2025 Community Health Needs Assessment

Glenbeigh

ARMC Healthcare System

Cleveland Clinic affiliate

Board Approved: October 2025

Glenbeigh 2025 Community Health Needs Assessment

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Executive Summary

Introduction/Background

Glenbeigh is part of the Ashtabula Regional Medical Center (ARMC) Healthcare System, a Cleveland Clinic affiliate. It's main campus includes an inpatient hospital along with four (4) freestanding extended treatment buildings with a maximum capacity of 188 total beds. Glenbeigh also has eight (8) sober living residences along with five (5) outpatient centers serving northeast Ohio and western Pennsylvania. In 2024, to better serve the Ohio community, Glenbeigh began offering comprehensive outpatient telehealth care services in addition to in-person services from the Outpatient Center of Canton. Glenbeigh provides premier treatment to adults with substance use disorders; providing assessments, detoxification, rehabilitation, extended treatment, recovery services and much more. More information about Glenbeigh's treatment services can be found at https://www.glenbeigh.com/ while more information about ARMC Healthcare System can be found at https://www.acmchealth.org/.

During the formation of this 2025 Community Health Needs Assessment (CHNA), COVID-19, the infectious disease caused by the SARS-CoV-2 virus, no longer substantially impacted access to treatment services. Yet, the long-term effects continue to alter the delivery of substance use treatment and recovery support as demographics shifted compared to prior CHNA's. Primary data collection was completed using a mix of surveys and other means. For the 2025 CHNA, Glenbeigh sought input from the defined service community, which includes communities where outpatient centers are located. Primary data was collected from people living with substance use disorders, people personally impacted by an individual with a substance use disorder, community leaders and people working with individuals affected by alcohol and drug addiction.

In February 2025, Glenbeigh commenced work on a comprehensive Community Health Needs Assessment (CHNA) to identify significant health needs related to substance use disorders as well as addiction treatment and recovery support. Primary data was collected between April and July 2025. The CHNA was completed in a timeline consistent with the requirements set forth in the Affordable Care Act[1], per Ohio's State Health Improvement Plan[2] and by the Internal Revenue Service[3]. The ultimate goal of this CHNA is to further Glenbeigh's commitment to community health and population health management. The findings from this assessment will be utilized by Glenbeigh to guide community benefit initiatives and to engage collaborative partners to address the identified health needs related to substance use disorders.

The following Community Health Needs Assessment includes both primary and secondary data that was collected and analyzed as a means of formulating key findings. In total, 92 stakeholders representing public and private organizations, social service agencies, health and human service entities, vulnerable populations as well as individuals and families directly affected by substance use disorders participated in the primary data interviews and surveys.

Secondary data was compiled from local, state and federal sources to provide insight on the impact of substance use disorders on the defined service community. Collected data included economic information, educational information, population changes, general demographics, drug use and overdose information, alcohol usage and other available statistics.

Glenbeigh remains dedicated to the communities where it has inpatient and outpatient facilities as well as those communities identified by the CHNA as significant service areas. Through the process of identifying key findings and creating a strategic implementation plan, Glenbeigh strives to be a strong partner in the community as well as an organization committed to elevating the health of individuals touched by addiction.

Through a collaborative network, Glenbeigh is committed to improving health, sustaining recovery and achieving obtainable, measurable goals.

Glenbeigh's 2025 CHNA was created with input and guidance from both the Ashtabula Regional Medical Center (ARMC) Healthcare System and Cleveland Clinic. The final CHNA was reviewed by the board and approved on October 29, 2025.

1. https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3
2. The 2025-2029 State Health Improvement Plan is currently under development and is not available when this report was completed.
3. https://www.irs.gov/charities-non-profits/annual-filing-and-forms

Defined Service Area/Community Definition

While the COVID-19 pandemic reduced Glenbeigh admissions, it also significantly shifted Glenbeigh's service community further into western Pennsylvania. From 2022 through 2024, Glenbeigh's service area remained predominantly throughout Northeastern Ohio, Western Pennsylvania and a few surrounding states.

For purpose of this report, Glenbeigh's primary service area is defined as eight counties with the highest volume of inpatient admissions based on the zip codes provided by patients served. In addition, Glenbeigh will continue to undertake community benefit initiatives in Trumbull and Stark Counties, Ohio bringing the service area to a total of 10 counties. Glenbeigh has outpatient centers located in Trumbull and Stark Counties. The leadership committee overseeing the development of the 2025 CHNA agreed that these two counties should be included in Glenbeigh's defined service area.

Ohio service area counties include Ashtabula, Cuyahoga, Stark, Summit and Trumbull. Service area counties in Pennsylvania include: Beaver, Crawford, Erie, Washington and Westmoreland. The total population of Glenbeigh's defined service community from the U.S. Census Bureau resident population estimate reported for July 1, 2024, is approximately 3,527,000. This is roughly a 23.6% decline in the population of Glenbeigh's defined service community compared to that of the 2022 CHNA.

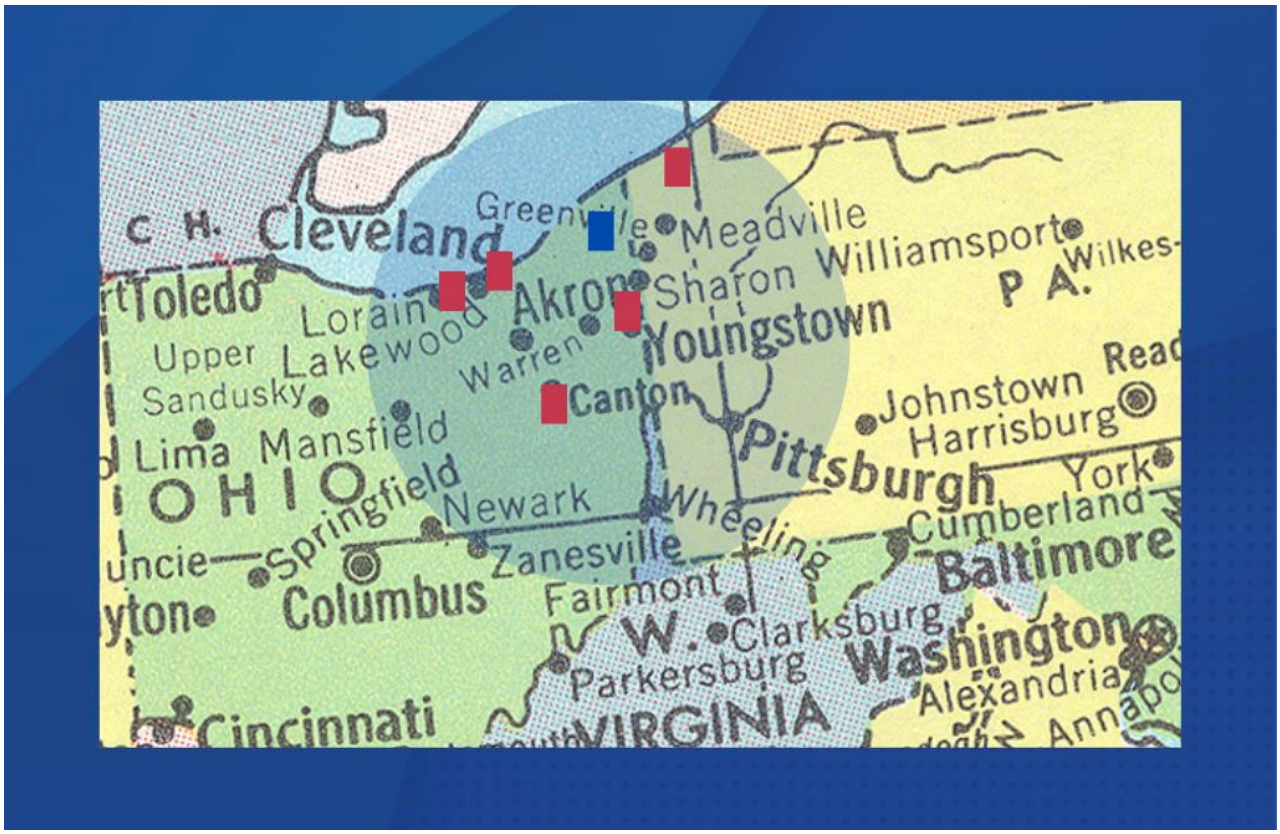
Ashtabula County, Ohio	Cuyahoga County, Ohio
Stark County, Ohio	Summit County, Ohio
Trumbull County, Ohio	Beaver County, Pennsylvania
Crawford County, Pennsylvania	Erie County, Pennsylvania
Washington County, Pennsylvania	Westmoreland County, Pennsylvania

Glenbeigh's inpatient hospital is located in Rock Creek, Ashtabula County, Ohio. Outpatient Centers are located in Beachwood and Rocky River in Cuyahoga County, Canton in Stark County and Niles in Trumbull County, Ohio. Glenbeigh has an outpatient center located in Erie, Pennsylvania to serve the western Pennsylvania community. The total population of counties (from the U.S. Census Bureau resident population estimate reported for 2024) with Glenbeigh services available locally is estimated at 2,179,641. This reflects roughly a 0.52% decrease compared to 2022 population estimates.

Beachwood, Ohio	Canton, Ohio
Niles, Ohio	Rock Creek, Ohio
Rocky River, Ohio	Erie, Pennsylvania

July 1, 2024 US Census Numbers:
https://www.census.gov/quickfacts/fact/table/westmorelandcountypennsylvania,washingtoncountypennsylvania,eriecountypennsylvania/PST045224

The following map highlights the communities served by Glenbeigh in Ohio and Pennsylvania.



Glenbeigh Outpatient Centers **Glenbeigh Inpatient Hospital**

Detailed information on Glenbeigh's service area is available in the secondary data section starting on page 14.

Hospital Profile

Glenbeigh, located in Rock Creek, Ashtabula County, Ohio, is a regional provider of inpatient and outpatient services for individuals with alcohol and/or drug addiction, also referred to as substance use disorders.

Providing treatment services since 1981, Glenbeigh is a non-profit hospital that is a member of the ARMC Healthcare System and a Cleveland Clinic affiliate. Glenbeigh also has outpatient treatment centers located in Beachwood, Cuyahoga County; Canton, Stark County; Niles, Trumbull County; and Rocky River, Cuyahoga County, in Ohio as well as Erie, Erie County, Pennsylvania.

Mission Statement:

To provide the highest quality healthcare to those in need of alcohol and drug addiction treatment and to support ongoing recovery efforts.

Mission. Glenbeigh's mission is to provide the highest quality healthcare to those in need of alcohol and drug addiction treatment and to support ongoing recovery efforts. Glenbeigh's mission is carried out without regard of race, ethnicity, marital status, color, religion, sex, national origin, disability, sexual orientation, gender identity or socioeconomic status.

Glenbeigh is staffed and equipped to provide treatment services to adults, 18 years and older. Individuals seeking treatment for minors under the age of 18 are referred to appropriate facilities.

Vision. Glenbeigh promotes a culture of safety and quality in all that we do; to always have the patient at the center of everything we do; to provide state of the art clinical services in the most cost-effective setting; to attract, develop, and retain quality employees in every area of our operation; to go the extra step to build positive referent relationships; to be financially sound; and to be the premier substance use disorder treatment provider within the country.

Values. At Glenbeigh, we care for individuals and families impacted by alcohol and drugs. We are committed to a philosophy of mutual respect and compassionate caring to guide patients on the path to sustained recovery. We practice empathy and active listening in all our interactions. We are dedicated to leading by example and promoting Glenbeigh values.

Patient Care Services at Glenbeigh includes inpatient and outpatient evaluation and treatment. The inpatient hospital collaborates with outpatient centers to provide the best care possible for the individual, to improve outcomes, to engage family members in the treatment process, and to ensure services are consistent with our mission, vision, values and goals. Patient care services are provided to all patients by a collaborative team of professional and ancillary staff members.

Addiction is an illness that, if left untreated, results in the progressive physical, mental, emotional, social and spiritual deterioration of individuals and their families. With treatment, individuals with substance use disorders have the capacity to lead meaningful and productive lives. Successful treatment for addiction is a combination of medical and clinical practices, taking every aspect of each individual into careful consideration to develop a unique treatment plan. Patient care is provided in an atmosphere of privacy, dignity and respect and includes:

Inpatient Services

Glenbeigh's Rock Creek facility has over 180 licensed chemical dependency beds for the provision of treatment services twenty-four hours a day, seven days a week. The inpatient regimen is individually prescribed and supervised by physicians and monitored by nursing, counseling and clinical staff. Inpatient services include: comprehensive evaluations, medically managed withdrawal (detoxification), group therapy, individual therapy, Eye Movement Desensitization and Reprocessing (EMDR) therapy, Cognitive Behavioral Therapy (CBT), specialized groups, patient-centered care, educational lectures, family programming, fitness regiments and pain management.

Intensive Outpatient Treatment/Aftercare

Intensive Outpatient Treatment (IOP) is a concentrated, structured, inter-disciplinary clinical service designed to treat clients in a program where the goal is to achieve ongoing abstinence. It addresses the treatment needs of clients who have completed inpatient treatment or whose clinical conditions do not require inpatient or residential care yet would benefit from a structured treatment program. Ongoing Aftercare sessions are available at each of Glenbeigh's six locations for clients who have completed in-person or telehealth Intensive Outpatient Treatment. Family participation is welcomed in both IOP and Aftercare sessions on a weekly basis. Engaging and educating family is vital to successful long-term recovery.

Extended Residential Treatment and Transitional Living

Extended Residential Treatment, Transitional Living and Recovery Housing are part of the continuum of care provided at Glenbeigh. Extended residential treatment is designed to help rehabilitate those who appear unable to maintain sobriety following primary care. Candidates often have met with repeated setbacks in the past or, because of early onset of substance use disorders, have not developed the skills necessary to sustain abstinence or be successful in recovery. These patients require additional time in a highly structured program with continued access to medical and clinical staff. Extended residential treatment assists patients in establishing a solid foundation in recovery and making personal changes to achieve lasting recovery. The purpose of transitional housing is to provide people leaving inpatient treatment with a safe living environment, free from alcohol and other drugs, with continued access to clinicians. The benefits of living in this type of community in early recovery are:

- Residents can work a program of recovery based on the principles learned in treatment.
- Residents can learn communication skills essential for healthy relationships with other people.
- Transitional living helps develop coping skills and builds self-esteem.
- It is an environment where residents can develop beliefs, values and attributes that are consistent with the recovery themes of acceptance, humility, service to others and gratitude.
- Prepares participants to transition to recovery housing where they have more independence and actively pursue education and/or employment.

Family Programs

Glenbeigh offers programming expressly for loved ones, aged 16 and older, touched by the disease of addiction and who have family in treatment. The family program includes educational presentations, group sessions and family conferences. Telehealth options are available and open to anyone who has a loved one with a substance use disorder. Glenbeigh is committed to strengthening families and believes they are an integral component of the treatment process therefore the programing is provided at no additional charge. The family program is an opportunity for loved ones to work with addiction counselors, learn about addiction, treatment and recovery and to begin the healing process.

Research Components

Glenbeigh utilized an in-depth, comprehensive approach to identifying the needs of people affected by substance use disorder within its defined service area and in areas where Glenbeigh has outpatient facilities. For the purposes of this report, Glenbeigh formulated key findings within the collective service areas using primary and secondary data. A variety of quantitative and qualitative research factors were used to formulate the 2025 CHNA. The components used to collect primary data include:

- Key Stakeholder Informant Surveys
- Leadership Surveys
- Recovery Community Surveys

Each element provided Glenbeigh with a unique perspective on the community's needs related to substance use disorders. Selected demographics varied and included individuals who have completed treatment for alcohol or drug use from any treatment center, family members, treatment providers, physicians, ancillary agency representatives and community leaders. Summaries of each component are included in this report. Detailed accounts of the findings can be viewed in the individual module.

ARMC Healthcare System and Glenbeigh leadership were engaged in the planning process and provided guidance during the formulation of the assessment. Past assessments were referenced to ensure questions obtained relative metrics. Furthermore, community members were engaged throughout the process to ensure the assessment captured data relevant to individuals affected by addiction.

To obtain primary data, this community health assessment utilized written surveys of adults, age 18 and over, from various regions of Glenbeigh's overall service community. Online surveys were created to solicit input from a diverse group of individuals.

Between April and May, 2025, surveys were sent electronically and kept open for 90 days. A total of 15 individuals representing organizations, businesses and criminal justice participated in the general survey. A second survey was designed to capture basic demographic information from what would have been focus group participants. This survey was sent to alumni and people in the recovery community. An additional 69 people responded resulting in a total of 84 individuals providing community feedback from northeast Ohio and western Pennsylvania. Several questions were revisited from the previous CHNA to collect input on overall healthcare, mental health issues, employment and stigma. Two open-ended questions were utilized to gather information on barriers to treatment and an understanding of what community services participants feel improve quality of life.

To delineate key findings, Glenbeigh utilized secondary and primary data. Prevalence of issues defined in secondary data helped establish the scope and burden of need throughout the region. Primary data provided the details to ensure this assessment addresses the needs of the community that Glenbeigh serves. The approach Glenbeigh utilized to prioritize health issues is detailed in Appendix L.

Key Findings/Significant Community Health Needs

A number of community needs were identified as a result of conducting the 2025 CHNA. Significant Community Health Needs, or Key Findings, were based on the assessment of secondary data, which included a broad range of statistics, health indicators and resources, and of primary data, which was amassed from various stakeholders. The following needs emerged across the various research components and were identified as significant health needs within Glenbeigh's service area.

Socioeconomic Needs:

1. Substance abuse continues to affect people of all races and ages. Ohio households are aging with 65+ being the fastest growing age group. Income, along with other social and economic determinants, correspond to alcohol and drug use. Transportation remains a significant barrier.
2. Substance use continues to transition to different substances as drugs are removed from the supply chain and new combinations take their place. There was an increase in the use of Xylazine as it was added to more street drugs to enhance the effects. The use of poly-substances remains common with Fentanyl remaining present in the region. Drugs remain easily available and inexpensive.
3. Alcohol use varies by region with some areas showing increased use and others decreased use. The 2024 Ohio Health Value Dashboard reported that the largest increase in the leading cause of unintentional death was attributed to chronic liver disease and cirrhosis. Ohioans drink excessively more than people in many other states. Alcohol use remains a top substance of choice.
4. The number of overdose deaths have decreased, which is attributed to the regional distribution of free naloxone kits to reduce the effects of an opioid overdose and the transition away from opioid use.
5. While progress has been made, people living with active addiction continue to encounter roadblocks when seeking information on addiction, treatment and recovery. There continues to be a lack of understanding, education and information regarding treatment and support.
6. In many areas there remains a lack of recovery support options. While improvements have been made, including the Ohio mandate of certified recovery housing, there continues to be need for safe, affordable, recovery residences.
7. In 2019, The Ohio State Health Improvement Plan listed Nutrition as a second-tier priority factor. Food insecurity and adverse nutrition was mentioned in both primary and secondary data when formulating this 2025 CHNA. Nutrition can be tied to both poverty and financial insecurity, impacting entire families.

Health Needs:

1) Barriers exist that affect access to treatment either limiting or excluding certain demographics from obtaining treatment services. Telehealth remains an important resource.
2) Individuals with a substance use disorder often feel they do not need treatment. This trend was evident in the 2022 CHNA and continues.
3) Stigma continues yet progress has been made. Educating employers on how to help employees secure confidential treatment and return to work remains an important part of improving health.
4) The need for more healthcare providers continues. Workforce development remains critical, especially in rural communities.
5) The need for mental health services in conjunction with SUD treatment remains a top priority.

OBJECTIVES AND METHODOLOGY

Regulatory Requirements

Federal law requires that non-profit, tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA) every three years and adopt an Implementation Strategy that addresses the significant community health needs identified in the CHNA. In addition, the State of Ohio requires the CHNA align with priority topics as outlined in the State Health Improvement Plan (SHIP). As a result, Glenbeigh conducted an assessment that identifies the significant health needs within its defined service community. A secondary goal is to pinpoint potential collaborative partners working toward the same goals.

The regulations require that Glenbeigh:

- Take into account input from persons representing the broad interests of the community served, including those with expertise in public health issues.
- Make the CHNA widely available to the public.

The CHNA report must consist of certain information including, but not limited to:

- A description of the defined service area and how it was determined.
- An assessment of the health needs of that community.
- A description of how input was secured from persons representing a broad demographic range within the service community as well as those with special knowledge of, or expertise in, addiction, treatment and recovery.
- A description of the methodology used to ascertain the health needs of the community.
- A listing of organizations that contributed to the data collection or development of the CHNA.
- A prioritized, descriptive, list of the community's health needs identified through the CHNA.

Non-profit healthcare providers are also required to report information about the CHNA process and about community benefits they provide on IRS Form 990, Schedule H. As described in the Schedule H instructions, community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. Furthermore, the State of Ohio requires annual reporting to the Ohio Department of Health be submitted consisting of the complete Schedule H and any corresponding attachments.

Community benefit activities and programs seek to achieve specific goals, which include:

- Improving access to health services.
- Enhancing public health.
- Advancing increased general knowledge.
- Relief of a government burden to improve health.

To be reported, community need for the activity or program must be established, which can be done through the community health assessment. CHNAs identify significant health needs for particular geographic areas and populations by focusing on the following questions:

- Who in the community is most vulnerable in terms of health status or access to care?
- What are the unique health status and/or access needs for these populations?
- Where do these people live in the community?
- Why are these problems present?

How the significant community health needs will be addressed will be detailed in a separate Implementation Strategy available at www.glenbeigh.com.

Methodology

Federal regulations that govern the community health needs assessment process provide hospitals with the autonomy to define the community based on relevant facts and circumstances including the geographic locations served by the hospital. In defining its service community, Glenbeigh considered its primary service area, secondary service area and, as a provider of treatment for alcohol and drug addiction, focused on this specific subset within the defined service community. The CHNA examines both health issues and risk factors for the population covered by the assessment. Also taken into account are social, economic and environmental conditions known to influence alcohol and drug use.

Secondary Data Profile

Secondary data was obtained from a variety of institutions and government agencies and collected in the Secondary Data Profile section. Social determinants of health, particularly those that correlate with drug and alcohol use, were reported at county levels when available. Glenbeigh utilized information from multiple websites such as the Ohio Department of Health, Appalachian Regional Commission, Pennsylvania Office of Drug Surveillance and Misuse Prevention, Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for Health Statistics, Rural Health Information Hub, Centers for Disease Control and Prevention, Drug Enforcement Administration (DEA) and the U.S. Census Bureau among others. All data include a source citation and URLs for reference. Examples of collected data include unemployment rates, education levels and poverty statistics. Drug and alcohol use, abuse, and death rates were reported and compared, when possible, to both state and national statistics. Finally, trends in drug and alcohol use were researched as Glenbeigh strives to stay abreast of developing factors in an effort to best anticipate future care needs for the service population.

Secondary data, or data that are already existing and collected by other agencies or organizations, are also a key component of the CHNA. The tables included in the CHNA secondary data section represent the counties Glenbeigh has identified as service populations based on admissions and where outpatient treatment centers are located. Indicators that influence drug and alcohol use and abuse were included to

better understand the social determinants of health in the population. Data on drug and alcohol use and abuse, including overdose deaths, were included and compared to state and national data to provide information about prevalence. Additionally, Glenbeigh utilized the findings reported in the Ashtabula County 2025 Community Needs Assessment. Considering a wide array of information is vital when assessing community health needs to ensure the assessment captures relevant facts and perspectives thus improving accuracy and objectivity.

Primary Data Profile

Input from the community was obtained through electronic surveys and key interview results from the Ashtabula County 2025 CHNA. Participants represented the broad interests of the service community and included the general community along with individuals with special knowledge of, or expertise in, working with clients and families impacted by substance use disorders. Glenbeigh sent surveys to 29 key informants, which consisted of professionals from throughout Ohio and western Pennsylvania. Four (4) individuals completed the survey and provided feedback. Key informant data for the four respondents is available in Appendix A. An electronic survey was utilized to engage 11 additional professionals and strategic contacts representing the geographic areas of Ashtabula, Chagrin Falls, Cleveland, Niles, and Warren, in Ohio as well as Beaver, Erie, Pittsburgh and Washington in Pennsylvania. The survey was sent to 1,808 contacts with results detailed in Appendix B. Stakeholders from the survey group included counselors, social workers, therapists, family service organizations, court case managers, interventionists, EAP's (employee assistance program specialists), recovery housing owners, mental health providers, peer support specialists, and other specialists in the field of addiction. An additional 6,638 individuals representing the recovery community were surveyed with 69 participating and returning data found in Appendix C.

Given the scope of available resources, no focus groups were conducted for the 2025 CHNA. Instead, surveys were distributed to individuals in three (3) separate demographics, allowing for the collection of qualitative feedback within existing capacities. In person, key informant data was added from interviews conducted by Conduent for the Cleveland Clinic 2025 CHNA. This supplemental key informant data is located in Appendix D.

Participants include individuals in recovery as well as family members and other individuals who support the recovery community. The purpose of the surveys and interviews was to gather qualitative feedback from individuals with first-hand experience navigating the healthcare system for addiction services and living in recovery. These surveys provided Glenbeigh with a multi-faceted perspective of individual experience with addiction, treatment and recovery. Topics covered included access to services, workplace stigma and recovery support.

Collaborating Organizations

Glenbeigh is a member of the ARMC Healthcare System, which is affiliated with Cleveland Clinic. As such, in conducting this CHNA, Glenbeigh collaborated with both organizations. . Furthermore,

Ashtabula Regional Medical Center was involved in the development of the Ashtabula County 2025 Community Health Needs Assessment, working with the Ashtabula County Health Department as well as other healthcare providers and county agencies. Key Informant data was shared and used from these ancillary assessments.

Limitations/Information Gaps

It should be noted that data limitations exist when interpreting results. The findings of this CHNA may vary from those of other organizations conducted in the community. Differences may be caused by variances in data sources, the defined service area and community developments that may not be reflected in data sets. Moreover, it is important to note that while the same questions were asked using the same wording, data collection methods varied therefore, caution should be used when interpreting interview results as there may be a margin of error.

For the 2025 CHNA, Glenbeigh compiled the most recent data available at the time information was being researched. The research period began in January 2025 and ended in mid-August 2025. Secondary data, upon which this assessment relies, often measure community health in prior years. The impact of more recent public policy changes and developments may not be reflected in the secondary data.

SECONDARY DATA

A key component of the CHNA is the accumulation of secondary data. The following information details multiple indicators of social determinants of health related to alcohol and drug use across the defined service area. Social determinants such as income and education are known to significantly influence alcohol and drug use. Research has shown that indicators such as poverty, lower education levels and in some instances, race or ethnicity, can be associated with greater risk factors and poorer health outcomes.

Ashtabula County, Ohio

Glenbeigh's main hospital facility is located in Ashtabula County, Morgan Township, with a Rock Creek Zip Code in Ohio of 44084. Ashtabula County is a 2025 designated Health Resources and Services Administration (HRSA) Health Professional Shortage Area (HPSA) for primary care and dental health.

Data shows a date of 2021 for designated as a mental health shortage area for the county. (Source: https://data.hrsa.gov/tools/shortage-area/hpsa-find) According to U.S. Census Bureau Quick Facts, the population density of Ashtabula County as of July 1, 2024 was 96,906. This is a -0.7% population decrease since April 1, 2020.

Ashtabula County, Ohio

Population Estimates July 1, 2024	Ashtabula County: 96,906	Ohio: 11,883,304
Age and Sex		
Persons under 5 years, percent	5.4%	5.6%
Persons under 18 years, percent	21.7%	21.9%
Persons 65 years and over, percent	20.6%	18.7%
Female persons, percent	48.9%	50.7%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH#

Income & Poverty	Ashtabula County	Ohio
Median household income (in 2023 dollars), 2019-2023	$55,507	$69,680
Per capita income in past 12 months (in 2023 dollars), 2019-2023	$30,768	$39,455
Persons in poverty, percent	17.8%	13.3%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH#

Race and Origin	Ashtabula County	Ohio
White alone, percent	88.0%	76.7%
Black or African American alone, percent(a)	4.2%	13.4%
American Indian and Alaska Native alone, percent	0.4%	0.3%
Asian alone, percent(a)	0.5%	2.8%
Native Hawaiian and Other Pacific Islander alone, percent	0.1%	0.1%
Two or More Races, percent	2.6%	2.7%
Hispanic or Latino, percent	5.1%	4.8%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH#

Ashtabula County, Ohio

The United Way 2024 ALICE (Asset Limited, Income Constrained, Employed) report on financial hardship in Ohio (https://www.unitedforalice.org) along with U.S. Census Bureau data (https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH#) provide a deeper understanding of community statistics. Per the ALICE report, between 2021 and 2022, the number of households in poverty in Ohio increased by 17,879 (to 14% of all households) and the number of ALICE households increased by 26,602 (remaining 25% of all households), continuing a more than decade-long trend in growth of the ALICE population.

In 2022, 39% of Ohio's 4,857,452 households were below the ALICE Threshold. Additionally, from 2010 to 2022, the total number of ALICE households increased by 16%, while households in poverty increased by 1%.

The number of Ohio households headed by people age 65 and older are the fastest-growing age group in Ohio – up 32% between 2010 and 2022. In 2022, 49% of these households were below the ALICE Threshold. While Social Security helps reduce the poverty rate for households headed by older adults (12% in Ohio in 2022), benefits have not been enough to help bring older adults to financial stability. In 2022, monthly costs for the ALICE 65+ Survival Budget for one adult in Ohio were $827 more than the average Social Security payment of $1,657.

Overall, ALICE households earn above the Federal Poverty Level but cannot afford the basic cost of living in their county. Despite struggling to make ends meet, ALICE households often do not qualify for public assistance.

U.S. Census Bureau statistics confirms ALICE feedback, reporting Ashtabula County, Ohio with a 2018 total population of 97,493 that decreased to 96,906 in July 2024. Census Bureau statistics also showed the number of households increased from 38,614 to 38,959 yet, during the same time period, the number of Ashtabula County residents living in poverty increased from 16.5% in 2021 to 17.8% in 2024. The percent of people living in poverty in Ohio was reported at 13.3% while the national rate was 11.1%.

The unemployment rate in the county endured at above the state average. The median household income from 2019-2023 for Ashtabula County was $55,507. The Ohio rate was $69,680 and the national rate was $78,538. The total employment percent change for 2022-2023 was 0.1% for Ashtabula County, 2.4% for Ohio and 3.0% for the country.

Ashtabula County, Ohio

ALICE IN ASHTABULA COUNTY

ALICE is an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed — households that earn more than the Federal Poverty Level, but less than the basic cost of living for the county. While conditions have improved for some households, many continue to struggle, especially as wages fail to keep pace with the rising cost of household essentials (housing, child care, food, transportation, health care, and a basic smartphone plan). Households below the ALICE Threshold — ALICE households plus those in poverty — can't afford the essentials.

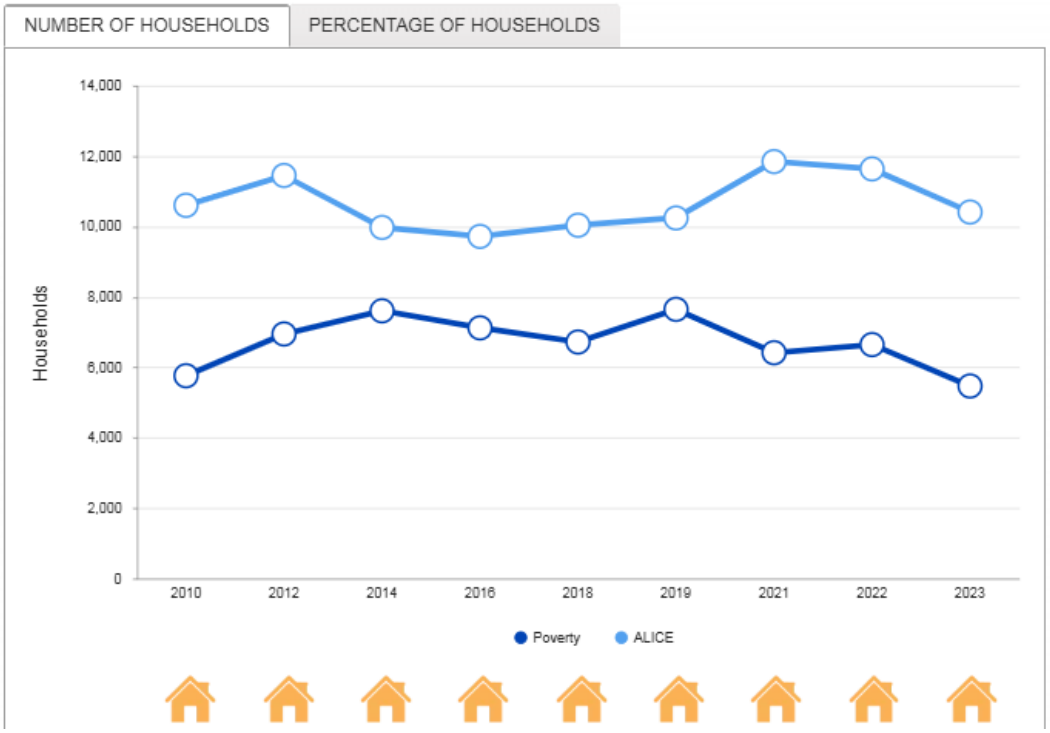
2023 Point-in-Time-Data

Population: 96,845 **Number of Households:** 37,507

Median Household Income: $57,577 (state average: $67,769)

Labor Force Participation Rate: 58% (state average: 64%)

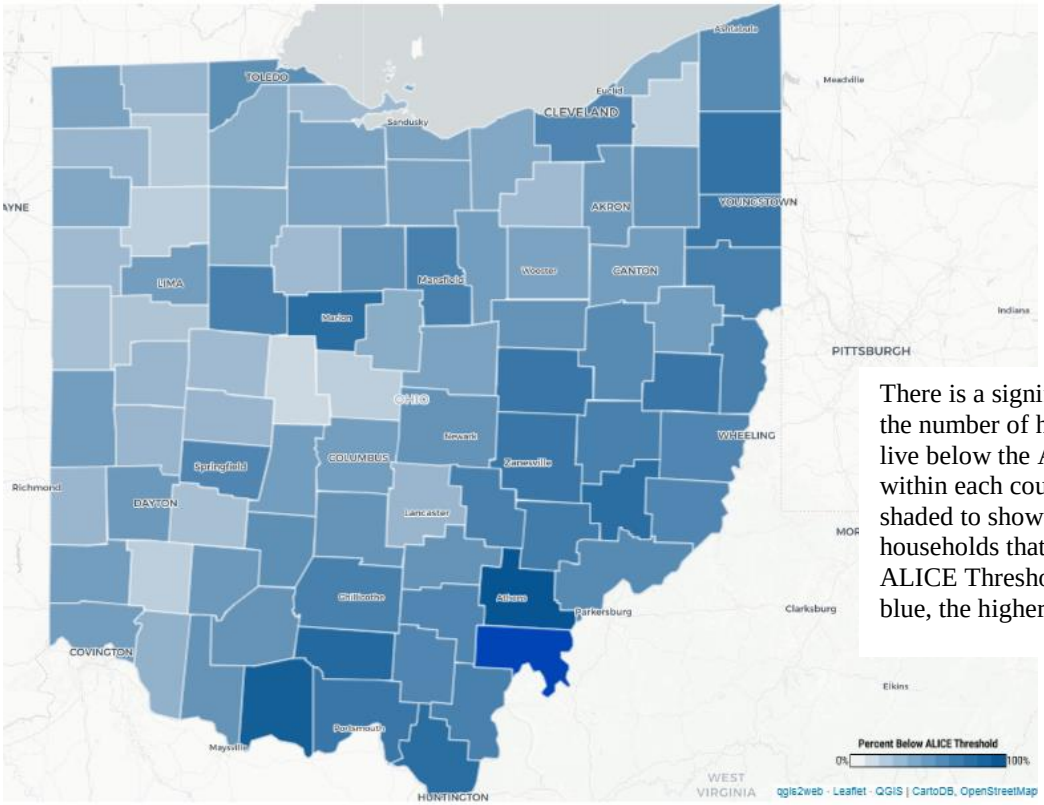
ALICE Households: 28% (state average 25%) **Households in Poverty:** 15% (state average 14%)



Sources: ALICE Threshold, 2010-2022; American Community Survey, 2010-2022

ALICE — Asset Limited, Income Constrained, Employed — households earn more than the Federal Poverty Level, but not enough to afford the basics where they live. Households below the ALICE Threshold (ALICE households and households in poverty) are forced to make tough choices, such as deciding between quality child care or paying the rent — choices that have long-term consequences for their families and communities.

Ohio Service Communities

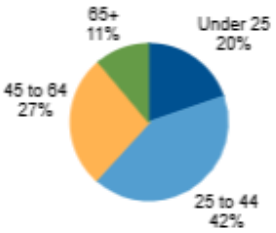


There is a significant variation in the number of households that live below the ALICE Threshold within each county. The map is shaded to show the percentage of households that are below the ALICE Threshold. The darker the blue, the higher the percentage.

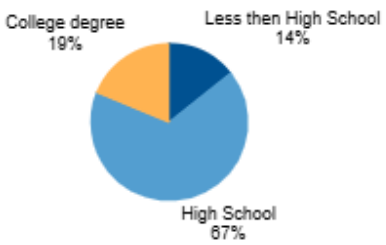
Source: United for ALICE, United Way 2024
https://unitedforalice.org/mapping-tool#7.9090851339545445/40.207/-82.666

Below ALICE Threshold Worker Characteristics

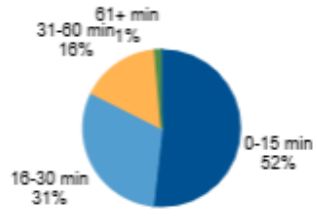
Age



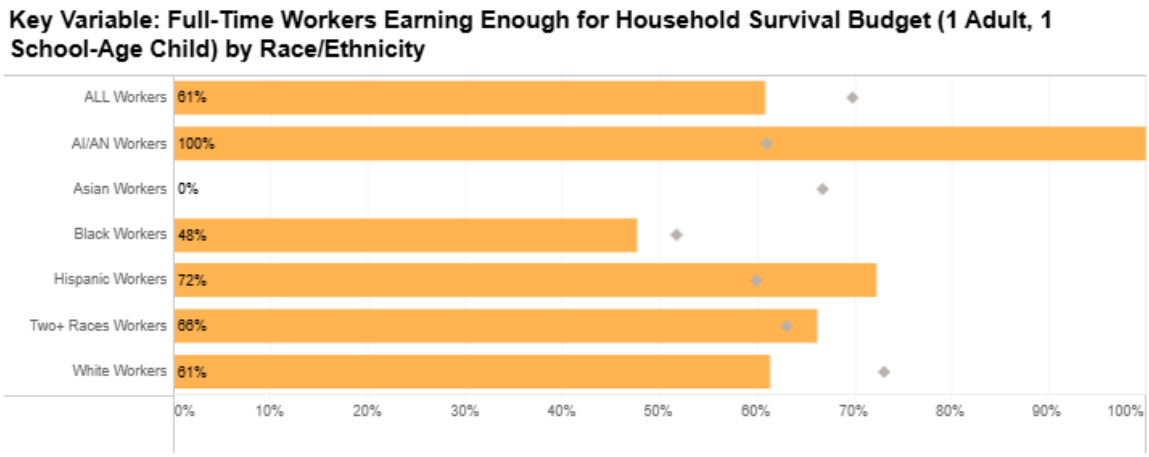
Educational Attainment



Commute Time



Ohio ALICE Data



Source: United for ALICE 2024 at https://unitedforalice.org/maps-and-data

TRENDS IN OHIO

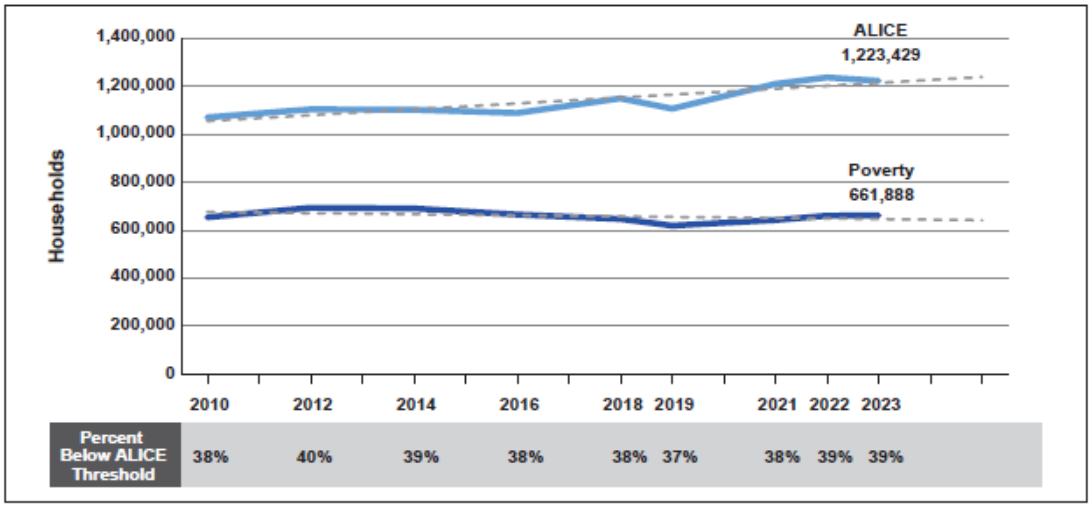
Over the last decade, the number of ALICE households in Ohio has been on the rise as wages have failed to keep up with the cost of household basics. When prices increase faster than wages, purchasing power decreases. This is especially challenging for ALICE households that are already struggling to make ends meet.

