19 pandemic. Innovative strategies were adopted to continue building capacity for addressing the community health needs.

Actions Taken Since Previous CHNA

Lodi Community Hospital's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2019 CHNA: Addiction and Mental Health, Chronic Disease Prevention and Management, Socioeconomic Concerns, Access to Affordable Health Care, Medical Research and Health Professions Education.

The ISR was conducted before the onset of COVID 19, and therefore, does not reflect the pandemic's impact which dramatically affected community and hospital services. Many of our hospital services were paused or deferred as we navigated the emergent COVID 19 landscape. Caring for our community is essential, and part of that is sharing accurate, up-to-date information on health-related topics with our community. We provided COVID 19 education, vaccine distribution and collaborative services with government, health departments and community-based organizations to keep our communities safe. As we continue to serve our communities, we are committed to addressing the needs identified in the previous ISR.

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

Addiction and Mental Health

Actions and Highlighted Impacts:

a. In addition to direct patient care, Cleveland Clinic's Opioid Awareness Center, provided intervention and treatment for substance abuse disorders to Cleveland Clinic caregivers and their family members.

    - Opioid misuse continues to be a public health emergency, contributing to over 50,000 U.S. deaths a year. About 40% of those deaths involve prescription opioids. Our comprehensive efforts to improve opioid prescribing have yielded reductions in these prescriptions by our providers for two years running, including a large improvement in 2021.

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

Lodi Community Hospital provides space to Alternative Paths which offers behavioral health services including alcohol and substance abuse counseling. It remained open during the pandemic, providing continued individual therapy programs to the community.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

a. Improve management of chronic conditions through Chronic Care Clinics employing a specialized model of care.

    - COVID 19 created a delay in treatment for many community members. We launched an effort to connect patients with care, proactively contacting over 300,000 patients and scheduling 57,000 appointments. This outreach is prompting more patients to complete recommended screening tests, allowing earlier detection of cancers and other diseases when they are most treatable. For example, 1,700 precancerous lesions of the colon have been detected earlier as a result — a key part of preventing colon cancer.
    - Many in-person community programs were paused by COVD 19. When COVID-19 vaccines became available, we co-led a nationwide campaign to encourage adults to get vaccinated. The coalition of 60 top hospitals and healthcare institutions communicated the vaccines' safety and effectiveness through diverse digital and traditional media. Throughout the years, our health experts explained and advocated the benefits of vaccination at every opportunity, from patient visits to national media appearances. In late 2021, when cases of the omicron variant surged and hospitals filled with unvaccinated patients, we joined with five other Northeast Ohio hospital systems in an advertising campaign urging the public to get vaccinated and take other precautions.

b. Provided free breast cancer screenings and blood sugar screenings through community events
    - Community Health screening programs were temporarily paused during peak covid-19 surge. Since reactivation of these programs, we have achieved pre-COVID health screening volumes.

c. Implemented health promotion messaging, health education, and outreach programs related to diabetes and chronic disease.
    - Community nurse and dietitian partnered with local food distribution non-profit to provide nutritional and health education to participants.
    - Incorporated nutritional information into community babysitting course.
    - Provided community diabetic education classes.

d. Offered CPR and AED trainings at the hospital and throughout the community.
    - Temporarily paused due to covid-19 restrictions. Since reactivation, offered both routinely scheduled courses as well as accommodations for small group scheduling to meet the needs of the community.
    - AED training offered as an add-on to babysitting course.

e. Provided unique community-based therapies and treatments including aquatic classes.
    - Aquatic classes temporarily paused due to covid-19 restrictions. Since reactivation, class volumes have been steadily increasing. New program registration format to allow participant self-scheduling and maintain class size in compliance with current COVID-19 restrictions.

Socioeconomic Concerns

Actions and Highlighted Impacts:

a. Cleveland Clinic implemented a system-wide social determinants screening tool for adult patients to identify needs such as alcohol abuse, depression, financial strain, food insecurity, intimate partner violence, and stress.

b. Through participation in the Community Meal Program and support of the Feeding Medina County initiative, provided free meals and distribute foods to community members.
    - Due to pandemic, Feeding Medina County distribution moved off-site to accommodate drive through access.
    - Hospital sponsored community meal converted to drive through distribution.
    - Free mask distribution 2020 to aid in the prevention of COVID-19.

c. Partnered with Medina Creative Housing to provide employment opportunities for community members with disabilities.
    - Due to COVID-19 restrictions this program was discontinued.

d. Sponsored the Free Clinic of Medina County to provide medical care for uninsured and underinsured community members.

e. Offered Safe Sitter classes to community members and Safe at Home classes to elementary students.
    - Continued to offer on-site classes throughout the pandemic with limited class size volume to comply with COVID-19 guidelines. Offered both routinely scheduled courses as well as accommodations for small group scheduling to meet the needs of the community.

f. Provided workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders.
    - Cleveland Clinic created initiatives to develop a skilled community youth workforce in vulnerable communities aligning with Health Anchor Network (HAN) and Placed-based Initiatives. Examples include:
    - Connected Career Rounds provided 4,233 middle and high school students from 76 schools across 7 states including Ohio.

Access to Affordable Health Care

Actions and Highlighted Impacts:

a. Patient Financial Advocates assisted patients in evaluating eligibility for financial assistance or public health insurance programs.
    - 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 2021, Cleveland Clinic health system provided over $178 million in financial assistance to its communities in Ohio, Florida, and Nevada.

b. Continued to partner with Medina Hospital and Akron General Medical Center to transfer patients for inpatient care as appropriate.

c. Utilizing medically secure online and mobile platforms, connected patients with Cleveland Clinic providers for telehealth and virtual visits.
    - In 2021, Cleveland Clinic provided 841,000 virtual visits.

- Established telehealth room located in Lodi Community Care Center to promote assess to care for specialty provider services.

Medical Research and Health Professions Education

Actions and Highlighted Impacts:

a. Through medical research, advance clinical techniques, devices and treatment protocols in the areas of cancer, heart disease, diabetes, and others.
    - Research into diseases and potential cures is an investment in people's long-term health.
    - In 2020, COVID-19 highlighted the significance of research in community health. Cleveland Clinic research findings increased knowledge about the virus and how best to respond to it. Our researchers developed the world's first COVID-19 risk-prediction model, enabling healthcare providers to calculate an individual patient's likelihood of testing positive for infection as well as their probable outcome from the disease.
    - For 2021, Cleveland Clinic's community benefit in support of research was $101 million.
b. Sponsored high-quality medical education training programs for physicians, nurses, and allied health professionals.
    - Cleveland Clinic provided a wide range of high-quality medical education that includes accredited training programs for residents, physicians, nurses and allied health professionals. By educating medical professionals, we ensure that the public receives the highest level of medical care and will have access to highly trained health professionals in the future. For 2021, Cleveland Clinic's community benefit in support of education was $322 million.
c. Provided onsite training to healthcare professionals in basic life support and advanced cardiac life support, and EMS training for fire and rescue services personnel.

Community Feedback

Community Health Needs Assessment reports from 2019 were published on the Lodi Hospital website. No community feedback has been received as of the drafting of this report. For more information regarding Cleveland Clinic Community Health Needs Assessments and Implementation Strategy reports, please visit www.clevelandclinic.org/CHNAreports or contact CHNA@ccf.org.

Appendix C: Secondary Data Scoring Tables

Table 5: Lodi Hospital Community Definition

Zip code	Postal Name
44214	Burbank
44215	Chippewa Lake
44217	Creston
44235	Homerville
44251	Westfield Center
44254	Lodi
44256	Medina
44273	Seville
44275	Spencer
44287	West Salem
44691	Wooster
44880	Sullivan

Table 6: Population Estimates for Each Zip Code

Zip code	City	Population
44214	Burbank	2,008
44215	Chippewa Lake	2,191
44217	Creston	4,188
44235	Homerville	1,722
44251	Westfield Center	869
44254	Lodi	4,683
44256	Medina	66,686
44273	Seville	6,815
44275	Spencer	3,413
44287	West Salem	7,968
44691	Wooster	44,601
44880	Sullivan	3,139

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

Zip Code	City	Families Below Poverty Level (%)
44214	Burbank	9.40%
44215	Chippewa Lake	6.80%
44217	Creston	3.70%
44235	Homerville	12.10%
44251	Westfield Center	6.40%
44254	Lodi	7.60%
44256	Medina	4.40%
44273	Seville	2.50%
44275	Spencer	4.00%
44287	West Salem	8.30%
44691	Wooster	7.40%
44880	Sullivan	14.80%

Table 8: Secondary Data Results by Health Topic—Medina, Wayne, Ashland Counties

HEALTH TOPICS	ASHLAND	MEDINA	WAYNE	AVG
Alcohol & Drug Use	1.37	1.47	1.12	1.32
Cancer	1.59	1.34	1.31	1.41
Children's Health	1.48	1.34	1.24	1.35
Diabetes	1.57	0.89	1.45	1.30
Health Care Access & Quality	1.44	1.54	1.53	1.50
Heart Disease & Stroke	1.71	1.19	1.42	1.44
Immunizations & Infectious Diseases	1.31	0.82	1.30	1.14
Maternal, Fetal & Infant Health	1.38	1.03	1.32	1.24
Medications & Prescriptions	1.39	2.50	1.78	1.89

Mental Health & Mental Disorders	1.66	1.34	1.81	1.61
Nutrition & Healthy Eating	1.31	1.64	1.44	1.46
Older Adults	1.59	1.35	1.45	1.46
Oral Health	1.40	1.11	1.19	1.24
Other Conditions	1.39	1.53	1.28	1.40
Physical Activity	1.30	1.36	1.48	1.38
Prevention & Safety	0.92	1.00	1.29	1.07
Respiratory Diseases	1.62	0.96	1.33	1.30
Tobacco Use	1.81	1.11	1.86	1.59
Wellness & Lifestyle	1.47	1.10	1.53	1.37
Women's Health	1.33	1.22	1.67	1.40
QUALITY OF LIFE TOPIC	**SCORE**			
Community	1.36	1.09	1.28	1.24
Economy	1.27	0.74	1.05	1.02
Education	1.19	1.22	1.24	1.22
Environmental Health	1.46	1.19	1.43	1.36

Secondary Data Scoring Indicators of Concern

From the secondary data scoring results, Medications and Prescriptions was identified as the top health need with a score of 1.89. Health Care Access & Quality ranked as the fourth highest scoring health need, with a score of 1.50. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 9 below. For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. The legend (Figure 31) on the right shows how to interpret the distribution gauges and trend icons used in the data scoring results for each health topic by county (Table 8).

Figure 31: Prioritized Health Needs

	If the needle is in the red, the county value is in the worst 25% (or worst quartile) of counties in the state or nation.
	If the needle is in the green, the county value is in the best 50% of counties in the state or nation.
	The indicator is trending down, significantly, and this is not the ideal direction.
	The indicator is trending down and this is not the ideal direction.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trendng up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction .
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.

Table 9. Data Scoring Results for Healthcare Access & Quality for the Lodi Hospital Community

Medina County

SCORE	HEALTH CARE ACCESS & QUALITY	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Consumer Expenditures: Health Insurance	5410.8		4371.7	4321.1			...
2.50	Consumer Expenditures: Medical Services	1419.1		1098.6	1047.4			...
2.50	Consumer Expenditures: Medical Supplies	259.4		204.8	194.9			...
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	781.2		638.9	609.6			...
1.72	Primary Care Provider Rate	60.3		76.7				
1.50	Non-Physician Primary Care Provider Rate	63.4		108.9				

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

Wayne County

SCORE	HEALTH CARE ACCESS & QUALITY	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Children with Health Insurance	75.8		95.2	94.3	…	…	…
1.89	Persons without Health Insurance	15.7		6.6		*2019*		
1.83	Consumer Expenditures: Medical Services	1064.3		1098.6	1047.4			…
1.83	Consumer Expenditures: Medical Supplies	196.3		204.8	194.9			…
1.72	Primary Care Provider Rate	51.7		76.7				
1.67	Adults with Health Insurance	84.3		90.9	87.1	…	…	…
1.67	Consumer Expenditures: Health Insurance	4333.6		4371.7	4321.1			…
1.67	Consumer Expenditures: Prescription and Non-Prescription Drugs	633.6		638.9	609.6			…

1.58	Clinical Care Ranking	52					...	...
1.50	Adults who Visited a Dentist	51.4		51.6	52.9			...
1.50	Non-Physician Primary Care Provider Rate	53.6		108.9				

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

Ashland County

SCORE	HEALTH CARE ACCESS & QUALITY	Ashland County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Dentist Rate	43		64.2				
1.89	Primary Care Provider Rate	44.7		76.7				
1.58	Adults who have had a Routine Checkup	77.4			76.6			...
1.58	Clinical Care Ranking	51					...	...