Between 2010 and 2023, the total number of households in Ohio increased by 8%, the number of households in poverty increased by 1%, and the number of ALICE households increased significantly more, by 14%.

Over time, the percentage of households below the ALICE Threshold in Ohio has fluctuated between 37% and 40%, holding at 39% for 2022 and 2023 (Figure 6). It will be important to track these trends in coming years to see if they continue or shift direction.

Figure 6. ALICE Households Grew, While Households in Poverty Remained Largely Flat

Number of Households by Income, Ohio, 2010-2023



Note: The gray dashed trend lines in this figure highlight the general direction of the point-in-time data for the years shown. These lines indicate whether the numbers of ALICE and poverty-level households have been generally increasing, decreasing, or remaining flat. The ALICE trend line is statistically significant at p<0.002; however, the Poverty trend line is not statistically significant, and caution should be used when making predictions.

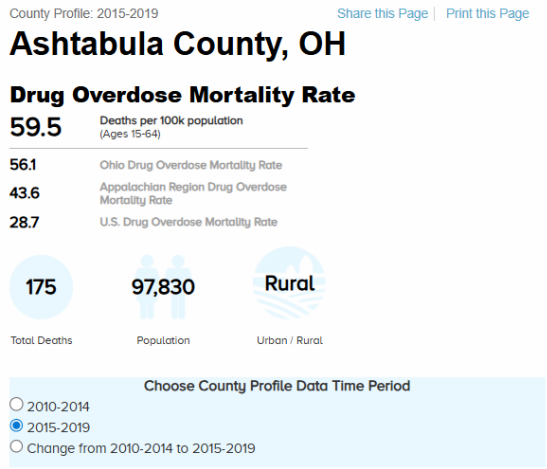
Sources: ALICE Threshold, 2010–2023; U.S. Census Bureau, American Community Survey, 2010–2023

Ohio ALICE Data

Figure 7. Cascading Benefits of Meeting Basic Needs

If households have sufficient income for…	Benefits for ALICE Households	Benefits for the Wider Community
Safe, Affordable Housing	Improved physical and mental health through safer environments and reduced stress; improved educational performance and outcomes for children; greater stability for household members; a means to build wealth and racial equity for homeowners	Expanded and updated housing stock, reduced systemic housing inequities; lower health care costs; reduced homelessness; increased opportunities for jobs and more money spent in local communities
Quality Child Care and Education	Increased labor force participation, lifetime earnings and retirement security for women; health benefits for children, school readiness, improved educational attainment and graduation rates; improved performance in higher education; higher lifetime earnings	Reduced racial/ethnic inequalities in learning and development; positive health, education, and economic outcomes for children and families; stronger community economies; more homebuyers and higher property values through availability of quality child care
Adequate Food	Decreased food insecurity; improved health (especially for children and adults age 65 and over); decreased likelihood of developmental delays and behavioral problems in school	Lower health care costs; improved school and workplace productivity; less spending on emergency food services; greater equity by gender, race/ethnicity and immigration status
Reliable Transportation	Decreased transportation insecurity; improved access to work/job opportunities, school and child care, health care and social services, food/retail markets, and support systems (friends, family, faith communities)	Improved air quality and reduced gasoline consumption/carbon emissions; increased economic opportunity through returns on investment; a more diverse labor market; decreased income disparities; more integrated neighborhoods
Quality Health Care	Better mental and physical health (including increased life expectancy); improved access to preventive care; fewer missed days of work and school; decreased need for emergency services; lower share of income spent on health	Decreased health care spending and strain on emergency services; reduced racial/ethnic disparities in insurance coverage and access to care; fewer communicable diseases; improved workplace productivity; decreased wealth-health gap; better outcomes during health crises
Reliable Technology	Improved access to job opportunities; expanded access to health information and telemedicine services; increased job and academic performance	Closing the "digital divide" in access to technology by income; increased economic development; increased connectivity and social inclusion that helps reduce social, economic, and political disparities
Savings	Ability to withstand emergencies without impacting long-term financial stability; greater asset accumulation over time (e.g., interest on savings; ability to invest in education, property, or finance a secure retirement)	Less spending on public services to cover basic needs like health care, food, and housing — especially for unexpected or emergency expenses

Source: United for Alice 2024 at: https://www.unitedforalice.org/all-reports Ohio



SOCIO DEMOGRAPHIC	Ashtabula County	Ohio	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	**89.5%**	78.9%	81.3%	60.7%
African American (non-Hispanic)	**3.4%**	12.2%	9.6%	12.3%
Hispanic or Latino	**4.2%**	3.8%	5.1%	18.0%
Other (non-Hispanic)	**2.9%**	5.1%	4.0%	9.0%
Age				
Under 15	**18.1%**	18.4%	17.5%	18.7%
15-64	**63.3%**	64.9%	64.6%	65.6%
65+	**18.5%**	16.7%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	**86.0%**	90.4%	87.2%	88.0%
Bachelor's Degree or more (25+)	**14.3%**	28.3%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	**14.5%**	11.9%	13.8%	10.3%
ECONOMIC				
Median Household Income	**$46,700**	$56,602	$46,074	$62,843
Poverty Rate	**19.9%**	14.0%	15.2%	13.4%
Unemployment Rate	**6.9%**	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	**3.5%**	4.0%	4.1%	4.8%
Mining	**0.6%**	0.5%	1.1%	1.3%
Manufacturing	**23.9%**	12.9%	13.1%	8.7%
Trade, Transportation, & Utilities	**16.1%**	18.9%	19.7%	18.9%

Source: Appalachian Regional Commission and NORC at the University of Chicago
https://overdosemappingtool.norc.org/

Ashtabula County 2025 Community Health Needs Assessment Data

Through a collaborative effort coordinated by *Healthy Ashtabula County*, Ashtabula County, Ohio, completed and published its 2025 Community Health Needs Assessment. The 2025 Ashtabula County CHNA is the result of a collaborative effort, which includes the Ashtabula County Health Department, the Ashtabula City Health Department, ARMC Healthcare System, the Conneaut City Health Department, University Hospitals Conneaut Medical Center, University Hospitals Geneva Medical Center and several other partners.

The intent of this collaborative effort was to help health departments, hospitals, social service agencies, other organizations and community stakeholders better understand the health needs and priorities of Ashtabula County residents. The 2025 Ashtabula County CHNA provides a comprehensive overview of the community's health status, illuminating areas of strength as well as areas in which there could be improvement.

Consistent with Public Health Accreditation Board requirements and IRS regulations, *Healthy Ashtabula County* uses the report to inform the development and implementation of strategies to address gaps in community health care and services. The Ashtabula County CHNA reported from representative survey results that 42% of respondents know someone in their community who has an abuse or addiction problem with alcohol and 34% know someone with an abuse or addiction problem with marijuana. The overall knowledge of someone with an abuse or addiction problem did not change from 2022.

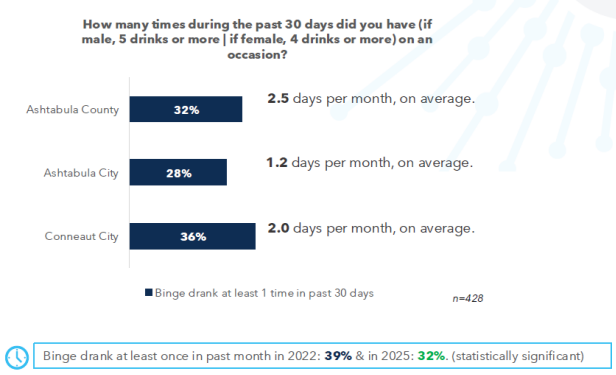
Ashtabula County, Ohio

In addition, approximately one-third of Ashtabula County adults (32%) reported binge drinking (i.e. five or more drinks on one occasion for men, four or more drinks on one occasion for women) at least once in the past month, a decrease from 39% reported through surveys in 2022.

Those with at least one child in the household reported being more likely to know someone with a methamphetamine abuse problem (44.3%) than those without any children in the household (12.9%). Those age 18-49 are more likely to know someone with a methamphetamine abuse problem (35.0%) than those age 50 or older (9.5%). Those with at least one child in the household are more likely to know someone with a prescription pain medicine abuse problem (34.8%) than those without any children in the household (10.8%). Those with at least one child in the household are more likely to know someone with an alcohol abuse problem (60.2%) than those without any children in the household (34.9%).

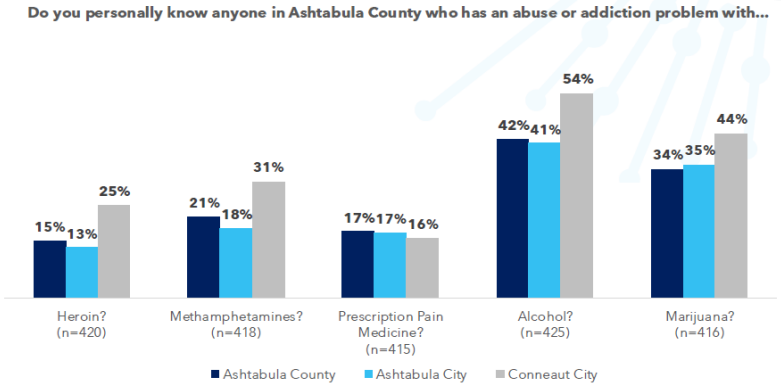
As age increases, the likelihood of knowing someone with a marijuana abuse problem decreases: 41.6% for those 18-59, 29.6% for those 60-69, and 9.6% for those 70 or older.

According to the representative survey, almost one-third (32%) of adult respondents binge drank at least once in the past month.



Binge drank at least once in past month in 2022: **39%** & in 2025: **32%**. (statistically significant)

According to the representative survey, 42% of respondents know someone in Ashtabula County who has an abuse or addiction problem with alcohol and 34% know someone with an abuse or addiction problem with marijuana.



Source: Ashtabula County 2025 CHNA

Ashtabula County, Ohio

The following information was pulled from the 2025 Ashtabula County CHNA to provide local insight into social determinants of health and barriers within Ashtabula County.

Economic instability is linked to food insecurity. People who are food insecure do not get adequate food or have disrupted eating patterns due to lack of money and other resources. The percentage of the population who lack adequate access to food is slightly higher in Ashtabula County than Ohio (18% and 15%, respectively).

INCOME & POVERTY		ASHTABULA CITY	CONNEAUT CITY	ASHTABULA COUNTY	OHIO
Income	Median household Income[1]	$43,782	$50,585	$55,507	$69,680
Poverty	People below 100% FPL[1]	31.6%	21.5%	18.3%	13.2%
	People below 125% FPL[1]	37.0%	28.6%	22.9%	16.9%
	People below 200% FPL[1]	54.1%	48.5%	40.4%	29.4%
Children	In households below 100% FPL[1]	39.0%	33.0%	26.0%	18.0%
Food Insecurity	Food insecure households[2]	--	--	17.6%	15.3%
	SNAP households[1]	33.3%	22.9%	18.5%	12.4%

Data are from 2019-2023. Sources: [1]U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023; [2]Feeding America, Map the Meal Gap, 2023

Healthy People 2030 objective not met: people living below poverty level (Ashtabula County **18.3%** vs. Target **8.0%**)

A lower percentage of Ashtabula County residents continue their education beyond an associate degree, compared to Ohio overall.

EDUCATIONAL ATTAINMENT		ASHTABULA CITY	CONNEAUT CITY	ASHTABULA COUNTY	OHIO
Educational Attainment	No high school	4.2%	1.6%	4.0%	2.6%
	Some high school, no diploma	12.0%	12.7%	8.5%	5.7%
	High school graduate	43.3%	43.2%	42.2%	32.3%
	Some college, no degree	20.2%	19.8%	20.4%	19.4%
	Associate's degree	7.5%	6.7%	8.9%	9.0%
	Bachelor's degree	8.6%	11.3%	10.6%	19.0%
	Graduate or professional degree	4.3%	4.8%	5.4%	11.9%

Data are from 2019-2023. Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023

Ashtabula County, Ohio

MENTAL HEALTH AND SUBSTANCE MISUSE

KEY FINDINGS

Mental Health

- 33% of adult residents have been diagnosed with anxiety and 29% with depression – both are significantly higher than the 2022 CHNA.
- 15% of youth and 4% of adults reported they had seriously considered attempting suicide in the past year.
- Those with lower household income experience more poor mental health on a variety of outcome measures.

Substance Misuse

- 20% of youth have ever vaped, and among them, 43% reported vaping at least one time in the past 30 days.
- 32% of adult residents reported binge drinking at least once within the past 30 days, significantly lower than 39% from the 2022 CHNA.
- 18% of adult residents used marijuana in the past 30 days, significantly higher than 8% from the last CHNA.

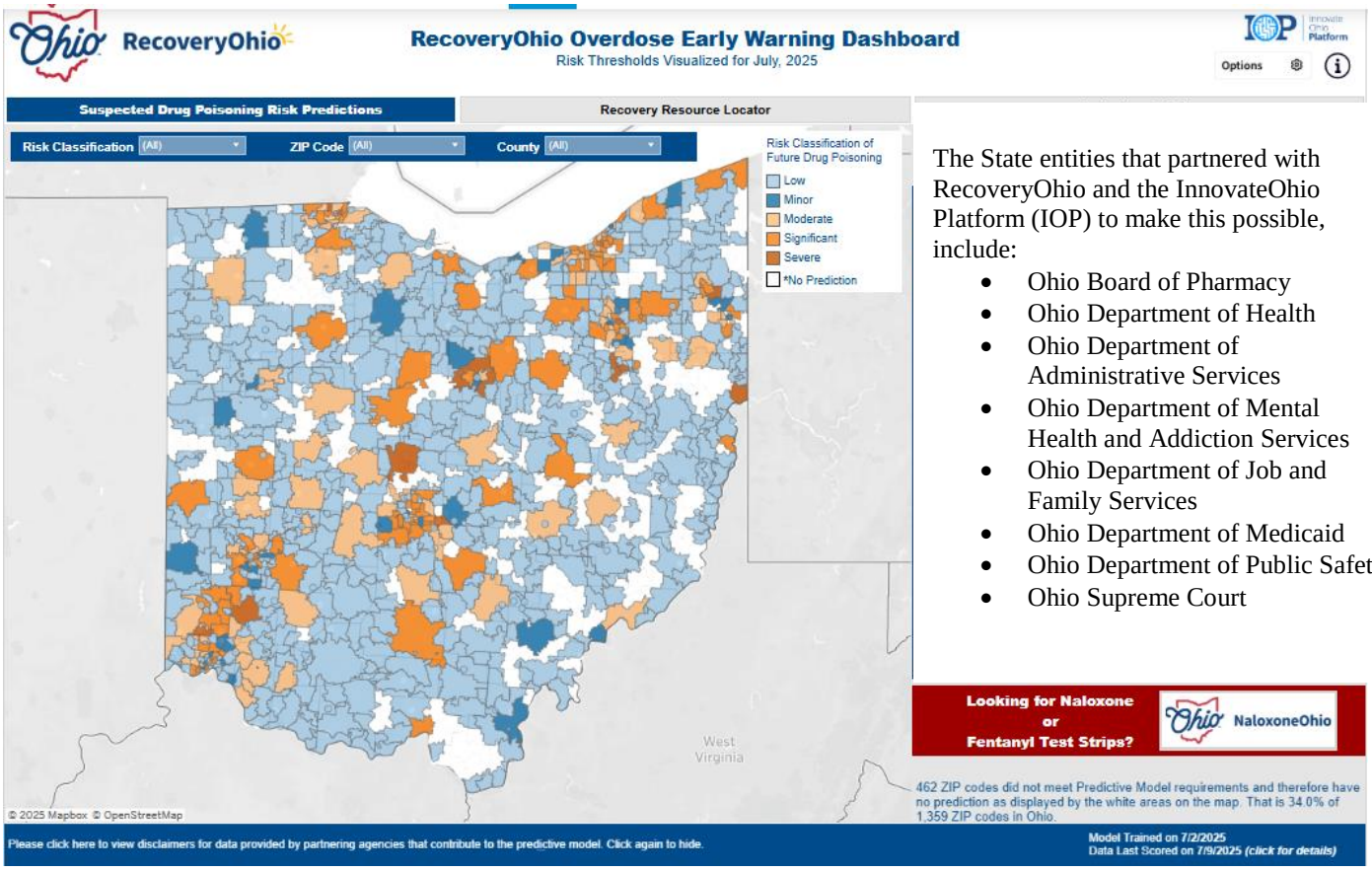
Source: Ashtabula County 2025 CHNA

Ohio State Data

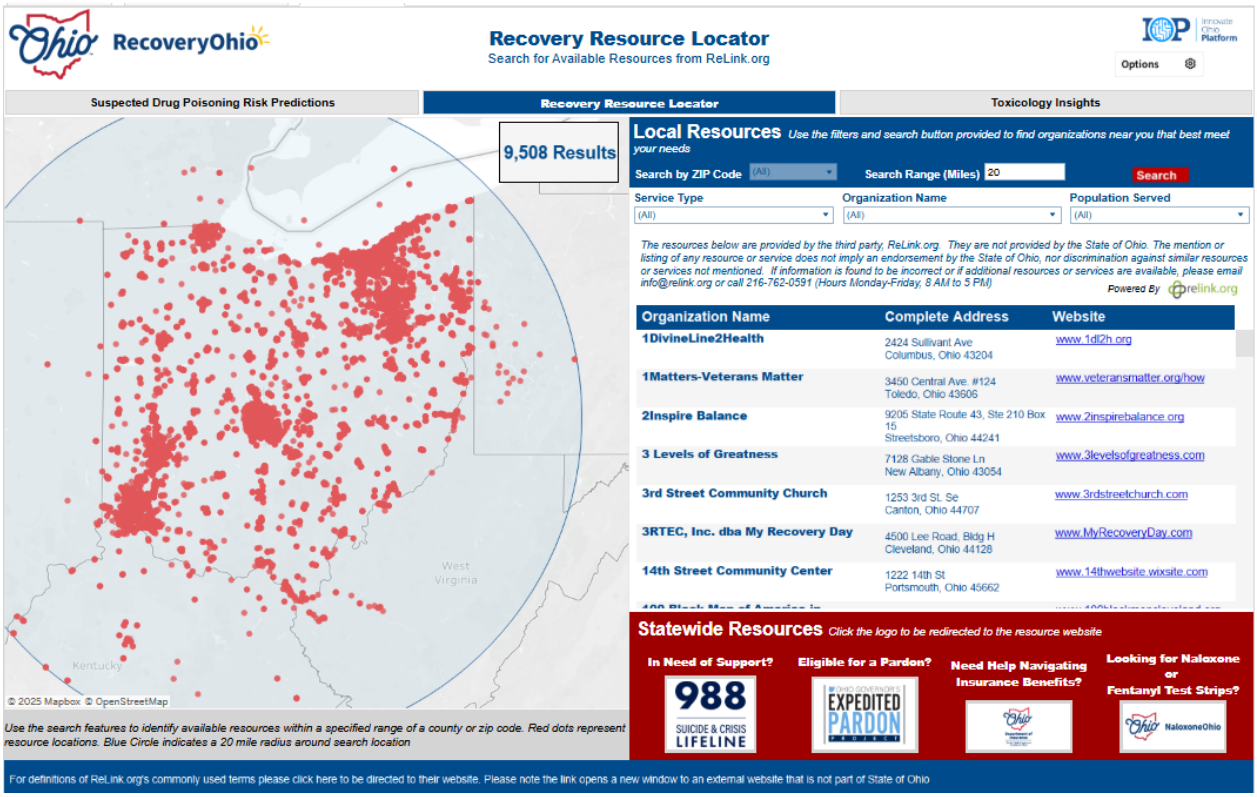
The Ohio Department of Health published The RecoveryOhio Initiative, which coordinates the work of State of Ohio departments, boards and commissions by leveraging existing resources and identifying new opportunities to improve mental health and substance use prevention, treatment, and recovery support services in Ohio. As part of its mission, RecoveryOhio led the development of a predictive model to forecast potential future drug poisoning outbreaks across the State. The model drills down to the County and ZIP Code levels. Also included are statewide illicit drug trends represented in an interactive map making metrics conveniently available to the public.

Inspiration

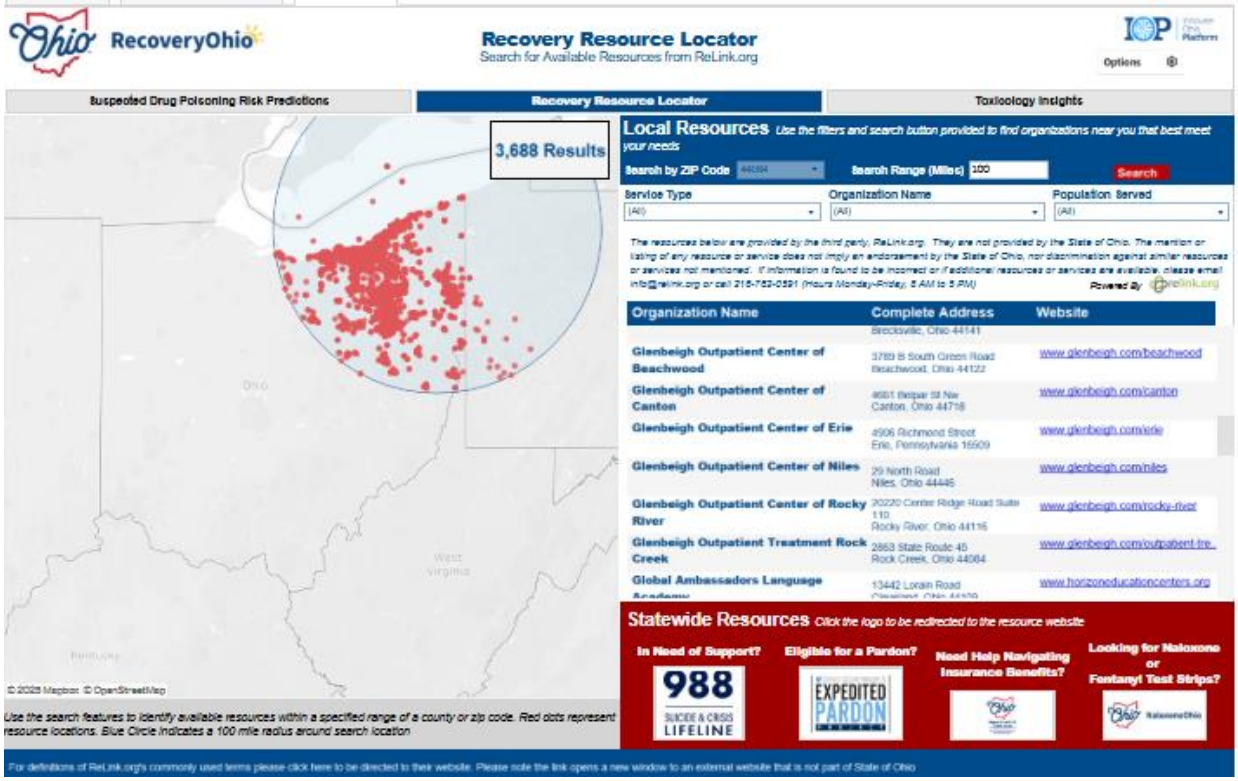
Insights derived from the map below are intended to help prevent drug poisonings by aligning resources in targeted communities at the right time and to provide citizens the support necessary to overcome substance abuse.



Source: Ohio Department of Health at:
https://data.ohio.gov/wps/portal/gov/data/view/recoh_od_early_warning?visualize=true



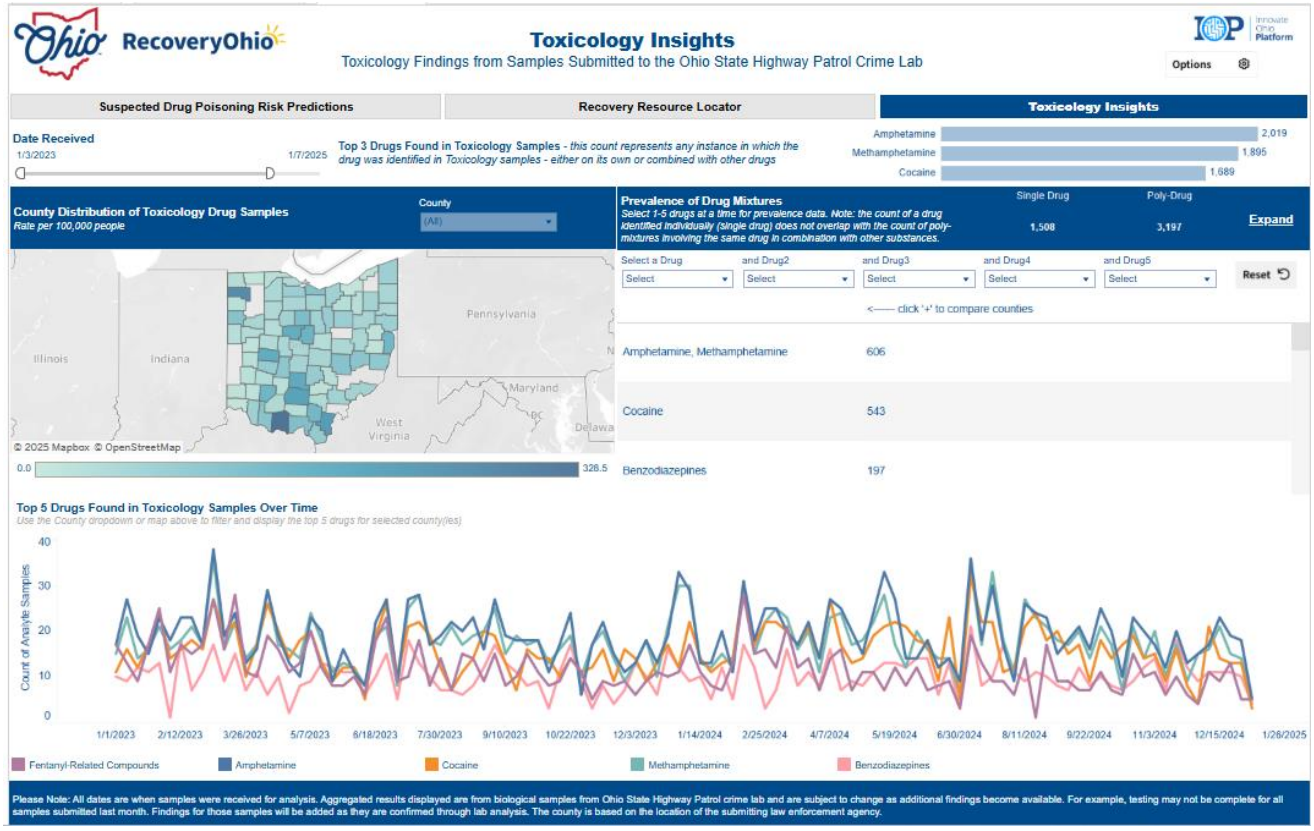
Source: Ohio Department of Health at:
https://data.ohio.gov/wps/portal/gov/data/view/recoh_od_early_warning?visualize=true



Ohio State Data

Northeast Ohio, which includes Ashtabula, Cuyahoga, Stark, Summit and Trumbull counties, areas that fall in Glenbeigh's defined service area, have a robust Recovery Resource network. Glenbeigh provides recovery support services in communities where outpatient centers are located. As part of Glenbeigh's commitment to improving the lives of those in recovery, the organization sponsors events and recovery resources throughout the region.

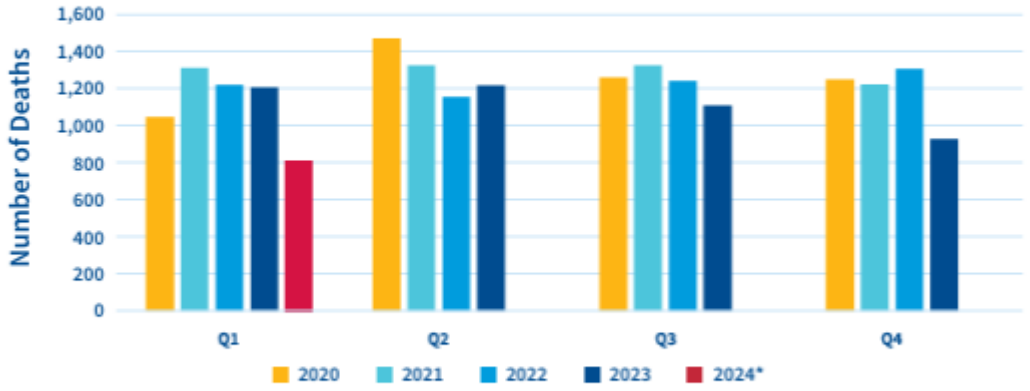
Ohio State – Substance Use and Overdose Data



Source: Ohio Department of Health at:
https://data.ohio.gov/wps/portal/gov/data/view/recoh_od_early_warning?visualize=true

Quarterly Trends

FIGURE 1. Number of Unintentional Drug Overdose Deaths by Quarter, Ohio, 2020-2024*



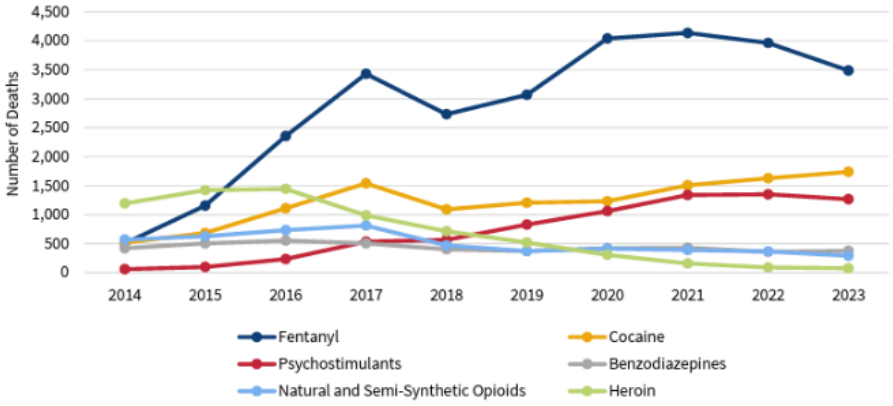
Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths

Source: Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths at: https://odh.ohio.gov

Drug Involvement

- From 2022 to 2023, there were increases in the number of unintentional drug overdose deaths involving the non-opioid drug categories of cocaine and benzodiazepines. The number of drug overdose deaths involving cocaine increased 7%, and deaths involving benzodiazepines increased 4%.
- In contrast, overall opioid-related unintentional drug overdose deaths decreased 11% from 2022 to 2023. Fentanyl-related deaths decreased 12%, while deaths involving natural and semi-synthetic opioids (e.g., oxycodone) and heroin decreased 20% and 17%, respectively.
- Psychostimulant-related deaths (e.g., methamphetamine) decreased 6% from 2022 to 2023. This was the first decrease in Ohio psychostimulant-related deaths for the years presented.

Figure 3. Number of Unintentional Drug Overdose Deaths Involving Select Drugs, Ohio, 2014-2023

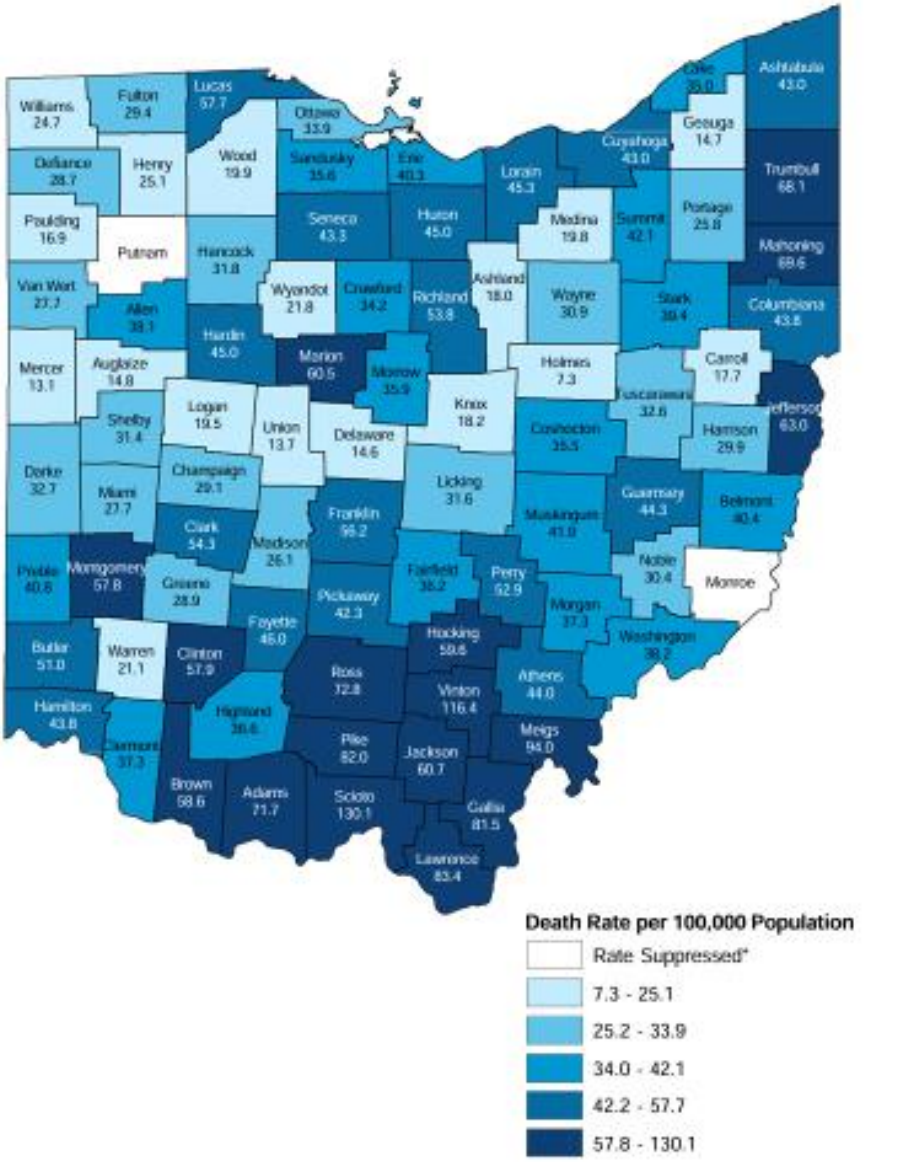


Source: https://odh.ohio.gov/know-our-programs/violence-injury-prevention-program/media/2023-annual-ohio-drug-overdose-report

The following map shows a summary of preliminary data developed to provide recent trends in unintentional drug overdose deaths using preliminary data. *Source: ODH Bureau of Vital Statistics.* Analysis: ODH Violence and Injury Epidemiology and Surveillance Section. The graph includes Ohio residents who died due to unintentional drug poisoning (underlying cause of death ICD-10 codes X40-X44). County is determined by county of residence. *Rates are suppressed when there are fewer than 10 total deaths. Per the Ohio Department of Health notes. This report is dated 2023.

Demographics: County

Figure 22. Average Age-Adjusted Rate of Unintentional Drug Overdose Deaths by County, Ohio, 2020-2023

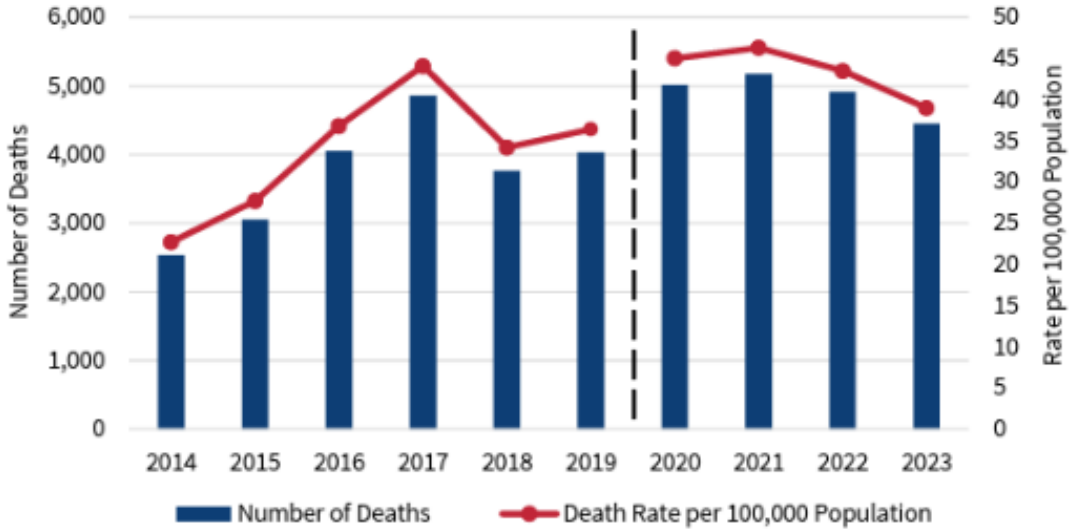


Source: Ohio Department of Health at: https://odh.ohio.gov

Unintentional Drug Overdose Deaths in Ohio

- In 2023, there were 4,452 unintentional drug overdose deaths. This was a 9% decrease in the number of deaths from 2022 and the second consecutive year for decreases in Ohio unintentional drug overdose deaths. From 2021 to 2022, there was a 5% decrease in the number of unintentional drug overdose deaths.

Figure 1. Number and Age-Adjusted Rate of Unintentional Drug Overdose Deaths by Year, Ohio, 2014-2023*



- In 2023, Ohio's age-adjusted rate of 39 deaths per 100,000 population also marked a decrease from the age-adjusted rate of 43.5 deaths per 100,000 population seen in 2022. Age-adjusted rate of deaths per population is a conventional statistical adjustment done in accordance with CDC standards to account for the difference in expected death rates among different age ranges.

Source: https://odh.ohio.gov/know-our-programs/violence-injury-prevention-program/media/2023-annual-ohio-drug-overdose-report

Ohio Department of Health data shows that in 2019, 4,028 and in 2020, 5,017 individuals died from unintentional drug overdoses. In 2021, that number increased to 5,174. Beginning in 2022, the total number of unintentional drug overdose deaths began to decrease in Ohio.

Table 2. Number and Percentage of Unintentional Drug Overdose Deaths Involving Select Drug Combinations, Ohio, 2014-2023

Drug Category	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Percentage of 2023 Unintentional Drug Overdose Deaths
Fentanyl	503	1,155	2,357	3,431	2,733	3,070	4,041	4,137	3,963	3,486	**78%**
Fentanyl + Cocaine	101	239	619	1,072	808	930	985	1,213	1,334	1,379	**31%**
Fentanyl + Psychostimulants	12	34	117	368	379	599	843	1,047	1,092	971	**22%**
Fentanyl + Benzodiazepines	81	159	273	318	255	239	320	341	267	275	**6%**
Fentanyl + Natural and Semi-Synthetic Opioids	79	170	367	477	260	231	278	261	244	177	**4%**
Fentanyl + Heroin	170	490	750	720	569	428	255	134	78	70	**2%**
Total Unintentional Drug Overdose Deaths	**2,531**	**3,050**	**4,050**	**4,854**	**3,764**	**4,028**	**5,017**	**5,174**	**4,915**	**4,452**	

Fentanyl includes fentanyl and fentanyl analogs (e.g., carfentanil). Psychostimulants include methamphetamine and other psychostimulants with potential for abuse (ICD-10 code T43.6). Natural and semi-synthetic opioids (e.g., oxycodone, hydrocodone) correspond to code T40.2. Multiple drugs are usually involved in overdose deaths. Individual deaths may be reported in more than one category. 5

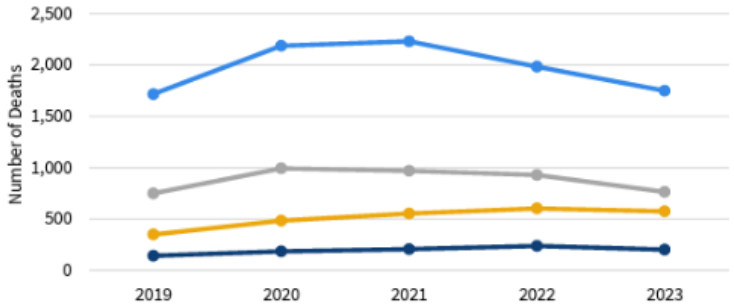
Source: https://odh.ohio.gov/know-our-programs/violence-injury-prevention-program/media/2023-annual-ohio-drug-overdose-report

The substances involved in unintentional drug overdose deaths continue to change and evolve.

Fentanyl:

- From 2022 to 2023, all sex and race/ethnicity groups experienced decreases in the number of fentanyl-related deaths.
- Fentanyl-related deaths among Black non-Hispanic females and males decreased 15% and 5%, respectively. Among White non-Hispanic females and males, fentanyl-related deaths decreased 18% and 12%, respectively.

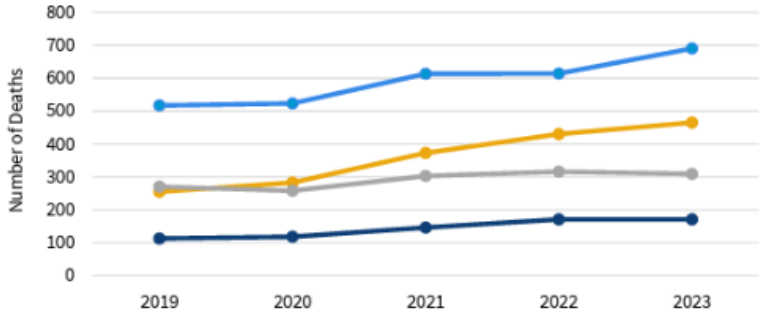
Figure 17a. Fentanyl



Cocaine:

- From 2022 to 2023, both Black non-Hispanic and White non-Hispanic males experienced increases in the number of cocaine-related deaths (8% and 12%, respectively).
- From 2022 to 2023, the number of cocaine-related deaths among Black non-Hispanic females remained the same, while deaths among White non-Hispanic females decreased 2%.

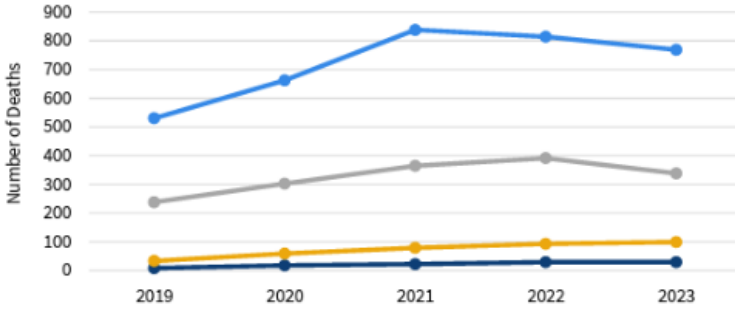
Figure 17b. Cocaine



Psychostimulants:

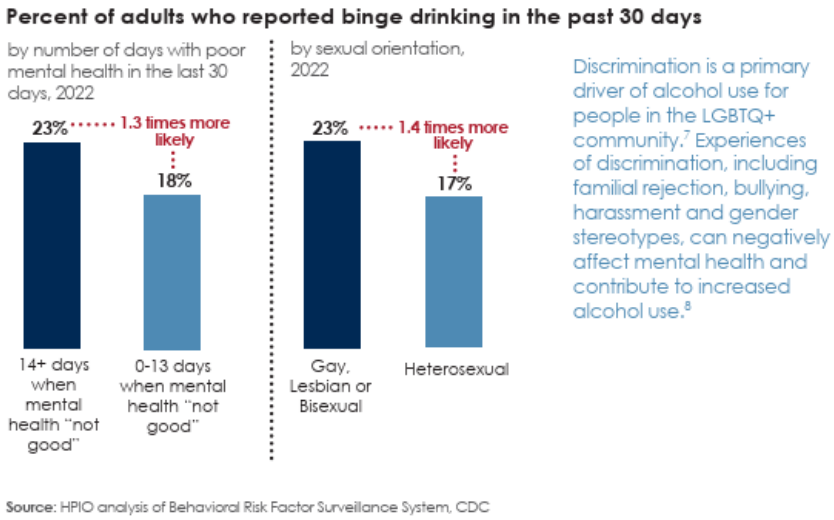
- In 2023, while the largest number of psychostimulant-related deaths was among White non-Hispanic females and males, the largest increase from 2022 to 2023 was among Black non-Hispanic males (6%).
- From 2022 to 2023, psychostimulant-related deaths among White non-Hispanic females and males decreased 14% and 6%, respectively.
- The number of psychostimulant-related deaths among Black non-Hispanic females remained the same during this period.

Figure 17c. Psychostimulants (e.g., methamphetamine)



This data reflects updated national standards used in the creation of race categories. Caution should be used when comparing data to that of previous reports using a different methodology to categorize race. Other race and ethnicity groups are not presented due to small numbers. Fentanyl includes fentanyl and fentanyl analogs (e.g., carfentanil). Psychostimulants include methamphetamine and other psychostimulants with potential for abuse (ICD-10 code T43.6). Multiple drugs are usually involved in overdose deaths. Individual deaths may be reported in more than one category.

Source: https://odh.ohio.gov/know-our-programs/violence-injury-prevention-program/media/2023-annual-ohio-drug-overdose-report



Source: Health Policy Institute of Ohio 2024 Health Value Dashboard at: https://www.healthpolicyohio.org/files/publications/databriefleadingcausesfinal.pdf

Ohio's overdose deaths continued to be driven by fentanyl, predominantly in combination with other drugs. Cocaine and psychostimulant use grew between 2019 and 2021 and this trend continued through 2024. During the same period, heroin use tapered off while the use of benzodiazepines and natural or semi-synthetic opioids stayed relatively unchanged.

While the number of fentanyl deaths decreased in Ohio starting in late 2023, many individuals seeking inpatient treatment at Glenbeigh who reported use of stimulants and marijuana were unaware that the substance they were using also contained fentanyl, Xylazine or other substances.

Alcohol use increased significantly between 2020 and 2022, when people were isolated due to global pandemic restrictions. Since, statistics show an overall decrease at the county and state level.

FIGURE 2. Number of Unintentional Drug Overdose Deaths Involving Fentanyl by Quarter, Ohio, 2022-2024*

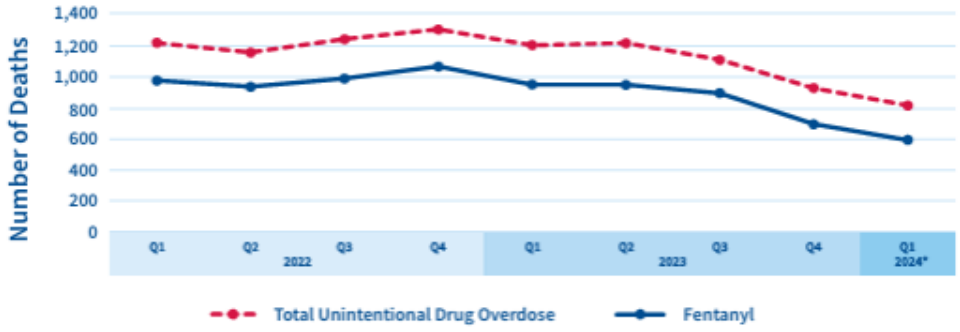
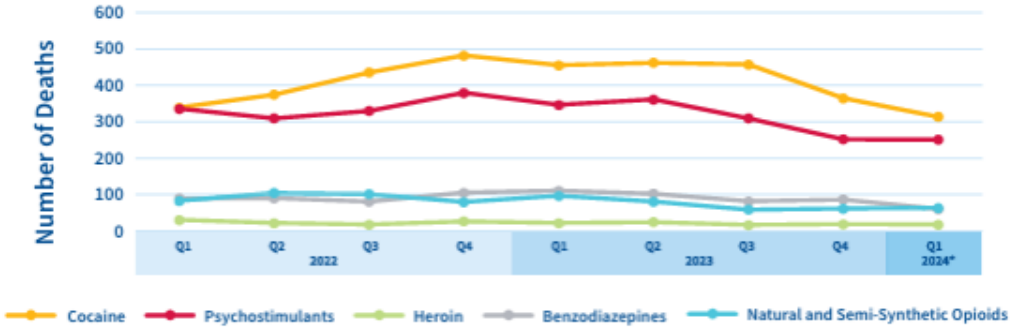


FIGURE 3. Number of Unintentional Drug Overdose Deaths Involving Select Drugs by Quarter, Ohio, 2022-2024*



Source: Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths at: https://odh.ohio.gov

Overdose Statistics by Race

FIGURE 4. Number of Unintentional Drug Overdose Deaths Among the White Non-Hispanic Population by Quarter, Ohio, 2022-2024*

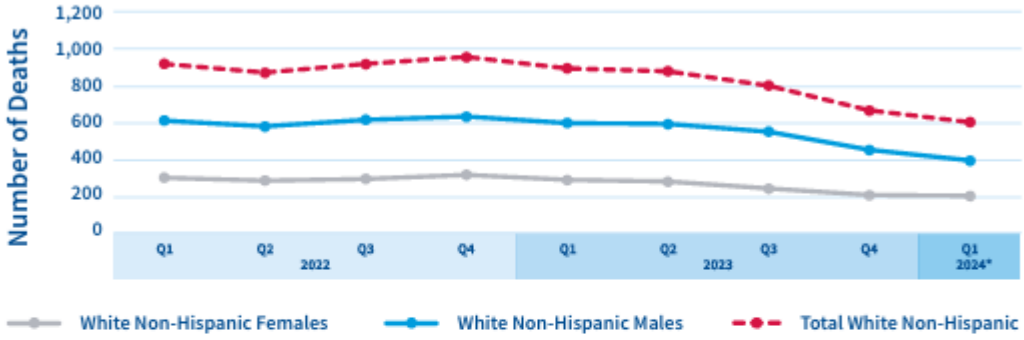


FIGURE 5. Number of Unintentional Drug Overdose Deaths Among the Black Non-Hispanic Population by Quarter, Ohio, 2022-2024*

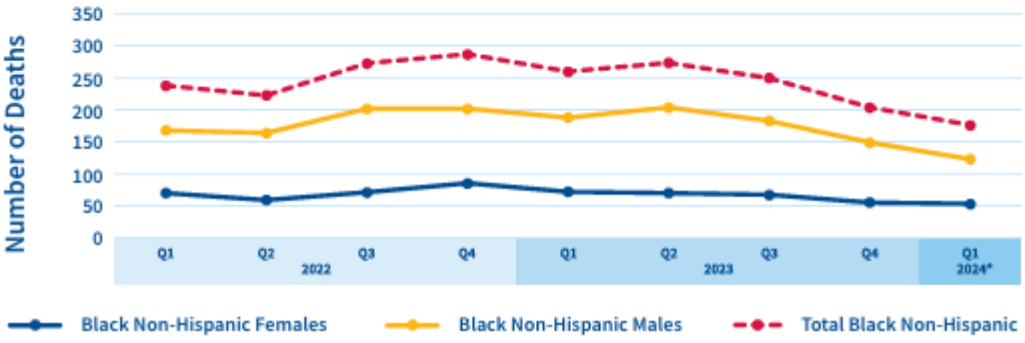
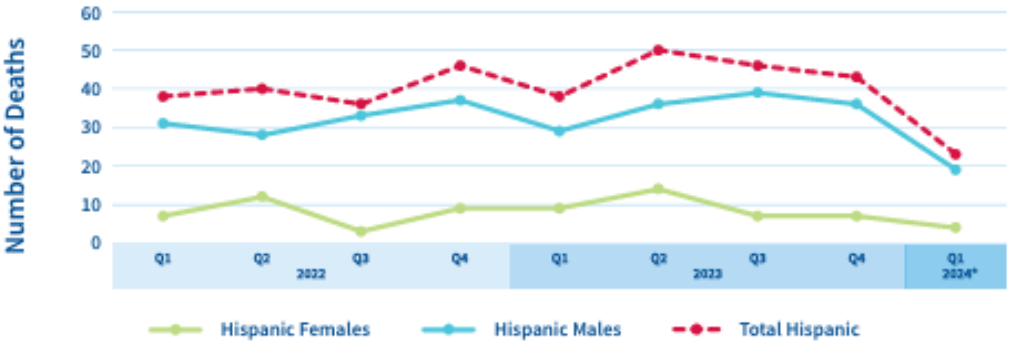


FIGURE 6. Number of Unintentional Drug Overdose Deaths Among the Hispanic Population by Quarter, Ohio, 2022-2024*



Source: Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths at: https://odh.ohio.gov

TABLE 4. Demographic Summary of Unintentional Drug Overdose Deaths, Ohio, 2022-2024*

Demographics	2022		2023		2024* (January - March)	
	Number	Percent	Number	Percent	Number	Percent
Age						
<15	7	<1%	9	<1%	2	<1%
15-24	249	5%	173	4%	23	3%
25-34	1,141	23%	906	20%	184	23%
35-44	1,371	28%	1,274	29%	226	28%
45-54	1,017	21%	936	21%	183	22%
55-64	852	17%	855	19%	138	17%
65+	278	6%	297	7%	58	7%
Sex						
Female	1,554	32%	1,356	30%	268	33%
Male	3,361	68%	3,096	70%	548	67%
Race / Ethnicity						
American Indian, Non-Hispanic	12	<1%	3	<1%	1	<1%
Asian/Pacific Islander, Non-Hispanic	16	<1%	8	<1%	3	<1%
Black, Non-Hispanic	1,021	21%	988	22%	176	22%
White, Non-Hispanic	3,662	75%	3,241	73%	604	74%
Multiracial, Non-Hispanic	34	1%	28	1%	6	1%
Hispanic	160	3%	177	4%	23	3%
Race / Ethnicity and Sex						
Black Non-Hispanic Females	285	6%	264	6%	53	7%
Black Non-Hispanic Males	736	15%	724	16%	123	15%
White Non-Hispanic Females	1,216	25%	1,038	23%	207	26%
White Non-Hispanic Males	2,446	50%	2,203	49%	397	49%
Hispanic Females	31	1%	37	1%	4	<1%
Hispanic Males	129	3%	140	3%	19	2%
Ohio	**4,915**		**4,452**		**816**	

Source: Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths at: https://odh.ohio.gov

Per the Ohio Department of Health Summary: This preliminary data summary has been developed to provide recent trends in unintentional drug overdose deaths using preliminary 2024 vital statistics mortality data. Comparisons are made to finalized mortality data from 2020 to 2023. This summary is updated quarterly as additional mortality data is received. *2024 data is incomplete. Data presented through March 2024.

From the preliminary data chart above, unintentional drug overdose deaths stayed on trend continuing to be high among the White, non-Hispanic population. This population accounted for 73% of the 2023 drug overdoses deaths. Comparatively, the Black, non-Hispanic population accounted for 22% while the Hispanic population was at 4%. Overdose deaths for the White population continued to slowly trend down between Q4 2022 and Q1 2024. At the same time, overdose deaths among the Black population began to slowly trend upwards.

Treatment Episode Data Set

2024 Treatment Episode Data Set: Admissions (TEDS-A) Ohio

Ohio TEDS-A aged 12 years and older, by primary substance use and sex, age at admission, race, and ethnicity: Percent, 2024

OHIO	All Substances	Alcohol Only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants
Total (Number)	14,791	2,077	2,276	1,229	2,294	866	712	2,474	2,326	71	115	11	45	49	8
Total	100	14	15.4	8.3	15.5	5.9	4.8	16.7	15.7	0.5	0.8	0.1	0.3	0.3	0.1
SEX*	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**	**Tranquilizers**	**Sedatives**	**Hallucinogens**	**PCP**	**Inhalants**
Male	64.3	71.8	68.5	57.6	62	50.5	62.6	69.5	59.8	76.1	48.7	72.7	75.6	79.6	75
Female	35.7	28.2	31.5	42.4	38	49.5	37.4	30.5	40.2	23.9	51.3	27.3	24.4	20.4	25
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
RACE	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**	**Tranquilizers**	**Sedatives**	**Hallucinogens**	**PCP**	**Inhalants**
White	68.1	59.3	61.6	85.4	81.5	46.2	52.5	51.3	91	62	82.6	90.9	37.8	4.1	100
Black or African-American	26	34.9	33.2	9.2	12.4	48.4	37.8	41.2	5.4	29.6	11.3	9.1	51.1	93.9	0
American Indian or Alaska Native	0.3	0.3	0.3	0.7	0.2	0.6	0.3	0.4	0.3	0	0	0	0	0	0
Asian or Native Hawaiian or Other Pacific Islander	0.4	0.6	0.4	0.4	0.4	0.1	0.7	0.3	0.1	0	0	0	0	0	0
Other	1.4	1.6	1.3	2.1	1.7	0.8	2.1	1.7	0.7	2.8	1.7	0	0	0	0
Unknown	3.7	3.3	3.3	2.2	3.8	3.9	6.6	5	2.5	5.6	4.3	0	11.1	2	0
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
ETHNICITY	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**	**Tranquilizers**	**Sedatives**	**Hallucinogens**	**PCP**	**Inhalants**
Hispanic or Latino	3.7	2.9	4	5	3.7	4	4.6	4.2	2.3	2.8	2.6	0	4.4	4.1	0
Not Hispanic or Latino	91.3	91.3	91.9	91.1	91.7	93.3	89.7	89	93	90.1	90.4	90.9	84.4	93.9	87.5
Unknown	5	5.8	4.2	3.9	4.7	2.7	5.6	6.8	4.7	7	7	9.1	11.1	2	12.5
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/data/quick-statistics-results?parent_override_data_collection_id=1011&location_id=232&data_collection_id=1397&year=2024&parent_data_collection_id=1183

Ohio TEDS Admissions Report

Data from the TEDS admissions report for 2024 show that typically more men seek treatment for substance use disorders than women. This remains consistent through Glenbeigh's previous CHNA's and corresponds to treatment admissions at the Rock Creek inpatient facility. The percentages of men seeking treatment exceed women seeking treatment by 30 percentage points or more for alcohol with a secondary drug and for all substances. For alcohol alone, men exceeded women by over 40 percentage points. Almost equal amounts of men as women sought treatment for cocaine (smoked), amphetamines and tranquilizers.

TEDS data also shows a disparity in the drug of choice between Caucasian/White users and African American/Black users. The percentage of White users of alcohol only and alcohol with a secondary drug decreased from 71.4% in 2021 to 59.5% and 62.6% in 2021 to 61.6%. Black users were at 24.7% and 32.0%, in 2021, all increases from 2017. In 2024, the number of Black alcohol users increased to 34.9% while alcohol with a secondary drug increased slightly to 33.2%. Cocaine (smoked) use equaled out with 46.2% White and 48.4% Black reported admissions in 2024. In 2021, Cocaine use among the Black population decreased from 51.4% to 47.6% but remained the top drug of choice.

Appalachian Region: Eastern Ohio and Western Pennsylvania

The Appalachian Regional Commission (ARC) published the *Appalachian Region: A Date Overview From The 2019-2023 American Community Survey.* As part of the process, input was gathered from a diverse group of stakeholders to identify strengths, challenges and opportunities facing the Appalachian Region, along with ideas for strategies and solutions. While the context of the report was to advance economic prosperity, it identified social determinants of health affecting counties falling within the Appalachian Region. These counties include Beaver, Crawford, Erie, Washington and Westmoreland, which are part of Glenbeigh's 2025 CHNA defined service community in Pennsylvania, as well as Ashtabula and Trumbull counties in Ohio.

Appalachian Region within United States

Source: Appalachian Regional Commission Strategic Plan: Synthesis Report July 2021 https://www.arc.gov/wp-content/uploads/2022/01/ARC-Stakeholder-Synthesis-Report-Final-July-2021.pdf

Several areas explored in the ARC report are relevant to Glenbeigh's CHNA. The 2019-2023 report gave updated insight on how the Region was affected by, and people reacted to, economic, health and social impacts. Relevant takeaways on population trends include:

- The Appalachian Region had a population of 26.6 million persons in 2023 – just over one million more residents than in mid-2010. However, compared with the United States growth rate of 8.3 percent, growth in the region has been slower, at four percent.

- The Appalachian portion of eight states lost population between July 2010 and July 2023. And in five of those states – Mississippi, New York, Ohio, Virginia, and West Virginia – the population in Appalachian areas declined by more than three percent. Population loss was most common in counties outside of metropolitan areas. Of the 269 non-metropolitan counties in the region, 176 saw a decrease in population since 2010. Rural counties and counties adjacent to small metropolitan areas were especially susceptible to declining population size, with 76 of the 107 rural Appalachian counties – and 75 of the 117 non-metropolitan counties adjacent to small metros – seeing a decrease in population.

- Many of the high-growth counties, located in southern Appalachia also boast a diversified economy. Of the 72 counties where population growth met or exceeded the U.S. average, 33 were classified as "non-specialized" by the U.S. Department of Agriculture Economic Research Service (ERS) – meaning that their economies were not dependent on a single economic factor or industry. Yet, being a retirement-friendly county may have been the most impactful factor driving population growth in the region. Of the 72 Appalachian counties where population growth exceeded the national average, more than half were also "retirement destination" counties according to ERS.

- In contrast to high-growth counties, 246 of the 423 counties in the region saw a decline in population between July 2010 and July 2023. Of these, more than one in five have been classified as "manufacturing-dependent" by ERS, meaning that manufacturing in those counties accounted for 23 percent or more of the county's earnings or 16 percent of the county's employment. Lack of job opportunities may drive population decline, as six in ten of the 246 counties where population size decreased have been classified as low-employment counties by ERS (where less than 65 percent of adults 25 to 64-years-old were employed).

- Keeping with the national trend, Appalachia's population became older between 2010 and 2023. The region's pace of aging has been similar – albeit slightly slower – than the nation's, with a rise in age of 1.4 years compared with the U.S. increase of 1.9 years during this 13-year period.

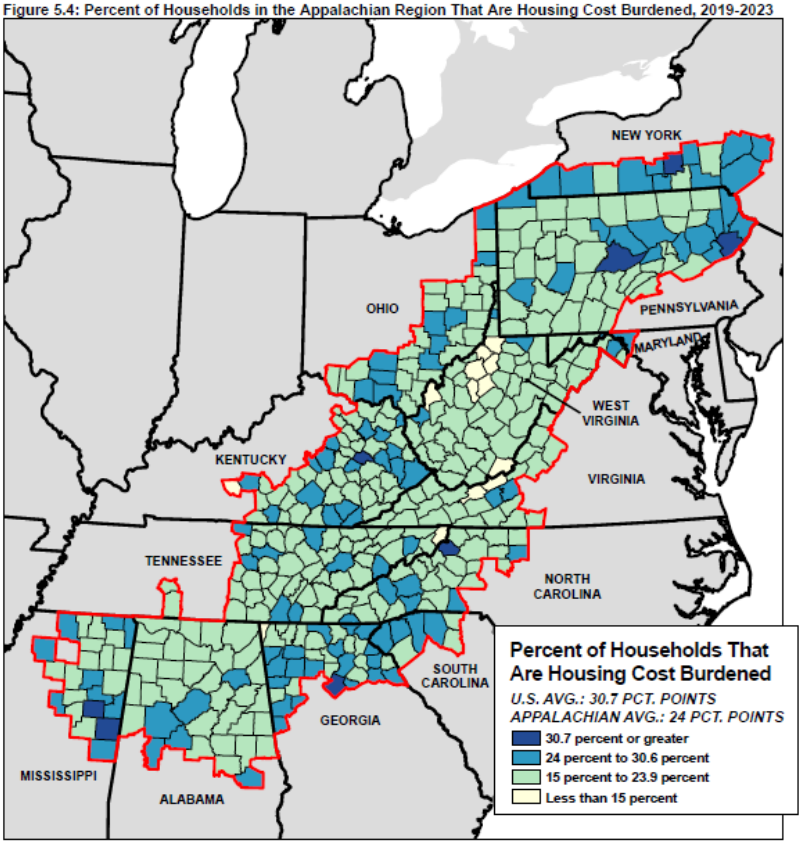
- Between July 1, 2010, and July 1, 2023, the share of people of color in the Appalachian Region rose by 4.8 percentage points, for a total of 21.3 percent (See Tables 3.1 and 3.2). Yet, compared with the national increase of 5.4 percentage points during the same period, the Appalachian Region's racial composition is changing more slowly and there are fewer people of color residing there than in the nation as a whole.

- At 80 percent, the share of Appalachian residents living in family households in 2019-2023 was 0.6 percentage points lower than in the 2014-2018 period This decline was

present in all of the Appalachian sub regions and county types, particularly in Northern and North Central Appalachia where there was a decline of one percentage point. The Appalachian portion of all 13 states saw a decline in the share of residents living in family households, and West Virginia and the Appalachian portions of Alabama, Ohio, Pennsylvania, New York, Mississippi, and Virginia saw declines exceeding the regional average.

- The share of households in the Appalachian Region facing housing cost burden – defined by housing costs exceeding 30 percent of household income – declined by 1.3 percentage points between 2014-2018 and 2019-2023. The prevalence of housing cost burden in the Appalachian Region fell more between the two time periods than in the nation overall (0.8 percentage points), and the decline was seen in all Appalachian sub-regions and county types. Yet, this decline reflects a decrease in cost burden prevalence for owner-occupied households only; during the same period housing cost burden among renters in Appalachia increased slightly (0.1 percentage points).

Figure 5.4: Percent of Households in the Appalachian Region That Are Housing Cost Burdened, 2019-2023



Map Title: Percent of Households that are Housing Cost Burdened, 2019-2023
Data Source: U.S. Census Bureau, 2019-2023 American Community Survey.

The share of households in the Appalachian Region that are housing cost burdened (where housing costs exceed 30 percent of monthly household income) is more than five percentage points lower than the nation as a whole. In 305 counties throughout Appalachia, the share is even lower – at less than 24 percent of households. In fact, the share of cost burdened households exceeds the national average in just eight of Appalachia's 423 counties – including Watauga County, North Carolina and Monroe County, Pennsylvania, where high percentages of vacant seasonal housing and thriving tourism industries may contribute to shortages in available housing and higher costs. Housing a college or university or proximity to major metropolitan areas may contribute to higher housing costs as well- as in the case of Tompkins County, New York (home to Cornell University) and Gwinnett County, Georgia (a suburb of Atlanta).

Source: The Appalachian Region: A Data Overview from the 2019-2023 American Community Survey https://www.arc.gov/report/the-appalachian-region-a-data-overview-from-the-2019-2023-american-community-survey/

Western Pennsylvania

Glenbeigh's defined service area continues to include areas of western Pennsylvania. Four counties, Beaver, Crawford, Erie and Washington, boarder Ohio. Pennsylvania communities continue to be significantly impacted by the use of drugs and alcohol.

Data in the **Overdose Mapping Act Annual Report – 2023 Office of Drug Surveillance and Misuse Prevention and Pennsylvania State Police May 2025** report published by the Pennsylvania Office of Drug Surveillance and Misuse Prevention (ODSMP):

The total number of overdose reversal drugs administered by authorized users to people suspected of overdosing in each county.

There were 4,681 opioid overdose reversal drugs administered by law enforcement to persons suspected of overdosing in Pennsylvania in the ODIN data. Pennsylvania had an overall rate of 3.61 per 10,000 population for overdose reversal drug administrations, with 24 counties exceeding the state rate. Erie County had the highest rate, followed by Blair, Cambria, Mercer, and Elk counties.

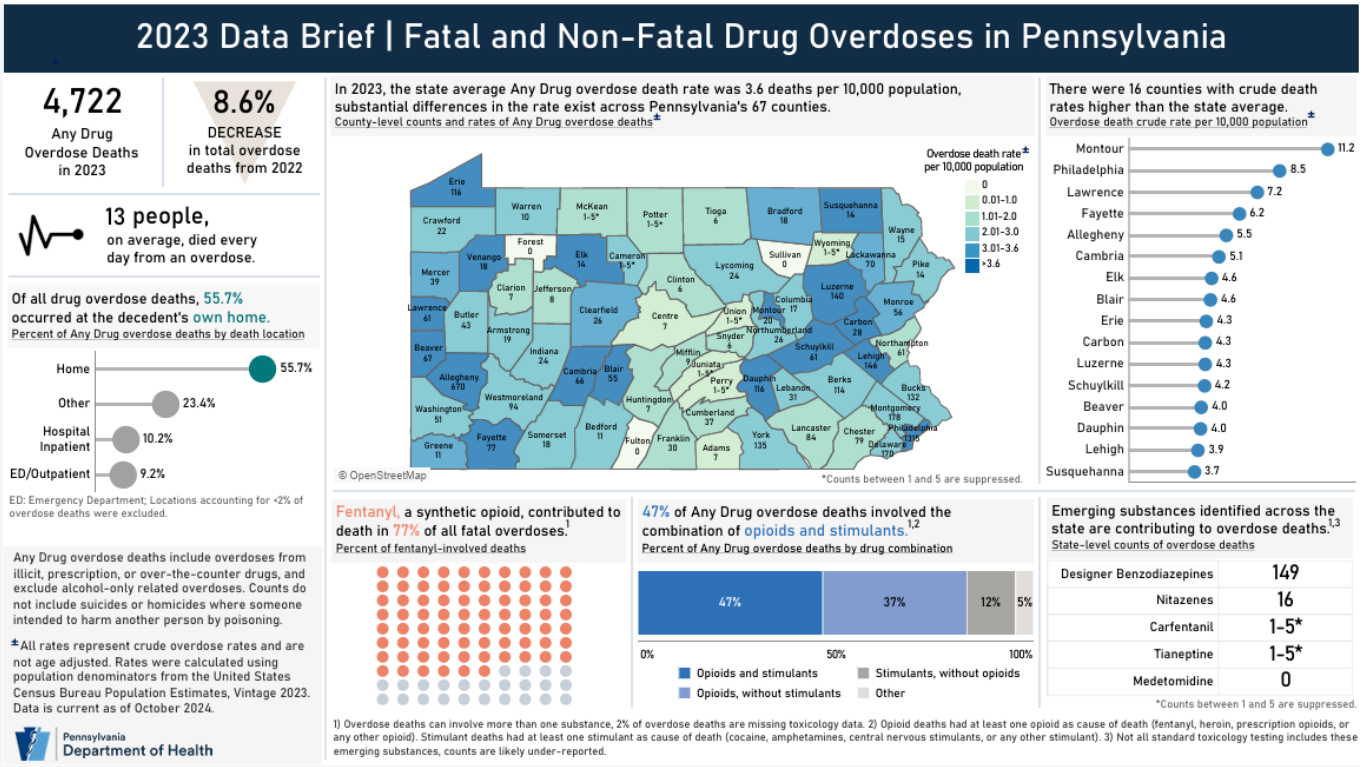
The total number of reported overdose deaths involving any opioid or synthetic opioid in each county.

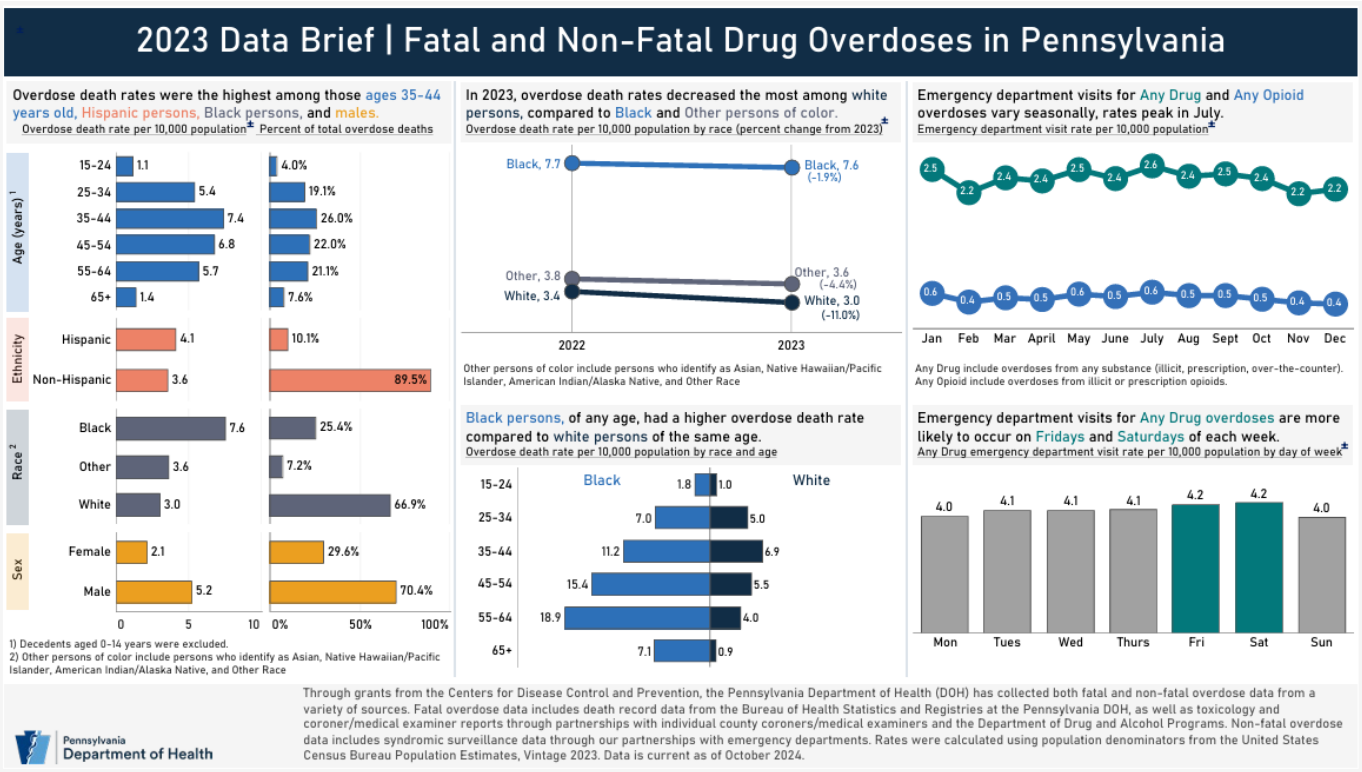
In the PA DOH data, there were 3,926 fatal overdoses involving opioids compared to the 968 in the ODIN data. Pennsylvania had an opioid overdose death rate of 3.03 per 10,000 population and 15 counties exceeding the state rate. The highest rate was in Philadelphia County, followed by Lawrence, Montour, Fayette, and Allegheny counties. From the ODIN data, Pennsylvania had a rate 0.75 per 10,000 population, and there were 38 counties with rates greater than the state. Susquehanna had the highest rate of opioid overdose deaths in the ODIN data; Dauphin, Erie, Elk, and Fayette counties were the next highest.

Nonfatal suspected overdoses:

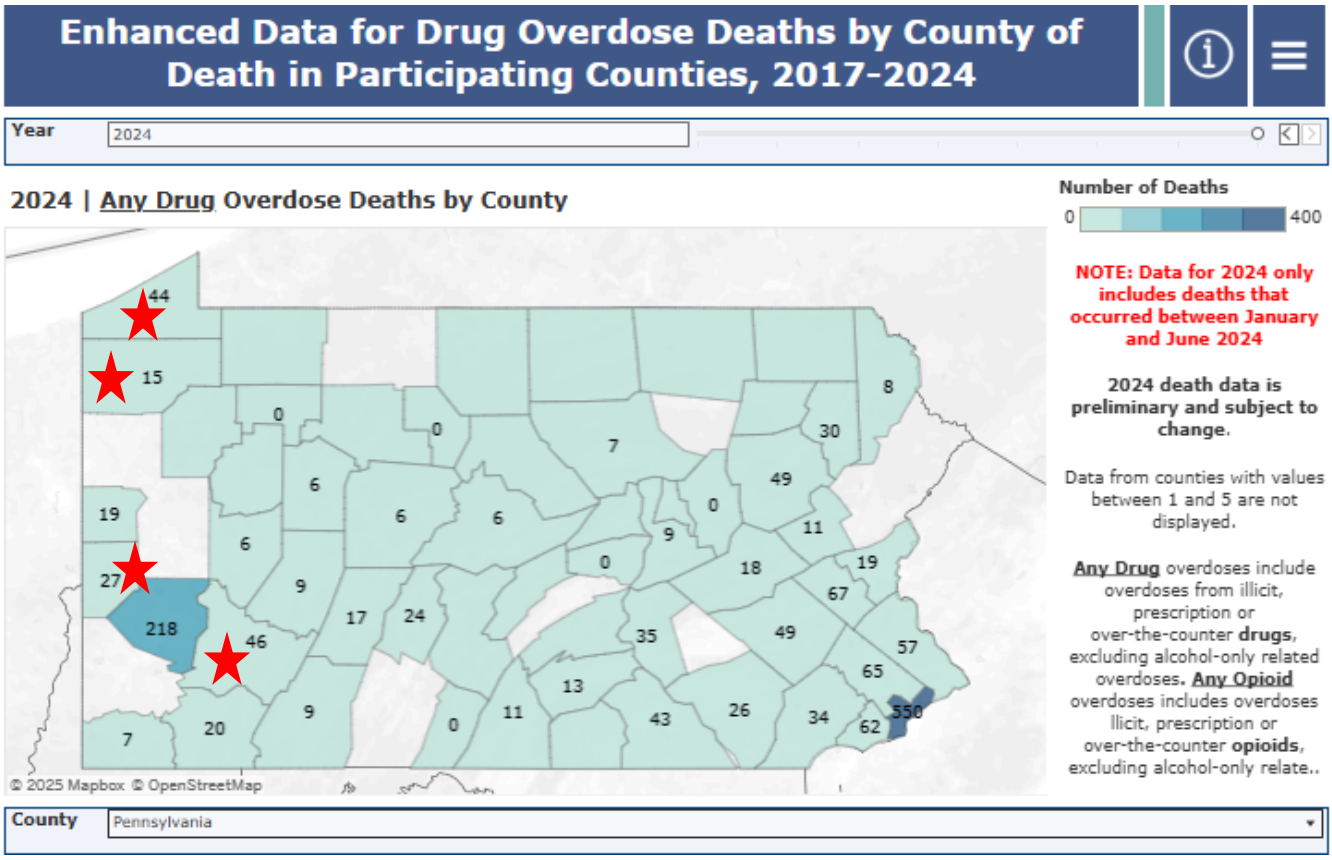
- 37,371 nonfatal suspected overdoses; rate of 28.83 per 10,000 population (PA DOH data).
- 6,452 nonfatal suspected overdoses; rate of 4.98 per 10,000 population (ODIN data).

Source: Commonwealth of Pennsylvania
https://www.pa.gov/agencies/health/healthcare-and-public-health-professionals/pdmp/data





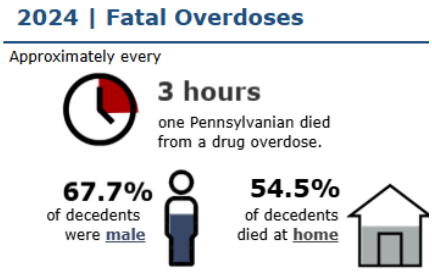
Source: Pennsylvania Office of Drug Surveillance and Misuse Prevention
https://www.pa.gov/agencies/health/healthcare-and-public-health-professionals/pdmp/data

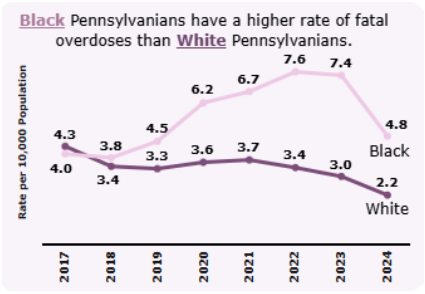


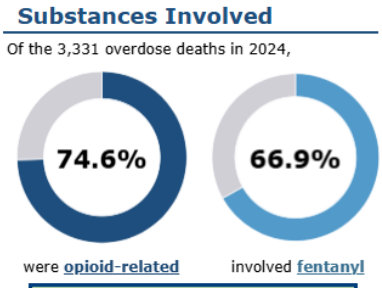
Source: Pennsylvania Office of Drug Surveillance and Misuse Prevention
https://public.tableau.com/app/profile/pennsylvania.pdmp/viz/PennsylvaniaODSMPDrugOverdoseSurveillanceInteractiveDataReport/Contents

Beaver County Drug Overdose Deaths: 27
Crawford County Drug Overdose Deaths: 15
Erie County Drug Overdose Deaths: 44
Washington County Drug Overdose Deaths: **
Westmoreland Drug Overdose Deaths:46
PA Total Drug Overdose Deaths: 1,680

* 2024 statistics only include data from January to June 2024 and do not reflect an entire year.
** Data either did not participate by reporting data or data was unavailable.