1.50	Adults who Visited a Dentist	50.9		51.6	52.9			...
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	619.6		638.9	609.6			...

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

Table 10: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #2: Behavioral Health (Mental Health and Substance Misuse)

From the secondary data scoring results, Mental Health & Mental Disorders had the second highest data score of all topic areas, with a score of 1.61. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 10 below.

Medina County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.92	Depression: Medicare Population	19		20.4	18.4			
1.89	Age-Adjusted Death Rate due to Suicide	15.7	12.8	15.1	14.1			
1.58	Adults Ever Diagnosed with Depression	21.2			18.8			...

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

Wayne County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	38.1		34	30.5			
2.50	Age-Adjusted Death Rate due to Suicide	16.7	12.8	15.1	14.1			
2.17	Poor Mental Health: Average Number of Days	5.2		4.8	4.1			...
1.92	Alzheimer's Disease or Dementia: Medicare Population	10.4		10.4	10.8			
1.92	Poor Mental Health: 14+ Days	16.9			13.6			...
1.75	Adults Ever Diagnosed with Depression	21.9			18.8			...
1.64	Depression: Medicare Population	19.2		20.4	18.4			
1.50	Self-Reported General Health Assessment: Good or Better	84.7		85.6	86.5			...

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

Ashland County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Ashland County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.36	Age-Adjusted Death Rate due to Alzheimer's Disease	47.4		34	30.5			
2.08	Poor Mental Health: 14+ Days	17			13.6			...
1.83	Poor Mental Health: Average Number of Days	5		4.8	4.1			...
1.75	Adults Ever Diagnosed with Depression	22.1			18.8			...
1.64	Alzheimer's Disease or Dementia: Medicare Population	10.2		10.4	10.8			
1.56	Age-Adjusted Death Rate due to Suicide	14.2	12.8	14.7	13.9			...
1.50	Self-Reported General Health Assessment: Good or Better	84.4		85.6	86.5			...

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

Table 11. Data Scoring Results for Behavioral Health (Substance Abuse) for the Lodi Hospital Community

From the secondary data scoring results, Alcohol & Drug Use had the 14th highest data score of all topic areas, with a score of 1.32. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 11 below.

Medina County

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

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

Wayne County

SCORE	ALCOHOL & DRUG USE	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Liquor Store Density	11.2		5.6	10.5			
1.92	Adults who Binge Drink	17.9			16.7			...

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

Ashland County

SCORE	ALCOHOL & DRUG USE	Ashland County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.72	Alcohol-Impaired Driving Deaths	44.1	28.3	32.2	27			
1.86	Mothers who Smoked During Pregnancy	12.7	4.3	11.5	5.5		...	
1.75	Adults who Binge Drink	17.1			16.7			...

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

Table 12: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #3: Chronic Disease Prevention & Management

Nutrition & Healthy Eating had the sixth highest data score of all topic areas with a score of 1.46. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 12.

Medina County

SCORE	NUTRITION & HEALTHY EATING	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Consumer Expenditures: Fast Food Restaurants	1814.2		1461	1638.9			...
2.50	Consumer Expenditures: High Sugar Foods	627		519	530.2			...
2.33	Consumer Expenditures: High Sugar Beverages	370		319.7	357			...

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

Wayne County

SCORE	NUTRITION & HEALTHY EATING	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.83	Consumer Expenditures: Fruits and Vegetables	818		864.6	1002.1			---
1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	82		80.9	80.4			---
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	41.4		41.5	41.2			---

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

Ashland County

SCORE	NUTRITION & HEALTHY EATING	Ashland County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Consumer Expenditures: Fruits and Vegetables	785.8		864.6	1002.1			---
1.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	82.1		80.9	80.4			---

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

Table 13: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #4: Socioeconomic Issues

Prevention & Safety ranked 20th among all health topics with a score of 1.07. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 13 below. Medina County did not have any indicators of concern. See Appendix C for the full list of indicators categorized within this topic.

Wayne County

SCORE	PREVENTION & SAFETY	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Age-Adjusted Death Rate due to Falls	16		10.5	9.5			
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.8		2.8	2.5	---	---	---

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

Ashland County

SCORE	PREVENTION & SAFETY	Ashland County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.64	Age-Adjusted Death Rate due to Falls	9.5		10	9.2			---

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

Table 14: Secondary Data Scoring Results by Health Topic for The Lodi Hospital Community in Rank Order by Topic Score

HEALTH TOPICS	AVG
Medications & Prescriptions	1.89
Mental Health & Mental Disorders	1.61
Tobacco Use	1.59
Health Care Access & Quality	1.50
Older Adults	1.46
Nutrition & Healthy Eating	1.46
Heart Disease & Stroke	1.44
Cancer	1.41
Women's Health	1.40
Other Conditions	1.40
Physical Activity	1.38
Wellness & Lifestyle	1.37
Children's Health	1.35
Alcohol & Drug Use	1.32
Respiratory Diseases	1.30
Diabetes	1.30
Maternal, Fetal & Infant Health	1.24
Oral Health	1.24
Immunizations & Infectious Diseases	1.14
Prevention & Safety	1.07
QUALITY OF LIFE TOPIC	**SCORE**
Environmental Health	1.36

Community	1.24
Education	1.22
Economy	1.02

SCORE	ALCOHOL & DRUG USE	UNITS	ASHLAND COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.72	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	44.1	28.3	32.2	27	*2015-2019*	8
1.86	Mothers who Smoked During Pregnancy	*percent*	12.7	4.3	11.5	5.5	*2020*	16
1.75	Adults who Binge Drink	*percent*	17.1			16.7	*2019*	3
1.42	Health Behaviors Ranking	*ranking*	35				*2021*	8
1.17	Adults who Drink Excessively	*percent*	17.7		18.5	19	*2018*	8
1.00	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	581		651.5	701.9	*2021*	6
0.97	Liquor Store Density	*stores/ 100,000 population*	5.6		5.6	10.5	*2019*	21
0.75	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	18.2		42	22.8	*2017-2019*	4
0.67	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	14.9		38.1	21	*2017-2019*	8
SCORE	**CANCER**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	50.6		41.3	38	*2014-2018*	11
2.58	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	22.4	8.9	14.8	13.4	*2015-2019*	11
2.58	Cancer: Medicare Population	*percent*	9.2		8.4	8.4	*2018*	5
2.08	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	107.1		107.2	106.2	*2014-2018*	11
1.92	Adults with Cancer	*percent*	8.3			7.1	*2019*	3
1.67	Colon Cancer Screening	*percent*	63.6	74.4		66.4	*2018*	3

1.64	All Cancer Incidence Rate	*cases/ 100,000 population*	459.2		467.5	448.6	*2014-2018*	11
1.61	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	168.4	122.7	169.4	152.4	*2015-2019*	11
1.61	Cervical Cancer Screening: 21-65	*Percent*	83.7	84.3		84.7	*2018*	3
1.47	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.4		67.3	57.3	*2014-2018*	11
1.44	Mammogram in Past 2 Years: 50-74	*percent*	73.4	77.1		74.8	*2018*	3
1.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20	15.3	21.6	19.9	*2015-2019*	11
0.97	Breast Cancer Incidence Rate	*cases/ 100,000 females*	114.4		129.6	126.8	*2014-2018*	11
0.94	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	38.6	25.1	45	36.7	*2015-2019*	11
0.61	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	15.8	16.9	19.4	18.9	*2015-2019*	11
0.36	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	6.1		12.2	11.9	*2014-2018*	11
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.22	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10.4	8.7	6.8		*2020*	2
2.00	Child Food Insecurity Rate	*percent*	17.9		17.4	14.6	*2019*	9
1.69	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.6		0.5		*2020*	18
1.36	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.8		1.9		*2020*	18
1.25	Projected Child Food Insecurity Rate	*percent*	18.5		18.5		*2021*	9

1.00	Children with Low Access to a Grocery Store	*percent*	0.7				*2015*	22
0.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	202.1		301.6	368.2	*2021*	6
SCORE	**COMMUNITY**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.72	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	44.1	28.3	32.2	27	*2015-2019*	8
2.22	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10.4	8.7	6.8		*2020*	2
2.03	Young Children Living Below Poverty Level	*percent*	25.4		23	20.3	*2015-2019*	1
1.86	Children Living Below Poverty Level	*percent*	21.5		19.9	18.5	*2015-2019*	1
1.83	Households with One or More Types of Computing Devices	*percent*	85.3		89.1	90.3	*2015-2019*	1
1.78	Workers Commuting by Public Transportation	*percent*	0.4	5.3	1.6	5	*2015-2019*	1
1.75	Per Capita Income	*dollars*	26017		31552	34103	*2015-2019*	1
1.69	People 25+ with a Bachelor's Degree or Higher	*percent*	20.9		28.3	32.1	*2015-2019*	1
1.67	Adults with Internet Access	*percent*	93.6		94.5	95	*2021*	7
1.67	Households with a Smartphone	*percent*	78.3		80.5	81.9	*2021*	7
1.67	Households with an Internet Subscription	*percent*	79.5		82.4	83	*2015-2019*	1
1.67	Households with No Car and Low Access to a Grocery Store	*percent*	3.1				*2015*	22
1.67	Persons with an Internet Subscription	*percent*	82.2		86.2	86.2	*2015-2019*	1

1.53	Workers who Drive Alone to Work	*percent*	83.9		82.9	76.3	*2015-2019*	1
1.50	Households with a Computer	*percent*	84.4		85.2	86.3	*2021*	7
1.50	Households with Wireless Phone Service	*percent*	96		96.8	97	*2020*	7
1.47	Households without a Vehicle	*percent*	7.3		7.9	8.6	*2015-2019*	1
1.44	People Living Below Poverty Level	*percent*	13.8	8	14	13.4	*2015-2019*	1
1.42	Median Household Income	*dollars*	52823		56602	62843	*2015-2019*	1
1.42	Social and Economic Factors Ranking	*ranking*	34				*2021*	8
1.19	Linguistic Isolation	*percent*	1.1		1.4	4.4	*2015-2019*	1
1.14	Solo Drivers with a Long Commute	*percent*	30.7		31.1	37	*2015-2019*	8
1.06	Violent Crime Rate	*crimes/ 100,000 population*	118.9		303.5	394	*2017*	17
0.86	Mean Travel Time to Work	*minutes*	22.9		23.7	26.9	*2015-2019*	1
0.83	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	106.1		121.7	148.8	*2021*	6
0.75	Voter Turnout: Presidential Election	*percent*	76.8		74		*2020*	19
0.69	Single-Parent Households	*percent*	20.5		27.1	25.5	*2015-2019*	1
0.53	Homeownership	*percent*	67.5		59.4	56.2	*2015-2019*	1
0.53	People 65+ Living Alone	*percent*	23.6		28.8	26.1	*2015-2019*	1
0.53	Youth not in School or Working	*percent*	0.6		1.8	1.9	*2015-2019*	1
0.50	Social Associations	*membership associations/ 10,000 population*	19.2		11	9.3	*2018*	8
0.36	Workers who Walk to Work	*percent*	4.5		2.2	2.7	*2015-2019*	1
SCORE	**DIABETES**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.17	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	27.9		25.3	21.5	*2017-2019*	4
1.67	Diabetes: Medicare Population	*percent*	27.7		27.2	27	*2018*	5
0.86	Adults 20+ with Diabetes	*percent*	7.2				*2019*	4
SCORE	**ECONOMY**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.03	Young Children Living Below Poverty Level	*percent*	25.4		23	20.3	*2015-2019*	1
2.00	Child Food Insecurity Rate	*percent*	17.9		17.4	14.6	*2019*	9
2.00	Food Insecurity Rate	*percent*	13.6		13.2	10.9	*2019*	9
1.86	Children Living Below Poverty Level	*percent*	21.5		19.9	18.5	*2015-2019*	1
1.86	Overcrowded Households	*percent of households*	1.8		1.4		*2015-2019*	1
1.83	Persons with Disability Living in Poverty (5-year)	*percent*	29.3		29.5	26.1	*2015-2019*	1
1.75	Per Capita Income	*dollars*	26017		31552	34103	*2015-2019*	1
1.69	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	22
1.64	Size of Labor Force	*persons*	26088				*Oct-21*	20
1.53	People Living 200% Above Poverty Level	*percent*	66.8		68.8	69.1	*2015-2019*	1
1.50	Households with a Savings Account	*percent*	68		68.8	70.2	*2021*	7
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	22
1.44	People Living Below Poverty Level	*percent*	13.8	8	14	13.4	*2015-2019*	1
1.42	Median Household Income	*dollars*	52823		56602	62843	*2015-2019*	1
1.42	Social and Economic Factors Ranking	*ranking*	34				*2021*	8