County Profile: 2015-2019 Share this Page | Print this Page

Beaver County, PA

Drug Overdose Mortality Rate

71.3 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

344	165,833	Urban
Total Deaths	Population	Urban / Rural

Choose County Profile Data Time Period

- ○ 2010-2014
- ◉ 2015-2019
- ○ Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Beaver County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	**89.5%**	76.4%	81.3%	60.7%
African American (non-Hispanic)	**5.7%**	10.7%	9.6%	12.3%
Hispanic or Latino	**1.6%**	7.3%	5.1%	18.0%
Other (non-Hispanic)	**3.2%**	5.6%	4.0%	9.0%
Age				
Under 15	**16.0%**	17.1%	17.5%	18.7%
15-64	**63.1%**	65.0%	64.6%	65.6%
65+	**20.9%**	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	**93.1%**	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	**24.7%**	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	**13.2%**	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	**$57,807**	$61,744	$46,074	$62,843
Poverty Rate	**11.0%**	12.4%	15.2%	13.4%
Unemployment Rate	**4.9%**	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	**8.2%**	4.3%	4.1%	4.8%
Mining	**0.3%**	0.9%	1.1%	1.3%
Manufacturing	**12.2%**	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	**22.2%**	19.2%	19.7%	18.9%

County Profile: 2015-2019 Share this Page | Print this Page

Crawford County, PA

Drug Overdose Mortality Rate

55.2 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

134	85,665	Rural
Total Deaths	Population	Urban / Rural

Choose County Profile Data Time Period

- ○ 2010-2014
- ◉ 2015-2019
- ○ Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Crawford County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	**94.8%**	76.4%	81.3%	60.7%
African American (non-Hispanic)	**1.6%**	10.7%	9.6%	12.3%
Hispanic or Latino	**1.3%**	7.3%	5.1%	18.0%
Other (non-Hispanic)	**2.3%**	5.6%	4.0%	9.0%
Age				
Under 15	**17.1%**	17.1%	17.5%	18.7%
15-64	**62.9%**	65.0%	64.6%	65.6%
65+	**20.0%**	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	**89.0%**	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	**21.1%**	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	**14.3%**	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	**$50,304**	$61,744	$46,074	$62,843
Poverty Rate	**13.2%**	12.4%	15.2%	13.4%
Unemployment Rate	**5.3%**	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	**2.7%**	4.3%	4.1%	4.8%
Mining	**2.1%**	0.9%	1.1%	1.3%
Manufacturing	**24.9%**	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	**14.9%**	19.2%	19.7%	18.9%

Source: Appalachian Regional Commission and NORC at the University of Chicago
https://overdosemappingtool.norc.org/

County Profile: 2015-2019 Share this Page | Print this Page

Erie County, PA

Drug Overdose Mortality Rate

46.3 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

386 Total Deaths | 273,835 Population | Urban Urban / Rural

Choose County Profile Data Time Period

- 2010-2014
- (•) 2015-2019
- Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Erie County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	**84.2%**	76.4%	81.3%	60.7%
African American (non-Hispanic)	**6.8%**	10.7%	9.6%	12.3%
Hispanic or Latino	**4.2%**	7.3%	5.1%	18.0%
Other (non-Hispanic)	**4.7%**	5.6%	4.0%	9.0%
Age				
Under 15	**17.7%**	17.1%	17.5%	18.7%
15-64	**65.0%**	65.0%	64.6%	65.6%
65+	**17.4%**	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	**91.3%**	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	**27.9%**	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	**12.5%**	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	**$51,529**	$61,744	$46,074	$62,843
Poverty Rate	**16.0%**	12.4%	15.2%	13.4%
Unemployment Rate	**5.4%**	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	**3.2%**	4.3%	4.1%	4.8%
Mining	**0.4%**	0.9%	1.1%	1.3%
Manufacturing	**16.5%**	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	**17.1%**	19.2%	19.7%	18.9%

County Profile: 2015-2019 Share this Page | Print this Page

Washington County, PA

Drug Overdose Mortality Rate

74.7 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

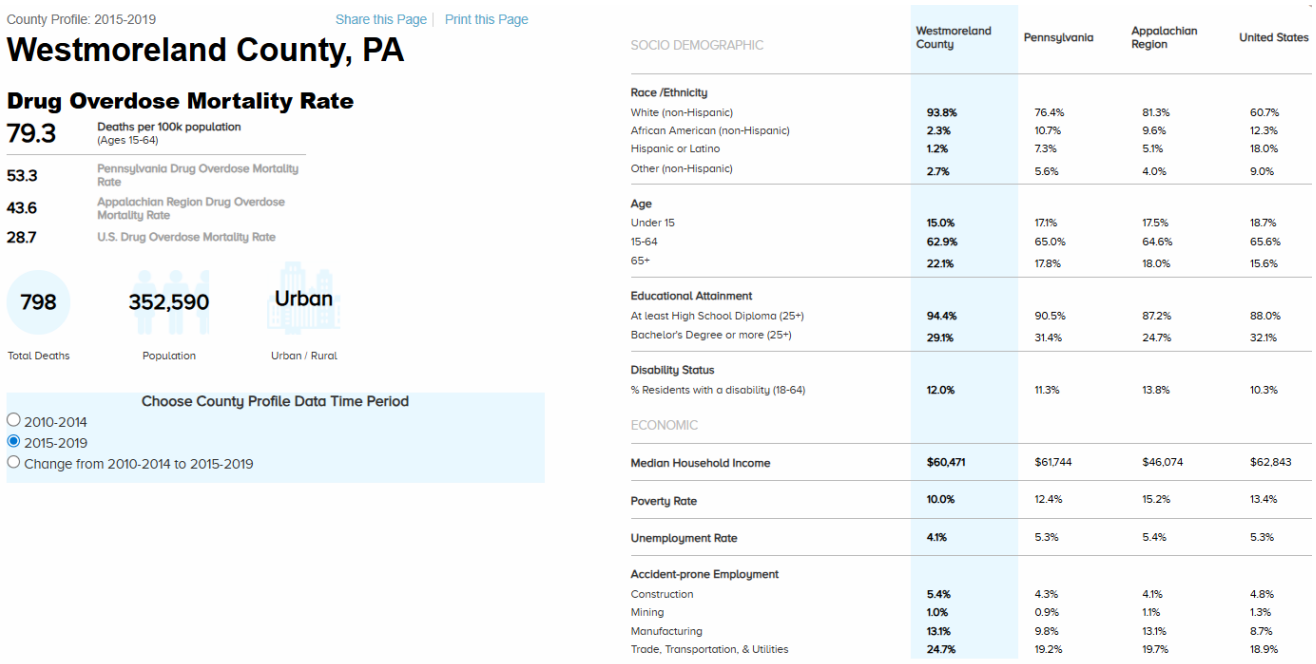
442 Total Deaths | 207,212 Population | Urban Urban / Rural

Choose County Profile Data Time Period

- 2010-2014
- (•) 2015-2019
- Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Washington County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	**92.2%**	76.4%	81.3%	60.7%
African American (non-Hispanic)	**3.0%**	10.7%	9.6%	12.3%
Hispanic or Latino	**1.7%**	7.3%	5.1%	18.0%
Other (non-Hispanic)	**3.1%**	5.6%	4.0%	9.0%
Age				
Under 15	**16.1%**	17.1%	17.5%	18.7%
15-64	**63.8%**	65.0%	64.6%	65.6%
65+	**20.1%**	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	**93.1%**	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	**30.0%**	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	**11.9%**	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	**$63,543**	$61,744	$46,074	$62,843
Poverty Rate	**9.2%**	12.4%	15.2%	13.4%
Unemployment Rate	**5.0%**	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	**8.0%**	4.3%	4.1%	4.8%
Mining	**4.9%**	0.9%	1.1%	1.3%
Manufacturing	**10.1%**	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	**18.7%**	19.2%	19.7%	18.9%

Source: Appalachian Regional Commission and NORC at the University of Chicago
https://overdosemappingtool.norc.org/



County Profile: 2015-2019 Share this Page | Print this Page

Westmoreland County, PA

Drug Overdose Mortality Rate

79.3 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

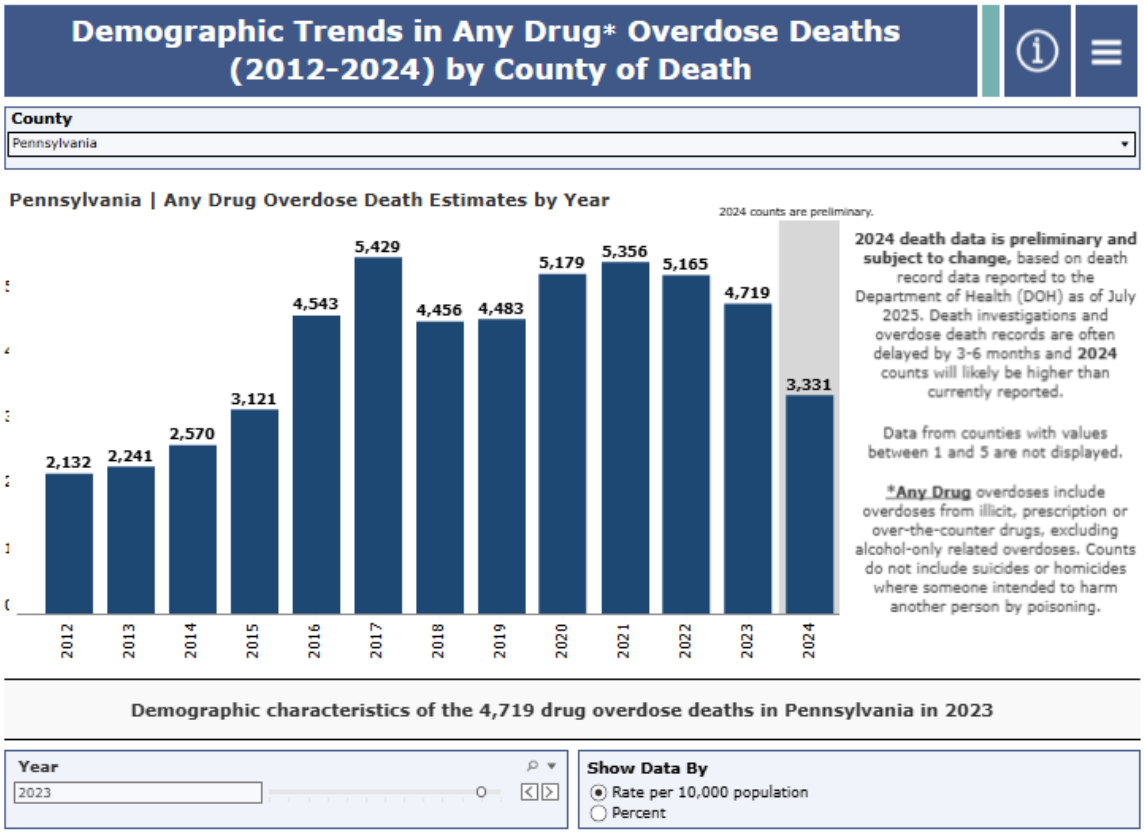
798 Total Deaths | 352,590 Population | Urban / Rural

Choose County Profile Data Time Period

- 2010-2014
- 2015-2019
- Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Westmoreland County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	93.8%	76.4%	81.3%	60.7%
African American (non-Hispanic)	2.3%	10.7%	9.6%	12.3%
Hispanic or Latino	1.2%	7.3%	5.1%	18.0%
Other (non-Hispanic)	2.7%	5.6%	4.0%	9.0%
Age				
Under 15	15.0%	17.1%	17.5%	18.7%
15-64	62.9%	65.0%	64.6%	65.6%
65+	22.1%	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	94.4%	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	29.1%	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	12.0%	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	$60,471	$61,744	$46,074	$62,843
Poverty Rate	10.0%	12.4%	15.2%	13.4%
Unemployment Rate	4.1%	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	5.4%	4.3%	4.1%	4.8%
Mining	1.0%	0.9%	1.1%	1.3%
Manufacturing	13.1%	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	24.7%	19.2%	19.7%	18.9%

Source: Appalachian Regional Commission and NORC at the University of Chicago
https://overdosemappingtool.norc.org/



Source: Pennsylvania Office of Drug Surveillance and Misuse Prevention
https://public.tableau.com/app/profile/pennsylvania.pdmp/viz/PennsylvaniaODSMPDrugOverdoseSurveillanceInteractiveDataReport/Contents

Source: Pennsylvania Office of Drug Surveillance and Misuse Prevention
https://public.tableau.com/app/profile/pennsylvania.pdmp/viz/PennsylvaniaODSMPDrugOverdoseSurveillanceInteractiveDataReport/Contents

2024 Treatment Episode Data Set: Admissions (TEDS-A) Pennsylvania

Pennsylvania TEDS-A aged 12 years and older, by primary substance use and sex, age at admission, race, and ethnicity: Percent, 2024

PENNSYLVANIA	All Substances	Alcohol Only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants
Total (Number)	22,170	5,424	3,406	3,696	1,911	1,423	747	2,241	2,810	43	235	14	54	112	8
Total	100	24.5	15.4	16.7	8.6	6.4	3.4	10.1	12.7	0.2	1.1	0.1	0.2	0.5	0
SEX*	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**	**Tranquilizers**	**Sedatives**	**Hallucinogens**	**PCP**	**Inhalants**
Male	73.9	76.5	79.8	69.2	70	68	75.8	77.8	70.5	81.4	66	50	81.5	75.9	62.5
Female	26.1	23.5	20.2	30.8	30	32	24.2	22.2	29.5	18.6	34	50	18.5	24.1	37.5
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

RACE	All Substances	Alcohol Only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants
White	71.6	75.4	67.3	76.5	74.6	45.7	57	58.9	90.3	79.1	73.6	78.6	42.6	10.7	87.5
Black or African-American	17.5	11.5	23.2	12.1	16.4	44	27.3	25.1	5	11.6	17.9	14.3	37	77.7	12.5
American Indian or Alaska Native	0.2	0.1	0.2	0.2	0.3	0.2	0.1	0.2	0.1	2.3	0.4	0	0	0	0
Asian or Native Hawaiian or Other Pacific Islander	0.4	0.9	0.4	0.3	0.2	0.3	0.5	0.4	0	0	0	0	0	0.9	0
Other	7.3	9	6.3	7.8	6.1	6.9	10.2	9.9	3	7	6	7.1	11.1	8.9	0
Unknown	3	3	2.6	3.1	2.5	2.9	4.8	5.5	1.6	0	2.1	0	9.3	1.8	0
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
ETHNICITY	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**	**Tranquilizers**	**Sedatives**	**Hallucinogens**	**PCP**	**Inhalants**
Hispanic or Latino	10.6	12.3	8.2	10.7	8.9	11	16.2	17.7	4.2	2.3	7.7	0	18.5	12.5	12.5
Not Hispanic or Latino	83.8	82	85.3	84.5	83.8	83.2	78.6	77.1	91.8	95.3	86.8	85.7	64.8	76.8	75
Unknown	5.6	5.7	6.5	4.8	7.3	5.8	5.2	5.2	4.1	2.3	5.5	14.3	16.7	10.7	12.5
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)

https://www.samhsa.gov/data/quick-statistics-results?parent_override_data_collection_id=1011&location_id=238&data_collection_id=1397&year=2024&parent_data_collection_id=1183

TEDS data for Pennsylvania show that White use outpaces every other demographic in both alcohol and other substance use. Cocaine (smoked) and Hallucinogens are the two drugs of choice where a second demographic, Black users (44.0 and 37), have numbers close to White users (45.7 and 42.6). PCP use is exceptionally high in the Black population, outpacing all other demographics at 77.7. At the same time, Amphetamine use among the White population is the greatest among all demographics at 90.3.

Population Change

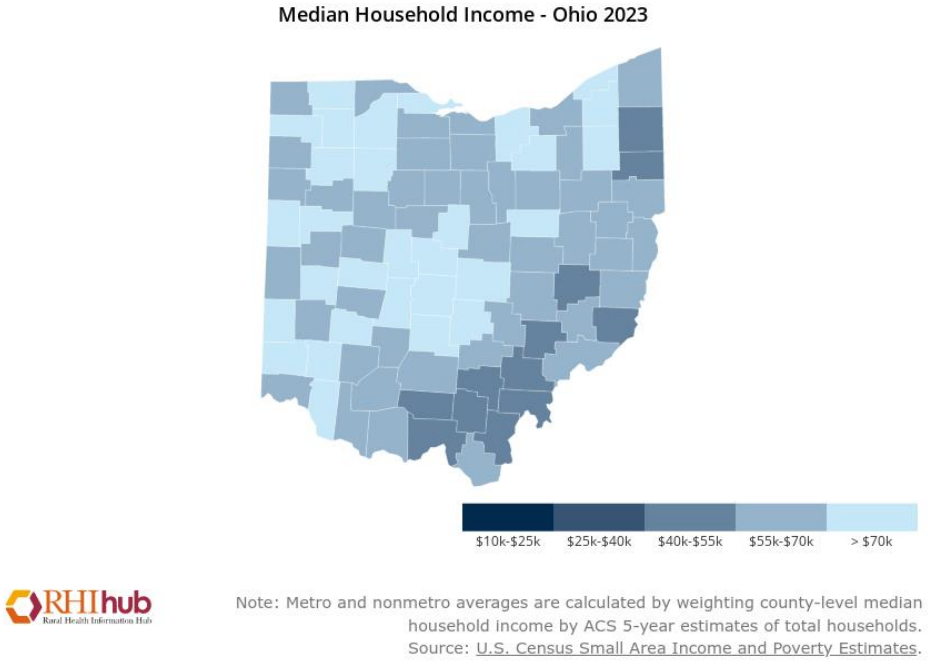
Population fluctuations can transform communities. Traditionally, population decline often goes hand-in-hand with reduced employment opportunities, limited pay or career growth opportunities, increased taxation and a loss of healthcare as well as other services. Drug and alcohol use rates tend to be higher in areas with higher levels of persons living in poverty, higher unemployment rates, and lower median household income. Significant population growth can overtax systems. It can cause a lack of beds in healthcare settings or reduced access to assistance at social service or other agencies. Glenbeigh experienced a service area shift from the 2022 CHNA, which is why historical data is not presented for all counties. Despite state and national population growth, Glenbeigh's service area continues to experience a population decrease. Westmoreland County, Pennsylvania, is the exception with a reported population increase.

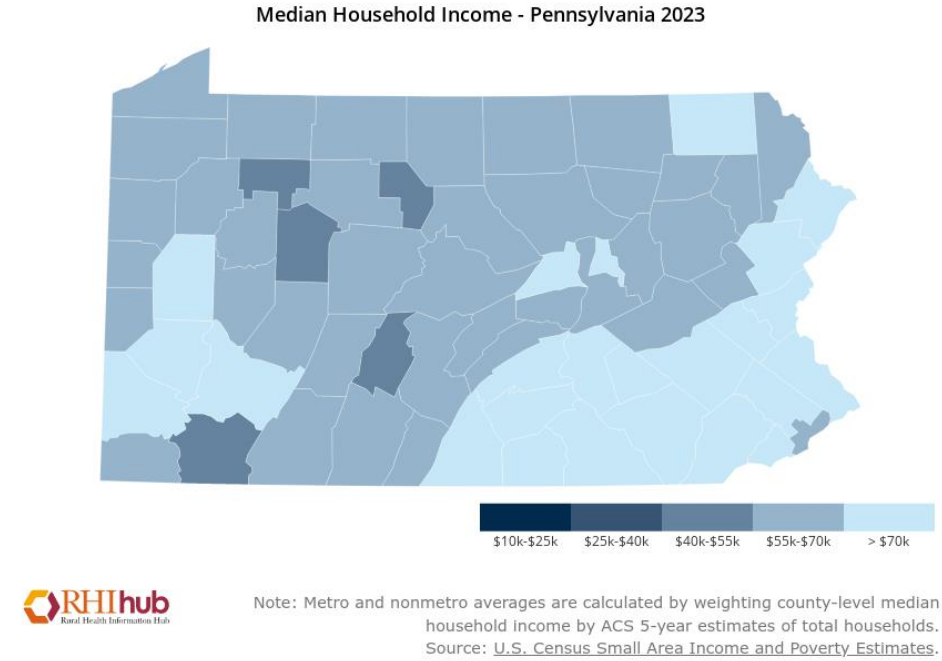
Population Data

	2010 Population	2020 Population	2024 Population
United States	**308,745,538**	**331,893,745**	**340,110,990**
Ohio	**11,536,504**	**11,799,448**	**11,883,304**
Ashtabula County	101,497	97,574	96,906
Cuyahoga County	1,280,122	1,264,817	1,240,594
Stark County			374,091
Summit County	541,781	540,428	538,370
Trumbull County	210,312	201,997	200,300
Pennsylvania	**12,702,379**	**13,002,700**	**13,078,751**
Beaver County			165,540
Crawford County			82,089
Erie County	280,566	270,876	267,750
Washington County	207,820	209,349	210,434
Westmoreland County			350,935

Source: U.S. Census Bureau, Population, percent change – April 1, 2010 to July 1, 2018, (V2018)
https://www.census.gov/quickfacts/fact/table/US/PST045218
2024 Data from: U.S. Census Bureau at https://data.census.gov/advanced

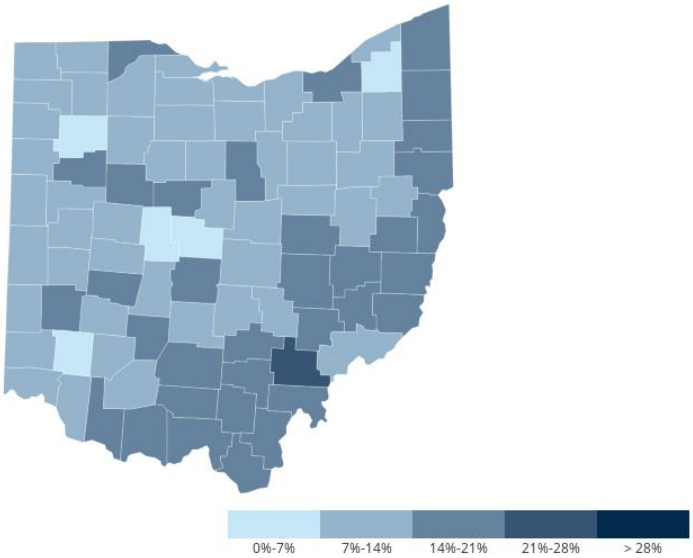
Social Determinants 2023





Source: Rural Health Information Hub https://www.ruralhealthinfo.org/data-explorer?id=213&state

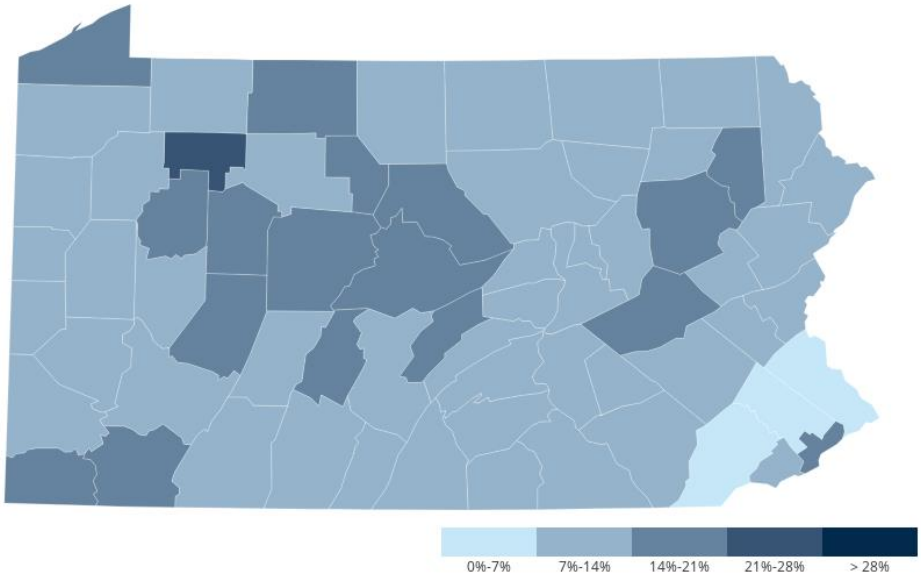
Poverty - Ohio 2023



RHIhub Rural Health Information Hub

Source: U.S. Census Small Area Income and Poverty Estimates.

Poverty - Pennsylvania 2023

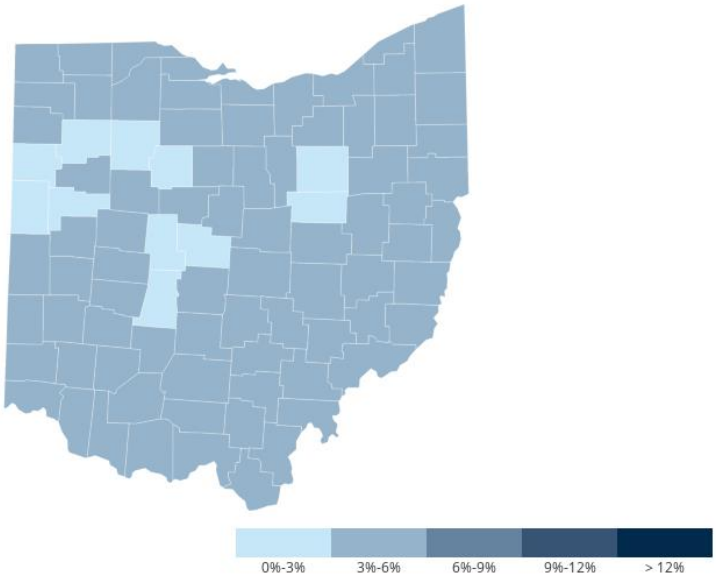


RHIhub Rural Health Information Hub

Source: U.S. Census Small Area Income and Poverty Estimates.

Source: Rural Health Information Hub https://www.ruralhealthinfo.org/data-explorer?id=213&state

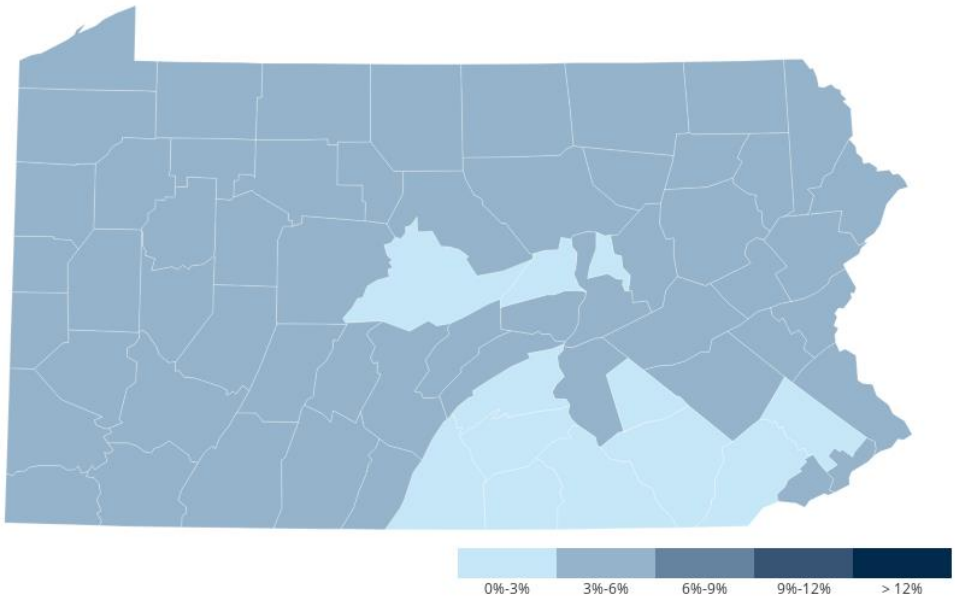
Unemployment Rate - Ohio 2023



RHIhub Rural Health Information Hub

Source: USDA Economic Research Service.

Unemployment Rate - Pennsylvania 2023



RHIhub Rural Health Information Hub

Source: USDA Economic Research Service.

Source: Rural Health Information Hub https://www.ruralhealthinfo.org/data-explorer?id=213&state

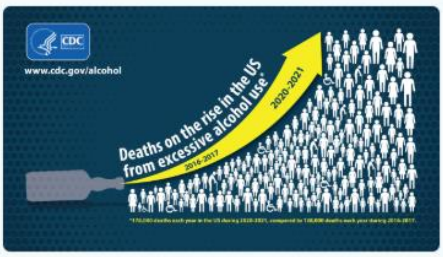
The Centers for Disease Control and Prevention attributes specific economic costs to excessive alcohol use. These include: an overall national cost of $249 billion, which equates to roughly $2.05 per drink or $807 per person; losses in workplace productivity accounted for 72% of the total cost, health care expenses at 11% and other costs were due to a combination of criminal justice expenses, motor vehicle crash costs and property damage. Excessive alcohol consumption cost Ohio $8.5 billion in 2010, the latest published data available from the CDC.

Facts About U.S. Deaths from Excessive Alcohol Use

For Everyone
AUGUST 6, 2024

KEY POINTS

- Excessive alcohol use is a leading preventable cause of death in the United States.
- About 178,000 people die from excessive drinking each year.
- These deaths occur from both drinking alcohol over several years or drinking too much on one occasion.
- Everyone can take steps to protect their own and others' health and learn about proven ways to prevent excessive alcohol use.



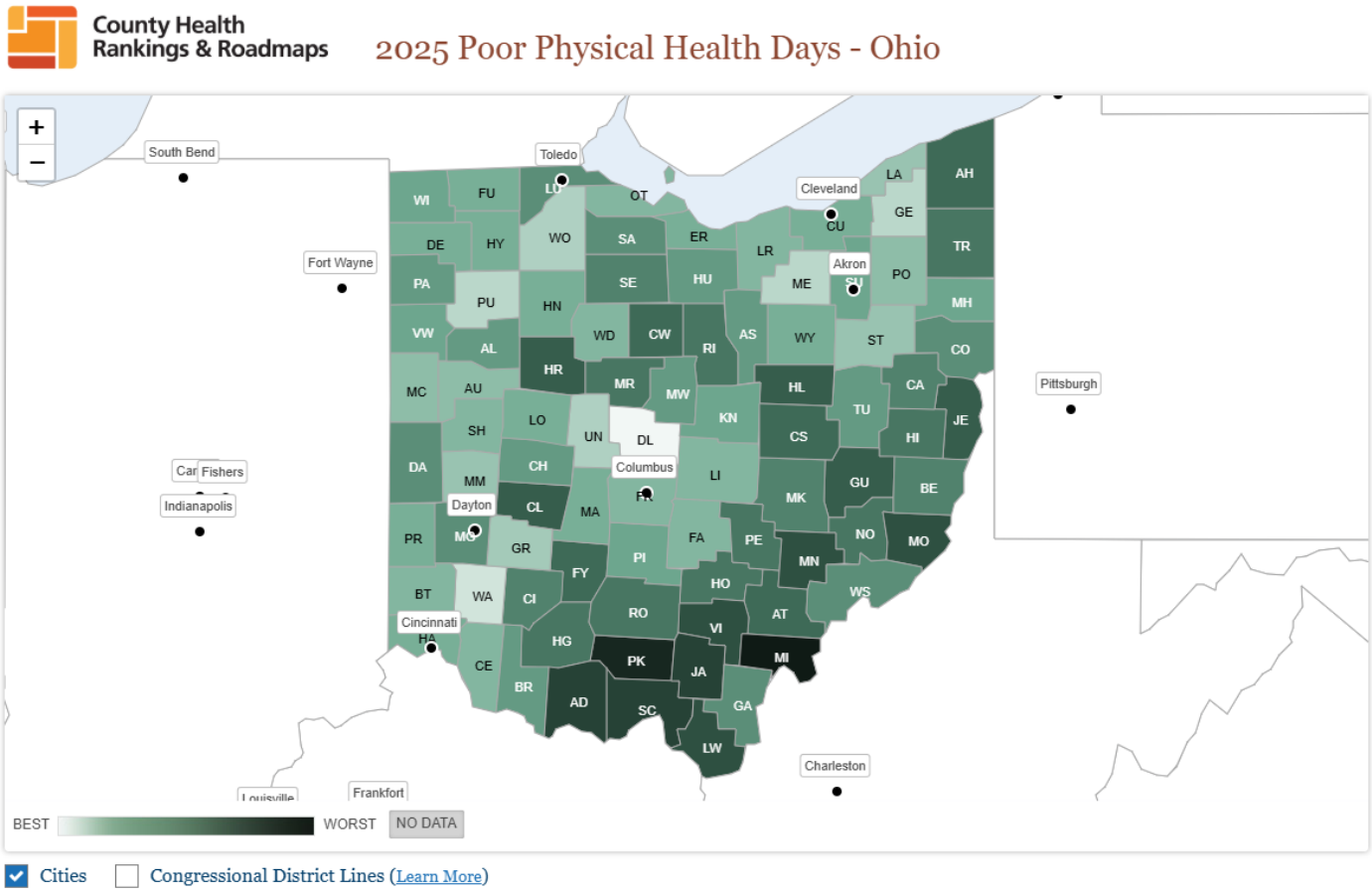
U.S. deaths each year (2020–2021)

Excessive alcohol use:

Source: Centers for Disease Control: https://www.cdc.gov/alcohol/facts-stats/index.html

County Health Rankings 2025 Data – Ohio

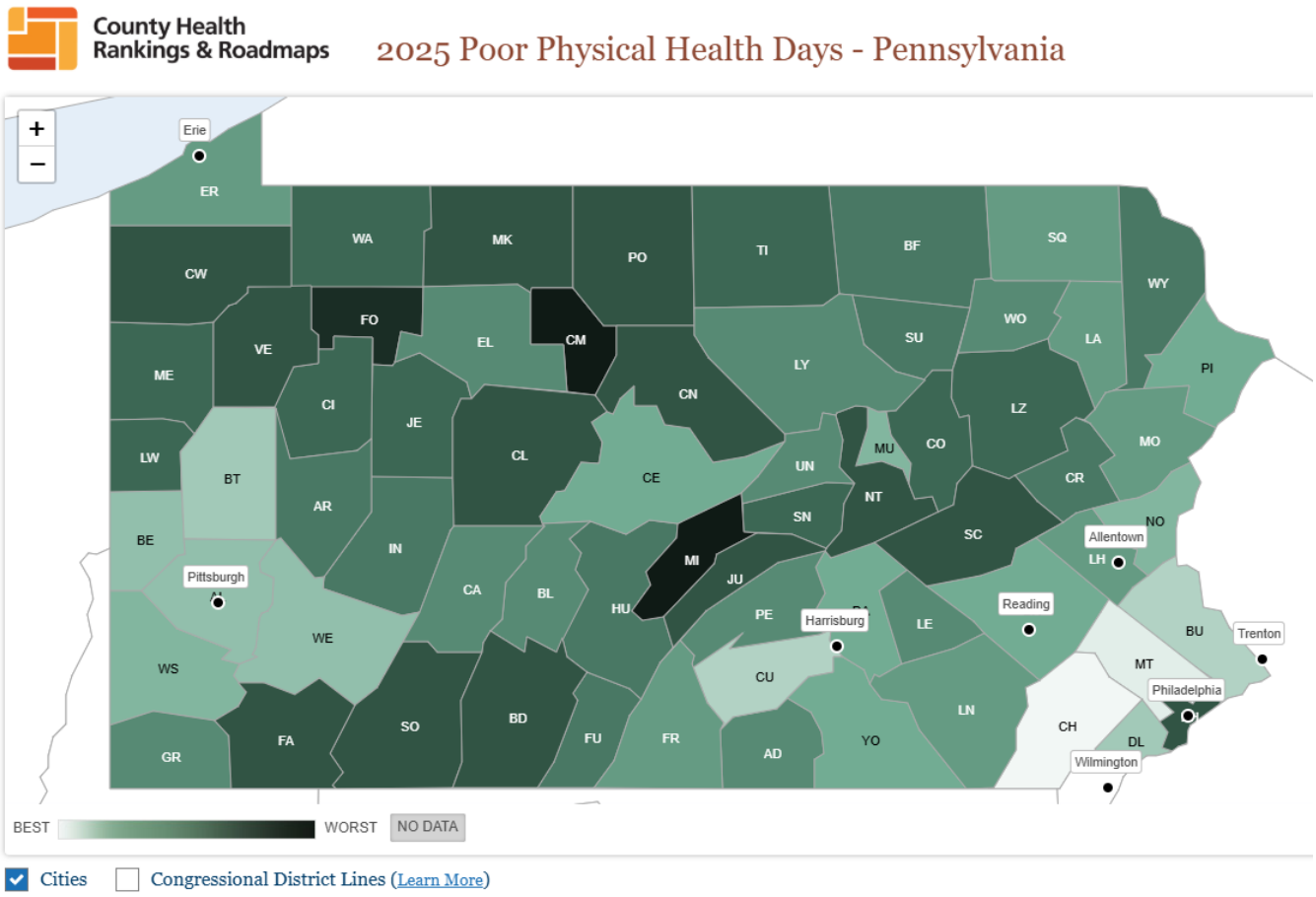
Quality of life	Ohio	United States
Poor Physical Health Days	4.3	3.9
Low Birth Weight	9%	8%
Poor Mental Health Days	6.1	5.1
Poor or Fair Health	18%	17%



Source: County Health Rankings and Roadmaps https://www.countyhealthrankings.org/health-data/

County Health Rankings 2025 - Pennsylvania

Quality of life	Pennsylvania	United States
Poor Physical Health Days	3.9	3.9
Low Birth Weight	8%	8%
Poor Mental Health Days	5.1	5.1
Poor or Fair Health	17%	17%



Source: County Health Rankings and Roadmaps https://www.countyhealthrankings.org/health-data/

Access to Healthcare

Access to Healthcare by County

	% Without Health Insurance (2024)	Mental Health Providers* (2024)
United States	**N/A**	**N/A**
Ohio	**8.0%**	**290:1**
Ashtabula	11.0%	420:1
Cuyahoga	8.0%	200:1
Stark	8.0%	270:1
Summit	8.0%	260:1
Trumbull	10.0%	420:1
Pennsylvania	**7.0%**	**350:1**
Beaver	5.0%	600:1
Crawford	10.0%	1,190:1
Erie	7.0%	350:1
Washington	6.0%	590:1
Westmoreland	5.0%	450:1

Comparing data from Glenbeigh's 2022 CHNA, the percentage of adults without health insurance remained relatively the same with a slight decrease in Summit County of 1%. Ashtabula and Trumbull counties continue to have higher percentages of uninsured adults than the Ohio state average.

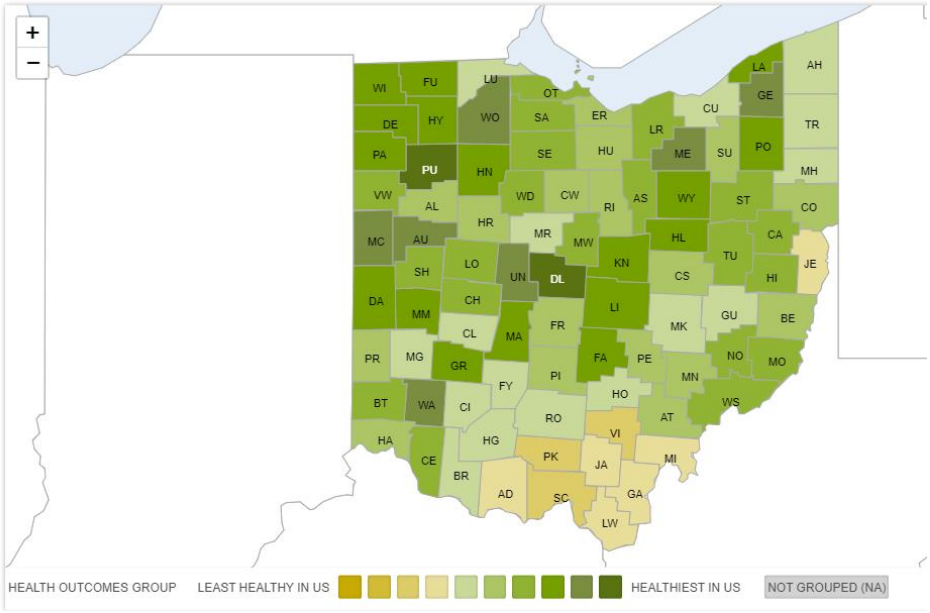
While inequities continue to exist for access to mental health providers, which is evidenced by the ratio of providers to the general population in each county, the number of mental health providers has increased since the 2022 CHNA, lowering the ratio. Crawford County, Pennsylvania was added to the defined service area in 2025 and has a significantly high number of adults without health insurance and ratio of mental health providers.

Measure Methods: Uninsured Adults is the percentage of the population ages 18 to 64 that have no health insurance coverage in a given county. Uninsured Adults was created using complex statistical modeling. Modeling generates more stable estimates for places with small numbers of residents or survey responses. There are also drawbacks to using modeled data. The smaller the population or sample size of a county, the more the estimates are derived from the model itself and the less they are based on survey responses. Models make statistical assumptions about relationships that may not hold in all cases. Finally, there is no perfect model and each model generally has limitations specific to their methods.

Source: County Health Rankings. * Ratio shows population: mental health providers.
https://www.countyhealthrankings.org/health-data/

County Health Rankings & Roadmaps

2024 Health Outcomes - Ohio



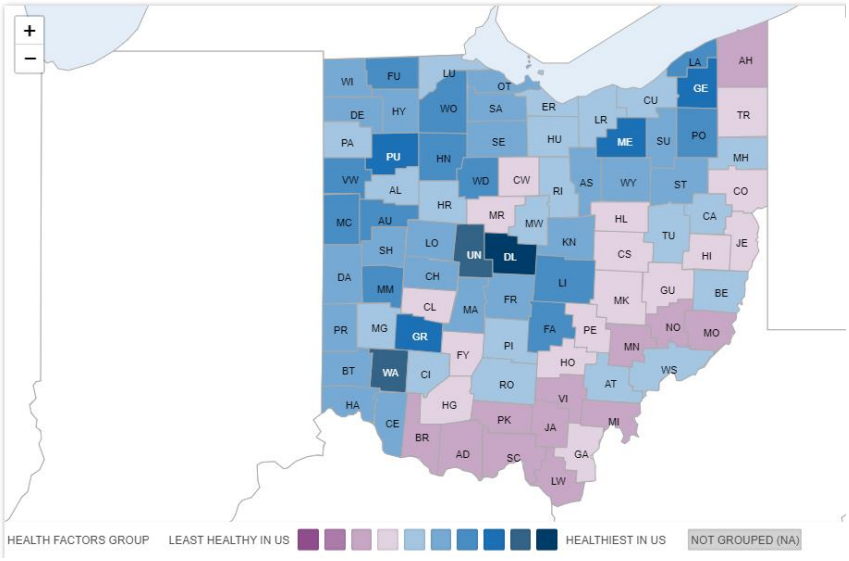
The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest counties in the state are dark green. Ranks are based on two types of measures: how long people live and how healthy people feel while alive.

Note: Ohio has a total of 88 counties.

The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic and physical environment factors.

County Health Rankings & Roadmaps

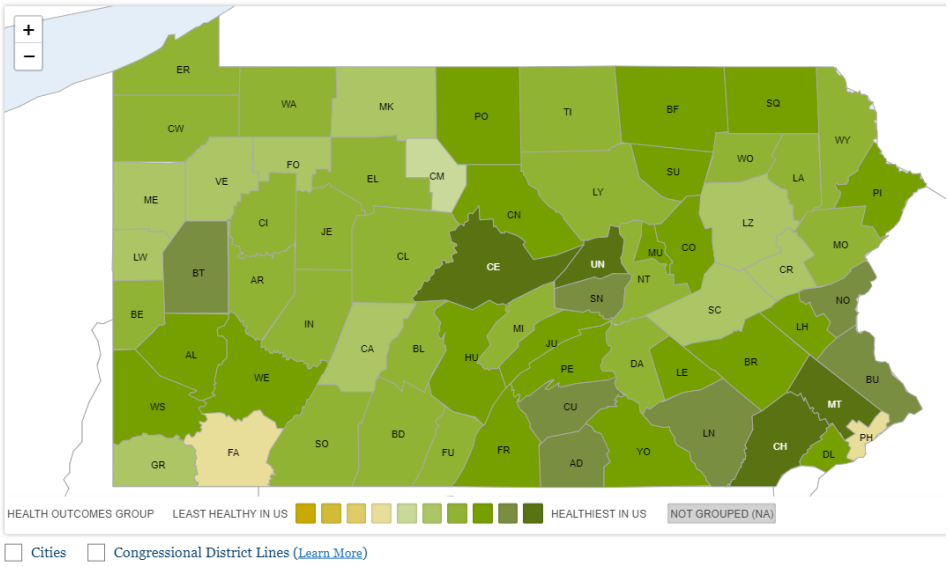
2024 Health Factors - Ohio



Source: County Health Rankings: 2024 https://www.countyhealthrankings.org/

County Health Rankings & Roadmaps

2024 Health Outcomes - Pennsylvania



The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest counties in the state are dark green. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.

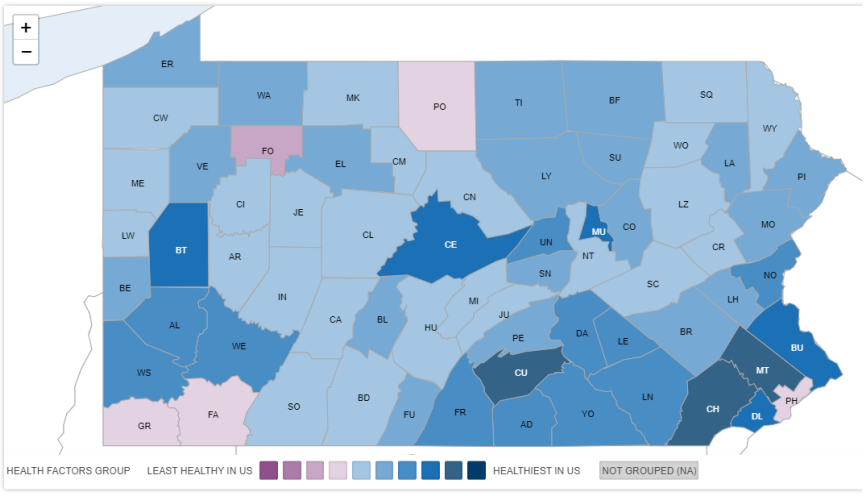
Erie, Crawford and Beaver counties rank mid-level while Washington and Westmoreland counties rank at a healthier level.

Note: Pennsylvania has a total of 67 counties.

The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

County Health Rankings & Roadmaps

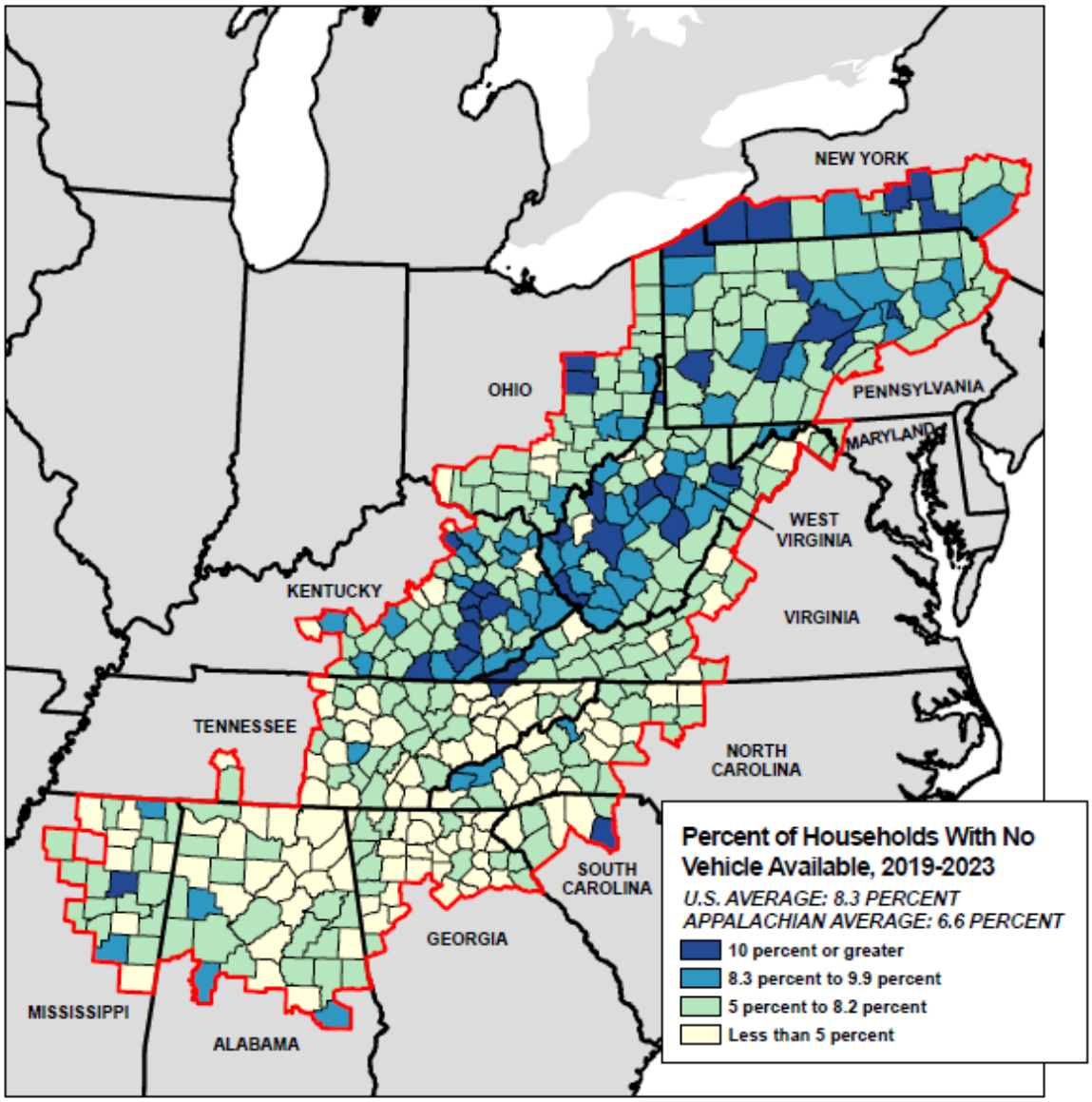
2024 Health Factors - Pennsylvania



Source: County Health Rankings: https://www.countyhealthrankings.org/health-data/pennsylvania?year=2025&measure=Population+Health+and+Well-being&tab=1&mapView=state

Transportation

Figure 8.3: Percent of Households in the Appalachian Region With No Vehicle Available, 2019-2023



Map Title: Percent of Households in the Appalachian Region With No Vehicle Available, 2019-2023
Data Source: U.S. Census Bureau, 2019-2023 American Community Survey.

Having a reliable mode of transportation can be an important part of many household members' abilities to gain and keep employment. Yet in Appalachia, 6.6 percent of households have no vehicle available to get to current and/or potential employment. While this is lower than the national average of 8.3 percent, that is not the case in much of the Appalachian Region. In fact, there were 35 Appalachian counties where at least one in 10 households had no vehicle available; 29 of these counties were in four states – New York, Pennsylvania, West Virginia, and Kentucky. Yet in 115 other counties in the region, less than five percent of households were without any motor vehicle. South Central and Southern Appalachia had 96 of the counties in the latter group.

Source: The Appalachian Region: A Data Overview from the 2019-2023 American Community Survey
https://www.arc.gov/report/the-appalachian-region-a-data-overview-from-the-2019-2023-american-community-survey/

The Ashtabula County 2025 Community Health Needs Assessment examined the demographic and household characteristics of the population in Ashtabula County. The county covers 703 square miles and is predominately rural. Glenbeigh's inpatient treatment center is located near the center of the county in Rock Creek, Ohio. Individuals surveyed correspond to reports that transportation remains a significant barrier to accessing services, healthcare and necessities such as groceries and sundries. According to the Ashtabula County 2025 CHNA, the number of households in the county without a vehicle is 7.8%, a decrease from 9.0% in 2022. For the entire state of Ohio, the average is 7.4%, a decrease from 7.7% in 2022.

According to the American Public Transportation Association, 45% of Americans have no access to public transportation, which is no significant change from 2022. Within Glenbeigh's defined service community, limited public transportation is available in urban areas. Rural populations rely on private transportation.

HOUSEHOLD CHARACTERISTICS		ASHTABULA CITY	CONNEAUT CITY	ASHTABULA COUNTY	OHIO
Marital Status (15+ years old)	Currently married	35.2%	36.6%	45.6%	47.1%
	Separated	3.9%	3.2%	2.0%	1.5%
	Divorced	17.4%	14.6%	14.7%	11.9%
	Widowed	7.2%	7.4%	8.0%	6.2%
	Never Married	36.3%	38.2%	29.7%	33.3%
Household Size	Household size (avg)	2.3	2.3	2.4	2.4
Household Members	Kids present	28.8%	31.8%	28.3%	28.3%
	Seniors present	30.3%	30.8%	36.0%	31.3%
	Grandparents as caregivers	--	--	10.9%	7.0%
Transportation	Without a vehicle	11.7%	9.6%	7.8%	7.40%
Internet	With broadband internet	87.0%	87.6%	85.8%	88.8%

Data are from 2019-2023. Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023

Source: Ashtabula County 2025 Community Health Needs Assessment

Trends in Alcohol and Drug Use

Alcohol Use

The following table reveals health behaviors associated with problematic alcohol use. Excessive drinking is defined as: a woman averaging more than one alcoholic beverage per day or more than three alcoholic beverages on a single occasion or a male averaging more than two beverages per day or four in a single occasion in the last 30 days. This is reported as the percentage of the population who engage in this behavior. Alcohol impairment significantly contributes to driving deaths in both Ohio and Pennsylvania. County Health Rankings 2025 Annual Data Release used data from 2022.

Alcohol Use

County	Excessive Drinking (Percentage of Adults) 2022	Alcohol-Impaired Driving Deaths (Percentage of total driving deaths 2018-2022)
Ohio	21%	32%
Ashtabula	19%	34%
Cuyahoga	21%	43%
Stark	20%	34%
Summit	20%	39%
Trumbull	20%	41%
Pennsylvania	20%	25%
Beaver	23%	28%
Crawford	21%	27%
Erie	21%	28%
Washington	23%	32%
Westmoreland	22%	32%

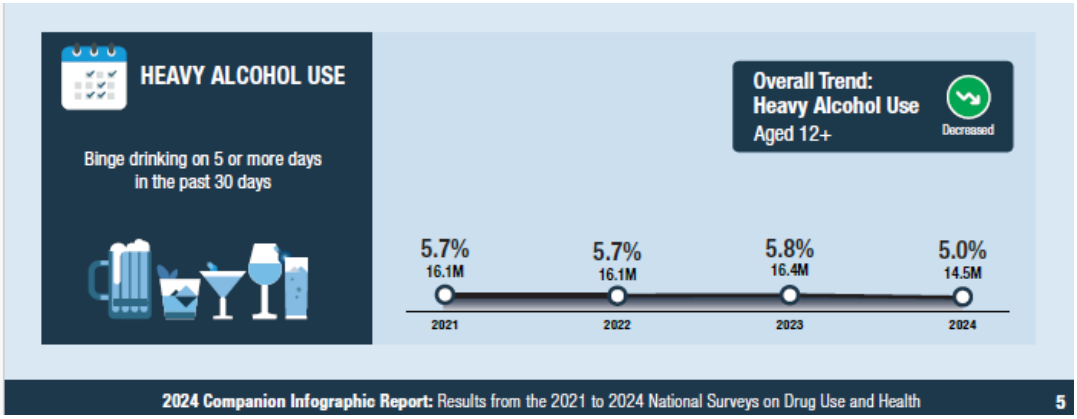
Source: County Health Rankings: https://www.countyhealthrankings.org/health-data/pennsylvania?year=2025&measure=Excessive+Drinking*&tab=1

Alcohol use within Glenbeigh's service area varies. In Ohio, no service counties had less alcohol-impaired driving deaths than the state average. Ashtabula and Trumbull were significantly above the state rate. In Pennsylvania, no service counties were below the state percentage. Overall, Pennsylvania counties have a lower percentage of total driving deaths involving alcohol than Ohio, yet higher percentages of reported excessive drinking.

Source: National Institute of Health at https://www.rethinkingdrinking.niaaa.nih.gov/

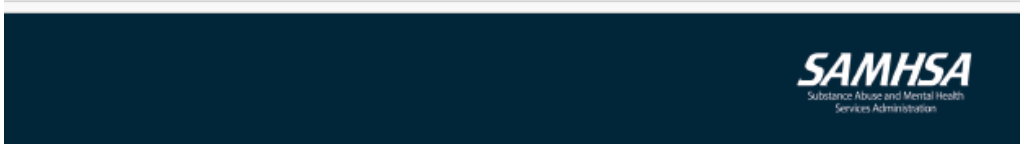
The 2024 National Survey on Drug Use and Health (NSDUH) used multimode data collection, in which respondents completed the survey in person or via the web. Estimates based on multimode data collection in 2024 are not comparable with estimates from the 2020 NSDUH or prior years. However, 2024 marked the first year in which 4 years of comparable data were available for selected estimates. Therefore, in addition to providing estimates for 2024, this document summarizes whether selected estimates of interest showed a statistically significant change from 2021 through 2024.

Source: SAMHSA **2024 Companion Infographic Report:** Results from the 2021 to 2024 National Surveys on Drug Use and Health

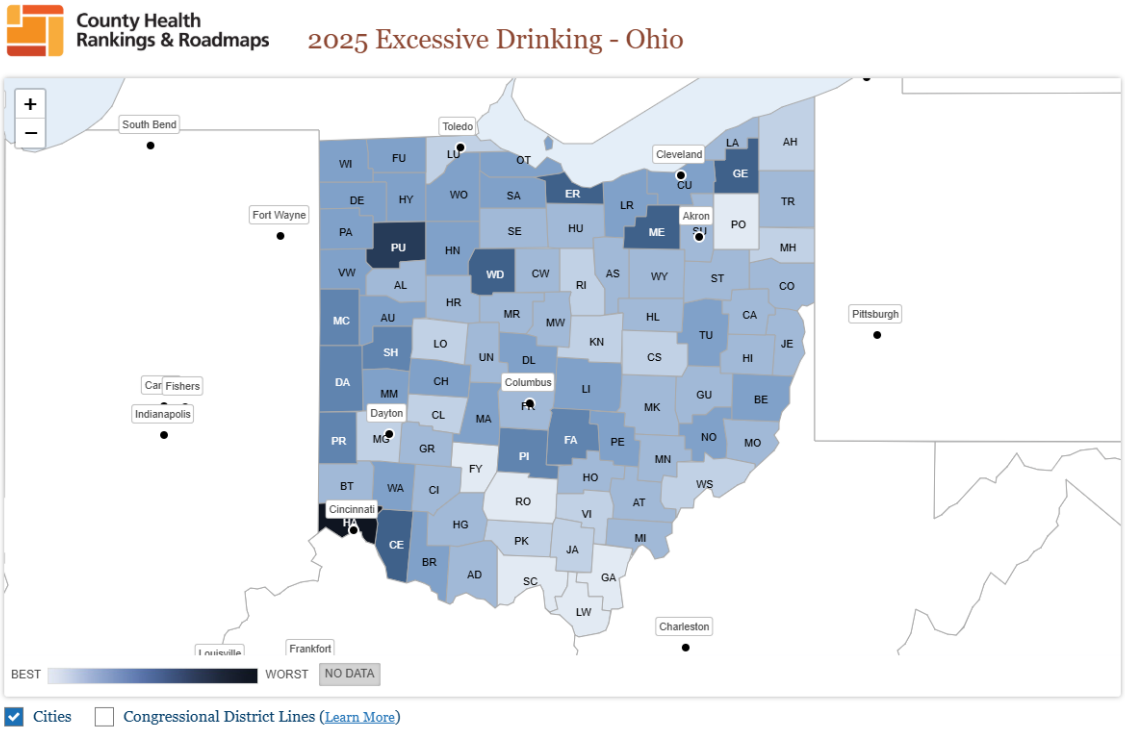


Alcohol Use

- Among the 134.3 million current alcohol users aged 12 or older in 2024, 57.9 million people (or 43.1%) were past month binge drinkers.
- Among people aged 12 or older, the percentage who engaged in binge drinking in the past month declined from 21.7% (or 60.6 million people) in 2021 to 20.1% (or 57.9 million people) in 2024. Percentages also declined from 2021 to 2024 among young adults aged 18 to 25 and adults aged 26 or older but showed no change among adolescents aged 12 to 17.
- The percentage of people aged 12 to 20 who used alcohol in the past month declined from 15.6% (or 6.1 million people) in 2021 to 13.3% (or 5.1 million people) in 2024, but the percentage for binge alcohol use in the past month among underage people showed no change.



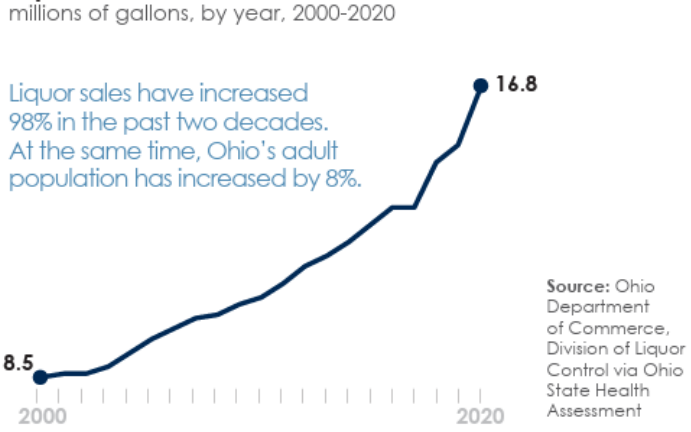
Source: SAMHSA **2024 Companion Infographic Report:** Results from the 2021 to 2024 National Surveys on Drug Use and Health

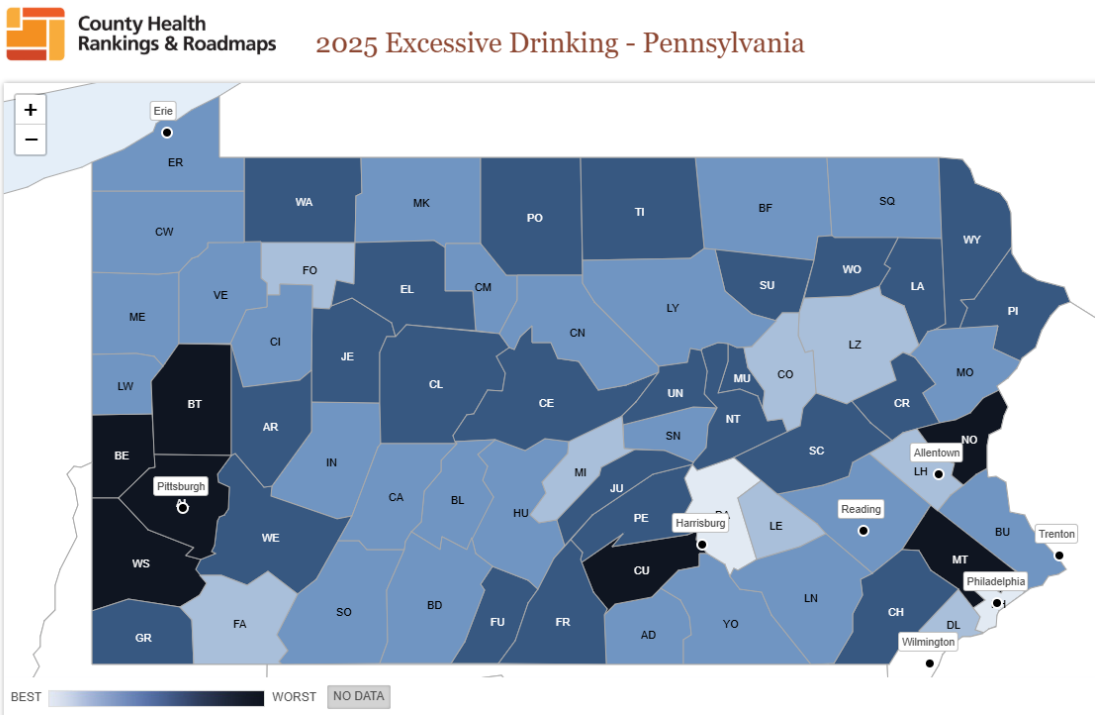


Source: County Health Rankings 2025: https://www.countyhealthrankings.org/health-data/

Ohioans drink excessively more than people in many other states. Deaths among working-age Ohioans related to chronic liver disease and cirrhosis have increased by 72% since 2007 (as displayed on page 2). These deaths are directly related to alcohol overuse.[4] Alcohol overuse also contributes to other leading causes of death, including some heart diseases.[5]

Alcohol use is influenced by many factors, including stress, trauma, mental health challenges and experiences of discrimination. And it can worsen symptoms of mental health conditions over time.[6]





Source: County Health Rankings 2025: https://www.countyhealthrankings.org/health-data/

Beaver and Washington counties in Pennsylvania, which fall within Glenbeigh's 2025 defined service area have high rates of reported accounts of excess drinking. Excessive drinking includes adults reporting binge or heavy drinking.

Source: https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics-z/alcohol-facts-and-statistics/alcohol-use-united-states-age-groups-and-demographic-characteristics

Drug Statistics

The states of Ohio and Pennsylvania have consistently led the nation in drug overdoses. Both Ohio and Pennsylvania ranked among the top ten states in the nation with the highest number of drug related deaths. In 2020, Ohio lost 5,204 residents while Pennsylvania lost 5,168 residents, ranking third and fourth among the top ten. In 2022, Pennsylvania dropped to a rank of 5th yet 5,169 individuals deceased due to a drug overdose. Ohio dropped from a rank of 3rd to 6th despite only 60 less deaths occurring. By 2023, the number of deaths in Ohio decreased to 4,662 while Pennsylvania was at 4,717. Ohio, ranked 11, and Pennsylvania, ranked 16, both states having considerably less numbers overdose deaths in 2023.

Drug Overdose Mortality by State 2022

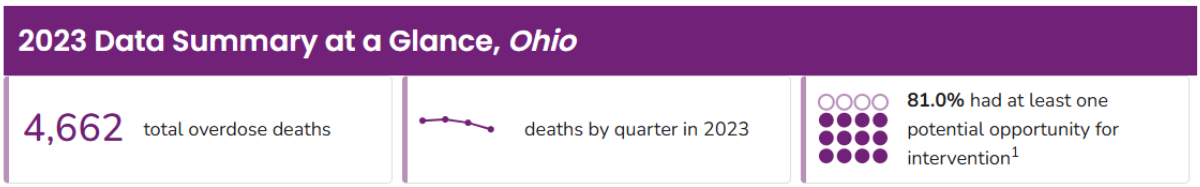
Data Table

Location	Death Rate (Click for Rankings)	Deaths
California	26.9	10,952
Florida	35.2	7,551
New York	31.4	6,358
Texas	18.2	5,489
Pennsylvania	40.9	5,169
Ohio	45.6	5,144
North Carolina	41.8	4,310
Illinois	30	3,849
Tennessee	56	3,825
Michigan	30.7	2,997

Source: Centers for Disease Control and Prevention: https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

It is not uncommon for residents living in poverty to face multiple challenges resulting from lower levels of education, low wages, limited access to job opportunities and limited access to health care as well as high crime rates. Socioeconomic factors such as a poor living environment affect quality of life and may lead to alcohol and drug usage resulting in a shorter lifespan and increased health disparities.

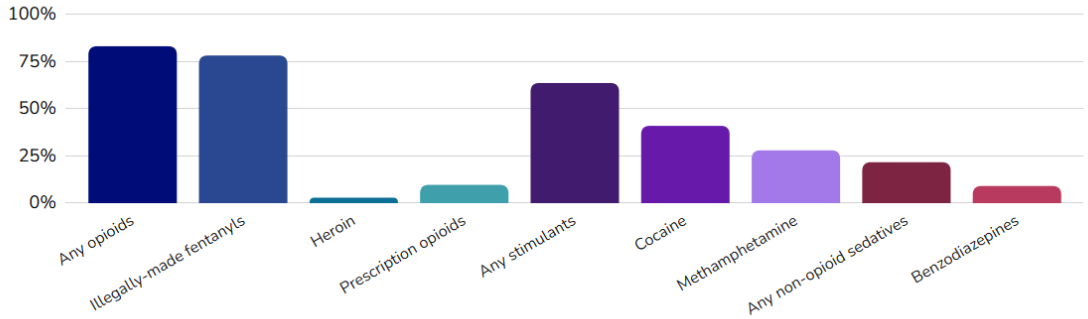
Ohio Drug Statistics



Source: Centers for Disease Control: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/fatal/dashboard/

Percentages[10] of overdose deaths involving select drugs and drug classes in 2023, *Ohio*

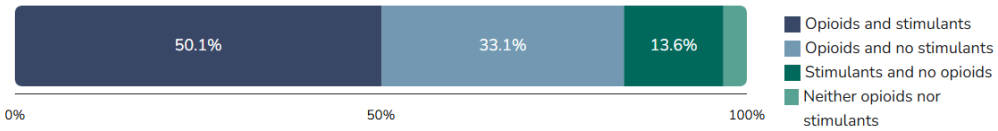
83.2% of deaths involved at least one opioid and 63.7% involved at least one stimulant. Illegally-made fentanyls were the most commonly involved opioids. The most common stimulant involved in overdose deaths was cocaine.

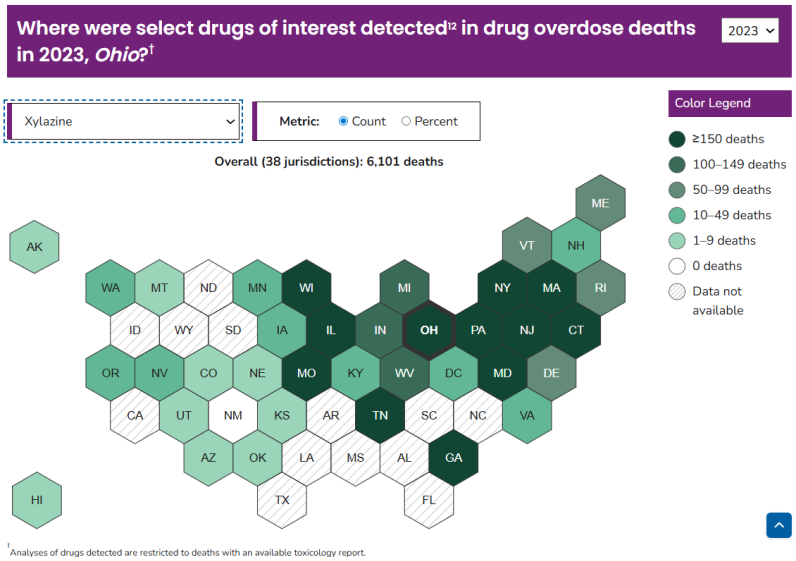


Opioids, often combined with other drugs, continue to contribute to a significant number of overdose deaths.

Distribution of overdose deaths by opioid and stimulant involvement in 2023, *Ohio*

The largest percentage of deaths involved opioids and stimulants, while 3.2% of overdose deaths involved neither opioids nor stimulants.

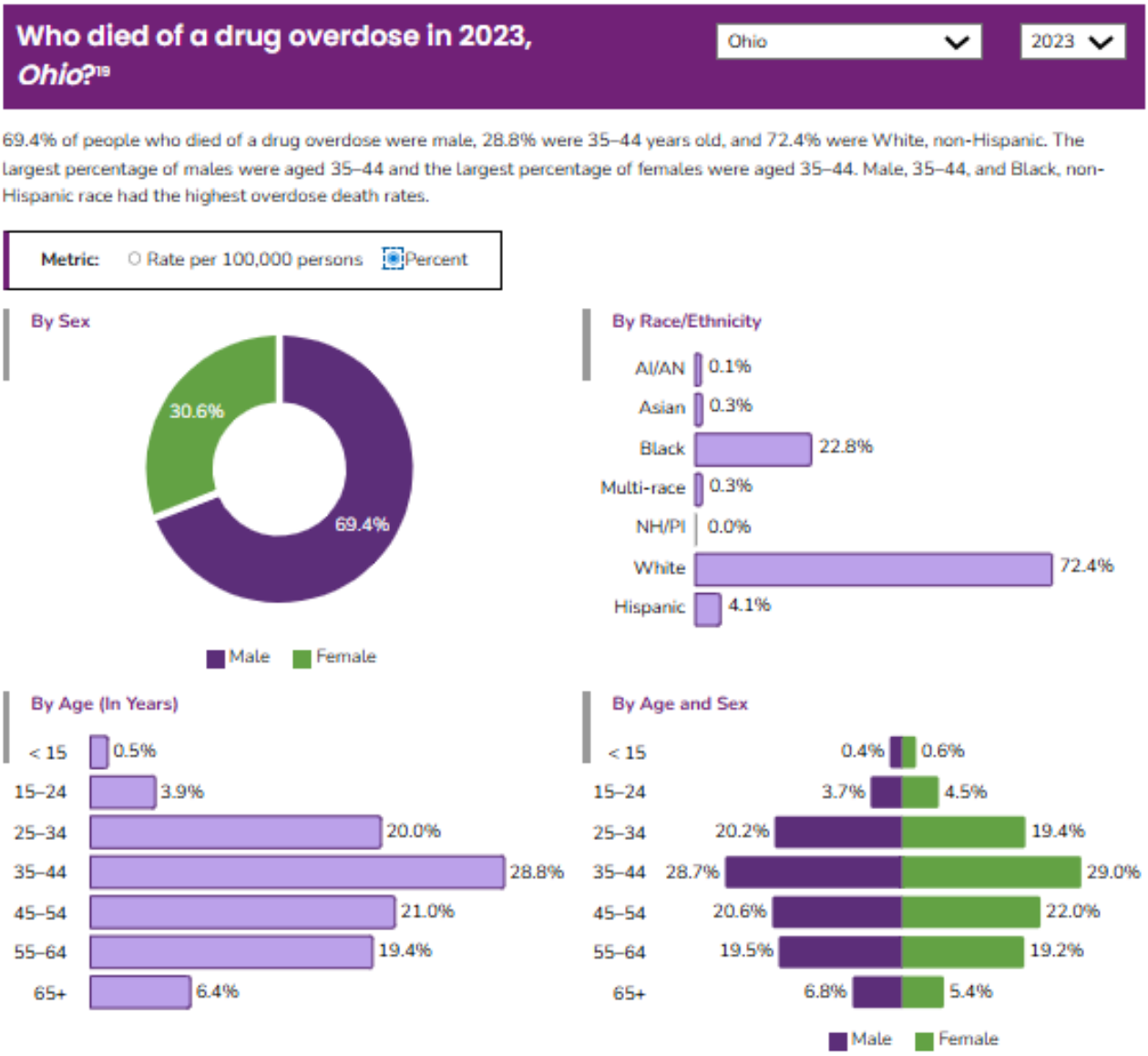




The use of stimulants, either in place of opioids, or combined with opioids, has been increasingly reported by individuals seeking treatment.

Glenbeigh has been tracking the use of Xylazine by testing individuals admitted for treatment with a drug of choice listed as an opioid. Many patients are unaware that they are using Xylazine. Wound care is provided for Xylazine users as needed.

Source: Centers for Disease Control: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/fatal/dashboard/

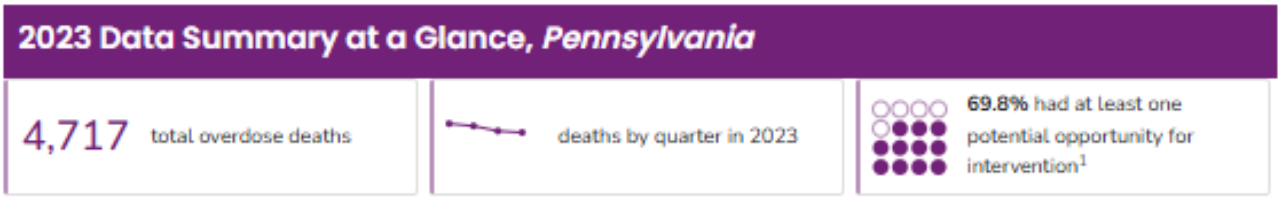


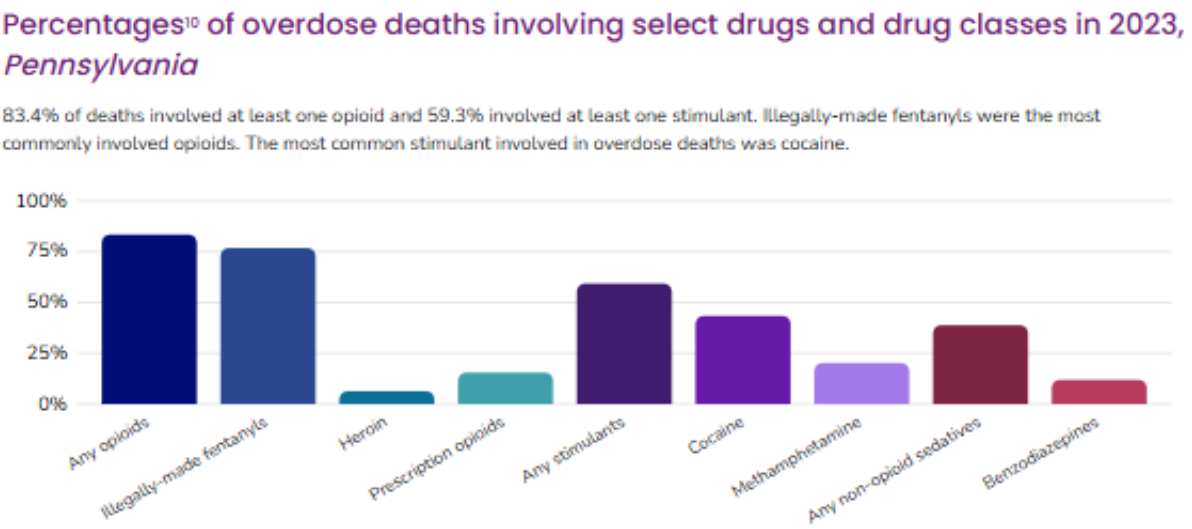
In 2020 Ohio, White males between the ages of 25 and 54 were the largest population succumbing to drug overdoses at a 79.0%. The 2023 rate decreased to 72.4%.

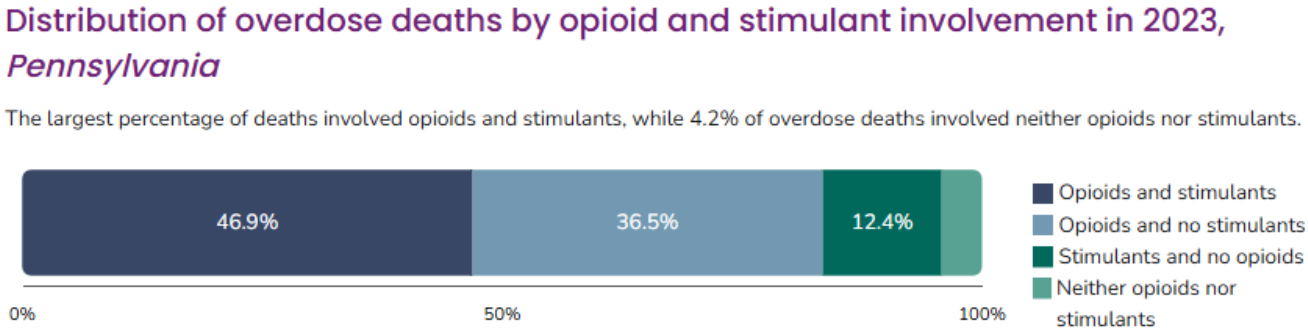
During the same period, the Black male population dying from drug overdoses increased from 16.8% in 2020 to 22.8% in 2023. According to data from the Office of Drug Surveillance, in Pennsylvania, this demographic was identified in 2022 as emerging as at the highest risk for fatal overdoses.