1.33	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	64.7		61.6		*2018*	24
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	23.4		24.5		*2018*	24
1.25	Projected Child Food Insecurity Rate	*percent*	18.5		18.5		*2021*	9
1.25	Projected Food Insecurity Rate	*percent*	14.1		14.1		*2021*	9
1.19	Students Eligible for the Free Lunch Program	*percent*	25.4				*2019-2020*	12
1.17	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14.2		14.6	14.4	*2021*	7
1.17	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7173.7		7828	8900.1	*2021*	6
1.17	Households that are Below the Federal Poverty Level	*percent*	11.8		13.8		*2018*	24
1.14	People 65+ Living Below Poverty Level	*percent*	7.3		8.1	9.3	*2015-2019*	1
1.03	Severe Housing Problems	*percent*	12.4		13.7	18	*2013-2017*	8
1.00	Low-Income and Low Access to a Grocery Store	*percent*	1.4				*2015*	22
0.83	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3744.4		3798.7	5460.2	*2021*	6
0.69	Households with Cash Public Assistance Income	*percent*	1.9		2.9	2.4	*2015-2019*	1
0.67	Income Inequality		0.4		0.5	0.5	*2015-2019*	1
0.64	Renters Spending 30% or More of Household Income on Rent	*percent*	33.9		44.9	49.6	*2015-2019*	1
0.53	Homeownership	*percent*	67.5		59.4	56.2	*2015-2019*	1

0.53	Youth not in School or Working	*percent*	0.6		1.8	1.9	*2015-2019*	1
0.42	Families Living Below Poverty Level	*percent*	7.8		9.9	9.5	*2015-2019*	1
0.42	Unemployed Workers in Civilian Labor Force	*percent*	3.4		3.8	4.3	*Oct-21*	20
SCORE	**EDUCATION**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.69	People 25+ with a Bachelor's Degree or Higher	*percent*	20.9		28.3	32.1	*2015-2019*	1
1.53	Student-to-Teacher Ratio	*students/ teacher*	16.9				*2019-2020*	12
1.33	8th Grade Students Proficient in English/Language Arts	*percent*	56		52.7		*2020-2021*	14
1.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	988.2		1200.4	1492.4	*2021*	6
1.17	High School Graduation	*percent*	95.2	90.7	92		*2019-2020*	14
1.14	8th Grade Students Proficient in Math	*percent*	61.2		42.6		*2020-2021*	14
1.00	4th Grade Students Proficient in Math	*percent*	75.6		59.4		*2020-2021*	14
0.86	4th Grade Students Proficient in English/Language Arts	*percent*	73.6		56		*2020-2021*	14
0.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	202.1		301.6	368.2	*2021*	6
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.47	Houses Built Prior to 1950	*percent*	31.5		26.2	17.5	*2015-2019*	1
2.17	Access to Exercise Opportunities	*percent*	60		83.9	84	*2020*	8
1.92	Adults with Current Asthma	*percent*	10.3			8.9	*2019*	3

1.86	Overcrowded Households	*percent of households*	1.8		1.4		*2015-2019*	1
1.69	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.6		0.5		*2020*	18
1.69	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	22
1.67	Households with No Car and Low Access to a Grocery Store	*percent*	3.1				*2015*	22
1.67	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	22
1.64	Number of Extreme Precipitation Days	*days*	34				*2019*	13
1.64	Recognized Carcinogens Released into Air	*pounds*	126				*2020*	23
1.64	Weeks of Moderate Drought or Worse	*weeks per year*	2				*2020*	13
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	22
1.42	Physical Environment Ranking	*ranking*	35				*2021*	8
1.36	Asthma: Medicare Population	*percent*	4.8		4.8	5	*2018*	5
1.36	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.8		1.9		*2020*	18
1.36	Number of Extreme Heat Days	*days*	14				*2019*	13
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	22
1.17	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.6				*2016*	22
1.03	Grocery Store Density	*stores/ 1,000 population*	0.3				*2016*	22
1.03	Severe Housing Problems	*percent*	12.4		13.7	18	*2013-2017*	8
1.00	Children with Low Access to a Grocery Store	*percent*	0.7				*2015*	22
1.00	Low-Income and Low Access to a Grocery Store	*percent*	1.4				*2015*	22
1.00	People 65+ with Low Access to a Grocery Store	*percent*	1				*2015*	22

0.97	Food Environment Index	*index*	8.1		6.8	7.8	*2021*	8
0.97	Liquor Store Density	*stores/ 100,000 population*	5.6		5.6	10.5	*2019*	21
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Dentist Rate	*dentists/ 100,000 population*	43		64.2		*2019*	8
1.89	Primary Care Provider Rate	*providers/ 100,000 population*	44.7		76.7		*2018*	8
1.58	Adults who have had a Routine Checkup	*percent*	77.4			76.6	*2019*	3
1.58	Clinical Care Ranking	*ranking*	51				*2021*	8
1.50	Adults who Visited a Dentist	*percent*	50.9		51.6	52.9	*2021*	7
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	619.6		638.9	609.6	*2021*	6
1.33	Adults with Health Insurance: 18+	*percent*	90.3		90.2	90.6	*2021*	7
1.33	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4193.6		4371.7	4321.1	*2021*	6
1.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1029.9		1098.6	1047.4	*2021*	6
1.33	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	190.2		204.8	194.9	*2021*	6
1.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	67.3		108.9		*2020*	8
1.08	Adults without Health Insurance	*percent*	12			13	*2019*	3
1.00	Mental Health Provider Rate	*providers/ 100,000 population*	226.2		261.3		*2020*	8
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.42	Ischemic Heart Disease: Medicare Population	*percent*	29.6		27.5	26.8	*2018*	5
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.5		9	8.4	*2018*	5
2.14	Hyperlipidemia: Medicare Population	*percent*	52.2		49.4	47.7	*2018*	5
2.08	Cholesterol Test History	*percent*	83.6			87.6	*2019*	3
2.06	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	106	71.1	101.4	90.5	*2017-2019*	4
1.92	Adults who Experienced Coronary Heart Disease	*percent*	8.1			6.2	*2019*	3
1.83	Hypertension: Medicare Population	*percent*	61.4		59.5	57.2	*2018*	5
1.58	Adults who Experienced a Stroke	*percent*	3.9			3.4	*2019*	3
1.50	High Blood Pressure Prevalence	*percent*	35.7	27.7		32.6	*2019*	3
1.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40	33.4	42.5	37.2	*2017-2019*	4
1.42	High Cholesterol Prevalence: Adults 18+	*percent*	33.4			33.6	*2019*	3
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.4			76.2	*2019*	3
1.25	Heart Failure: Medicare Population	*percent*	12.6		14.7	14	*2018*	5
1.19	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	55		55.4		*2019*	13
1.19	Stroke: Medicare Population	*percent*	3.6		3.8	3.8	*2018*	5
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.22	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.9	1.4	1.1		*2020*	15

1.86	Overcrowded Households	*percent of households*	1.8		1.4		*2015-2019*	1
1.69	Persons Fully Vaccinated Against COVID-19	*percent*	42.4				*4-Feb-22*	4
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48		48.6	49.4	*2021*	7
1.47	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14		14.4	13.8	*2017-2019*	4
1.17	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	11.2	11.1	13.7		*2019*	15
0.92	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	36.9		36.7	67.6	*4-Feb-22*	10
0.86	Chlamydia Incidence Rate	*cases/ 100,000 population*	215		504.8		*2020*	15
0.86	Gonorrhea Incidence Rate	*cases/ 100,000 population*	26.2		262.6		*2020*	15
0.50	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0.3	1.6	*4-Feb-22*	10
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.67	Mothers who Received Early Prenatal Care	*percent*	53.2		68.9	76.1	*2020*	16
2.08	Infant Mortality Rate	*deaths/ 1,000 live births*	12.1	5	6.9		*2019*	16
1.86	Mothers who Smoked During Pregnancy	*percent*	12.7	4.3	11.5	5.5	*2020*	16
1.67	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	19.8		19.5		*2016*	16
1.03	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	4.7		6.8		*2020*	16
0.92	Preterm Births	*percent*	6.8	9.4	10.3		*2020*	16
0.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	202.1		301.6	368.2	*2021*	6

0.75	Babies with Very Low Birth Weight	*percent*	0.6		1.4	1.3	*2020*	16
0.61	Babies with Low Birth Weight	*percent*	5.3		8.5	8.2	*2020*	16
SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	619.6		638.9	609.6	*2021*	6
1.33	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1029.9		1098.6	1047.4	*2021*	6
1.33	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	190.2		204.8	194.9	*2021*	6
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.36	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	47.4		34	30.5	*2017-2019*	4
2.08	Poor Mental Health: 14+ Days	*percent*	17			13.6	*2019*	3
1.83	Poor Mental Health: Average Number of Days	*days*	5		4.8	4.1	*2018*	8
1.75	Adults Ever Diagnosed with Depression	*percent*	22.1			18.8	*2019*	3
1.64	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.2		10.4	10.8	*2018*	5
1.56	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	14.2	12.8	14.7	13.9	*2016-2018*	4
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.4		85.6	86.5	*2021*	7
1.25	Depression: Medicare Population	*percent*	17.9		20.4	18.4	*2018*	5

1.00	Mental Health Provider Rate	*providers/ 100,000 population*	226.2		261.3		*2020*	8
SCORE	**NUTRITION & HEALTHY EATING**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	785.8		864.6	1002.1	*2021*	6
1.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	82.1		80.9	80.4	*2021*	7
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.1		41.5	41.2	*2021*	7
1.17	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	479.1		519	530.2	*2021*	6
0.83	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1309		1461	1638.9	*2021*	6
0.67	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	294		319.7	357	*2021*	6
SCORE	**OLDER ADULTS**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Cancer: Medicare Population	*percent*	9.2		8.4	8.4	*2018*	5
2.42	Ischemic Heart Disease: Medicare Population	*percent*	29.6		27.5	26.8	*2018*	5
2.36	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	47.4		34	30.5	*2017-2019*	4
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.5		9	8.4	*2018*	5
2.14	Hyperlipidemia: Medicare Population	*percent*	52.2		49.4	47.7	*2018*	5

2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.9		36.1	33.5	*2018*	5
1.97	COPD: Medicare Population	*percent*	13.5		13.2	11.5	*2018*	5
1.83	Hypertension: Medicare Population	*percent*	61.4		59.5	57.2	*2018*	5
1.75	Adults 65+ with Total Tooth Loss	*percent*	17			13.5	*2018*	3
1.75	Adults with Arthritis	*percent*	31			25.1	*2019*	3
1.75	Chronic Kidney Disease: Medicare Population	*percent*	24.4		25.3	24.5	*2018*	5
1.67	Colon Cancer Screening	*percent*	63.6	74.4		66.4	*2018*	3
1.67	Diabetes: Medicare Population	*percent*	27.7		27.2	27	*2018*	5
1.64	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.5		10	9.2	*2015-2017*	4
1.64	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.2		10.4	10.8	*2018*	5
1.36	Asthma: Medicare Population	*percent*	4.8		4.8	5	*2018*	5
1.25	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	32.7			32.4	*2018*	3
1.25	Depression: Medicare Population	*percent*	17.9		20.4	18.4	*2018*	5
1.25	Heart Failure: Medicare Population	*percent*	12.6		14.7	14	*2018*	5
1.19	Stroke: Medicare Population	*percent*	3.6		3.8	3.8	*2018*	5
1.17	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	20.9		20.5	34.3	*2021*	6
1.14	People 65+ Living Below Poverty Level	*percent*	7.3		8.1	9.3	*2015-2019*	1
1.00	People 65+ with Low Access to a Grocery Store	*percent*	1				*2015*	22

0.97	Osteoporosis: Medicare Population	*percent*	4.9		6.2	6.6	*2018*	5
0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	33.4			28.4	*2018*	3
0.53	People 65+ Living Alone	*percent*	23.6		28.8	26.1	*2015-2019*	1
SCORE	**ORAL HEALTH**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Dentist Rate	*dentists/ 100,000 population*	43		64.2		*2019*	8
1.75	Adults 65+ with Total Tooth Loss	*percent*	17			13.5	*2018*	3
1.50	Adults who Visited a Dentist	*percent*	50.9		51.6	52.9	*2021*	7
0.36	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	6.1		12.2	11.9	*2014-2018*	11
SCORE	**OTHER CONDITIONS**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.9		36.1	33.5	*2018*	5
1.75	Adults with Arthritis	*percent*	31			25.1	*2019*	3
1.75	Chronic Kidney Disease: Medicare Population	*percent*	24.4		25.3	24.5	*2018*	5
1.42	Adults with Kidney Disease	*Percent of adults*	3.3			3.1	*2019*	3
0.97	Osteoporosis: Medicare Population	*percent*	4.9		6.2	6.6	*2018*	5
0.36	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	9.3		14.5	12.9	*2017-2019*	4

SCORE	PHYSICAL ACTIVITY	UNITS	ASHLAND COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Access to Exercise Opportunities	*percent*	60		83.9	84	*2020*	8
1.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	82.1		80.9	80.4	*2021*	7
1.69	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	22
1.67	Households with No Car and Low Access to a Grocery Store	*percent*	3.1				*2015*	22
1.67	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	22
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	22
1.42	Health Behaviors Ranking		35				*2021*	8
1.36	Adults 20+ who are Sedentary	*percent*	24.4				*2019*	4
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	22
1.17	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.6				*2016*	22
1.03	Grocery Store Density	*stores/ 1,000 population*	0.3				*2016*	22
1.00	Children with Low Access to a Grocery Store	*percent*	0.7				*2015*	22
1.00	Low-Income and Low Access to a Grocery Store	*percent*	1.4				*2015*	22
1.00	People 65+ with Low Access to a Grocery Store	*percent*	1				*2015*	22
0.97	Food Environment Index	*index*	8.1		6.8	7.8	*2021*	8
0.94	Adults 20+ who are Obese	*percent*	26.1	36			*2019*	4
0.36	Workers who Walk to Work	*percent*	4.5		2.2	2.7	*2015-2019*	1
SCORE	**PREVENTION & SAFETY**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.64	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.5		10	9.2	*2015-2017*	4

1.03	Severe Housing Problems	*percent*	12.4		13.7	18	*2013-2017*	8
0.67	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	17.8		40.2	21.4	*2017-2019*	4
0.67	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	14.9		38.1	21	*2017-2019*	8
0.61	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	40.3	43.2	68.8	48.9	*2017-2019*	4
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.31	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	60.6		47.8	39.6	*2017-2019*	4
2.22	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.9	1.4	1.1		*2020*	15
2.08	Adults who Smoke	*percent*	23.6	5	21.4	17	*2018*	8
2.00	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	3.3		2.2	2	*2021*	7
1.97	COPD: Medicare Population	*percent*	13.5		13.2	11.5	*2018*	5
1.92	Adults with COPD	*Percent of adults*	10.2			6.6	*2019*	3
1.92	Adults with Current Asthma	*percent*	10.3			8.9	*2019*	3
1.67	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.6		4.3	4.1	*2021*	7
1.50	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	469.2		487.9	422.4	*2021*	6
1.47	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14		14.4	13.8	*2017-2019*	4
1.47	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62.4		67.3	57.3	*2014-2018*	11
1.36	Asthma: Medicare Population	*percent*	4.8		4.8	5	*2018*	5

0.94	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	38.6	25.1	45	36.7	*2015-2019*	11
0.92	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	36.9		36.7	67.6	*4-Feb-22*	10
0.50	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0.3	1.6	*4-Feb-22*	10
SCORE	**TOBACCO USE**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.08	Adults who Smoke	*percent*	23.6	5	21.4	17	*2018*	8
2.00	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	3.3		2.2	2	*2021*	7
1.67	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.6		4.3	4.1	*2021*	7
1.50	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	469.2		487.9	422.4	*2021*	6
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	82.1		80.9	80.4	*2021*	7
1.75	Insufficient Sleep	*percent*	39	31.4	40.6	35	*2018*	8
1.75	Poor Physical Health: 14+ Days	*percent*	15.1			12.5	*2019*	3
1.67	Poor Physical Health: Average Number of Days	*days*	4.4		4.1	3.7	*2018*	8
1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.1			18.6	*2019*	3
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48		48.6	49.4	*2021*	7

1.50	High Blood Pressure Prevalence	*percent*	35.7	27.7		32.6	*2019*	3
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.4		85.6	86.5	*2021*	7
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.1		41.5	41.2	*2021*	7
1.25	Morbidity Ranking	*ranking*	17				*2021*	8
1.17	Life Expectancy	*years*	77.9		77	79.2	*2017-2019*	8
0.83	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1309		1461	1638.9	*2021*	6
SCORE	**WOMEN'S HEALTH**	**UNITS**	**ASHLAND COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.61	Cervical Cancer Screening: 21-65	*Percent*	83.7	84.3		84.7	*2018*	3
1.44	Mammogram in Past 2 Years: 50-74	*percent*	73.4	77.1		74.8	*2018*	3
1.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20	15.3	21.6	19.9	*2015-2019*	11
0.97	Breast Cancer Incidence Rate	*cases/ 100,000 females*	114.4		129.6	126.8	*2014-2018*	11

Ashland Data Sources

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

SCORE	ALCOHOL & DRUG USE	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Liquor Store Density	*stores/ 100,000 population*	11.2		5.6	10.5	*2019*	21
1.92	Adults who Binge Drink	*percent*	17.9			16.7	*2019*	3
1.33	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	596.4		651.5	701.9	*2021*	6
1.25	Health Behaviors Ranking		8				*2021*	8
1.19	Mothers who Smoked During Pregnancy	*percent*	10.3	4.3	11.5	5.5	*2020*	16
0.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	21.5		42	22.8	*2017-2019*	4
0.53	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	17.8		38.1	21	*2017-2019*	8
0.50	Adults who Drink Excessively	*percent*	16.5		18.5	19	*2018*	8
0.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	23.2	28.3	32.2	27	*2015-2019*	8
SCORE	**CANCER**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.56	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	22.7	16.9	19.4	18.9	*2015-2019*	11
2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.9	15.3	21.6	19.9	*2015-2019*	11
1.78	Mammogram in Past 2 Years: 50-74	*percent*	71	77.1		74.8	*2018*	3
1.75	Adults with Cancer	*percent*	8.2			7.1	*2019*	3
1.75	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	101.5		107.2	106.2	*2014-2018*	11
1.64	Breast Cancer Incidence Rate	*cases/ 100,000 females*	123.1		129.6	126.8	*2014-2018*	11
1.61	Cervical Cancer Screening: 21-65	*Percent*	83.3	84.3		84.7	*2018*	3

1.47	Cancer: Medicare Population	*percent*	7.6		8.4	8.4	*2018*	5
1.33	Colon Cancer Screening	*percent*	66.2	74.4		66.4	*2018*	3
1.14	All Cancer Incidence Rate	*cases/ 100,000 population*	432.2		467.5	448.6	*2014-2018*	11
1.11	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	155.4	122.7	169.4	152.4	*2015-2019*	11
1.08	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7		7.9	7.7	*2014-2018*	11
0.86	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	38		41.3	38	*2014-2018*	11
0.69	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	55.4		67.3	57.3	*2014-2018*	11
0.61	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	12.5	8.9	14.8	13.4	*2015-2019*	11
0.61	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	35.6	25.1	45	36.7	*2015-2019*	11
0.08	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	9.6		12.2	11.9	*2014-2018*	11
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Children with Health Insurance	*percent*	75.8		95.2	94.3	*2019*	1
1.61	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.6	8.7	6.8		*2020*	2
1.33	Children with Low Access to a Grocery Store	*percent*	3.6				*2015*	22
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	234.9		301.6	368.2	*2021*	6
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.1		1.9		*2020*	18

1.00	Child Food Insecurity Rate	*percent*	14.7		17.4	14.6	*2019*	9
0.92	Projected Child Food Insecurity Rate	*percent*	15.5		18.5		*2021*	9
0.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	18
SCORE	**COMMUNITY**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.47	Households without a Vehicle	*percent*	9.4		7.9	8.6	*2015-2019*	1
2.42	Workers Commuting by Public Transportation	*percent*	0.2	5.3	1.6	5	*2015-2019*	1
2.14	Linguistic Isolation	*percent*	2.3		1.4	4.4	*2015-2019*	1
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.8		2.8	2.5	*2015-2019*	4
2.00	Households with No Car and Low Access to a Grocery Store	*percent*	5.3				*2015*	22
1.83	Households with One or More Types of Computing Devices	*percent*	85		89.1	90.3	*2015-2019*	1
1.83	Persons with an Internet Subscription	*percent*	80.9		86.2	86.2	*2015-2019*	1
1.69	People 25+ with a Bachelor's Degree or Higher	*percent*	22.2		28.3	32.1	*2015-2019*	1
1.64	People 65+ Living Alone	*percent*	27		28.8	26.1	*2015-2019*	1
1.61	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.6	8.7	6.8		*2020*	2
1.53	Voter Turnout: Presidential Election	*percent*	73.7		74		*2020*	19
1.53	Youth not in School or Working	*percent*	1.9		1.8	1.9	*2015-2019*	1
1.50	Adults with Internet Access	*percent*	94.1		94.5	95	*2021*	7
1.50	Households with a Computer	*percent*	84.9		85.2	86.3	*2021*	7
1.50	Households with a Smartphone	*percent*	78.9		80.5	81.9	*2021*	7
1.50	Households with an Internet Subscription	*percent*	80		82.4	83	*2015-2019*	1