Source: Centers for Disease Control and Prevention: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/fatal/dashboard/

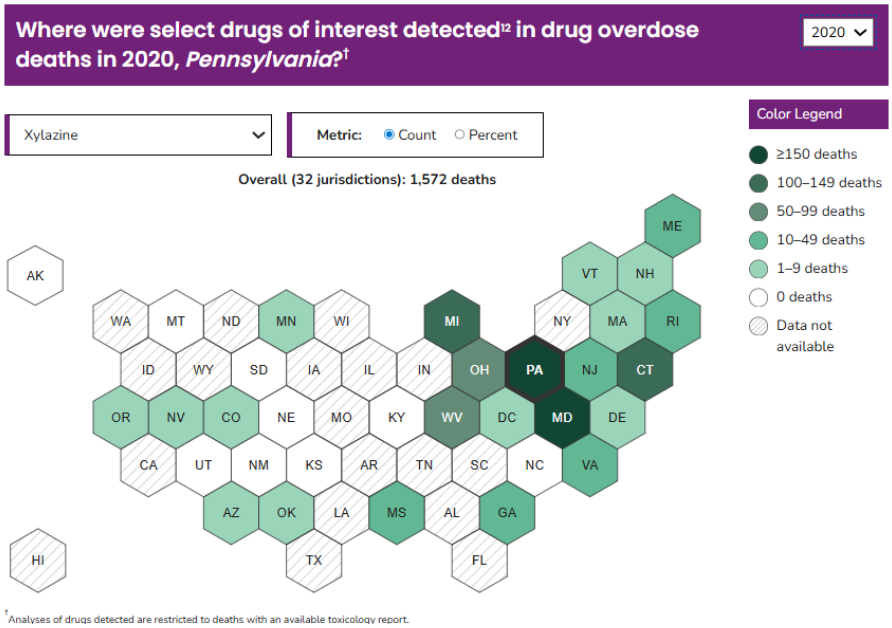
Pennsylvania Drug Statistics



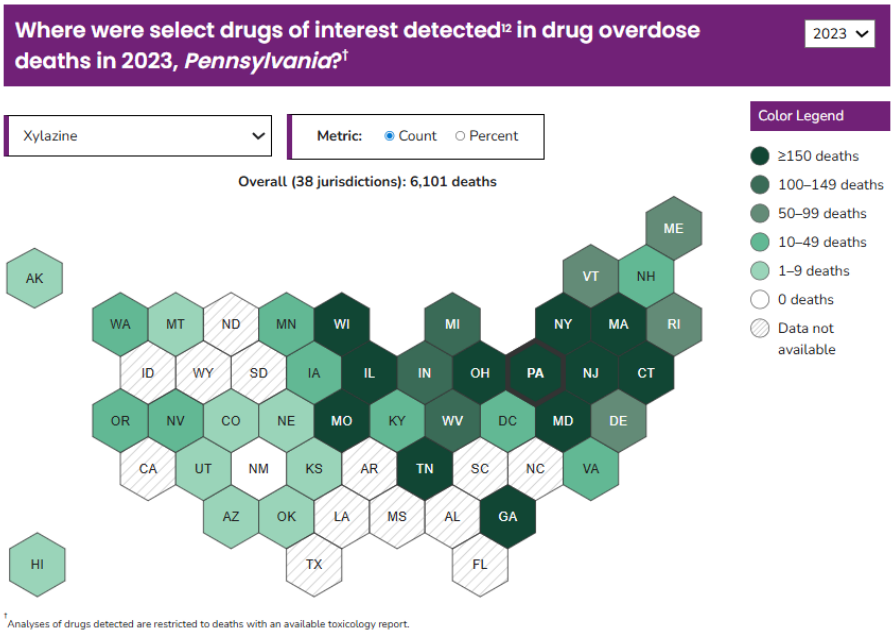




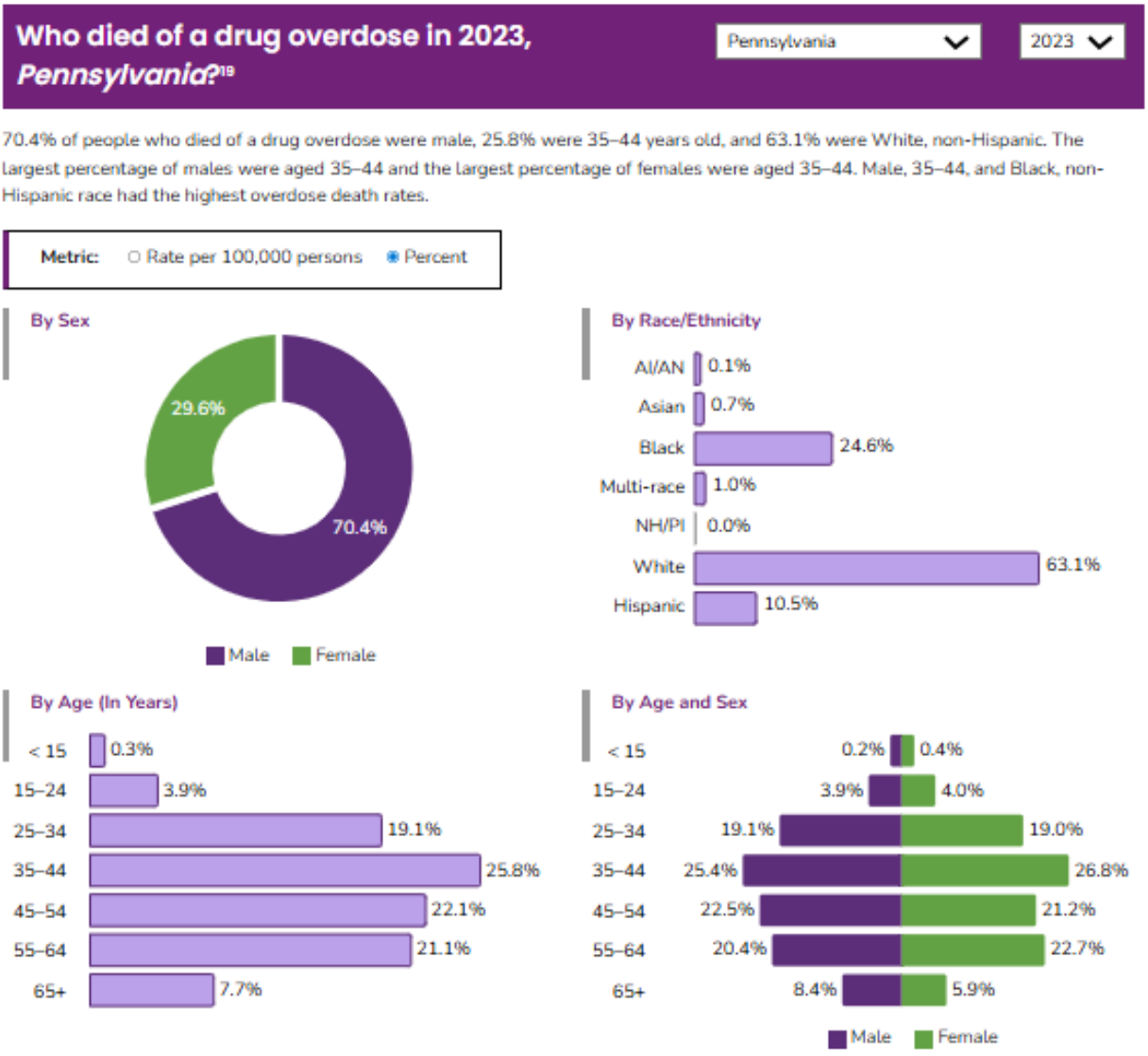
Source: Centers for Disease Control and Prevention: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/fatal/dashboard/



Source: Centers for Disease Control and Prevention: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/fatal/dashboard/



For several years, Glenbeigh has been monitoring the use of Xylazine in patients admitted for treatment services. The addition of, and use of, Xylazine was initially reported on the eastern seaboard and spread through Pennsylvania into Ohio. The above graphs show how Xylazine spread westward, being detected in reported overdose deaths, between 2020 and 2023.



Source: Centers for Disease Control: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/fatal/dashboard/

Pennsylvania shows White males between the ages of 25 and 54 were the largest population dying due to drug overdoses at a 63.1% in 2023. The 2020 rate for this demographic was 71.3%.

Concurrently, the Black male population dying from drug overdoses increased from 18.9% in 2020 to 24.6% in 2023.

The Ashtabula County 2025 Community Health Needs Assessment surveyed area residents, including community leaders, to learn their perspective on various health issues including the impact of substance use in the community. Responses provide insight on substance use issues in the community.

"Over the last five years we have an exploding homeless population…There's people living in little tent cities throughout the community that I have never seen in my whole life…These homeless people that, whether it's [related to] mental health or drug addiction."

"Dual diagnosis drug addiction and mental illness. We have a high suicide rate for the size county we have."

"Opioid addictions, amphetamines, methamphetamines, other classic drugs of abuse. Marijuana, you name it. Alcohol."

"It's unfortunate that it exists for not only those who are afflicted with those addiction diseases, but for the families who also are coping with those who are addicted. We see the toll it takes on everybody. It's a strain on law enforcement, it's a strain on the court system, and you're seeing this cycle with some of them who are repeat offenders through the recidivism."

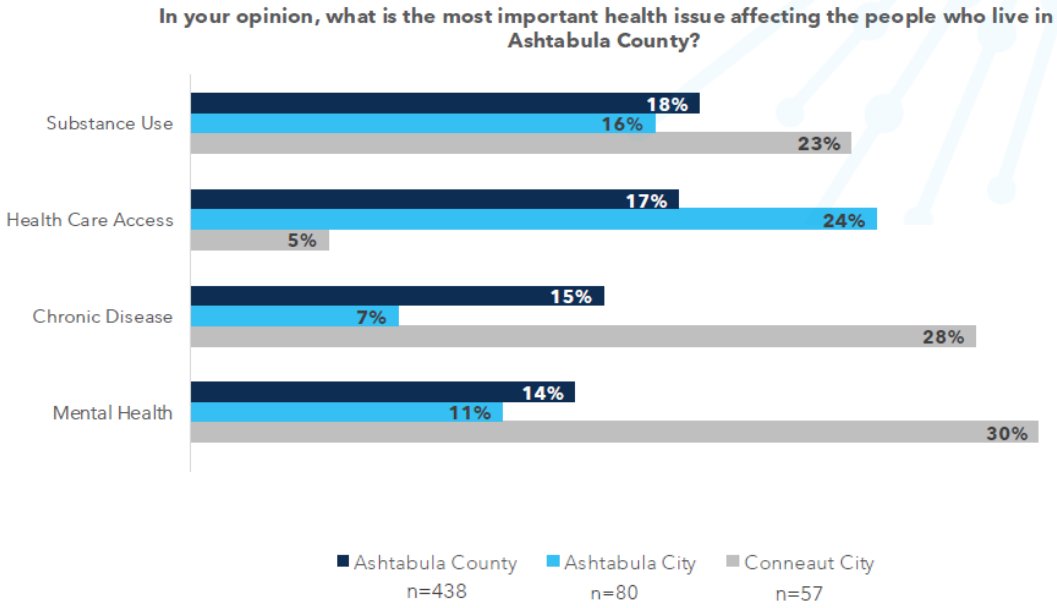
"There's mental health and then there's drugs…We're helping people who are medicating themselves because they're not going to get mental health services. But then when the time comes to getting health, they may be rejected for services because they're under the influence, but it's actually there to medicate their mental health."

Source: Ashtabula County 2025 CHNA

RESIDENTS' PRIORITIES

This section describes what residents perceive as the most important health issues in the community, according to the representative survey of adults and the stakeholder interviews.

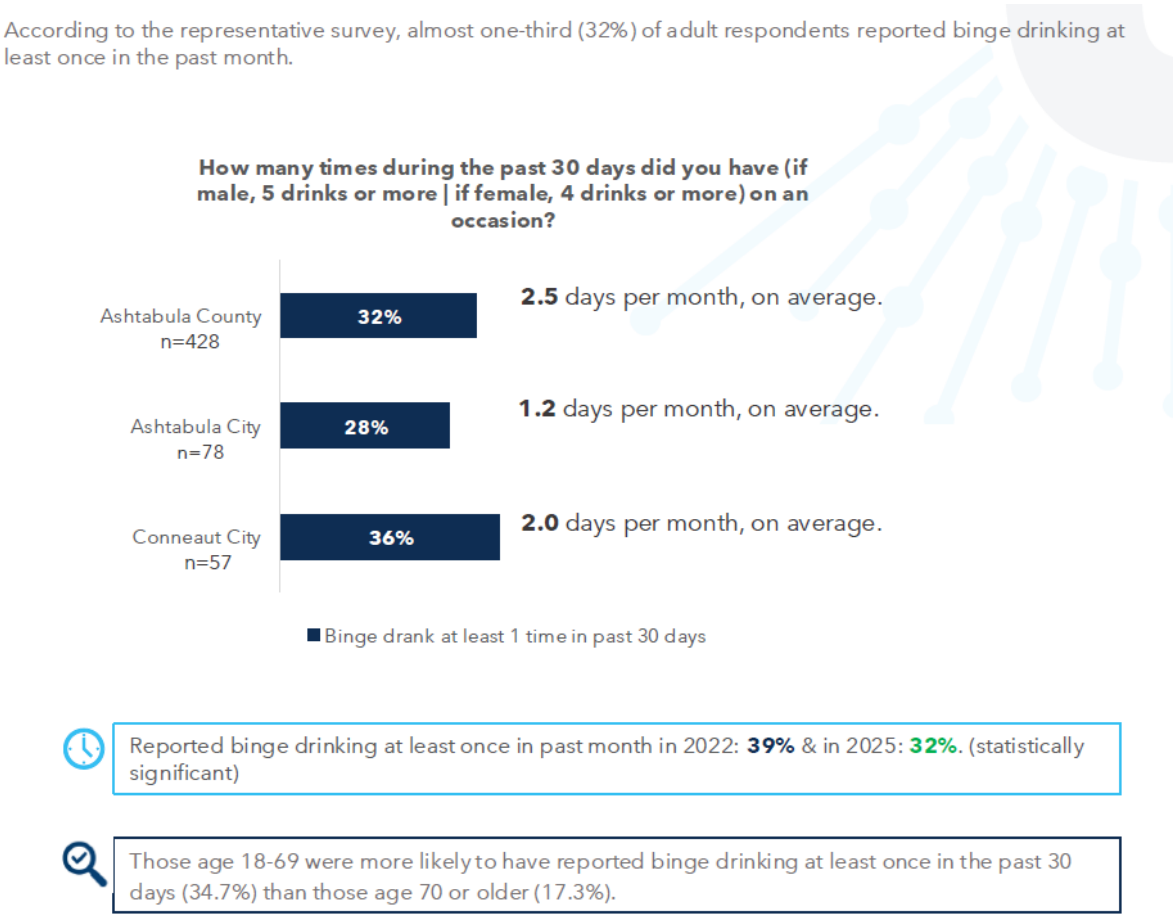
According to the representative survey, residents perceive substance use, health care access, chronic disease, and mental health as the most important health issues.



Ashtabula County Community Health Needs Assessment

Among the key findings, main barriers were the lack of health care resources, insufficient health insurance, poverty, lack of transportation and attitudes toward improving health issues. Residents reported more direct interaction within the community rather than relying on social media or other media sources and is similar to findings reported in 2023. This may correspond to the lack of access to broadband internet services within the community.

In the 2022 CHNA, survey participants noted an interest in receiving more information on mental health issues including depression and anxiety. More so for residents within the City of Ashtabula. While the report noted alcohol and drug problems among the top issues affecting county residents, there was little interest by the same participants in receiving help or information about drug abuse or alcohol abuse. When completing the survey, 74% of respondents indicated that they would NOT like to learn more about treatment or care options. At the same time 32% reported binge drinking at least once in the last month. This is a decrease from the 39% binge drinking activity reported in the 2022 health assessment.



Source: Ashtabula County 2025 CHNA

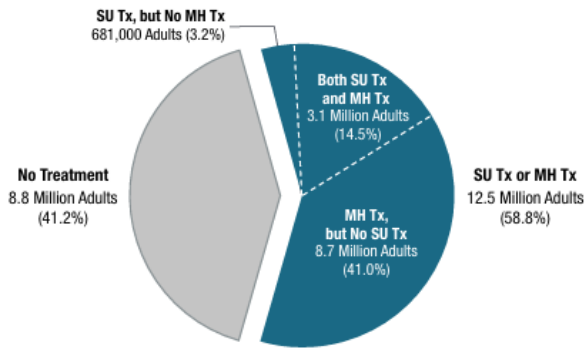
In the 2019 CHNA, 7% of Ashtabula County adults reported using marijuana in the past 6 months. This number increased to 8% in 2022 for the number reporting the use of marijuana in the past month. In 2025, 18% of county survey respondents used marijuana in the past 30 days (3.5 days per month on average).

Medical marijuana use was approved mid-2016 for Ohio residents. In 2022, 46% reported the use of marijuana for medical conditions while only 19% reported use solely for recreational purposes. Additionally, 35% reported using for both medical and non-medical purposes. By 2025, 18% reported using of marijuana for medical reasons, 26% for non-medical reasons and 56% for both medical and non-medical purposes.

This is a statistically significant increase in marijuana use in Ashtabula County

Substance Abuse and Mental Health Services Administration Data on Alcohol and Drug Use, Treatment and Recovery. National Survey on Drug Use and Health (NSDUH) Report

Figure 80. Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adults Aged 18 or Older with Past Year Substance Use Disorder and Any Mental Illness; 2024



21.2 Million Adults with a Substance Use Disorder and Any Mental Illness

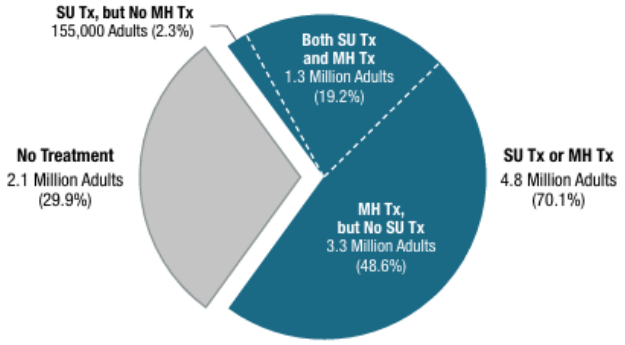
MH Tx = mental health treatment; SU Tx = substance use treatment.

Note: The numbers and percentages for the subdivisions may not add to the percentage for the whole division due to rounding.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol use disorder or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Figure 81. Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adults Aged 18 or Older with Past Year Substance Use Disorder and Serious Mental Illness; 2024



6.9 Million Adults with a Substance Use Disorder and Serious Mental Illness

MH Tx = mental health treatment; SU Tx = substance use treatment.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol use disorder or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

SAMHSA reported that receipt of treatment among Adults with Co-Occurring AMI and an SUD among the 21.2 million adults aged 18 or older in 2024 with co-occurring AMI and an SUD in the past year, 58.8 percent (or 12.5 million people) received either substance use treatment or mental health treatment in the past year, and 41.2 percent (or 8.8 million people) received neither type of treatment. Stated another way, about 2 in 5 adults aged 18 or older with co-occurring AMI and an SUD in the past year did not receive treatment for either condition.

An estimated 41.0 percent of adults aged 18 or older with co-occurring AMI and an SUD in the past year (or 8.7 million people) received only mental health treatment, 3.2 percent (or 681,000 people) received only substance use treatment, and 14.5 percent (or 3.1 million people) received both types of treatment. Among the 12.5 million adults aged 18 or older in 2024 with co-occurring AMI and an SUD who received either substance use treatment or mental health treatment in the past year (Figure 80), most received only mental health treatment (69.8 percent).

Note: The numbers and percentages for the subdivisions may not add to the percentage for the whole division due to rounding. Note: Substance use treatment includes treatment for drug or

alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol use disorder or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Percentages of adults aged 18 or older in 2024 with co-occurring AMI and an SUD in the past year who received either substance use treatment or mental health treatment in the past year ranged from 56.1 percent of young adults aged 18 to 25 (or 2.6 million people) to 60.0 percent of adults aged 50 or older (or 2.8 million people). An estimated 59.3 percent of adults aged 26 to 49 with co-occurring AMI and an SUD in the past year (or 7.1 million people) received either type of treatment.

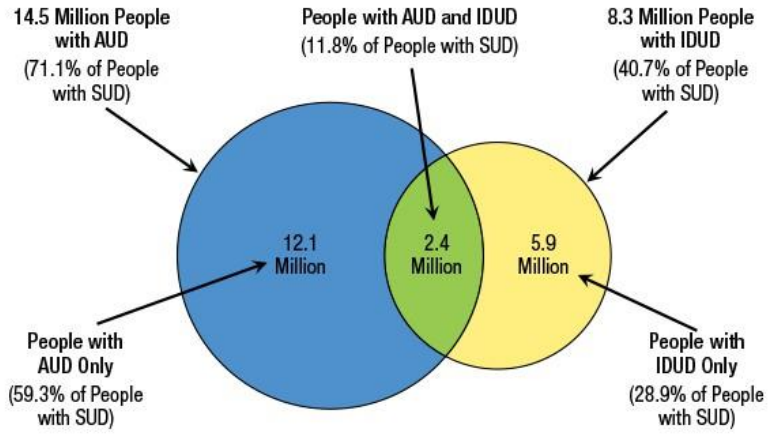
An estimated 48.6 percent of adults aged 18 or older with co-occurring SMI and an SUD in the past year (or 3.3 million people) received only mental health treatment, 2.3 percent (or 155,000 people) received only substance use treatment, and 19.2 percent (or 1.3 million people) received both types of treatment.

Among the 4.8 million adults aged 18 or older in 2024 with co-occurring SMI and an SUD who received either substance use treatment or mental health treatment in the past year (Figure 81), most received only mental health treatment (69.4 percent). An estimated 3.2 percent of these adults aged 18 or older received only substance use treatment, and 27.4 percent received both types of treatment. Among adults aged 18 or older in 2024 with co-occurring SMI and an SUD in the past year, 72.6 percent of young adults aged 18 to 25 (or 1.2 million people) and 71.0 percent of adults aged 26 to 49 (or 2.7 million people) received either substance use treatment or mental health treatment in the past year. Percentages could not be calculated with sufficient precision for adults aged 50 or older with co-occurring SMI and an SUD in the past year.

Source: SAMHSA Annual National Report; Key Substance Use and Mental Health Indicators in the United States
https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024#annual-national-report

SAMHSA reported that among the 20.4 million people aged 12 or older with a past year substance use disorder (SUD) in 2019, 71.1 percent (or 14.5 million people) had a past year alcohol use disorder, 40.7 percent (or 8.3 million people) had a past year illicit drug use disorder. Among the 14.5 million people with a past year alcohol use disorder, 12.1 million had an alcohol use disorder but not an illicit drug use disorder. Among the 8.3 million people with a past year illicit drug use disorder, 5.9 million had an illicit drug use disorder but not an alcohol use disorder. Among people with a past year SUD, 11.8 percent (or 2.4 million people) had both an alcohol use disorder and an illicit drug use disorder in the past year.

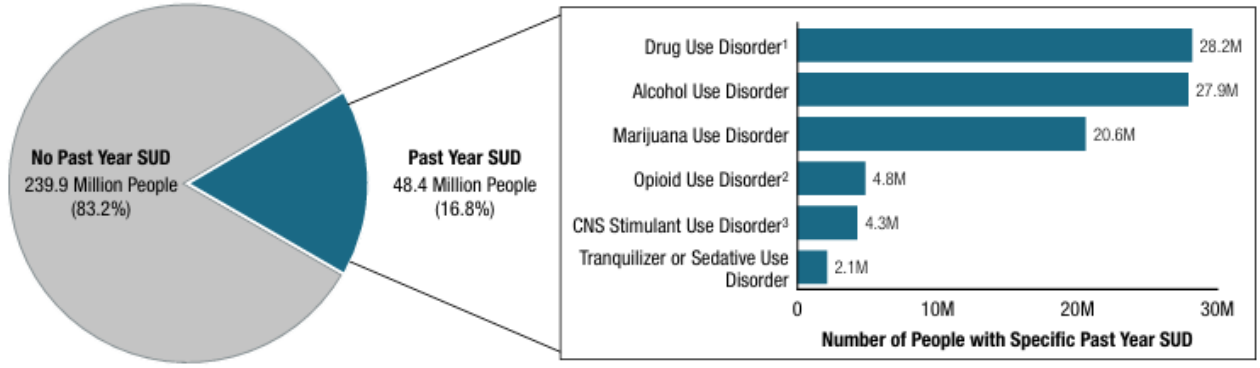
Figure 47. Alcohol Use Disorder (AUD) and Illicit Drug Use Disorder (IDUD) in the Past Year among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD): 2019



Source: SAMHSA National Survey on Drug Use and Health (NSDUH)
https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.ht m#mhisud

The 2019 National Survey on Drug Use and Health (NSDUH) report offered insight into the perceived need for substance use treatment. The 2019 national report published by SAMHSA estimated that the perceived need for substance use treatment among the approximate 18.9 million people aged 12 or older who had an existing SUD in the past year and who did not receive treatment at a specialty facility, 95.7 percent, or 18.1 million people, did not feel they needed treatment. Additionally, 3.0 percent, or 557,000 people, perceived a need for treatment but did not seek or secure treatment and 1.2 percent, or 236,000 people, sought treatment.

Figure 35. Past Year Substance Use Disorder (SUD): Among People Aged 12 or Older; 2024



CNS = central nervous system.

Note: The estimated numbers of people with SUDs are not mutually exclusive because people could have use disorders for more than one substance.

[1] Includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives). See footnote 2 for more information about opioid use disorder.

[2] Includes data from all past year users of heroin or prescription opioids. Respondents were not included if they used only nonopioid pain relievers and did not use heroin in the past year.

[3] Includes data from all past year users of cocaine, methamphetamine, or prescription stimulants.

Source: https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024#annual-national-report

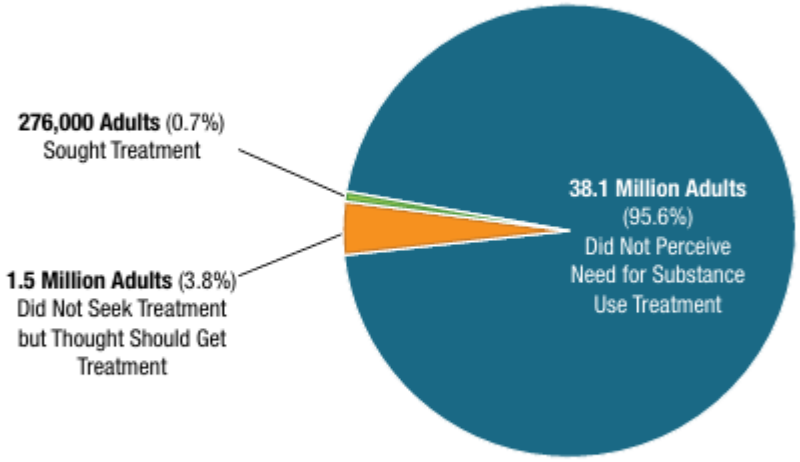
In 2024, SAMHSA reported that 48.4 million people aged 12 or older (or 16.8 percent of the population) had an SUD in the past year, including 27.9 million people who had an alcohol use disorder and 28.2 million people who had a drug use disorder (Figure 35). People who had an SUD in the past year tended to have an alcohol use disorder only or a drug use disorder only. About 1 in 6 people with a past year SUD (16.0 percent or 7.7 million people) had both an alcohol use disorder and a drug use disorder in the past year.

In the 2022 CHNA, NSDUH respondents were classified as having a perceived need for substance use treatment (i.e., treatment for problems related to their use of alcohol or illicit drugs) if they indicated that they felt they needed substance use treatment in the past year. Respondents may have a perceived need for substance use treatment, regardless of whether they had an SUD in the past year. In this report, estimates for the perceived need for substance use treatment are discussed only for people aged 12 or older who were classified as having an SUD in the past year but did not receive substance use treatment at a specialty facility.

Among 2019 survey participants with a past year SUD who did not receive substance use treatment at a specialty facility, 4.3 percent perceived that they needed treatment. The 2019 percentage was similar to the percentages in most years from 2015 to 2018.

2024 statistics show 95.6% did not believe they need treatment and only 0.7% actually seeking treatment services.

Figure 73. Perceptions of Need for Substance Use Treatment: Among Adults Aged 18 or Older with a Past Year Substance Use Disorder Who Did Not Receive Substance Use Treatment in the Past Year; 2024



40.7 Million Adults with a Substance Use Disorder Who Did Not Receive Substance Use Treatment

Note: The percentages may not add to 100 percent due to rounding.

Note: Adults with unknown information for perceptions of need for substance use treatment were excluded; therefore, the sum of the interior pieces does not add to the whole.

Source: SAMHSA National Survey on Drug Use and Health (NSDUH) https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024#annual-national-report

The following are directly from the SAMHSA 2024 National Survey Drug Use and Health (NSDUH) report:

Substance Use in the Past Month
Among people aged 12 or older in 2024, 58.3% (or 168.0 million people) used tobacco products, vaped nicotine, used alcohol, or used an illicit drug in the past month (also defined as "current use"), including 46.6% (or 134.3 million people) who drank alcohol, 16.7% (or 48.0 million people) who used a tobacco product, 9.6% (or 27.7 million people) who vaped nicotine and 16.7% (or 48.2 million people) who used an illicit drug.

Substance Use Disorders
In 2024, 48.4 million people aged 12 or older (or 16.8%) had a substance use disorder (SUD) in the past year, including 27.9 million people who had an alcohol use disorder (AUD), 28.2 million people who had a drug use disorder (DUD), and 7.7 million people who had both an AUD and a DUD. Among people aged 12 or older, the percentage who had a past year SUD showed no change from 2021 to 2024. However, the percentage who had a past year DUD increased from 8.7% (or 24.5 million people) in 2021 to 9.8% (or 28.2 million people) in 2024. The percentage who had a past year AUD declined from 10.6% (or 29.7 million people) in 2021 to 9.7% (or 27.9 million people) in 2024.

Among adults aged 26 or older, trends from 2021 to 2024 for any past year SUD, AUD, and DUD followed the same pattern as the trends for people aged 12 or older. Among young adults aged 18 to 25, trends for any SUD and AUD also showed the same pattern as for people aged 12 or older, but the percentage of young adults with a past year DUD showed no change. Among adolescents aged 12 to 17, the percentage who had an SUD declined from 2021 to 2024 and showed no change among those who had a past year AUD or DUD.

Among people aged 12 or older in 2024 who had a central nervous system (CNS) stimulant use disorder in the past year that was due to their misuse of CNS stimulants in the past year (i.e., use of cocaine or methamphetamine or misuse of prescription stimulants), about half (48.3%) had a severe disorder and 28.5% had a mild disorder.

Among people aged 12 or older in 2024 who had an opioid use disorder in the past year that was due to their use of heroin or misuse of prescription opioids, 37.1% had a severe disorder, and 42.4% had a mild disorder.

Reasons for Not Seeking Treatment

The NSDUH report for 2024 further explored reasons for not receiving specialty substance use treatment. "NSDUH respondents who did not receive substance use treatment in the past 12 months but felt they needed treatment were asked to report the reasons for not receiving treatment. Common reasons expressed for not receiving specialty substance use treatment despite the individual perceiving a need for treatment were:

- Not being ready to stop using (39.9 percent) - remained stable between 2015 and 2019
- Did not know where to go to get treatment (23.8 percent) - higher than the percentages in 2015 (12.5 percent) and 2017 (10.9 percent), but similar to the percentages in 2016/2018
- Having no health care coverage and not being able to afford the cost of treatment (20.9

percent) - lower than the 2018 percentage (32.5 percent), but similar to the percentages in 2015 to 2017

Among the 40.7 million adults aged 18 or older in 2024 who had an SUD in the past year and did not receive substance use treatment, 95.6 percent (or 38.1 million people) did not perceive that they needed treatment. That is, they did not seek treatment and did not think they should get it.

An estimated 4.4 percent of adults with an SUD in the past year who did not receive treatment (or 1.8 million people) either sought treatment or did not seek treatment but thought they should get it. This percentage includes 0.7 percent of adults (or 276,000 people) who sought treatment and 3.8 percent of adults (or 1.5 million people) who did not seek treatment but thought they should get it.

Need for Substance Use Treatment: Among Adults Aged 18 or Older with a Past Year Substance Use Disorder Who Did Not Receive Substance Use Treatment in the Past Year; 2024 276,000 Adults (0.7%) Sought Treatment 1.5 Million Adults (3.8%) Did Not Seek Treatment but Thought Should Get Treatment 38.1 Million Adults (95.6%) Did Not Perceive Need for Substance Use Treatment 40.7 Million Adults with a Substance Use Disorder Who Did Not Receive Substance Use Treatment

Reasons for Not Receiving Substance Use Treatment among Adults Aged 18 or Older
Among adults aged 18 or older in 2024 with a past year SUD who perceived an unmet need for treatment, the following were the three most common reasons for not receiving substance use treatment:

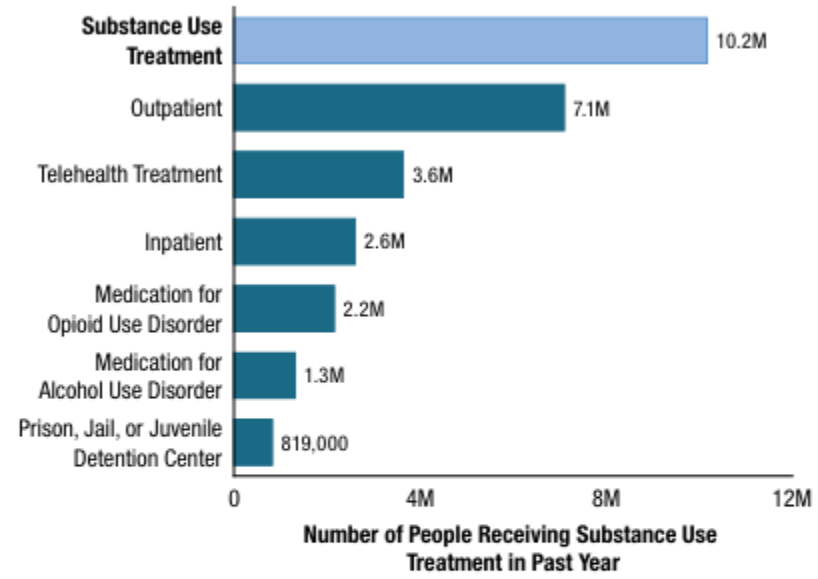
- thinking they should have been able to handle their alcohol or drug use on their own (75.5 percent),
- not being ready to start treatment (65.0 percent), and
- not being ready to stop or cut back on using alcohol or drugs (59.5 percent)

Percentages for additional reasons were not necessarily significantly different from one another. Therefore, ranking of these reasons should not be assumed. Nevertheless, the following were additional common reasons for not receiving substance use treatment:

- thinking that treatment would cost too much (45.3 percent);
- being worried about what people would think or say if they got treatment (43.2 percent);
- not having enough time for treatment (41.3 percent);
- not knowing how or where to get treatment (38.9 percent);
- not being able to find a treatment program or healthcare professional they wanted to go to (35.8 percent);
- thinking bad things would happen if people knew they were in treatment, such as losing their job, home, or children (34.4 percent);
- being worried that information would not be kept private (33.0 percent); and
- not having health insurance coverage for treatment (32.4 percent)

Source: SAMHSA National Survey on Drug Use and Health (NSDUH) https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024#annual-national-report

Figure 70. Types and Locations of Substance Use Treatment Received in the Past Year: Among People Aged 12 or Older; 2024



Note: Types of substance use treatment and locations where people received substance use treatment are not mutually exclusive because respondents could report that they received treatment in more than one setting in the past year.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication for alcohol use disorder or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Because respondents who used prescription pain relievers or heroin in their lifetime were shown a list of medications that are prescribed to treat opioid use disorder, respondents who used prescription pain relievers but not heroin in their lifetime and who reported use of these medications were assumed to have received medication for opioid use disorder.

Source: SAMHSA National Survey on Drug Use and Health (NSDUH) https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024#annual-national-report

Perceived Recovery as Defined by SAMHSA National Survey on Drug Use and Health

Respondents who reported ever having a problem with alcohol or drug use were asked if they considered themselves (at the time of the interview) in recovery or to have recovered from a substance use problem.

Among adults, aged 18 or older in 2019, 11.4 percent (or 28.2 million people) admitted having a problem with alcohol or drugs at some time. This is a similar percentage as reported in 2018 (11.0 percent). Moreover, among the 28.2 million adults in 2019 who believed they ever had a substance use problem, 75.5 percent (or 21.2 million people) considered themselves to be in recovery or to have recovered from their alcohol or drug use problem, which was similar to the percentage in 2018 (74.5 percent).

Questions were added to the 2019 NSDUH interview to assess the receipt of medication- assisted treatment (MAT) for problems with alcohol use or opioid misuse. NSDUH respondents aged 12 or older who reported receiving any treatment in the past year for problems related to their use of alcohol were asked to report whether a doctor or other health professional prescribed them medication in the past year to help reduce or stop their use of alcohol. Questions on MAT for opioid misuse were asked if respondents aged 12 or older reported ever using heroin or ever misusing prescription pain relievers *and* reported receiving any treatment in the past year for illicit drug use problems. These respondents were asked whether a doctor or other health professional prescribed them medication in the past year to help reduce or stop their use of heroin, misuse of prescription pain relievers, or both. Respondents also were informed that MAT for opioid misuse was different from medications given to stop a drug overdose.

Medication-Assisted Treatment for Alcohol Use

Among the 14.5 million people aged 12 or older in 2019 with a past year alcohol use disorder, 7.6 percent (or 1.1 million people) received treatment for alcohol use at any location in the past year, and 1.6 percent (or 228,000 people) received MAT in the past year for alcohol use. Among the 2.5 million people aged 12 or older in 2019 who received alcohol use treatment at any location in the past year (regardless of whether they had a past year alcohol use disorder, 11.3 percent (or 286,000 people) received MAT in the past year for alcohol use. In contrast, among the 1.1 million people aged 12 or older in 2019 who had a past year alcohol use disorder and received alcohol use treatment at any location in the past year, 20.7 percent (or 228,000 people) received MAT in the past year for alcohol use.

In the 2024 report, 0.5 percent of people aged 12 or older in 2024 (or 1.3 million people) received MAUD in the past year. Among the 27.9 million people aged 12 or older with a past year alcohol use Key Substance Use and Mental Health Indicators in the United States: 2.5 percent (or 697,000 people) received MAUD in the past year.

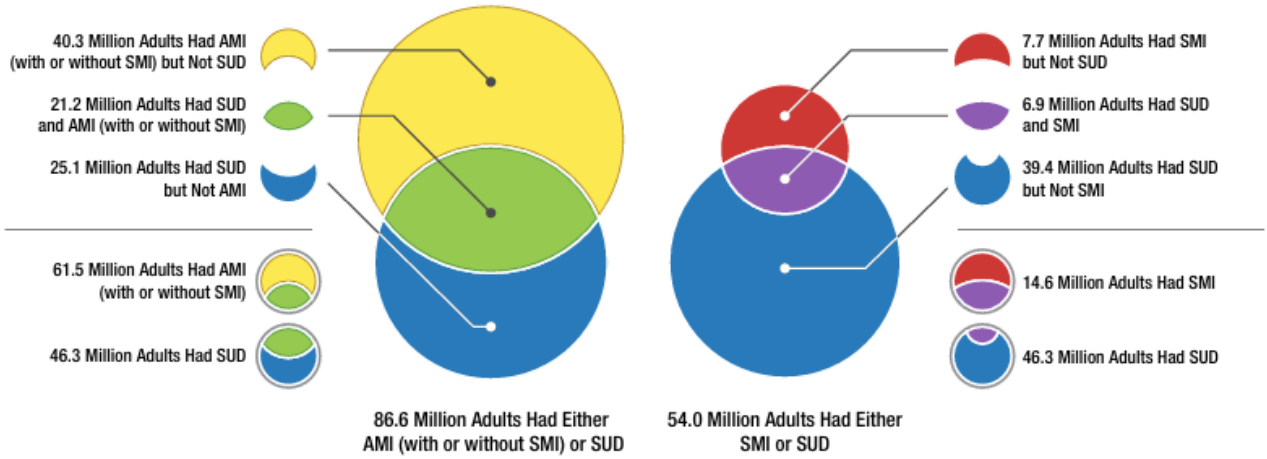
Medication-Assisted Treatment for Opioid Misuse

Among the 2.3 million people aged 12 or older in 2019 who received illicit drug use treatment (i.e., not necessarily for opioid misuse) in the past year, 28.7 percent (or 664,000 people) received MAT in the past year for opioid misuse. Among the 1.6 million people aged 12 or older with a past year opioid use disorder, 18.1 percent (or 294,000 people) received MAT in the past year for opioid misuse.

In the 2024 report, as noted previously, 0.7 percent of people aged 12 or older in 2024 (or 2.2 million people) received MOUD in the past year. Among the 4.8 million people aged 12 or older with a past year opioid use disorder, 17.0 percent (or 818,000 people) received MOUD in the past year.

Source: SAMHSA National Survey on Drug Use and Health (NSDUH)

Figure 57. Any Mental Illness (AMI), Serious Mental Illness (SMI), or Substance Use Disorder (SUD) in the Past Year: Among Adults Aged 18 or Older; 2024



Source: SAMHSA National Survey on Drug Use and Health (NSDUH) https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024#annual-national-report

The NSDUH reported Co-Occurring AMI and SUD Among adults aged 18 or older in 2024, 33.0 percent (or 86.6 million people) had either AMI or an SUD in the past year (Figure 57). Among the 61.5 million adults with AMI, about one third (21.2 million people) had an SUD. However, the 21.2 million adults who had both AMI and an SUD represent slightly less than half of the 46.3 million adults who had an SUD in the past year.

In 2024, 13.3 percent of young adults aged 18 to 25 (or 4.7 million people) had AMI and an SUD in the past year. In addition, 40.6 percent of adults aged 26 to 49 (or 43.0 million people) and 22.7 percent of adults aged 50 or older (or 27.6 million people) had either AMI or an SUD in the past year.

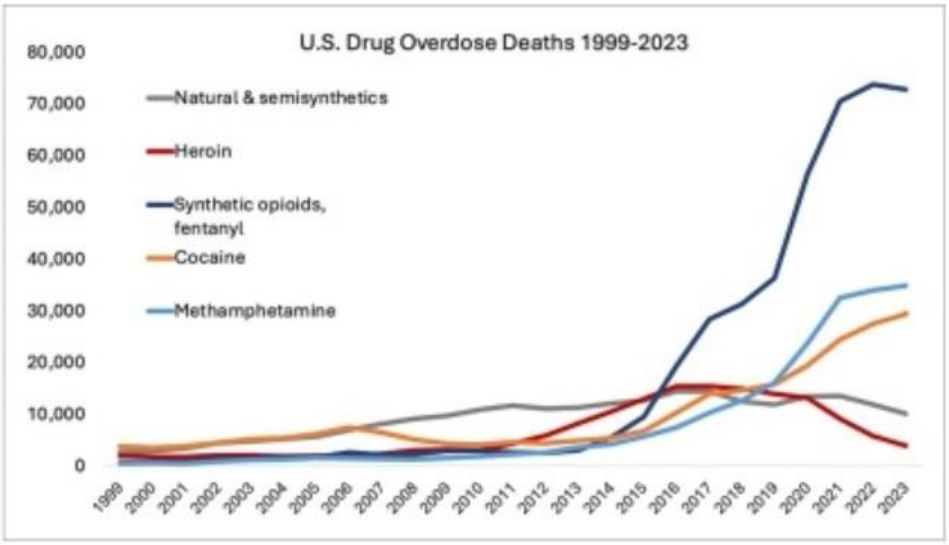
Among adults aged 18 or older in 2024, 20.6 percent (or 54.0 million people) had either SMI or an SUD in the past year (Figure 57). Among the 46.3 million adults who had an SUD in the past year, most (39.4 million people) did not have SMI. Among the 14.6 million adults who had SMI, however, nearly half (6.9 million people) also had an SUD. Approximately 3 in 10 young adults aged 18 to 25 in 2024 had either SMI or an SUD in the past year (30.5 percent or 10.6 million people).