1.50	Households with Wireless Phone Service	*percent*	96.1		96.8	97	*2020*	7
1.50	Violent Crime Rate	*crimes/ 100,000 population*	180.9		303.5	394	*2017*	17
1.42	Per Capita Income	*dollars*	27884		31552	34103	*2015-2019*	1
1.25	Social and Economic Factors Ranking	*ranking*	22				*2021*	8
1.03	Workers who Drive Alone to Work	*percent*	78.5		82.9	76.3	*2015-2019*	1
0.92	Median Household Income	*dollars*	58300		56602	62843	*2015-2019*	1
0.83	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	106.8		121.7	148.8	*2021*	6
0.78	People Living Below Poverty Level	*percent*	11.3	8	14	13.4	*2015-2019*	1
0.69	Children Living Below Poverty Level	*percent*	16.4		19.9	18.5	*2015-2019*	1
0.69	Young Children Living Below Poverty Level	*percent*	17.2		23	20.3	*2015-2019*	1
0.64	Workers who Walk to Work	*percent*	4		2.2	2.7	*2015-2019*	1
0.53	Mean Travel Time to Work	*minutes*	20.5		23.7	26.9	*2015-2019*	1
0.53	Social Associations	*membership associations/ 10,000 population*	14.1		11	9.3	*2018*	8
0.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	23.2	28.3	32.2	27	*2015-2019*	8
0.36	Homeownership	*percent*	68.5		59.4	56.2	*2015-2019*	1
0.25	Solo Drivers with a Long Commute	*percent*	23.6		31.1	37	*2015-2019*	8
0.08	Single-Parent Households	*percent*	15.9		27.1	25.5	*2015-2019*	1
SCORE	**DIABETES**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.31	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	31.6		25.3	21.5	*2017-2019*	4
1.03	Adults 20+ with Diabetes	*percent*	8.2				*2019*	4
1.00	Diabetes: Medicare Population	*percent*	25.4		27.2	27	*2018*	5
SCORE	**ECONOMY**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.86	Overcrowded Households	*percent of households*	1.9		1.4		*2015-2019*	1
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.5				*2017*	22
1.67	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	26.3		24.5		*2018*	24
1.53	Youth not in School or Working	*percent*	1.9		1.8	1.9	*2015-2019*	1
1.50	Food Insecurity Rate	*percent*	12		13.2	10.9	*2019*	9
1.50	Households with a Savings Account	*percent*	68.3		68.8	70.2	*2021*	7
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	22
1.47	Persons with Disability Living in Poverty (5-year)	*percent*	26.6		29.5	26.1	*2015-2019*	1
1.42	Per Capita Income	*dollars*	27884		31552	34103	*2015-2019*	1
1.36	Size of Labor Force	*persons*	59579				*Oct-21*	20
1.33	Low-Income and Low Access to a Grocery Store	*percent*	5				*2015*	22
1.25	Projected Food Insecurity Rate	*percent*	12.7		14.1		*2021*	9
1.25	Social and Economic Factors Ranking	*ranking*	22				*2021*	8
1.17	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7433.7		7828	8900.1	*2021*	6

1.17	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	66.2		61.6		*2018*	24
1.00	Child Food Insecurity Rate	*percent*	14.7		17.4	14.6	*2019*	9
1.00	Households that are Below the Federal Poverty Level	*percent*	7.6		13.8		*2018*	24
1.00	Income Inequality		0.4		0.5	0.5	*2015-2019*	1
0.97	People 65+ Living Below Poverty Level	*percent*	7.2		8.1	9.3	*2015-2019*	1
0.92	Median Household Income	*dollars*	58300		56602	62843	*2015-2019*	1
0.92	Projected Child Food Insecurity Rate	*percent*	15.5		18.5		*2021*	9
0.92	Students Eligible for the Free Lunch Program	*percent*	28				*2019-2020*	12
0.86	Households with Cash Public Assistance Income	*percent*	2.1		2.9	2.4	*2015-2019*	1
0.83	Adults who Feel Overwhelmed by Financial Burdens	*percent*	14		14.6	14.4	*2021*	7
0.83	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3627.5		3798.7	5460.2	*2021*	6
0.78	People Living Below Poverty Level	*percent*	11.3	8	14	13.4	*2015-2019*	1
0.75	People Living 200% Above Poverty Level	*percent*	69.7		68.8	69.1	*2015-2019*	1
0.75	Severe Housing Problems	*percent*	13		13.7	18	*2013-2017*	8
0.69	Children Living Below Poverty Level	*percent*	16.4		19.9	18.5	*2015-2019*	1
0.69	Renters Spending 30% or More of Household Income on Rent	*percent*	38.4		44.9	49.6	*2015-2019*	1
0.69	Young Children Living Below Poverty Level	*percent*	17.2		23	20.3	*2015-2019*	1
0.42	Families Living Below Poverty Level	*percent*	7.5		9.9	9.5	*2015-2019*	1

0.36	Homeownership	*percent*	68.5		59.4	56.2	*2015-2019*	1
0.33	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	17.5		19.7	26.5	*2019*	1
0.25	Unemployed Workers in Civilian Labor Force	*percent*	3		3.8	4.3	*Oct-21*	20
SCORE	**EDUCATION**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.69	People 25+ with a Bachelor's Degree or Higher	*percent*	22.2		28.3	32.1	*2015-2019*	1
1.53	Student-to-Teacher Ratio	*students/ teacher*	16.2				*2019-2020*	12
1.42	8th Grade Students Proficient in Math	*percent*	60		42.6		*2020-2021*	14
1.17	4th Grade Students Proficient in Math	*percent*	74		59.4		*2020-2021*	14
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	234.9		301.6	368.2	*2021*	6
1.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	968.6		1200.4	1492.4	*2021*	6
1.00	4th Grade Students Proficient in English/Language Arts	*percent*	68.1		56		*2020-2021*	14
1.00	8th Grade Students Proficient in English/Language Arts	*percent*	65.6		52.7		*2020-2021*	14
1.00	High School Graduation	*percent*	95.8	90.7	92		*2019-2020*	14
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Access to Exercise Opportunities	*percent*	66.7		83.9	84	*2020*	8
2.00	Households with No Car and Low Access to a Grocery Store	*percent*	5.3				*2015*	22

2.00	Liquor Store Density	*stores/ 100,000 population*	11.2		5.6	10.5	*2019*	21
1.86	Overcrowded Households	*percent of households*	1.9		1.4		*2015-2019*	1
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.5				*2017*	22
1.67	People 65+ with Low Access to a Grocery Store	*percent*	2.9				*2015*	22
1.64	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	22
1.58	Adults with Current Asthma	*percent*	9.9			8.9	*2019*	3
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	22
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	22
1.42	Physical Environment Ranking	*ranking*	33				*2021*	8
1.36	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	5
1.36	Number of Extreme Heat Days	*days*	14				*2019*	13
1.36	Number of Extreme Precipitation Days	*days*	32				*2019*	13
1.36	PBT Released	*pounds*	2117.7				*2020*	23
1.36	Recognized Carcinogens Released into Air	*pounds*	3237.3				*2020*	23
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	5				*2020*	13
1.33	Children with Low Access to a Grocery Store	*percent*	3.6				*2015*	22
1.33	Low-Income and Low Access to a Grocery Store	*percent*	5				*2015*	22
1.17	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*	22
1.17	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	22

1.14	Food Environment Index	*index*	8		6.8	7.8	*2021*	8
1.08	Houses Built Prior to 1950	*percent*	23.2		26.2	17.5	*2015-2019*	1
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.1		1.9		*2020*	18
0.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	18
0.75	Severe Housing Problems	*percent*	13		13.7	18	*2013-2017*	8
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Children with Health Insurance	*percent*	75.8		95.2	94.3	*2019*	1
1.89	Persons without Health Insurance	*percent*	15.7		6.6		*2019*	1
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1064.3		1098.6	1047.4	*2021*	6
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	196.3		204.8	194.9	*2021*	6
1.72	Primary Care Provider Rate	*providers/ 100,000 population*	51.7		76.7		*2018*	8
1.67	Adults with Health Insurance	*percent*	84.3		90.9	87.1	*2019*	1
1.67	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4333.6		4371.7	4321.1	*2021*	6
1.67	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	633.6		638.9	609.6	*2021*	6
1.58	Clinical Care Ranking	*ranking*	52				*2021*	8
1.50	Adults who Visited a Dentist	*percent*	51.4		51.6	52.9	*2021*	7
1.50	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	53.6		108.9		*2020*	8

1.44	Dentist Rate	*dentists/ 100,000 population*	43.2		64.2		*2019*	8
1.42	Adults who have had a Routine Checkup	*percent*	77.9			76.6	*2019*	3
1.33	Adults with Health Insurance: 18+	*percent*	90.3		90.2	90.6	*2021*	7
1.08	Adults without Health Insurance	*percent*	12.2			13	*2019*	3
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	342.2		261.3		*2020*	8
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.39	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	113.8	71.1	101.4	90.5	*2017-2019*	4
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.6		9	8.4	*2018*	5
1.75	Cholesterol Test History	*percent*	84.2			87.6	*2019*	3
1.64	Hyperlipidemia: Medicare Population	*percent*	48.7		49.4	47.7	*2018*	5
1.64	Ischemic Heart Disease: Medicare Population	*percent*	27.4		27.5	26.8	*2018*	5
1.58	Adults who Experienced a Stroke	*percent*	3.8			3.4	*2019*	3
1.58	Adults who Experienced Coronary Heart Disease	*percent*	7.8			6.2	*2019*	3
1.58	Adults who Have Taken Medications for High Blood Pressure	*percent*	77.7			76.2	*2019*	3
1.33	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	55		55.4		*2019*	13
1.33	High Blood Pressure Prevalence	*percent*	34.7	27.7		32.6	*2019*	3
1.31	Hypertension: Medicare Population	*percent*	57.2		59.5	57.2	*2018*	5
1.25	High Cholesterol Prevalence: Adults 18+	*percent*	33.2			33.6	*2019*	3

0.69	Heart Failure: Medicare Population	*percent*	12.6		14.7	14	*2018*	5
0.53	Stroke: Medicare Population	*percent*	3.1		3.8	3.8	*2018*	5
0.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	35.6	33.4	42.5	37.2	*2017-2019*	4
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	17.3	11.1	13.7		*2019*	15
1.86	Overcrowded Households	*percent of households*	1.9		1.4		*2015-2019*	1
1.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.4		14.4	13.8	*2017-2019*	4
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.7		0.3	1.6	*4-Feb-22*	10
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.2		48.6	49.4	*2021*	7
1.25	Persons Fully Vaccinated Against COVID-19	*percent*	44.6				*4-Feb-22*	4
1.17	Gonorrhea Incidence Rate	*cases/ 100,000 population*	56.2		262.6		*2020*	15
1.00	Chlamydia Incidence Rate	*cases/ 100,000 population*	201.4		504.8		*2020*	15
0.92	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	15
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	16.6		36.7	67.6	*4-Feb-22*	10
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.50	Infant Mortality Rate	*deaths/ 1,000 live births*	9	5	6.9		*2019*	16
2.39	Mothers who Received Early Prenatal Care	*percent*	57.2		68.9	76.1	*2020*	16
1.31	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	4.3		6.8		*2020*	16
1.19	Mothers who Smoked During Pregnancy	*percent*	10.3	4.3	11.5	5.5	*2020*	16
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	234.9		301.6	368.2	*2021*	6
1.06	Babies with Low Birth Weight	*percent*	7		8.5	8.2	*2020*	16
0.86	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	12.2		19.5		*2016*	16
0.78	Preterm Births	*percent*	7.6	9.4	10.3		*2020*	16
0.61	Babies with Very Low Birth Weight	*percent*	0.7		1.4	1.3	*2020*	16
SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1064.3		1098.6	1047.4	*2021*	6
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	196.3		204.8	194.9	*2021*	6
1.67	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	633.6		638.9	609.6	*2021*	6
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	38.1		34	30.5	*2017-2019*	4

2.50	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	16.7	12.8	15.1	14.1	*2017-2019*	4
2.17	Poor Mental Health: Average Number of Days	*days*	5.2		4.8	4.1	*2018*	8
1.92	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.4		10.4	10.8	*2018*	5
1.92	Poor Mental Health: 14+ Days	*percent*	16.9			13.6	*2019*	3
1.75	Adults Ever Diagnosed with Depression	*percent*	21.9			18.8	*2019*	3
1.64	Depression: Medicare Population	*percent*	19.2		20.4	18.4	*2018*	5
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.7		85.6	86.5	*2021*	7
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	342.2		261.3		*2020*	8
SCORE	**NUTRITION & HEALTHY EATING**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.83	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	818		864.6	1002.1	*2021*	6
1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	82		80.9	80.4	*2021*	7
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.4		41.5	41.2	*2021*	7
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1360.5		1461	1638.9	*2021*	6
1.33	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	497.4		519	530.2	*2021*	6

1.00	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	304		319.7	357	*2021*	6
SCORE	**OLDER ADULTS**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	38.1		34	30.5	*2017-2019*	4
2.50	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	16		10.5	9.5	*2017-2019*	4
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.6		9	8.4	*2018*	5
1.92	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.4		10.4	10.8	*2018*	5
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	34.3		36.1	33.5	*2018*	5
1.75	Adults 65+ with Total Tooth Loss	*percent*	16.7			13.5	*2018*	3
1.75	Adults with Arthritis	*percent*	31.6			25.1	*2019*	3
1.67	People 65+ with Low Access to a Grocery Store	*percent*	2.9				*2015*	22
1.64	Depression: Medicare Population	*percent*	19.2		20.4	18.4	*2018*	5
1.64	Hyperlipidemia: Medicare Population	*percent*	48.7		49.4	47.7	*2018*	5
1.64	Ischemic Heart Disease: Medicare Population	*percent*	27.4		27.5	26.8	*2018*	5
1.64	People 65+ Living Alone	*percent*	27		28.8	26.1	*2015-2019*	1
1.47	Cancer: Medicare Population	*percent*	7.6		8.4	8.4	*2018*	5
1.42	Chronic Kidney Disease: Medicare Population	*percent*	23.1		25.3	24.5	*2018*	5
1.36	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	5
1.33	Colon Cancer Screening	*percent*	66.2	74.4		66.4	*2018*	3
1.31	Hypertension: Medicare Population	*percent*	57.2		59.5	57.2	*2018*	5

1.14	COPD: Medicare Population	*percent*	11.8		13.2	11.5	*2018*	5
1.08	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	32			28.4	*2018*	3
1.00	Diabetes: Medicare Population	*percent*	25.4		27.2	27	*2018*	5
0.97	People 65+ Living Below Poverty Level	*percent*	7.2		8.1	9.3	*2015-2019*	1
0.92	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	34.1			32.4	*2018*	3
0.83	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	20.1		20.5	34.3	*2021*	6
0.81	Osteoporosis: Medicare Population	*percent*	4.9		6.2	6.6	*2018*	5
0.69	Heart Failure: Medicare Population	*percent*	12.6		14.7	14	*2018*	5
0.53	Stroke: Medicare Population	*percent*	3.1		3.8	3.8	*2018*	5
SCORE	**ORAL HEALTH**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.75	Adults 65+ with Total Tooth Loss	*percent*	16.7			13.5	*2018*	3
1.50	Adults who Visited a Dentist	*percent*	51.4		51.6	52.9	*2021*	7
1.44	Dentist Rate	*dentists/ 100,000 population*	43.2		64.2		*2019*	8
0.08	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	9.6		12.2	11.9	*2014-2018*	11
SCORE	**OTHER CONDITIONS**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	34.3		36.1	33.5	*2018*	5
1.75	Adults with Arthritis	*percent*	31.6			25.1	*2019*	3

1.42	Adults with Kidney Disease	*Percent of adults*	3.2			3.1	*2019*	3
1.42	Chronic Kidney Disease: Medicare Population	*percent*	23.1		25.3	24.5	*2018*	5
0.81	Osteoporosis: Medicare Population	*percent*	4.9		6.2	6.6	*2018*	5
0.36	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	8.9		14.5	12.9	*2017-2019*	4
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.17	Adults 20+ who are Obese	*percent*	36.3	36			*2019*	4
2.00	Access to Exercise Opportunities	*percent*	66.7		83.9	84	*2020*	8
2.00	Households with No Car and Low Access to a Grocery Store	*percent*	5.3				*2015*	22
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.5				*2017*	22
1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	82		80.9	80.4	*2021*	7
1.67	People 65+ with Low Access to a Grocery Store	*percent*	2.9				*2015*	22
1.64	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	22
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	22
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	22
1.33	Children with Low Access to a Grocery Store	*percent*	3.6				*2015*	22
1.33	Low-Income and Low Access to a Grocery Store	*percent*	5				*2015*	22
1.25	Health Behaviors Ranking	*ranking*	8				*2021*	8

1.19	Adults 20+ who are Sedentary	*percent*	22.7				*2019*	4
1.17	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*	22
1.17	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	22
1.14	Food Environment Index	*index*	8		6.8	7.8	*2021*	8
0.64	Workers who Walk to Work	*percent*	4		2.2	2.7	*2015-2019*	1
SCORE	**PREVENTION & SAFETY**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	16		10.5	9.5	*2017-2019*	4
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.8		2.8	2.5	*2015-2019*	4
1.11	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	57.4	43.2	68.8	48.9	*2017-2019*	4
0.83	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	20.4		40.2	21.4	*2017-2019*	4
0.75	Severe Housing Problems	*percent*	13		13.7	18	*2013-2017*	8
0.53	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	17.8		38.1	21	*2017-2019*	8
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.7		4.3	4.1	*2021*	7
1.92	Adults who Smoke	*percent*	22.8	5	21.4	17	*2018*	8
1.83	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	3.1		2.2	2	*2021*	7
1.75	Adults with COPD	*Percent of adults*	9.8			6.6	*2019*	3

1.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.4		14.4	13.8	*2017-2019*	4
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	470.6		487.9	422.4	*2021*	6
1.58	Adults with Current Asthma	*percent*	9.9			8.9	*2019*	3
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.7		0.3	1.6	*4-Feb-22*	10
1.36	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	5
1.14	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	42.3		47.8	39.6	*2017-2019*	4
1.14	COPD: Medicare Population	*percent*	11.8		13.2	11.5	*2018*	5
0.92	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	1.1		*2020*	15
0.69	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	55.4		67.3	57.3	*2014-2018*	11
0.61	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	35.6	25.1	45	36.7	*2015-2019*	11
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	16.6		36.7	67.6	*4-Feb-22*	10
SCORE	**TOBACCO USE**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4.7		4.3	4.1	*2021*	7
1.92	Adults who Smoke	*percent*	22.8	5	21.4	17	*2018*	8
1.83	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	3.1		2.2	2	*2021*	7

1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	470.6		487.9	422.4	*2021*	6
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.17	Poor Physical Health: Average Number of Days	*days*	4.5		4.1	3.7	*2018*	8
1.67	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	82		80.9	80.4	*2021*	7
1.58	Insufficient Sleep	*percent*	38.6	31.4	40.6	35	*2018*	8
1.58	Poor Physical Health: 14+ Days	*percent*	14.6			12.5	*2019*	3
1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.2			18.6	*2019*	3
1.50	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.2		48.6	49.4	*2021*	7
1.50	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.4		41.5	41.2	*2021*	7
1.50	Self-Reported General Health Assessment: Good or Better	*percent*	84.7		85.6	86.5	*2021*	7
1.42	Morbidity Ranking	*ranking*	23				*2021*	8
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1360.5		1461	1638.9	*2021*	6
1.33	High Blood Pressure Prevalence	*percent*	34.7	27.7		32.6	*2019*	3
1.17	Life Expectancy	*years*	78		77	79.2	*2017-2019*	8
SCORE	**WOMEN'S HEALTH**	**UNITS**	**WAYNE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.22	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.9	15.3	21.6	19.9	*2015-2019*	11
1.78	Mammogram in Past 2 Years: 50-74	*percent*	71	77.1		74.8	*2018*	3
1.64	Breast Cancer Incidence Rate	*cases/ 100,000 females*	123.1		129.6	126.8	*2014-2018*	11
1.61	Cervical Cancer Screening: 21-65	*Percent*	83.3	84.3		84.7	*2018*	3
1.08	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7		7.9	7.7	*2014-2018*	11

Wayne County Data Sources

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

SCORE	ALCOHOL & DRUG USE	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	40.7	28.3	32.2	27	*2015-2019*	9
2.50	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	821.2		651.5	701.9	*2021*	7
1.92	Adults who Binge Drink	*percent*	17.6			16.7	*2019*	4
1.33	Adults who Drink Excessively	*percent*	18.5		18.5	19	*2018*	9
1.25	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	25.1		42	22.8	*2017-2019*	5
1.25	Health Behaviors Ranking		4				*2021*	9
1.19	Mothers who Smoked During Pregnancy	*percent*	6.9	4.3	11.5	5.5	*2020*	17
1.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.1		38.1	21	*2017-2019*	9
0.08	Liquor Store Density	*stores/ 100,000 population*	1.7		5.9	10.6	*2018*	22
SCORE	**CANCER**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	135.8		107.2	106.2	*2014-2018*	12

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

0.61	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	36.5	25.1	45	36.7	*2015-2019*	12
0.44	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	11.4	8.9	14.8	13.4	*2015-2019*	12
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.72	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.4	8.7	6.8		*2020*	3
1.33	Children with Health Insurance	*percent*	95.4		95.2	94.3	*2019*	1
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	19
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2020*	19
0.75	Projected Child Food Insecurity Rate	*percent*	11.7		18.5		*2021*	10
0.50	Child Food Insecurity Rate	*percent*	10.6		17.4	14.6	*2019*	10
SCORE	**COMMUNITY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

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

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

0.36	Single-Parent Households	*percent*	16		27.1	25.5	*2015-2019*	1
0.28	People Living Below Poverty Level	*percent*	6	8	14	13.4	*2015-2019*	1
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	33.9		28.3	32.1	*2015-2019*	1
0.08	Median Household Income	*dollars*	76600		56602	62843	*2015-2019*	1
0.08	Per Capita Income	*dollars*	37788		31552	34103	*2015-2019*	1
SCORE	**DIABETES**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.50	Adults 20+ with Diabetes	*percent*	9.2				*2019*	5
0.81	Diabetes: Medicare Population	*percent*	23.9		27.2	27	*2018*	6
0.36	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	18.8		25.3	21.5	*2017-2019*	5
SCORE	**ECONOMY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	9561.5		7828	8900.1	*2021*	7
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.64	Size of Labor Force	*persons*	93296				*Sep-21*	21
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23

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

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

0.28	People Living Below Poverty Level	*percent*	6	8	14	13.4	*2015-2019*	1
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9
0.25	Unemployed Workers in Civilian Labor Force	*percent*	3.1		4.3	4.6	*Sep-21*	21
0.08	Median Household Income	*dollars*	76600		56602	62843	*2015-2019*	1
0.08	People Living 200% Above Poverty Level	*percent*	82.8		68.8	69.1	*2015-2019*	1
0.08	Per Capita Income	*dollars*	37788		31552	34103	*2015-2019*	1
SCORE	**EDUCATION**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
2.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1490.7		1200.4	1492.4	*2021*	7
1.58	Student-to-Teacher Ratio	*students/ teacher*	18.3				*2019-2020*	13
1.50	8th Grade Students Proficient in Math	*percent*	62.1		57.3		*2018-2019*	15
1.00	4th Grade Students Proficient in Math	*percent*	86.3		74.3		*2018-2019*	15
0.86	4th Grade Students Proficient in English/Language Arts	*percent*	79		63.3		*2018-2019*	15
0.72	High School Graduation	*percent*	96.3	90.7	92		*2019-2020*	15

0.58	8th Grade Students Proficient in English/Language Arts	*percent*	74		58.3		*2018-2019*	15
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	33.9		28.3	32.1	*2015-2019*	1
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23
1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	23
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.5				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.36	Number of Extreme Heat Days	*days*	14				*2019*	14
1.36	Number of Extreme Precipitation Days	*days*	28				*2019*	14
1.36	PBT Released	*pounds*	676.8				*2020*	24

1.36	Recognized Carcinogens Released into Air	*pounds*	447				*2020*	24
1.36	Weeks of Moderate Drought or Worse	*weeks per year*	1				*2020*	14
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.2				*2015*	23
1.25	Adults with Current Asthma	*percent*	9.4			8.9	*2019*	4
1.25	Physical Environment Ranking	*ranking*	10				*2021*	9
1.19	Asthma: Medicare Population	*percent*	4.7		4.8	5	*2018*	6
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	19
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2020*	19
1.11	Annual Ozone Air Quality		A				*2017-2019*	2
1.11	Annual Particle Pollution		A				*2017-2019*	2
1.03	Overcrowded Households	*percent of households*	1.1		1.4		*2015-2019*	1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23