In addition, about one fourth of adults aged 26 to 49 (26.0 percent or 27.6 million people) and about one eighth of adults aged 50 or older (13.0 percent or 15.9 million people) had SMI or an SUD in the past year.

Source: SAMHSA National Survey on Drug Use and Health (NSDUH) https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024#annual-national-report

Drug Trends

National Institute on Drug Abuse (NIDA) Data



Source: National Institute on Drug Abuse Strategic Plan https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message

As reported in the 2022 CHNA, the National Institute on Drug Abuse (NIDA) is the lead federal agency tasked with investigating and publishing information on drug use and addiction. After decades of research, substance use disorder (SUD) is understood as a chronic but treatable brain disorder that emerges from the complex interplay of biological, social, and developmental factors.

NIDA's strategic plan, covering 2022 to 2026, noted that drug overdoses in the United States have been increasing exponentially for at least 40 years. While substances of choice have transitioned over the years, opioids have been involved in most overdoses over the past two decades. The opioid crisis began with the misuse of prescription opioids. When prescription availability was limited, heroin use increased. Since 2016, synthetic opioids, including fentanyl and fentanyl compounds, are involved in a significant number of overdose deaths.

NIDA's plan states, "Provisional data from the Centers for Disease Control and Prevention show a record high of close to 109,000 overdose deaths in 2021, with more than 75 percent involving opioids. Stimulants also have reemerged as an overdose threat. From 2012 through 2021, the number of deaths involving methamphetamine increased nearly 13-fold (from ~2,600 to nearly 33,500); the number involving cocaine increased nearly six-fold (from ~4,400 to nearly 25,000). The alarming increase in stimulant-involved overdose deaths is a stark illustration that we face an evolving addiction and overdose crisis characterized by shifting use of different substances and use of multiple drugs and drug classes together.

The collision of the overdose crisis with the coronavirus disease 2019 (COVID-19) pandemic puts people with SUDs at particular risk. Drug use and overdose markedly increased after the pandemic began; the 34 percent increase in overdose deaths between 2019 and 2020 was the largest one-year increase ever recorded. Individuals with SUDs are at higher risk for COVID-19 and its adverse outcomes. Social isolation and stress—factors long known to drive substance use and relapse—are likely contributing factors."

Updated in 2024, NIDA reported on research led to the development of effective prevention and treatment interventions, providing hope for the more than 40 million people in the United States with SUDs and their loved ones.

As reported, drug overdoses in the United States started to rise beginning in the late 1990s, driven by the over-prescription of opioids for pain that resulted in diversion and a rise in opioid addiction and overdoses. This subsequently expanded to overdoses from heroin and fentanyl, worsening the overdose crisis. More recently, the co-use of stimulants has compounded the problem.

The escalation of drug overdose deaths began to decelerate in 2021, and data from the Centers for Disease Control and Prevention showed a significant decrease in deaths in 2023, with provisional data suggesting this continued in 2024. It is critical that scientific solutions continue to be developed and deployed to address an evolving addiction and overdose crisis characterized by shifting use of different substances and the concomitant use of multiple drugs and drug classes.

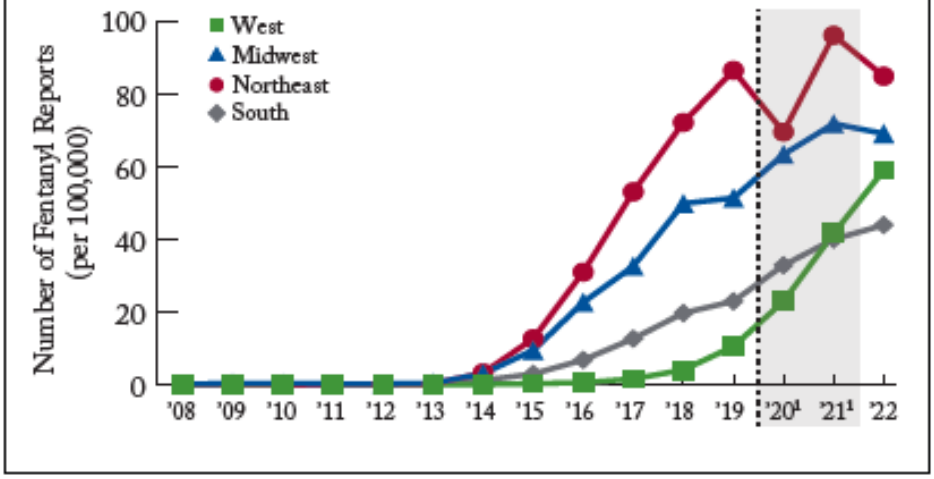
In the face of an ongoing addiction and overdose crisis, NIDA's FY 2022-2026 Strategic Plan continues to represent advances in drug addiction research and commitment to advancing all aspects of addiction science in the service of improving people's lives.

Currently, fentanyl and other synthetic opioids other than methadone, frequently in combination with cocaine and methamphetamine, are driving overdose fatalities, which in 2023 led to 105,007 deaths.[3]
Overdose fatalities still account for tens of thousands of deaths annually and there are nearly 9 million Americans ages 12 and older who misused opioids in the past year, and an estimated 5.7 million with OUD, which is appraised to be an undercount. In parallel, chronic pain affects 50 million adults in the United States with nearly 20 million living daily with chronic pain that interferes with their lives and if improperly treated, puts them at risk for illicit opioid misuse alongside the risk of OUD and overdoses.

Source: National Institute on Drug Abuse NIDA Strategic Plan https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message and at https://nida.nih.gov/publications/2022-2026-nida-strategic-plan/heal-opioid-use-disorder-overdose-strategic-plan/nida-heal-opioid-use-disorder-overdose-strategic-plan-fy-2025

Drug Enforcement Agency (DEA) Data

Figure 1.7 Regional trends in fentanyl reported per 100,000 people aged 15 or older, January 2008–December 2022



Fentanyl reports, from 2008 to 2014, show a gradual increase in the West when compared to other regions. Reports remained steady through 2013 for the Midwest, Northeast, and South until substantial increases began in 2014/2015 and continued through 2021. In 2022, fentanyl reports decreased in the Northeast and Midwest while reports increased in the South and West.

Source: U.S. Drug Enforcement Administration, Diversion Control Division. National Forensic Laboratory Information System: NFLIS Drug Annual Report. https://www.nflis.deadiversion.usdoj.gov/publicationsRedesign.xhtml

National Forensic Laboratory Information System Data

The National Forensic Laboratory Information System (NFLIS) Drug 2020 Annual Report was used to compile data on tracked drug trends in the 2022 CHNA and updated using available data published online in July 2025.

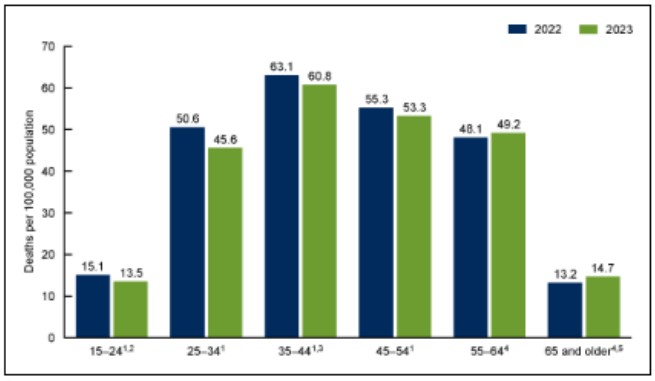
For fentanyl, the Northeast showed a gradual increase from 2006 to 2014, followed by considerable increases from 2015 through 2019 and a recent decrease in 2020. Reports were steady from 2006 through 2013 for the Midwest, West, and South until substantial increases began in 2014. In the most recent data, Fluoralfentanyl was reported as first appearing in NFLIS in 2015. Reports of Fluoralfentanyl increased significantly from fewer than 10 reports annually to over 15,000 reports in 2021 and to more than 22,000 reports in 2022.

The latest information also indicates that from 2008 to 2010, oxycodone reports increased then steadily declined through 2022. Psilocin/psilocybin use has more than doubled from 2016 through 2022.

Source: U.S. Drug Enforcement administration, Diversion Control Division. National Forensic Laboratory Information System: NFLIS Drug Annual Report.
https://www.nflis.deadiversion.usdoj.gov/publicationsRedesign.xhtml

Centers for Disease Control and Prevention Data

Figure 2. Drug overdose death rate, by selected age group: United States, 2022 and 2023



[1]Significant decrease between 2022 and 2023 ($p < 0.05$).
[2]Group was significantly lower than all others in 2023 ($p < 0.05$).
[3]Group was significantly higher than all others in 2022 and 2023 ($p < 0.05$).
[4]Significant increase between 2022 and 2023 ($p < 0.05$).
[5]Group was significantly lower than all others in 2022 ($p < 0.05$).
NOTE: Drug overdose deaths are identified using the *International Classification of Diseases, 10th Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Source: Centers for Disease Control and Prevention https://www.cdc.gov/nchs/products/databriefs/db522.htm#section_1

Corresponding data from the Centers for Disease Control and Prevention indicates:

- The rate of drug overdose deaths decreased among young and middle-aged adults from 2022 to 2023.
- From 2022 to 2023, the rate of drug overdose deaths decreased among people ages 15–24 (from 15.1 deaths per 100,000 to 13.5), 25–34 (50.6 to 45.6), 35–44 (63.1 to 60.8), and 45–54 (55.3 to 53.3).
- Between 2022 and 2023, the rate of drug overdose deaths increased among adults ages 55–64 (from 48.1 to 49.2) and 65 and older (13.2 to 14.7). In both 2022 and 2023, the rate of drug overdose deaths was highest for adults ages 35–44. In 2022, the rate was lowest for adults age 65 and older, but in 2023 the rate was lowest for people ages 15–24.
- From 2022 to 2023, adults age 65 and older experienced the largest percentage increase in the rate of drug overdose deaths (11.4%), and the largest decrease was for people ages 15–24 (10.6%).
- The age-adjusted rate of drug overdose deaths increased from 8.9 deaths per 100,000 standard population in 2003 to 32.6 in 2022; however, the rate decreased to 31.3 in 2023.
- Rates decreased between 2022 and 2023 for people ages 15–54 and increased for adults age 55 and older.

Provisional data from the CDC's National Center for Health Statistics indicate there were an estimated 80,391 drug overdose deaths in the United States during 2024—a decrease of 26.9% from the 110,037 deaths estimated in 2023.

Almost all states across the nation saw decreases; Louisiana, Michigan, New Hampshire, Ohio, Virginia, West Virginia, and Wisconsin and Washington, D.C., experienced declines of 35% or more. In contrast, South Dakota and Nevada had slight increases compared to the same period in 2023.

The new data show overdose deaths involving opioids decreased from an estimated 83,140 in 2023 to 54,743 in 2024. Overdose deaths involving cocaine and psychostimulants (like methamphetamine) decreased as well.

After a period of increase between 2013 and 2022, rates of drug overdose deaths involving synthetic opioids other than methadone, which includes fentanyl, fentanyl analogs, and tramadol, decreased between 2022 and 2023.

The age-adjusted rate of drug overdose deaths involving synthetic opioids other than methadone, which includes fentanyl, fentanyl analogs, and tramadol, was mostly stable from 2003 (0.5 deaths per 100,000 standard population) to 2013 (1.0) and then increased through 2021 (21.8), with different rates of change over time. From 2022 to 2023, the rate decreased by 2.2% from 22.7 to 22.2.

After increasing from 2003 to 2006 and decreasing from 2006 to 2017, the age-adjusted rate of drug overdose deaths involving methadone remained stable through 2023.

After no significant change from 2020 to 2021, the age-adjusted rate of drug overdose deaths involving natural and semisynthetic opioids, which includes drugs such as morphine, oxycodone, and hydrocodone, decreased 17.1% from 3.5 in 2022 to 2.9 in 2023.

The age-adjusted rate of drug overdose deaths involving heroin decreased 33.3% from 1.8 in 2022 to 1.2 in 2023.

Source: Centers for Disease Control and Prevention https://www.cdc.gov/nchs/products/databriefs/db522.htm#section_1

Recommendations for Addressing Substance Use Issues

2023 Ohio State Health Assessment
At the time of compiling information for this CHNA, the State of Ohio had not yet published a new state health assessment. It was in progress and the following information was available from the Ohio Department of Health at Ohio 2023 State Health Assessment https://odh.ohio.gov/about-us/state-health-assessment

Ohio University (OU) served as the lead organization conducting the SHA under the guidance of the Ohio Department of Health (ODH). The Ohio State University's Government Resource Center and the University of Toledo collaborated with OU and ODH in the SHA development process. The information gathering process was guided by the 2020-2022 SHIP framework, which prioritized three categories of health factors and three categories of health outcomes.

Prioritized Health Factors: The top five factors identified by discussion groups that should remain in the SHIP include: housing, nutrition, poverty, local access to healthcare providers, and unmet need for mental healthcare. The most frequently mentioned factors to add to the SHIP are transportation, food security, cultural competency, violence, and health literacy. Prioritized Health Outcomes: The top five outcomes identified by discussion groups that should remain in the SHIP include: depression, suicide, maternal morbidity, drug overdose deaths, and youth drug use. The most frequently suggested priority health outcome to be added to the SHIP was obesity, followed by anxiety, trauma, cancer, and hypertension. Emerging Issues Several of the emerging issues identified by the discussion groups were related to current or suggested health factors and outcomes. They may be unpredictable and their significance may grow over time. The top emerging issues include: cultural competency, mistrust of institutions, long COVID, aging Ohioans, and sexually transmitted infections - particularly syphilis.

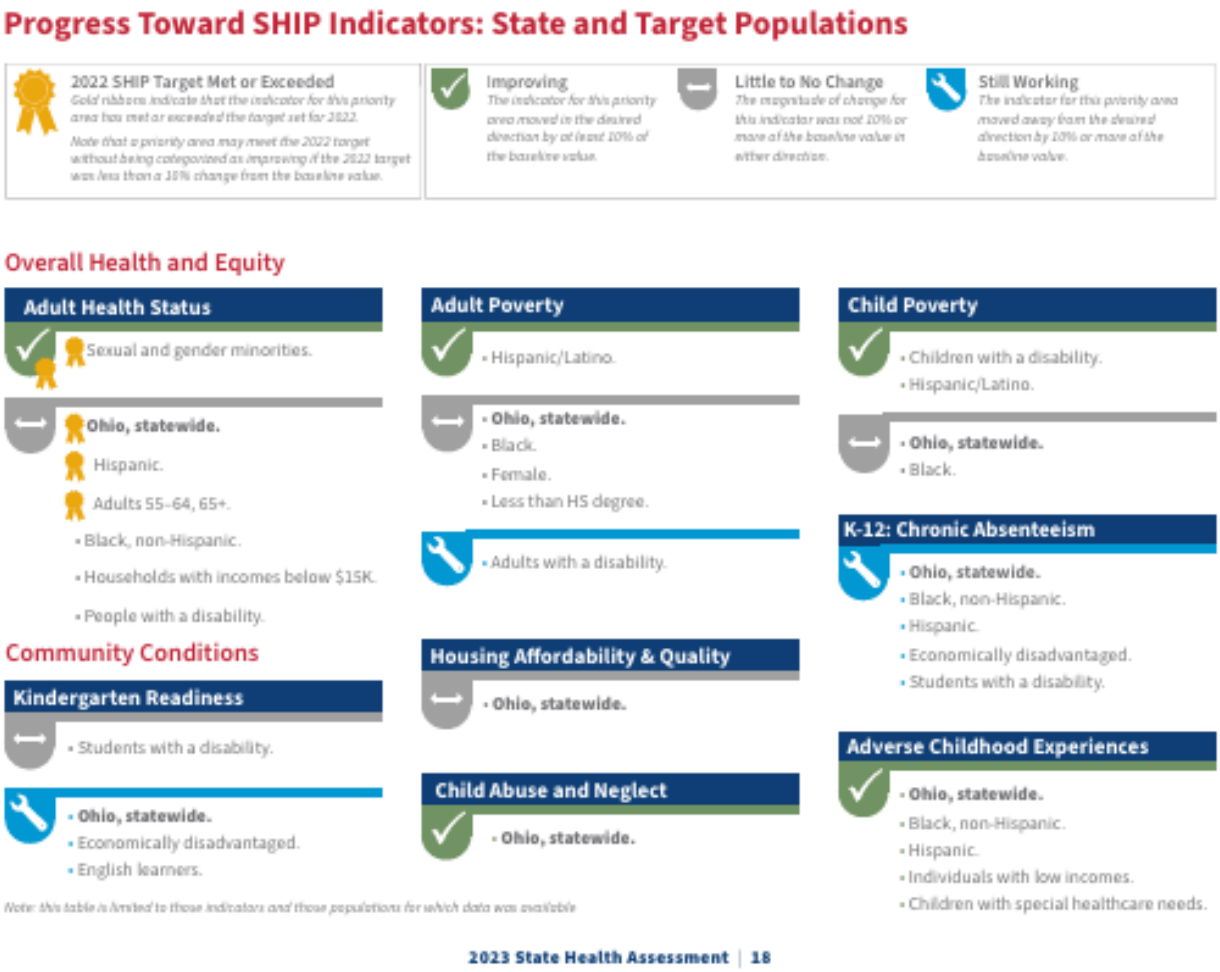
Persistent Challenges:

- Mental health and substance use continue to adversely impact Ohioans in significant ways. Rates of depression among both youth and adults have increased. SHA contributors strongly indicated that anxiety is increasing among youth and adults in ways previously unseen. The number of suicides in Ohio has increased since 2017.
- Many Ohioans face obstacles when it comes to accessing healthcare. These obstacles include insufficient access to health insurance, low levels of health literacy, limited culturally and linguistically appropriate care, and shortages of healthcare providers. Healthcare providers who accept Medicaid are in especially short supply.
- Many of the underlying drivers of health, such as income, food security, and access to safe, affordable housing, have not improved since the last SHA.
- Not all Ohioans have equal access to the resources that promote and protect health such as healthy food stores, bike paths, community centers, and more. This is a challenge for rural and urban areas. Contributors to the 2023 SHA echoed the call to action issued in previous SHAs to address the disparities in health outcomes for minority groups.

New and Emerging Issues:

- As Ohio's senior population grows, organizations that serve seniors are expressing increasing concern about the gaps in resources available for them. Examples include reliable transportation and mobility supports, especially for seniors desiring to age in their own residences.

Ohio is an aging state. It is estimated that by 2025 more than 1 in 4 Ohioans will be aged 60 and older.



Source: Ohio 2023 State Health Assessment https://odh.ohio.gov/about-us/state-health-assessment

Progress Toward SHIP Indicators: State and Target Populations

(continued)

2022 SHIP Target Met or Exceeded
Gold ribbons indicate that the indicator for this priority area has met or exceeded the target set for 2022. Note that a priority area may meet the 2022 target without being categorized as improving if the 2022 target was less than a 10% change from the baseline value.

Improving
The indicator for this priority area moved in the desired direction by at least 10% of the baseline value.

Little to No Change
The magnitude of change for this indicator was not 10% or more of the baseline value in either direction.

Still Working
The indicator for this priority area moved away from the desired direction by 10% or more of the baseline value.

Access to Care

Health Insurance: Uninsured Adults
- Black, Hispanic and non-Hispanic.
- Hispanic/Latino.
- Individuals with income below 138% Federal Poverty Level.
- Male.
- **Ohio, statewide.**

Health Insurance: Uninsured Children
- **Ohio, statewide.**
- Hispanic/Latino.
- Households with annual income below 200% Federal Poverty Level.

Mental Health Professional Shortage
- **Ohio, statewide.**

Adults With Past Year Mental Illness with Unmet Needs
- **Ohio, statewide.**

Youth Major Depression with Unmet Needs
- **Ohio, statewide.**

Primary Care Health Professional Shortage Areas
- **Ohio, statewide.**

Mental Health and Addiction

Youth Depression
- **Ohio, statewide.**

Youth Suicide
- **Ohio, statewide.**
- White, non-Hispanic.
- Males.

Youth Alcohol Use
- **Ohio, statewide.**
- Female.

Youth Marijuana Use
- **Ohio, statewide.**
- Black.
- LGBTQ+.
- Hispanic.

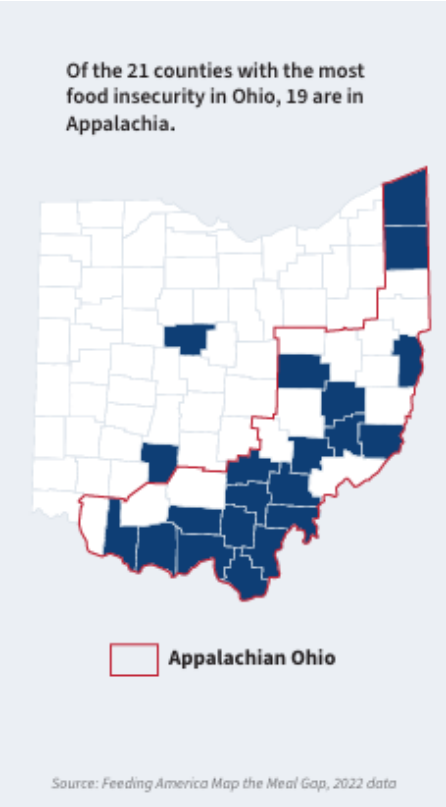
Unintentional Drug Overdose Deaths
- **Ohio, statewide.**
- Adults 25–34, 35–44, 45–54.
- Male.
- Residents of Appalachian and urban counties.

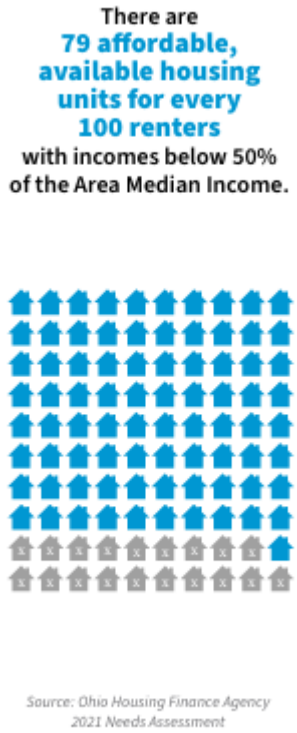
Adult Suicide
- Adults, ages 55-64.
- Residents of Appalachian counties.
- **Ohio, statewide.**
- Adults 35–44.
- Male.

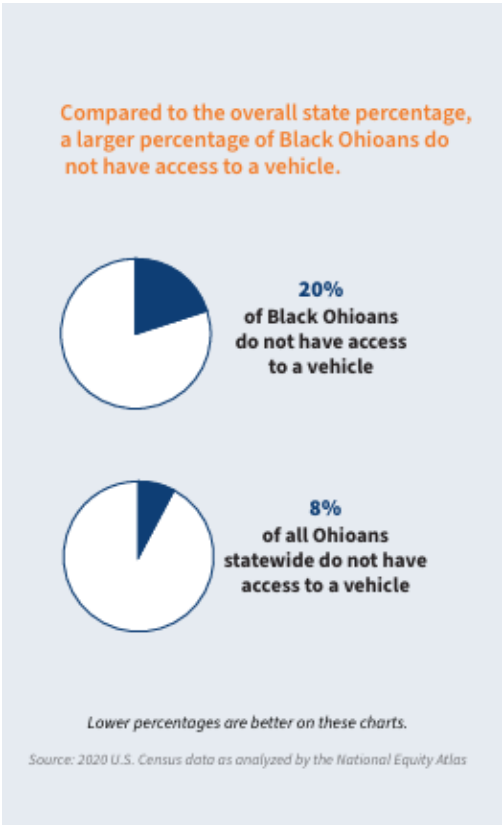
Adult Depression
- **Ohio, statewide.**

Note: this table is limited to those indicators and those populations for which data was available

Source: Ohio 2023 State Health Assessment https://odh.ohio.gov/about-us/state-health-assessment







Source: Ohio 2023 State Health Assessment https://odh.ohio.gov/about-us/state-health-assessment

Access to Quality Affordable Housing

The size of Ohio's housing stock is insufficient, especially for Ohioans with low incomes. There has been no increase in the rate of available housing for renters with income below 50% of the Area Median Income since the last SHA. When housing is available, it is not always affordable. Housing advocates estimate that, on average, renters in Ohio require a full-time job that pays at least $19.09 an hour in order to be able to afford a two-bedroom unit priced at fair market rent. In Ohio, the average wage of renters is $18.47, and in 2023 the minimum wage was $10.10. This puts affordable housing out of reach for many of Ohio's 1,588,226 renters. When housing is both available and affordable, it is not always safe or of sufficient quality. Statewide, 12.6% of housing units in Ohio have at least one feature defined by the Census as a housing problem: overcrowding, lack of kitchen facilities, lack of plumbing facilities, or high cost.

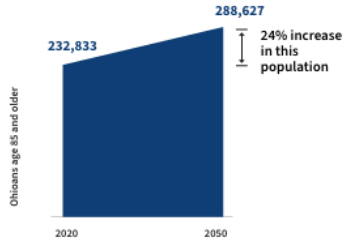
Homelessness

Representatives of organizations that serve priority populations reported that their clients are experiencing homelessness for longer periods of time than before: "People are staying in shelters for longer periods of time. It's harder to get people out of shelter[s] and out of homelessness. This can lead to additional health factors." For some, this trend has progressed to the point that there has been a "normalizing of houselessness, [a] normalizing of not having space and place".

Resources for Older Ohioans

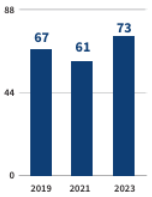
As Ohio's population age 60+ grows, and specifically those 85 and older, organizations that serve seniors are expressing increasing concern about the adequacy of resources available to support them, especially those who wish to remain in their homes. Resources like reliable transportation, safety and mobility supports for the homes of seniors aging in place, geriatric care managers, adult day care programs, respite care for care providers, and assistance with meals and personal care will be increasingly in-demand as this population grows.

By 2050, Ohio is expected to be home to over 55,000 more seniors 85 and older than it is today.



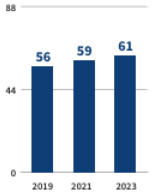
Source: Ohio Development Agency, State of Ohio Population Projections Overview, 2020-2050

The number of Ohio counties with a primary health professional shortage area has increased from 2019 to 2023.



Lower numbers are better on this graph.
Source: Baseline HRSA, as compiled by the Ohio Department of Health
Notes: Monitoring, no targets

The number of Ohio counties with a mental health professional shortage area has increased from 2019 to 2023.

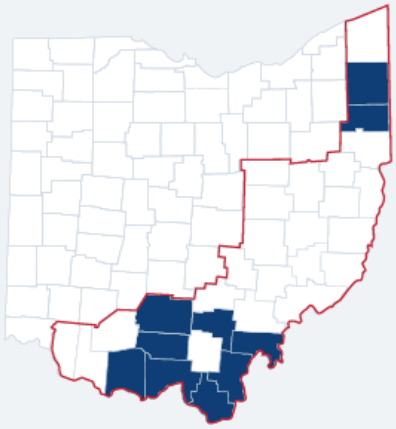


Lower numbers are better on this graph.
Source: Baseline HRSA, as compiled by the Ohio Department of Health
Notes: Monitoring, no targets

Healthcare Access and Quality

Healthcare providers who participated in the SHA data-collection process indicated that there is a great deal of burnout in their professions, which is reducing the already limited supply of available providers. An estimated 2.4 million Ohioans live in Primary Care Health Professional Shortage Areas. Source: Baseline HRSA, as compiled by the Ohio Department of Health. Roughly 5.2 million Ohioans live in Mental Healthcare Professional Shortage Areas and an estimated 2 million Ohioans live in Dental Health Professional Shortage Areas.

The 10 counties with the highest average age-adjusted rates of unintentional drug overdose deaths by county between 2020-2023 are in Appalachia.



Source: Source:
ODH Bureau of Vital Statistics. Analysis: ODH Violence and Injury Epidemiology and Surveillance Section. Includes Ohio residents who died due to unintentional drug poisoning (underlying cause of death ICD-10 codes X40-X44).

Opioids and Overdose

A large majority (93.8%) of health departments and hospitals identified substance use as a priority health issue in their recent health assessments. Unintentional overdose deaths in Ohio are driven largely by the use of fentanyl in combination with other drugs. In 2023, the unintentional drug overdose death rate for Black non-Hispanics (64.9 deaths per 100,000 population) continued to surpass the rate for White non-Hispanics (37.6 deaths per 100,000 population). Black non-Hispanic males had the highest drug overdose death rate in Ohio compared with other sex and race/ethnicity groups.[18]

Source: Ohio 2023 State Health Assessment https://odh.ohio.gov/about-us/state-health-assessment

Barriers to Health Care – National Outlook

NIDA reports that barriers to health care services can be logistical, such as difficulties accessing care for people who are experiencing homelessness, living in rural communities or lack reliable access to transportation. Others may involve policy or regulatory impediments that limit or slow the deployment of an intervention. Legal systems pose particular challenges, as evidence-based treatments are often not the standard of practice in prisons and jails.

NIDA supports projects to study ways to connect people to care, with approaches ranging from utilizing telemedicine to leveraging partnerships with schools, legal systems, community organizations, and others. In addition, even when services are available, they are often fractured.

Research demonstrates that people who receive continuity of care (i.e., quality care over time), such as supportive services beyond initial treatment, have better outcomes. Yet, continuity of care is not standard practice, and barriers exist in terms of lack of standard models and insurance reimbursement

Key Focus Areas

- Test the implementation of telemedicine-based approaches and digital technologies for expanding the reach of effective SUD treatment.
- Develop strategies for overcoming barriers to delivering preventive care and treatment for individuals with SUDs and HIV and other infectious illnesses.
- Develop interventions to reduce barriers to health care access for people with SUDs and co-occurring conditions.

Source: https://nida.nih.gov/about-nida/2022-2026-strategic-plan/priority-area-4#Goal4-2

National Institute on Drug Abuse (NIDA)

The National Institute on Drug Abuse published recommendations included in the 2022 CHNA to address the addiction crisis which are still relevant in 2025. The NIDA strategic plan identified areas to improve outcomes. These areas include:

- **Reduce Stigma**. According to the NIDA plan, people with substance use disorders (SUDs) are often marginalized by work, families, friends and health care providers. People in active addiction or even those in recovery are often viewed negatively in society. Stigma may prevent people from openly discussing their struggles with substances, which is a barrier to seeking or obtaining treatment or other care services. Additionally, the NIDA report notes that if care is sought, providers may not deliver adequate care. Consequently, NIDA is prioritizing research to identify and combat stigma and develop approaches to improve engagement in treatment.
- **Reduce Health Disparities**. Social, economic and environmental disadvantages affect people with and without substance use issues. NIDA's proposed solutions include identifying and developing approaches that address inequities for people living in rural areas where there are few treatment options, limited child-care resources and barriers to transportation. Solutions should also concentrate on racial barriers and the provision of equitable care. Intervention, treatment and recovery support should identify needs and be culturally responsive.
- **Comprehensive Care**. Individuals with substance use disorders often require comprehensive physical and mental health care. For many, other health conditions such as HIV, Hepatitis, Tuberculosis and chronic pain need to be treated concurrently with addiction services. NIDA recommends continued research to develop strategies for delivering comprehensive care.

Source: NIDA. 2022, September 20. Director's Message. Retrieved from https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message on 2022, September 22
https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message

The NIDA strategic plan also redefined recovery. It suggested that recovery from substance use disorders be broadened to beyond complete abstinence from mood altering substances to a general improvement of an individual's health and well-being. This would redefine recovery to include abstinence as well as the lessening of substance use. Recovery would still include the development of effective coping strategies and the improvement of physical and mental health.

NIDA proposed continuing research to explore recovery strategies, such as family-based support networks for youth, peer recovery support models, virtual reality-based mindfulness and other digital health approaches as well as strategies tailored to specific populations and settings.

NIDA recognized the importance of recovery support both during and after treatment. The strategic plan suggested further work to promote peer recovery support as well as effective recovery strategies that address stigma, racial inequities, housing instability, legal system barriers and other barriers that keep people from sustaining long-term recovery.

Key Focus Areas from the 2022 NIDA Strategic Plan:

- Understand the mechanisms by which recovery support groups exert their effects.
- Support research on different pathways by which people recover from SUDs.
- Incorporate a broader range of clinical outcomes in recovery research beyond abstinence and reduced drug use, such as improved quality of life and health or reduction in risk behaviors and medical consequences.
- Develop and refine research methods for evaluating recovery support services and support research on the efficacy of these services.
- Develop novel interventions for sustained recovery that target factors that increase vulnerability for relapse.
- Investigate the impact of stigma and other social determinants of health on recovery.

Source: NIDA. 2022, September 20. Director's Message. Retrieved from https://nida.nih.gov/about-nida/2022-2026-strategic- plan/directors-message on 2022, September 22
https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message

The 2024 Companion Infographic Report: Results from the 2021 to 2024 National Surveys on Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) published the *2024 Companion Infographic Report: Results from the 2021 to 2024 National Surveys on Drug Use and Health*. This infographic is a visual presentation of selected estimates from the 2021-2024 National Surveys on Drug Use and Health (NSDUHs). Selected national indicators included in this CHNA report on substance use, substance use disorders, mental health issues, substance use treatment, and recovery from substance use problems for population aged 12 or older in the United States.

The following information was sourced from: Substance Abuse and Mental Health Services Administration. (2025). *2024 Companion infographic report: Results from the 2021 to 2024 National Surveys on Drug Use and Health* (SAMHSA Publication No. PEP25-07-006). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases

Definitions

SUBSTANCE USE

Binge alcohol use means consumption of four or more drinks on the same occasion for females and five or more drinks on the same occasion for males on at least 1 day in the past 30 days. **Heavy alcohol use** means binge drinking on 5 or more days in the past 30 days.

Illegally made fentanyl (IMF) refers to fentanyl that is produced by clandestine laboratories instead of the pharmaceutical industry. Therefore, IMF cannot be obtained from a doctor or pharmacy. It comes in forms such as powder, pills, or blotter paper.

Illicit drug use includes the use of marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription drugs (pain relievers, tranquilizers, stimulants, or sedatives). **Misuse of prescription drugs** means use in any way not directed by a doctor, such as use without a prescription of one's own, or use in greater amounts, more often, or longer than told to take a drug. Estimates for illicit drug use and misuse of prescription drugs do not include IMF.

Central nervous system stimulant misuse includes the misuse of prescription stimulants or the use of cocaine or methamphetamine.

Opioid misuse includes the misuse of prescription opioids or the use of heroin. Estimates for opioid misuse do not include IMF.

SUBSTANCE USE DISORDERS

Substance use disorders (SUDs) are characterized by impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home. Respondents who used alcohol or drugs in the past 12 months were classified as having SUDs in that period if they met criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5).[3] Respondents who used marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutic drugs were classified as having a **drug use disorder (DUD)** if they had a disorder related to any of these substances that they used in the past year. Respondents were classified as having an **opioid use disorder (OUD)** if they had a disorder related to their use of heroin or prescription opioids in the past year. Respondents who used alcohol in the past year were classified as having an **alcohol use disorder (AUD)** if they met criteria for an AUD in the past year. Respondents were classified as having an SUD if they had an AUD or a DUD in the past year.

TREATMENT

Substance use treatment means the receipt of treatment or counseling in the past 12 months for the use of alcohol or drugs in an inpatient location, in an outpatient location, through the use of medications for alcohol use disorder or opioid use disorder, via telehealth treatment, or in a prison, jail, or juvenile detention center.

Mental health treatment means the receipt of treatment or counseling for any problem with mental health, emotions, or behavior in the past 12 months in an inpatient location, in an outpatient location, through the use of prescription medication, via telehealth treatment, or in a prison, jail, or juvenile detention center.

RECOVERY

Respondents aged 18 or older were asked whether they thought they ever had a problem with their use of drugs or alcohol or whether they ever had a problem with their mental health. Respondents who reported that they ever had a problem with their drug or alcohol use were asked whether they considered themselves (at the time they were interviewed) to be in recovery or to have recovered from their drug or alcohol use problem. Similarly, respondents aged 18 or older who reported that they ever had a problem with their mental health were asked whether they considered themselves (at the time they were interviewed) to be in recovery or to have recovered from their mental health issue.

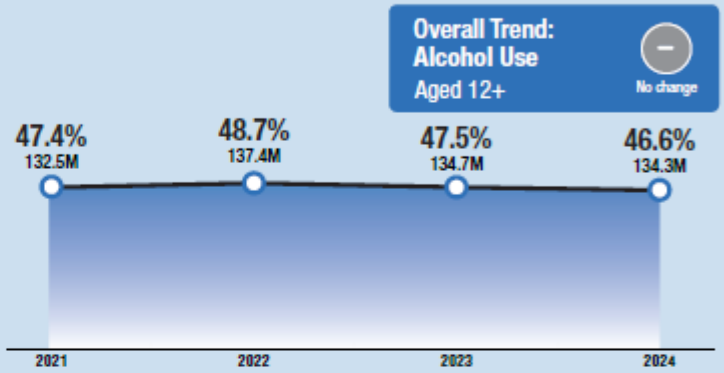
Substance Use

Alcohol Use in the Past Month

NSDUH asked respondents aged 12 or older about their alcohol use in the 30 days before the interview.

ALCOHOL USE

1 drink on at least 1 day

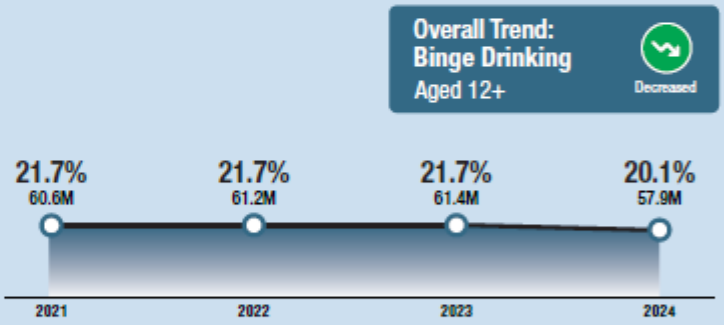


BINGE DRINKING

Number of drinks on the same occasion on at least 1 day

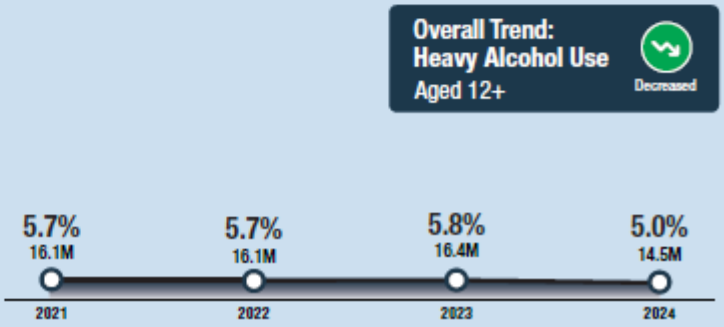
Males 5 or more

Females 4 or more



HEAVY ALCOHOL USE

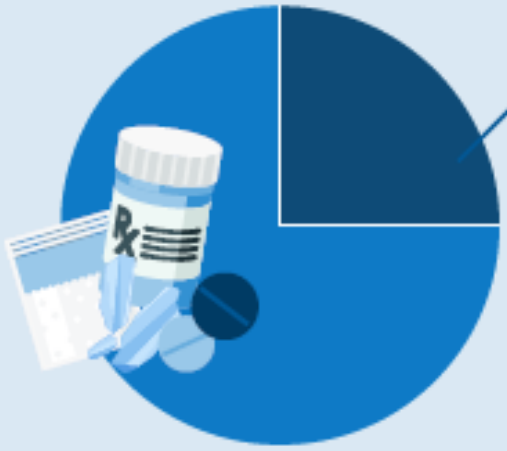
Binge drinking on 5 or more days in the past 30 days



Substance Use

Illicit Drug Use in the Past Year

NSDUH asked respondents aged 12 or older about their use of drugs in the 12 months before the interview.