1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.83	Access to Exercise Opportunities	*percent*	92.1		83.9	84	*2020*	9
0.53	Houses Built Prior to 1950	*percent*	12.5		26.2	17.5	*2015-2019*	1
0.36	Food Environment Index	*index*	8.6		6.8	7.8	*2021*	9
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9
0.08	Liquor Store Density	*stores/ 100,000 population*	1.7		5.9	10.6	*2018*	22
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	5410.8		4371.7	4321.1	*2021*	7
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1419.1		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	259.4		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	781.2		638.9	609.6	*2021*	7
1.72	Primary Care Provider Rate	*providers/ 100,000 population*	60.3		76.7		*2018*	9
1.50	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	63.4		108.9		*2020*	9
1.44	Dentist Rate	*dentists/ 100,000 population*	53.4		64.2		*2019*	9

1.39	Persons without Health Insurance	*percent*	4.3		6.6		*2019*	1
1.33	Adults with Health Insurance	*percent*	94.4		90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	95.4		95.2	94.3	*2019*	1
1.33	Mental Health Provider Rate	*providers/ 100,000 population*	140.8		261.3		*2020*	9
1.25	Clinical Care Ranking	*ranking*	4				*2021*	9
0.92	Adults who have had a Routine Checkup	*percent*	79.5			76.6	*2019*	4
0.83	Adults who Visited a Dentist	*percent*	56.6		51.6	52.9	*2021*	8
0.83	Adults with Health Insurance: 18+	*percent*	92.4		90.2	90.6	*2021*	8
0.75	Adults without Health Insurance	*percent*	9.5			13	*2019*	4
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.4		9	8.4	*2018*	6
1.81	Hyperlipidemia: Medicare Population	*percent*	50		49.4	47.7	*2018*	6
1.42	Adults who Have Taken Medications for High Blood Pressure	*percent*	78			76.2	*2019*	4

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

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

2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*	7
1.19	Mothers who Smoked During Pregnancy	*percent*	6.9	4.3	11.5	5.5	*2020*	17
1.11	Mothers who Received Early Prenatal Care	*percent*	74.7		68.9	76.1	*2020*	17
0.86	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	1.6		6.8		*2020*	17
0.86	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	13.4		19.5		*2016*	17
0.78	Infant Mortality Rate	*deaths/ 1,000 live births*	1.8	5	6.9		*2019*	17
0.78	Preterm Births	*percent*	7.6	9.4	10.3		*2020*	17
0.75	Babies with Low Birth Weight	*percent*	5.7		8.5	8.2	*2020*	17
0.61	Babies with Very Low Birth Weight	*percent*	0.6		1.4	1.3	*2020*	17
SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1419.1		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	259.4		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	781.2		638.9	609.6	*2021*	7

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

2.50	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1814.2		1461	1638.9	*2021*	7
2.50	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	627		519	530.2	*2021*	7
2.33	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	370		319.7	357	*2021*	7
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.2		41.5	41.2	*2021*	8
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.67	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	1043.8		864.6	1002.1	*2021*	7
SCORE	**OLDER ADULT HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.2		36.1	33.5	*2018*	6
2.31	Atrial Fibrillation: Medicare Population	*percent*	9.4		9	8.4	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6

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

0.94	Colon Cancer Screening	*percent*	68.2	74.4		66.4	*2018*	4
0.81	Diabetes: Medicare Population	*percent*	23.9		27.2	27	*2018*	6
0.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	36.5			28.4	*2018*	4
0.75	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	38.5			32.4	*2018*	4
0.75	Adults 65+ with Total Tooth Loss	*percent*	11			13.5	*2018*	4
0.69	Heart Failure: Medicare Population	*percent*	12.9		14.7	14	*2018*	6
0.69	Ischemic Heart Disease: Medicare Population	*percent*	24.7		27.5	26.8	*2018*	6
0.64	People 65+ Living Below Poverty Level	*percent*	5.2		8.1	9.3	*2015-2019*	1
SCORE	**ORAL HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.44	Dentist Rate	*dentists/ 100,000 population*	53.4		64.2		*2019*	9
1.42	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.4		12.2	11.9	*2014-2018*	12
0.83	Adults who Visited a Dentist	*percent*	56.6		51.6	52.9	*2021*	8

0.75	Adults 65+ with Total Tooth Loss	*percent*	11			13.5	*2018*	4
SCORE	**OTHER CONDITIONS**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.2		36.1	33.5	*2018*	6
2.14	Osteoporosis: Medicare Population	*percent*	6.6		6.2	6.6	*2018*	6
1.75	Adults with Arthritis	*percent*	30			25.1	*2019*	4
1.42	Chronic Kidney Disease: Medicare Population	*percent*	23		25.3	24.5	*2018*	6
0.92	Adults with Kidney Disease	*Percent of adults*	2.8			3.1	*2019*	4
0.36	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	8.7		14.5	12.9	*2017-2019*	5
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Workers who Walk to Work	*percent*	0.9		2.2	2.7	*2015-2019*	1
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*	23
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*	23
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*	23

1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*	23
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.5				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.2				*2015*	23
1.25	Health Behaviors Ranking		4				*2021*	9
1.03	Adults 20+ who are Sedentary	*percent*	21.1				*2019*	5
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.94	Adults 20+ who are Obese	*percent*	27.8	36			*2019*	5
0.83	Access to Exercise Opportunities	*percent*	92.1		83.9	84	*2020*	9
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.36	Food Environment Index		8.6		6.8	7.8	*2021*	9

SCORE	PREVENTION & SAFETY	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	9.7		10.5	9.5	*2017-2019*	5
1.47	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	23.6		40.2	21.4	*2017-2019*	5
1.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.1		38.1	21	*2017-2019*	9
0.67	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	43.8	43.2	68.8	48.9	*2017-2019*	5
0.25	Severe Housing Problems	*percent*	10.4		13.7	18	*2013-2017*	9
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.72	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.1	1.4	1.1		*2020*	16
1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	472.9		487.9	422.4	*2021*	7
1.47	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	43.7		47.8	39.6	*2017-2019*	5
1.42	Adults with COPD	*Percent of adults*	7.9			6.6	*2019*	4

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

1.67	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	472.9		487.9	422.4	*2021*	7
1.33	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	2.3		2.2	2	*2021*	8
0.92	Adults who Smoke	*percent*	17.9	5	21.4	17	*2018*	9
0.50	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.7		4.3	4.1	*2021*	8
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1814.2		1461	1638.9	*2021*	7
1.42	Insufficient Sleep	*percent*	37.5	31.4	40.6	35	*2018*	9
1.33	High Blood Pressure Prevalence	*percent*	33.7	27.7		32.6	*2019*	4
1.25	Morbidity Ranking	*ranking*	4				*2021*	9
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.2		41.5	41.2	*2021*	8
0.92	Poor Physical Health: 14+ Days	*percent*	12.5			12.5	*2019*	4

0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	50.9		48.6	49.4	*2021*	8
0.83	Life Expectancy	*years*	80.1		77	79.2	*2017-2019*	9
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	88.2		85.6	86.5	*2021*	8
0.75	Self-Reported General Health Assessment: Poor or Fair	*percent*	16.5			18.6	*2019*	4
0.67	Poor Physical Health: Average Number of Days	*days*	3.6		4.1	3.7	*2018*	9
SCORE	**WOMEN'S HEALTH**	**UNITS**	**MEDINA COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.7		129.6	126.8	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	74.8	77.1		74.8	*2018*	4
0.89	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	5.1		7.9	7.7	*2014-2018*	12
0.89	Cervical Cancer Screening: 21-65	*Percent*	86.8	84.3		84.7	*2018*	4

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

Medina County Data Sources

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

Appendix D: Community Input Assessment Tools

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health and Well-being

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

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

Section #3: Barriers to Health

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

Section #4: COVID-19

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

Section #5: Addressing the Challenges & Solutions

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

Section #6: Conclusion

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

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

Appendix E: Community Partners and Resources

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

Federally Qualified Health Centers

Ohio's Association of Community Health Centers (OACHC) is a not-for-profit membership association representing Federally Qualified Health Centers (FQHCs).[27] FQHCs are established to promote access to ambulatory care in areas designated as medically underserved. These clinics provide primary care, mental health, and dental services for lower-income members of the community. FQHCs receive enhanced reimbursement for Medicaid and Medicare services and most also receive federal grant funds under Section 330 of the Public Health Service Act. OACHC represents Ohio's 57 Community Health Centers at 400 locations, including multiple mobile units The following FQHC clinics and networks operate in the Lodi Hospital Community:

- Medina County Health Department
- Third Street Family Health Services

Hospitals

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

- Aultman Orrville Hospital
- Summa Health System – Barberton Campus
- University Hospitals (Multiple Locations)
- Wooster Community Hospital

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

Other Community Resources

A wide range of agencies, coalitions, and organizations that provide health and social services is available in the region served by Lodi Hospital. United Way 2-1-1 Ohio maintains a large, online database to help refer individuals in need to health and human services in Ohio. This is a service of the Ohio Department of Social Services and is provided in partnership with the Council of Community Services, The Planning Council, and United Way chapters in Cleveland. United Way 2-1-1 Ohio contains information on organizations and resources in the following categories:

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

Additional information about these resources is available at: http://www.211oh.org/

Appendix F: Acknowledgements

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

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Lodi Hospital

Implementation Strategy Report

2022

LODI HOSPITAL 2022 IMPLEMENTATION STRATEGY REPORT

2022 Community Health Needs Assessment
Implementation Strategy Report for Years 2023 – 2025

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LODI HOSPITAL 2022 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 findings of the Lodi Community Hospital Community Health Needs Assessment ("CHNA"). The Implementation Strategy Report (ISR) includes the priority community health needs identified during the 2022 CHNA and hospital-specific strategies to address those needs from 2023 through 2025.

A. Description of Hospital

Lodi Hospital, a member of Cleveland Clinic Akron General, has proudly provided community-based healthcare to people of southwest Medina County and portions of Lorain, Ashland, and Wayne Counties since 1920. Lodi Community Hospital is designated as a Critical Access Hospital (CAH) and serves as one of thirty three CAHs in the State of Ohio. The 20 staffed bed[28] hospital offers a comprehensive range of services: Acute and skilled care; Full range of outpatient diagnostic, rehabilitation, and physical therapy services; Occupational healthcare; Outpatient and general, minimally invasive surgery; Radiology services and a state-of-the-art 24-hour emergency room. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/lodi-hospital

The hospital is part of the Cleveland Clinic health system, which includes an academic medical center near downtown Cleveland, fourteen regional hospitals in northeast Ohio, a children's hospital, a children's rehabilitation hospital, five southeast Florida hospitals, and several other facilities and services across Ohio, Florida, and Nevada.

Lodi Hospital's mission is:

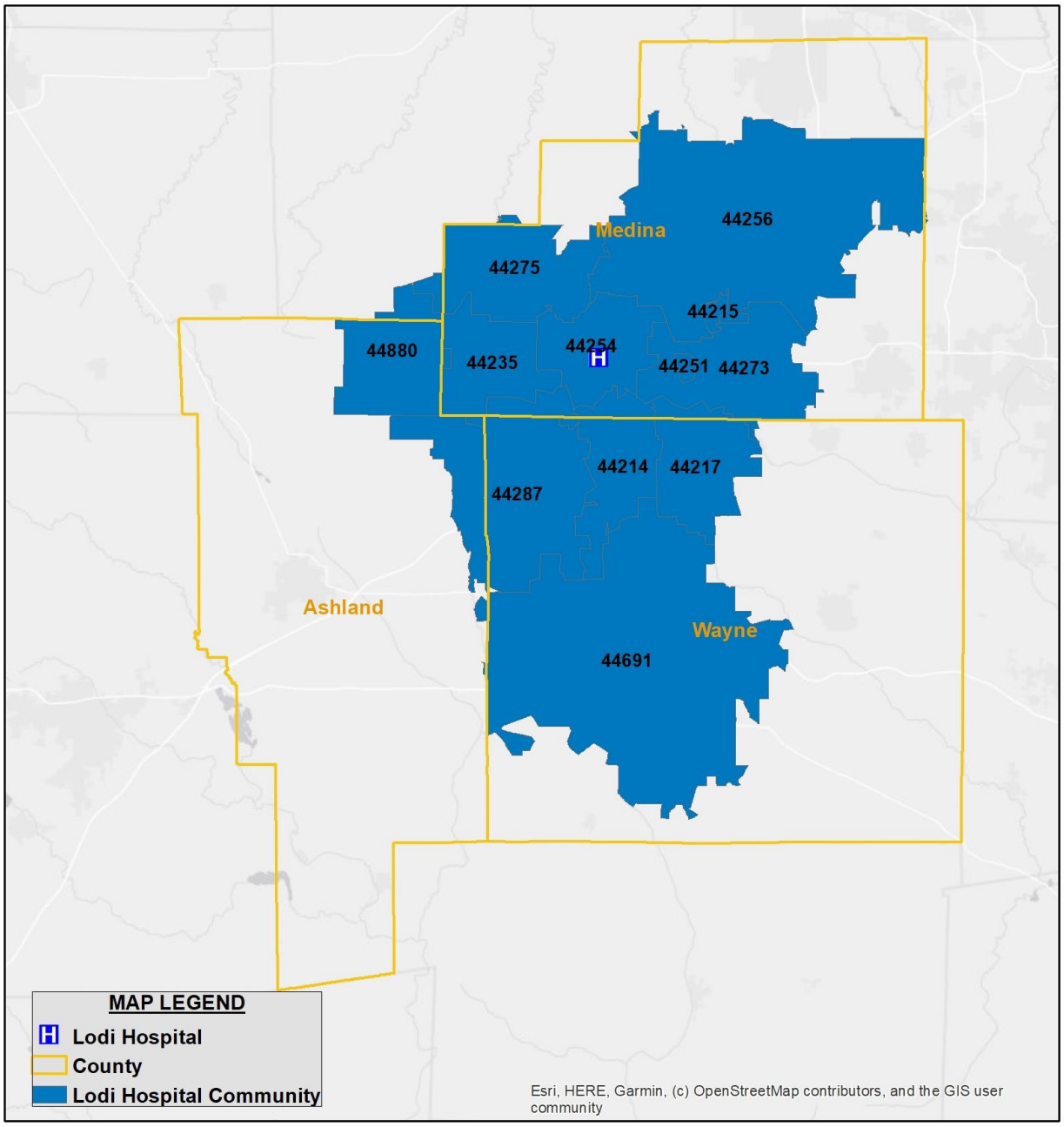
Caring for life, researching for health, and educating those who serve.

II. COMMUNITY DEFINITION

For purposes of this report, the Lodi Hospital community definition is an aggregate of 12 zip codes in Medina, Wayne, and Ashland Counties comprising approximately 75% of inpatient, outpatient, and emergency department visits in 2021 (Figure 1).

[28] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) 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.

Figure 1: Lodi Hospital Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of leadership at Lodi Hospital and Cleveland Clinic, representing several departments of the organizations, including clinical administration, medical operations, nursing, finance, population health, and community relations. This team incorporated input from the hospital's community and local non-profit organizations to prioritize selected strategies and determine possible collaborations. Alignment with county Community Health Assessments (CHA) as well as the State Health Assessment (SHA), was also considered. Leadership at Lodi Hospital will utilize this Implementation

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

IV. SUMMARY OF THE COMMUNITY HEALTH NEEDS IDENTIFIED

Lodi Hospital's prioritized community health needs, as determined by analyses of quantitative and qualitative data, include:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Socioeconomic Issues

In addition to the prioritized community health needs, themes of health equity, social determinants of health, and medical research and education are intertwined in all community health components and impact multiple areas of community health strategies and delivery. Cleveland Clinic is committed to promoting health equity and healthy behaviors in our communities. The hospital addresses these overarching themes through a variety of services and initiatives, including cross-sector health and economic improvement collaborations, local hiring for the hospital workforce, mentoring of community residents, in-kind donation of time and sponsorships, anchor institution commitment, and caregiver training for inclusion and diversity.

COVID-19 Considerations

The COVID-19 global pandemic declared in early 2020 has caused extraordinary challenges for healthcare systems worldwide including Lodi Hospital. Keeping front-line workers and patients safe, securing protective equipment, developing testing protocols, and helping patients and families deal with the isolation needed to stop the spread of the virus all took priority as the pandemic took hold.

Many of the community benefit strategies noted in the previous 2019 implementation strategy were temporarily paused or adjusted to comply with current public health guidelines to ensure the health and safety of patients, staff, and other participants. Many of the strategies included in the 2023-2025 implementation strategy are a continuation or renewal of those that were paused during the pandemic as the community needs identified in the 2022 CHNA did not change greatly from those identified in the 2019 CHNA.

See the 2022 Lodi Hospital and other Cleveland Clinic CHNAs for more information:
www.clevelandclinic.org/CHNAReports

V. NEEDS HOSPITAL WILL ADDRESS

Each Cleveland Clinic hospital provides numerous services and programs in effort to address the health needs of the community. Implementation of our services focuses on addressing structural factors important for community health, strengthening trust with residents and stakeholders, ensuring community voice in developing strategies, and evaluating our strategies and programs.

Strategies within the ISRs are included according to the prioritized list of needs developed during the 2022 CHNA. These hospitals' community health initiatives combine Cleveland Clinic and local non-profit organizations' resources in unified efforts to improve health and health equity for our community members, especially low-income, underserved, and vulnerable populations.

A. Access to Healthcare

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

Cleveland Clinic continues to evaluate methods to improve patient access to care. All Cleveland Clinic hospitals will continue to provide medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. The financial assistance policy can be accessed here: Cleveland Clinic Financial Assistance.

Access to Healthcare Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Patient Financial Advocates assist patients in evaluating eligibility for financial assistance or public health insurance programs.	Increase the proportion of eligible individuals who are enrolled in various assistance programs.
B Address digital equity, utilize medically secure online and mobile platforms, connect patients with Cleveland Clinic providers for telehealth and virtual visits.	Overcome geographical and transportation barriers, and improve access to specialized care.

B. Behavioral Health

Lodi Hospital's 2022 CHNA also identified Behavioral Health as a prioritized need area. Behavioral Health encompasses Mental Health and Substance Use Disorders. Mental Health includes suicide, depression, and self-reported poor mental health rates. Substance Use Disorder relates to alcohol and drug use, including drug overdoses. Community members described mental health challenges in the community, exacerbated by COVID-19 related stressors, resulting in increased alcohol and drug use starting in adolescence as a means of coping.

Behavioral Health Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Continue collaboration with the Opioid Awareness Center, participation in the Northeast Ohio Hospital Opioid Consortium, and Medina County Opioid Task Force in coordinated efforts to reduce the widespread effect of the heroin and opioid crisis.	Reduce the number of individuals with opioid addiction and dependence.
B Continue to provide space to Alternative Paths, which offers behavioral health services, including alcohol and substance abuse counseling.	Increase the number of individuals with addiction and dependence who seek treatment.

C. Chronic Disease Prevention & Management

Lodi Hospital's CHNA identified chronic disease and other health conditions as prevalent in the community (ex. heart disease, stroke, diabetes, respiratory diseases, hypertension, obesity, cancer, COVID-19). Prevention and management of chronic disease initiatives seek to increase healthy behaviors in nutrition, physical activity, and tobacco cessation.

Chronic Disease Prevention & Management Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Implement health promotion, health education, support groups, and outreach events related to heart disease and stroke, cancer, respiratory disease, women's health, and obesity, therefore reducing behavioral risk factors.	Decrease smoking, improve physical activity, improve nutrition, increase the number of individuals with a regular source of care, increase cancer screening rates, improve screening follow-up rates.

Chronic Disease Prevention & Management (continued)

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
B	Provide free breast cancer screenings and blood sugar screenings through community events.	Increase breast cancer screening rates, increase the number of individuals with prediabetes who seek care, and improve early diagnosis for diabetes and pre-diabetes.
C	Offer CPR and AED trainings at the hospital and throughout the community.	Improve heart condition mortality rates.
D	Provide unique community-based therapies and treatments, including aquatic classes.	Improve recovery times, decrease complication rates, reduce stress.

D. Socioeconomic Issues

Lodi Hospital's 2022 CHNA demonstrated that health needs are multifaceted, involving medical as well as socioeconomic concerns. The assessment identified food security, affordable housing, employment, transportation, health literacy, structural racism, poverty, and environmental risk factors as significant concerns. Further, the primary and secondary impacts of COVID-19 have exacerbated many health disparities and barriers that were present before the pandemic. Socioeconomic Issues for this report are defined as a subset of social determinants of health (SDOH). Prevention & Safety, Affordable Housing, Violence, Falls, and Environmental Issues were prioritized socioeconomic issues described by primary and secondary data.

The Socioeconomic Initiatives highlighted for 2023 – 2025 include:

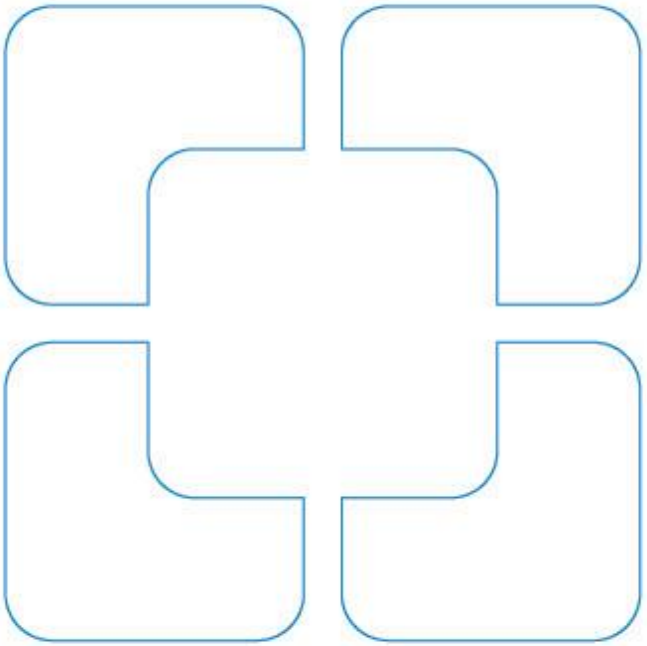
	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A	Continue a Cleveland Clinic common community referral data platform to coordinate services and ensure optimal communication.	Improve active referrals to community-based organizations, non-profits, and other healthcare facilities; track referral outcomes.
B	Continue participation in the Community Meal Program and support of the Feeding Medina County initiative, provide free meals, and distribute food to community members.	Improve food insecurity, increase access to healthy foods.

Socioeconomic Issues (continued)

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
C	Support the Free Clinic of Medina County to provide medical care for uninsured and underinsured community members.	Increase the number of individuals with a regular source of care, increase the number of individuals who receive a regular well-check, improve vaccination rates, Improve the number of patients who receive the right level of care.
D	Offer *Safe Sitter* classes to community members and *Safe at Home* classes to community youth.	Reduce injuries in child and adolescent populations, and decrease child mortality rates.
E	Provide workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders.	Increase diversity within the healthcare workforce, improve trust in providers, improve local provider shortages.

While this ISR outlines specific strategies and programs identified to address the 2022 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, and Socioeconomic Issues, it does not reflect all the work being done by Lodi Hospital to improve community health. Through this iterative process, opportunities are identified to grow and expand existing work in prioritized areas as well as implement additional programming in new areas. These ongoing strategic conversations will allow Lodi Hospital to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

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



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