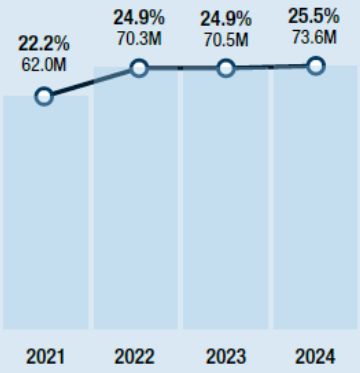


73.6 million

1 in 4
(25.5%) used illicit drugs in the past year in 2024

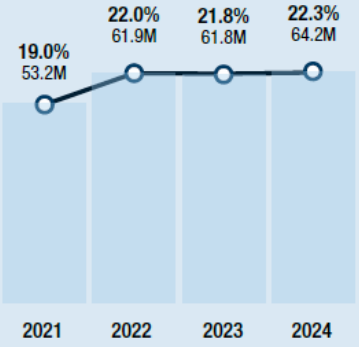
Any Illicit Drug Use

Overall Trend: Aged 12+ — Increased



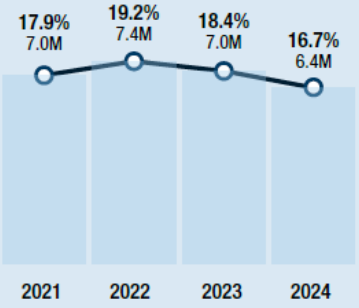
Marijuana Use

Overall Trend: Aged 12+ — Increased



Underage Marijuana Use

Overall Trend: Aged 12-20 — No change



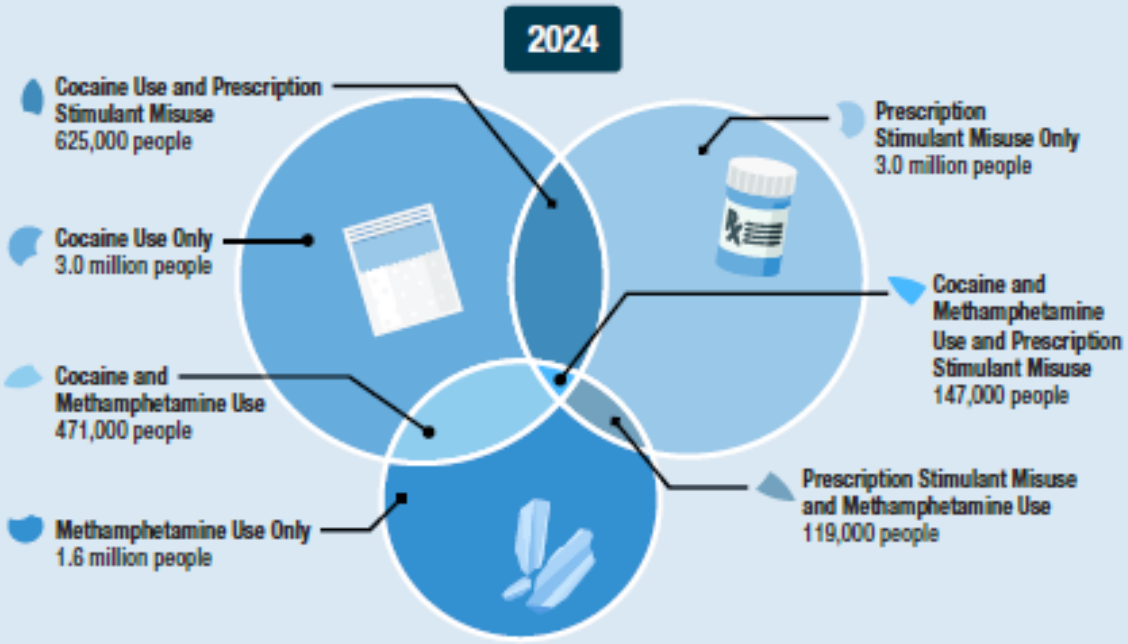
Illicit drug use includes the use of marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription drugs (pain relievers, tranquilizers, stimulants, or sedatives).

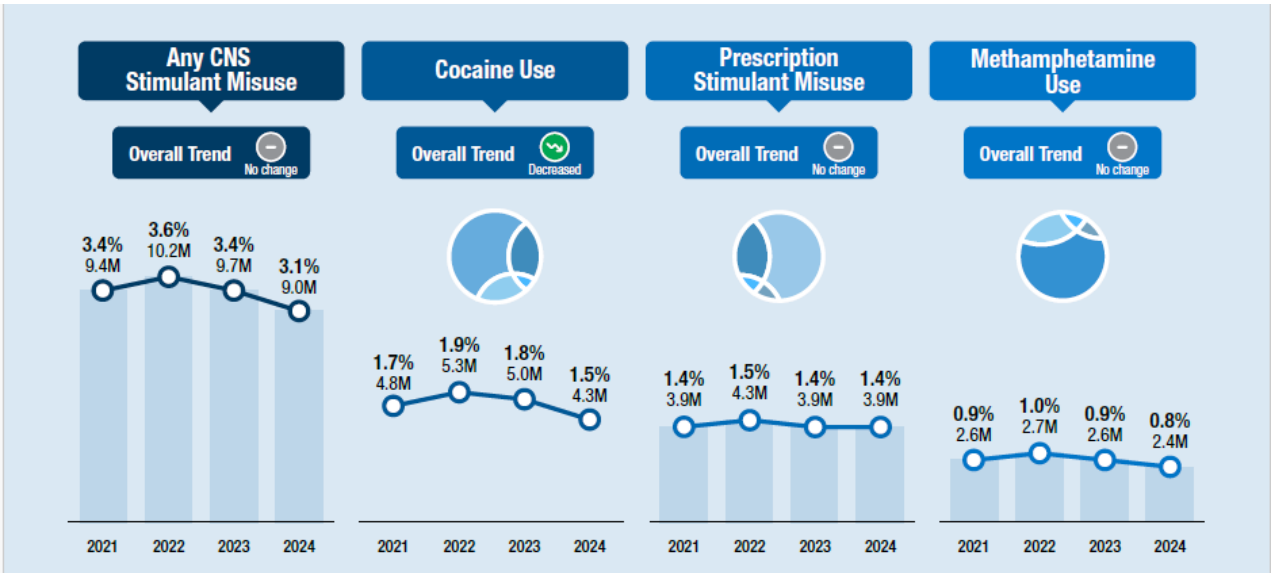
Misuse of prescription drugs means use in any way not directed by a doctor, such as use without a prescription of one's own, or use in greater amounts, more often, or longer than told to take a drug.

Substance Use

Central Nervous System Stimulant Misuse in the Past Year

NSDUH asked respondents aged 12 or older about their use of types of central nervous system (CNS) stimulants in the 12 months before the interview.

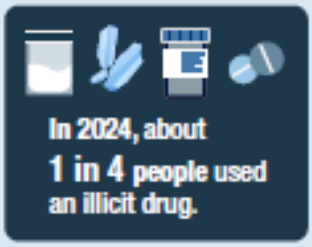




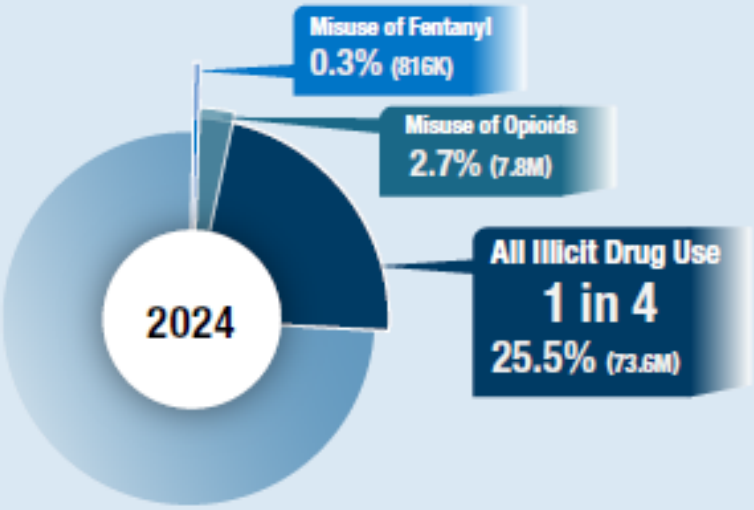
Substance Use

Opioid Misuse and Fentanyl Misuse in the Past Year

NSDUH asked respondents aged 12 or older about their use of opioids and fentanyl in the 12 months before the interview.

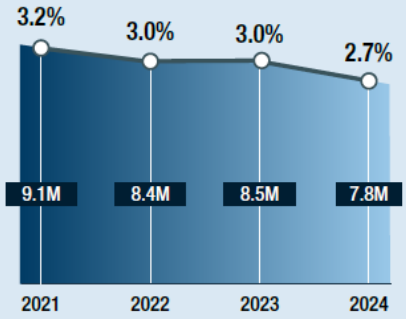


In 2024, about **1 in 4** people used an illicit drug.



Opioid Misuse

Overall Trend: Opioid Misuse — Decreased



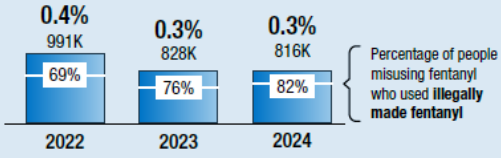
Fentanyl Misuse

Use of Illegally Made Fentanyl:

2022	69%	(686K)
2023	76%	(627K)
2024	82%	(668K)

Percentage of people misusing fentanyl who used **illegally made fentanyl**

Differences across Years:
There were no significant differences across years for estimates of fentanyl misuse.

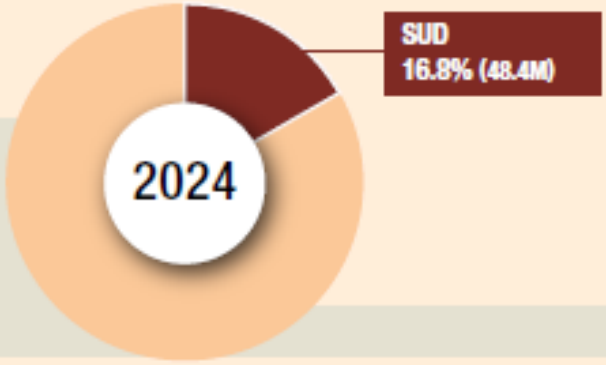


Misuse of fentanyl includes use of illegally made fentanyl or the misuse of prescription fentanyl in the past year. Estimates are not available for 2021 data.

Substance Use Disorders in the Past Year

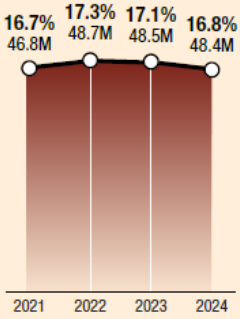
NSDUH asked respondents aged 12 or older about the effects of their drug or alcohol use on their lives in the 12 months before the interview.

Substance Use Disorder (SUD)



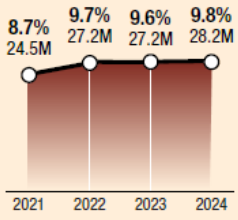
Substance Use Disorder (SUD)

Overall Trend: No change



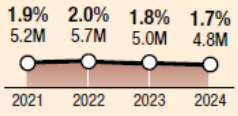
Drug Use Disorder (DUD)

Overall Trend: Increased



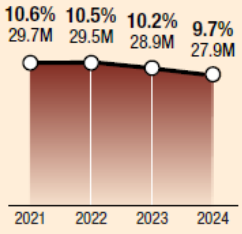
Opioid Use Disorder (OUD)

Overall Trend: No change



Alcohol Use Disorder (AUD)

Overall Trend: Decreased



SUD is characterized by impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Respondents were classified as having an SUD in the past year if they met criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition.

Respondents who used marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutic drugs were classified as having a **DUD** if they had a disorder related to any of these substances that they used in the past year.

Respondents were classified as having an **OUD** if they had a disorder related to their use of heroin or prescription opioids in the past year.

Respondents who used alcohol in the past year were classified as having an **AUD** if they met criteria for an AUD in the past year.

Respondents were classified as having an SUD if they had an AUD or a DUD in the past year.

Adult Receipt of Treatment

Substance Use Treatment | Mental Health Treatment

NSDUH asked respondents aged 18 or older about their receipt of substance use treatment and mental health treatment in the 12 months before the interview.

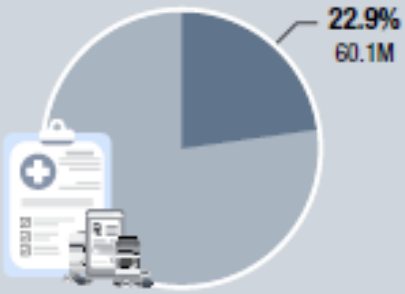
In 2024, **9.4 million** adults received substance use treatment, and **60.1 million** adults received mental health treatment.

2024

Substance Use Treatment

Treatment in an outpatient location was the most common setting.

Mental Health Treatment

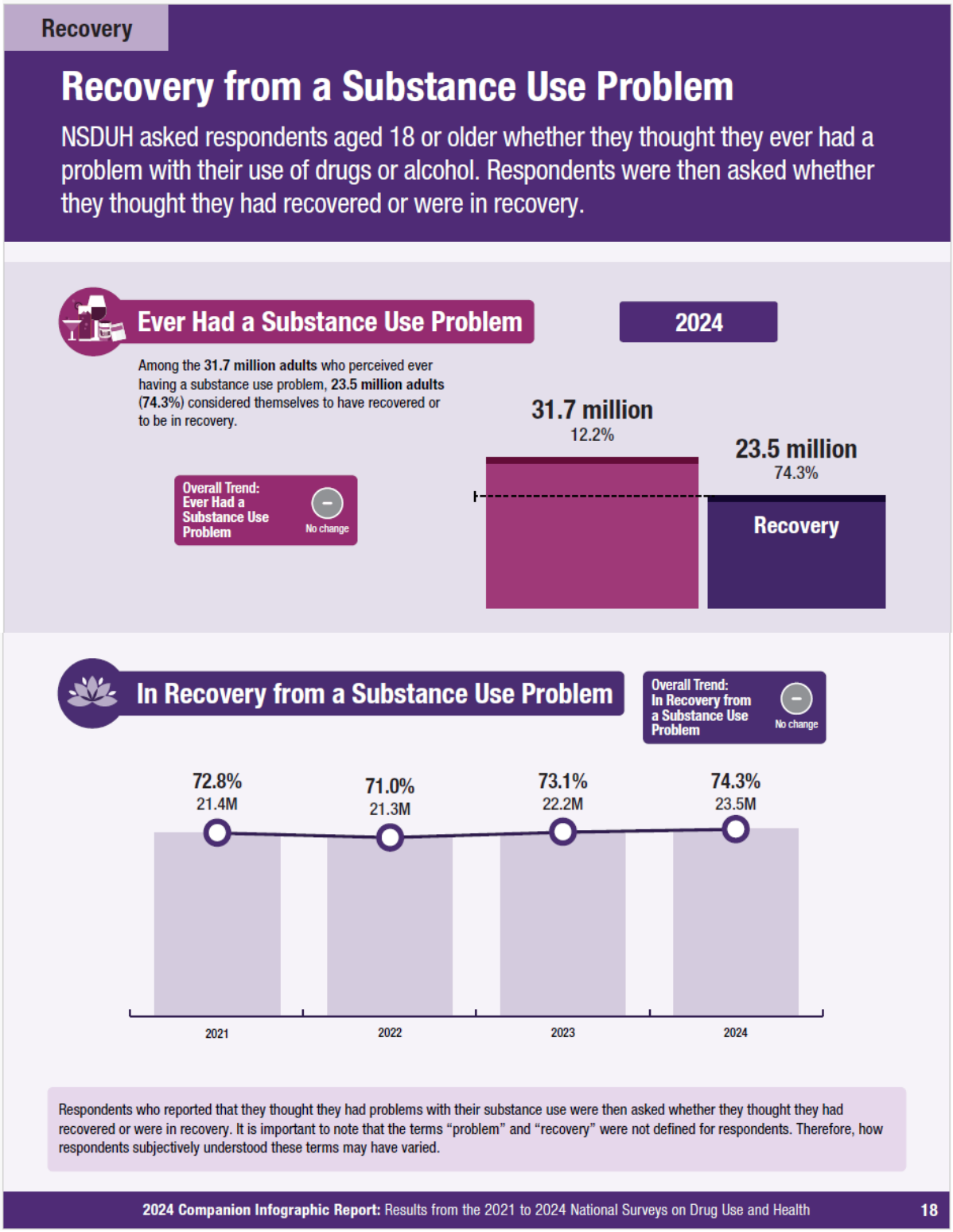


Prescription medication was the most common mental health treatment.

Estimates from 2021, 2022, and 2023 are not comparable with estimates from 2024 and have been excluded.

Substance use treatment means the receipt of treatment or counseling in the past 12 months for the use of alcohol or drugs in an inpatient location, in an outpatient location, through the use of medications for alcohol use disorder or opioid use disorder, via telehealth treatment, or in a prison, jail, or juvenile detention center.

Mental health treatment means the receipt of treatment or counseling for any problem with mental health, emotions, or behavior in the past 12 months in an inpatient location, in an outpatient location, through the use of prescription medication, via telehealth treatment, or in a prison, jail, or juvenile detention center.



Source: *2024 Companion infographic report: Results from the 2021 to 2024 National Surveys on Drug Use and Health* (SAMHSA Publication No. PEP25-07-006). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases

Secondary Data Analysis (Summary)

Demographics/Household Indicators

- Ashtabula County continues to have a lower median household income and per capita income than Ohio
- Ashtabula County has a significant percentage of persons living in poverty
- The number of people in Ashtabula County living in poverty increased to 17.8% in 2024
- The increasing number of households in poverty in Ohio is a decade long trend
- The Ohio poverty rate is 13.3%, the national poverty rate is 11.1%
- The majority of Glenbeigh's defined service area includes Appalachian Region counties
- The majority of Glenbeigh's defined service area has been impacted by population decline
- Employment growth in Ashtabula County in 2022-2023 was 0.1% while Ohio was at 2.4% and 3.0% nationally
- The median household income for the U.S. is $78,538, Ohio is $69,680 while Ashtabula County is $55,507
- More Ashtabula County residents completed High School (42.2%) compared to Ohio (32.3%)
- The number of Ohio households headed by people age 65 and older is the fastest growing group
- Appalachian's population became older between 2010 and 2023
- The share of people of color in the Appalachian Region increased to 21.3 percent
- The Appalachian portion of all 13 states saw a decline in the share of residents living in family households
- Housing cost burden among renters is Appalachia increased slightly
- In Ohio, 49% of the older population, individuals age 65 and older, live in households below the ALICE Threshold
- ALICE households often do not qualify for public assistance but do not have enough income to afford basics where they live

Access to Health Care

- Ashtabula County remains a HRSA designated health professional's shortage area for primary care, dental health and mental health
- Ashtabula County remains a HRSA designated medically underserved area
- Ashtabula and Trumbull counties have higher percentages of uninsured adults than the state average
- Access to reliable, affordable broadband remains a challenge in many Appalachian communities.
- Substance abuse treatment remains limited throughout Appalachia
- More people believe substance use and mental health issues should be treated collectively
- Collaboration among agencies remains a priority to provide prevention, intervention and treatment services
- While the number of mental health care providers has increased across the entire defined service community, there remains a high proportion of clients to providers
- Inequities continue to exist for access to mental health providers
- Self-help remains an important resource for people with substance use disorders
- Transportation remains limited throughout the Appalachian region

Education

- Compounding factors limit access to educational opportunities especially in the Appalachian Region
- Limited access to reliable, affordable broadband is a challenge to education and workforce development
- There remains a need for readily available educational and workforce development opportunities to advance careers
- Education and development opportunities are needed to build a qualified workforce to treat substance abuse and mental health issues
- There remains a need for more providers with the appropriate education and certification to work in the field of addiction treatment and social services

Health Behaviors

- Ashtabula County survey participants continue to express little interest in learning about treatment or recovery, which corresponds with national surveys
- Ashtabula County had 32% of adults reported binge drinking
- In Ashtabula County 44.3% of households with at least one child report knowing someone with a methamphetamine problem
- The overall defined service area continues to experience significant numbers of overdose deaths despite an overall decrease in the total number of overdose deaths
- Nationally, a high percentage of people classified as needing treatment continue to think they do not need treatment for their substance use
- Alcohol-use affects 62.5% of the population resulting in 4,126,082 emergency room visits and 178,307 annual deaths of which 61,063 are acute and 117,245 chronic
- In Appalachia, physical/mental health issues as well as substance use prevents many from working
- Drug of choice varies by race. The White population trends toward the use of sedatives, alcohol and opioids while the Black population trends toward the use of PCP and cocaine
- In 2024, overdose deaths in among Whites slowly trended down while at the same time, overdose deaths among Blacks slowly increased

Other

- Glenbeigh's defined service area includes several Appalachian Region areas
- The percentage of households with no vehicle and limited access to public transport remains problematic
- Appalachia remains territorial therefore solutions should be tailored to meet local needs
- Generational poverty within Appalachia complicates efforts to create jobs
- Substance abuse, child abuse and domestic violence interconnect with poverty
- The Appalachian Region continues to be impacted by a lack of affordable housing, healthcare and access to general services
- Transportation remains a challenge in rural communities
- Public transportation may be limited or unavailable in urban areas within the defined service area
- There is a need for more recovery support services for individuals as well as family members, including children

Socioeconomic factors directly affect the health needs of residents within Glenbeigh's defined service community. In 2025, the service community stretched across northeast Ohio and includes five counties in western Pennsylvania. The majority of the area remains in the Appalachian Region, which provides limited educational opportunities, employment options, income advancement and access to transportation, housing and health care. These limitations cause residents to focus on obtaining basic living needs such as food, shelter and clothing, for themselves and their families as the priority. Socioeconomic factors directly impact substance use. Secondary data shows that there are significant disparities between northeast Ohio and the rest of the state as well as western Pennsylvania versus the remainder of the commonwealth.

Economically disadvantaged families continue to face life challenges that affect their ability to access or secure resources and improve their health, education and overall living conditions. Limited employment opportunities often lead to the inability to secure a sustainable living wage resulting in a higher likelihood to engage in unhealthy behaviors. Typically, this includes excessive or binge alcohol consumption.

The population in the defined service community is aging, with reports showing older adults, age 65 and over, as the fastest growing demographic. ALICE reports show that this same demographic is financially challenged as Social Security does not cover monthly expenses by almost half of the average payment leaving older households struggling to make ends meet. Concurrently, the number of overdose deaths in the older population is also increasing.

Glenbeigh's defined service area has many factors contributing to the abuse of alcohol and the use of illicit substances. In general, the community recognizes the dangers of opioid use, especially fentanyl use, but do not recognize the dangers associated with fentanyl disguised as, or mixed with, other drugs. Compounding factors with substance abuse are increases in acute and chronic illness, malnutrition, eating disorders as well as endocrine disorders and other disorders.

Results from the primary data surveys revealed that respondents working in addiction treatment and ancillary fields reported that stigma continues to play a role in people delaying treatment for substance use disorders however stigma in the workplace is decreasing. Much of the public still believes that drugs prescribed by a physician are not addictive. Alcohol is more widely accepted and alcohol use continues unabated, affecting all demographics.

Communities within Glenbeigh's service area have made progress addressing substance use disorders resulting in a decrease in the number of overdose deaths. Distribution of Naloxone, an opioid overdose reversal drug, has saved countless lives. However, the increased use of non-opioid substances is becoming a challenge as these drugs do not respond to Naloxone in an overdose situation. Additionally, compounding health issues from substances such as Xylazine require specialized care to address wound issues. The general idea that treatment is not necessary for substance use issues, which has not changed since 2015, needs further exploration.

Drug and Alcohol Treatment Centers in the Service Communities

Facility	County
OHIO	
Community Counseling Center	Ashtabula
Glenbeigh Hospital	Ashtabula
Lake Area Recovery Center/Turning Point	Ashtabula
Signature Health	Ashtabula
BrightView	Ashtabula
Addiction Recovery Services	Cuyahoga
Applewood Centers Inc.	Cuyahoga
Bellefaire Jewish Children's Bureau	Cuyahoga
Catholic Charities Diocese Cleveland	Cuyahoga
Charak Center for Health and Wellness	Cuyahoga
Circle Health Services	Cuyahoga
Cleveland Christian Home Inc.	Cuyahoga
Cleveland Clinic	Cuyahoga
Cleveland Department of Health	Cuyahoga
Cleveland Treatment Center Inc.	Cuyahoga
Community Action Against Addiction	Cuyahoga
Community Assessment and	Cuyahoga
Glenbeigh Outpatient Center of Beachwood	Cuyahoga
Glenbeigh Outpatient Center of Rocky River	Cuyahoga
Harbor Light	Cuyahoga
Highland Springs Hospital	Cuyahoga
Hitchcock Center for Women Inc.	Cuyahoga
Key Decisions/Positive Choices Inc.	Cuyahoga
McIntyre Center Inc.	Cuyahoga
MetroHealth System	Cuyahoga
Moore Counseling and Mediation Service	Cuyahoga
MPTS Casa ALMA/Casa MARIA	Cuyahoga
New Directions Inc.	Cuyahoga
New Visions Unlimited Inc.	Cuyahoga
Northeast Ohio VA Healthcare System	Cuyahoga
OldSchool LLC	Cuyahoga
Psych Services Inc.	Cuyahoga
Recovery Resources	Cuyahoga
Rosary Hall	Cuyahoga
Salvation Army	Cuyahoga
Signature Health Inc.	Cuyahoga

Southwest General Health Center/Oakview	Cuyahoga
Stella Maris	Cuyahoga
Women's Recovery Center	Cuyahoga
Y Haven	Cuyahoga
Coleman Health Services	Stark
CommQuest Services Inc	Stark
Glenbeigh Outpatient Center of Canton	Stark
Northeast Ohio VA Healthcare System	Stark
Ohio Guidestone	Stark
Phoenix Rising Behavioral	Stark
Project Solutions of Stark County	Stark
Stark County TASC Inc	Stark
Summa Health	Stark
Summit Psychological Associates Inc	Stark
Akron Urban Minority Alcohol/DA	Summit
CHC Addiction Services	Summit
Child Guidance and Family Solutions	Summit
Cleveland Clinic Akron General	Summit
Community Health Center	Summit
Greenleaf Family Center	Summit
Interval Brotherhood Homes Inc.	Summit
Northeast Ohio Applied Health	Summit
Northeast Ohio VA Medical Center	Summit
OhioGuidestone	Summit
Oriana House	Summit
Pinnacle Treatment Center/Akron	Summit
Summa Health Saint Thomas Campus	Summit
Summit County Health District	Summit
Summit Psychological Associates Inc.	Summit
Urban Ounce of	Summit
Vantage Aging	Summit
COMPASS Family and Community Services	Trumbull
First Step Recovery	Trumbull
Glenbeigh Outpatient Center of Niles	Trumbull
Meridian Healthcare	Trumbull
NE Ohio Healthcare System	Trumbull
Serenity Center	Trumbull
Spero Health	Trumbull

PENNSYLVANIA	
Clear Choices LLC	Beaver
Drug and Alcohol Services of Beaver County	Beaver
Gateway Rehab	Beaver
Pinnacle Treatment Services of Aliquippa	Beaver
Alpine Springs	Crawford
Family Service Society	Crawford
French Creek Recovery Center	Crawford
Erie VAMC Crawford County Clinic	Crawford
Catholic Charities	Erie
Cove Forge Behavioral Health System	Erie
Esper Treatment Center	Erie
Gage House	Erie
Gateway Erie	Erie
Gaudenzia Erie Inc.	Erie
Glenbeigh Outpatient Center of Erie	Erie
House of Healing	Erie
New Directions Healthcare	Erie
Pyramid Healthcare Inc.	Erie
Safe Harbor Behavior Health of UPMC	Erie
Stairways Drug and Alcohol Outpatient	Erie
Veterans Affairs Medical Center	Erie
Abstinent Living at the Turning Point	Washington
Care Center Inc.	Washington
Echo Treatment Center	Washington
Greenbriar Treatment Center	Washington
Outside in School	Washington
Progressive Medical Specialists Inc.	Washington
Turning Point II	Washington
Wesley Family Services	Washington
Community Guidance Center	Westmoreland
Family Behavioral Resources Outpatient Mental Health Clinic	Westmoreland
Outside In Pathway to Recovery Outpatient	Westmoreland

Source: Substance Abuse and Mental Health Services Administration at https://findtreatment.gov/locator and https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/National_Directory_SA_facilities_2019.pdf

Other Community Resources

There are myriad agencies, coalitions and organizations that continue to work in Glenbeigh's defined service areas. The 988 Suicide & Crisis Lifeline, United Way Helpline 211 of Ohio, United Way of SW Pennsylvania and Help Network of Northeast Ohio, maintain considerable referral networks which are available at no charge to individuals in need of health and human services assistance. The United Way offers assistance in the following areas:

- Basic Needs – includes food, housing/shelters, transportation and assistance with utilities and other services
- Mental Health and Substance Abuse – includes counseling, mental health care facilities as well as evaluations, treatment programs and support services. Substance abuse services include suicide and crisis intervention/prevention, peer-to-peer support services and housing assistance for specific counties.
- Veterans Outreach – offering resources for veterans who are homeless or need assistance and other services
- Food – information on local food pantries and free meal sites
- Dispute Resolution – offering services to advocate on behalf of individuals in need and mediating disputes between two or more parties
- Victim's Assistance – connecting people to the victim's assistance program and the victims of crime support group
- Health – providing resource information on available health services throughout the community as well as information on assistance for individuals with developmental disabilities or special needs. Provides a connection to resources for seniors

A full listing of services and referral networks is available at https://www.helpnetworkneo.org/, https://www.samhsa.gov/find-help/988, or at https://www.211.org/ on the internet. In Pennsylvania, help is available through https://unitedwayswpa.org/ or https://www.upmc.com/services/behavioral-health/programs/emergency-crisis/resolve-crisis-services for crisis support. Immediate assistance is available by calling 988 or 211.

Primary Data Summary

Community input (primary data) was gathered through key informant surveys, through in-person contact and the use of an online survey system. A total of 84 viewpoints were gathered, assessed and documented. In addition, key informant data, collected by Conduent for the 2025 Cleveland Clinic Community Health Needs Assessment, representing Cuyahoga, Stark and Summit counties, was utilized and included in the Glenbeigh 2025 assessment. A total of 92 stakeholders participated in the provision of primary data.

Online surveys were sent by Glenbeigh during the summer of 2025. Survey participants represented a) key community leaders, b) professionals working in the field of addiction treatment or services and persons with public health and social service knowledge and c) people in the regional recovery community, which includes people in recovery, family members, loved ones and those who support recovery efforts. All participants were at least 18 years of age.

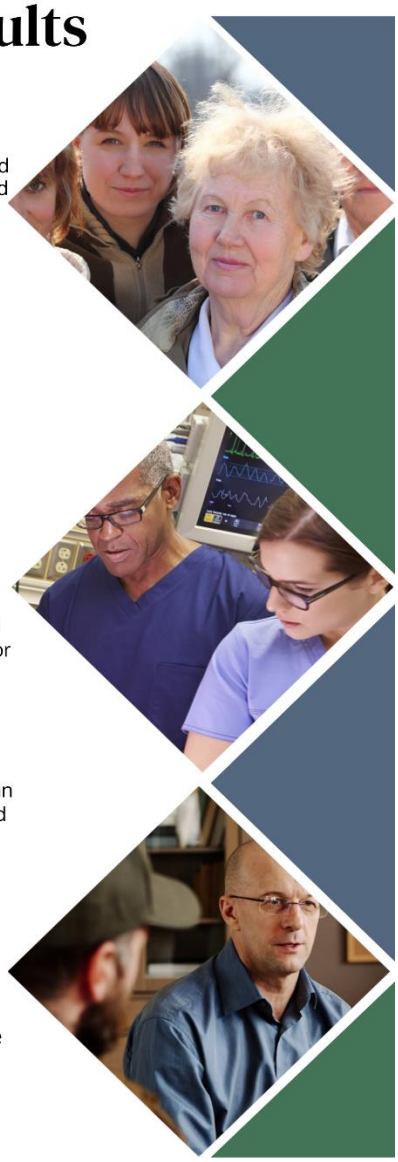
Twenty-nine individuals were invited to complete the key informant survey. A total of 8, or 32%, opened the survey, 8% clicked on the survey and 4 individuals completed the survey after it was resent via email with a link to the survey. An additional 11 individuals participated in the survey sent to 1,808 professionals working in the addiction treatment or ancillary fields. The survey had a 31% open rate, 469 individuals, and a 2% click rate. Another 69 individuals completed an online survey that was sent to individuals across Glenbeigh's defined service area who are part of the recovery community. A total of 6,638 surveys were sent to this group resulting in a 25% open rate or 1,582 individuals, and a 1% click rate.

Conduent conducted eight in-person interviews of community leaders, key informants, which provide detailed information on substance use and social determinants of health in areas that fall within Glenbeigh's defined service area. While Conduent conducted many more interviews throughout the Cleveland Clinic defined service area, Glenbeigh only included interview information relevant to our service area and specialized field of care.

Online surveys were designed to collect information on demographics and the social determinants of health affecting individuals and families as related to addiction, treatment and recovery. The following appendixes catalogue input collected from these methodologies and include supplemental information used to formulate the 2025 Community Health Needs Assessment.

Appendix A: Key Informant Survey

Key Informant Survey Results



Survey Participants

A total of four individuals participated in the Key Informant Survey. Participants included Ted St. John, Chief Executive of Hope Town and Tim Grealish of TEG Interventions. Two other individuals participated in the leadership survey, choosing to remain anonymous. Interviewees represent the following zip codes: 44446 44288 16503 and 15317

Recovery Connection

Of the respondents, two are in recovery with one providing services that include recovery housing, transportation, employment, peer support and recovery support while the other offers treatment placement and intervention services. One respondent is a service provider that works for an agency and the final participant did not share their recovery connection.

Providing Solutions

When asked how treatment, behavioral health and community partnerships can be improved to better serve individuals with SUDs and their families, key informants shared the following: focused and sustained partnerships are needed to bridge gaps; there is a need for more DDAP approved stepdown options that accept MAT; there are limited halfway houses available in many communities; while sober housing is more available, clients are often financially unable to afford, hence more funding is needed to support recovery. Suggestions include: Open another halfway house for men and one for women, grants are needed for 3/4 house funding until people can find a job and start earning an income. A sliding scale/income based would be helpful.

Workforce Development

When asked about workforce development opportunities for people in recovery, a respondent shared that with life skills and further education, there are opportunities to secure employment. The remaining respondents stated that people in recovery are not provided with life skills to secure or sustain employment; and people in recovery still struggle to secure viable employment.

Key Informant Survey Results

Stigma in the Workplace

When asked if they feel stigma continues in the workplace key informants shared that: there is bias but the stigma is lessening based on the overall workforce; there is stigma against people in recovery getting a hob, especially one that is flexible enough for them to continue IOP, MH, appointments, case management appointments, CRS appointments, etc; and while stigma continues, some employers are helping potential patients access treatment.

Access to Healthcare and Other Services

When asked if they believe people have access to quality healthcare in their community, all respondents replied "yes". This includes in person and telehealth care.

Barriers to Treatment

Respondents indicated that transportation and insurance; the disease itself - public education needs to continue; and unknown reasons as some people will not seek treatment even when having access to services are among the significant barriers to treatment.

All respondents believe there are not enough recovery support options in their area. These include recovery housing, recovery events and AA/NA meetings.

Community Assets

When asked for their opinion on what is being done well in the community in terms of addressing substance use disorders and improving quality of life, key informants shared the following insights: recovery support is available; more recovery options are evolving - slowly; drop-in centers are beneficial and needed but need bigger space and expanded hours; and CRS staff who are on the streets building relationships. One respondent noted that a detriment is the intense marketing efforts by local treatment centers that are usually sub-par.

Key Informant Survey Results

Other than a substance use disorder, what would you say is the most pressing need of the people affected by substance use? Please check your top two areas of need.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Mental Health Issues		3	75%
MAUD/MOUD (Medication Assisted Treatment)		1	25%
Housing Issues		2	50%
Employment/Occupational Issues		1	25%
Education/Literacy Issues		1	25%
Hunger/Access to Healthy Foods		0	0%
Community Engagement		1	25%
Health Coverage/Access to Quality Care		0	0%
Transportation		1	25%
Improving Overall Wellness		0	0%
Other		0	0%
	Total Responses	**4**	**100%**

Do you believe there are enough recovery support options in the area? These include recovery housing, recovery events, AA/NA meetings, etc.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Yes		0	0%
No		4	100%
	Total Responses	**4**	**100%**

Do you believe people have access to quality healthcare in your community? This includes in-person and telehealth options.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Yes		4	100%
No		0	0%
	Total Responses	**4**	**100%**

Key Informant Interview Statements Regarding Mental Health and Substance Abuse in Ashtabula County. Information from Key Informant Interviews conducted for the 2025 Ashtabula County Community Health Needs Assessment are as follows:

Barriers to Care – Ashtabula County, Ohio

"Some better form of transportation would be very helpful to bring south county residents to up to north county where the doctors are."

"There's a lot of people in our community who don't have a working car, and being a small, mostly rural county, we don't have a robust public transit system. Transportation to regular doctor visits and to pharmacies and things like that is an obstacle."

"Cost. And we see that a lot. These people that can't afford that medication…can't afford to go to the specialist. Healthcare cost is definitely the big one."

"If you have insurance, they make you jump through so many hoops to get [mental health care], and then you still have outrageous co pays that a person can't afford to go more than once a week. And so we probably need more mental health providers. But I think if you really have a mental health illness, that going once a week for an hour isn't going to help."

Source: Ashtabula County 2025 CHNA

Appendix B: Professionals Survey

Survey Results

Professionals Working Directly with Those Affected by Substance Use
Conducted June 1, 2025 - July 30, 2025

Total Respondents: 11

	Job Title	Education
01	Therapist	Graduate Degree
02	Case Manager - Public Agency	Graduate Degree
03	Case Manager - Private	Graduate Degree
04	Director	Graduate Degree
05	Not Currently Working in Field	Bachelor's Degree
06	Probation	Bachelor's Degree
07	Diversion Services	Graduate Degree
08	Clinical Director	Graduate Degree
09	Certified Recovery Specialist	Some College
10	Director	Graduate Degree
11	Executive Director	Graduate Degree

Zip Codes Represented:
44057 16001 44113 44484 44502 43537 44256 15217 15601 15222 44484

Survey Results

Individuals Working Directly with Those Affected by Substance Use
Conducted June 1, 2025 - July 30, 2025

4. How would you describe yourself?	5. Is there a sufficient number of resources for those in need of addiction services in the area?	6. Do you believe people have access to quality healthcare in your community? This includes in-person and telehealth options.	7. In general, do people in the area know where to go for, or how to secure, addiction treatment?
In recovery	No	No	Yes
Not in recovery	Yes	Yes	Yes
A loved one of someone in recovery	Yes	Yes	Yes
Not in recovery	No	Yes	No
Not in recovery	No	Yes	No
Not in recovery	Yes	Yes	Yes
In recovery	No	Yes	Yes
In recovery	Yes	Yes	No
In recovery	No	No	No
In recovery	Yes	Yes	Yes
A loved one of someone in recovery	No	No	No

What is the most significant barrier you feel people encounter when seeking treatment for substance use problems? (This can be lack of transportation, insurance or local services.)	In general, is there a need for more professional education on addiction and recovery in your community?
Insurances & money	Yes
Transportation	Yes
Lack of transportation and daycare. Additionally, pride hinders treatment.	Yes, there is a need for more professional education on addiction and recovery in my community especially on evenings and weekends.
Don't know how/where to start	Yes
Financial	Yes
Lack of transportation and insurance	Always
Transportation and the knowledge to begin the process	Yes
Lack of transportation, adverse social determinants of health	Yes
Fear of losing job/apartment or housing, lack of childcare and no one to watch pets.	Yes
No Insurance	Depends
Transportation	This is not a huge need

Survey Results

Individuals Working Directly with Those Affected by Substance Use
Conducted June 1, 2025 - July 30, 2025

Do you believe there are enough recovery support options in the area? These include recovery housing, recovery events, AA/NA meetings, etc.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Yes		4	36%
No		7	63%
	Total Responses	11	100%

Tell us a little more about transportation that your clients have. Most...

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Have a car or someone to drive them where and when needed.		7	63%
Use a bus or other public transportation		5	45%
Use private transportation like a Taxi, Uber or Lift		3	27%
Use a bike, scooter, skateboard or walk		1	9%
Have no affordable means of transportation and it is a significant barrier		3	27%
	Total Responses	11	100%

For OHIO Only: Are you aware of Project DAWN sites in your community? (Glenbeigh's Outpatient Centers are Project DAWN sites where people can secure a free Naloxone (Narcan) kit.)

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Yes		4	57%
No		3	42%
	Total Responses	7	100%

Survey Results

Individuals Working Directly with Those Affected by Substance Use
Conducted June 1, 2025 - July 30, 2025

In your opinion, what is being done well in the community in terms of addressing substance use disorders and improving quality of life?

There is a good support community for those in recovery IF they are ready to get in to recovery as well.

Getting the knowledge of drug treatment resources out to the community.

A complete continuum of recovery services exists but is not always available or accessible

Workshops, needstories

Recovery events, advertising / marketing of services

Narcan education and distribution is in full swing and it's helping

There are more options for Medically Assisted Recovery in the area, which is an improvement.

Lots of recovery supports -- Sober Living, AA, NA, sober events, etc.

Information sharing, drug free coalition work, treatment options for people on Medicaid are widespread. The need for female and family recovery houses and more financial assistance to stay in a recovery house is great due to all of the inpatient beds in the area.

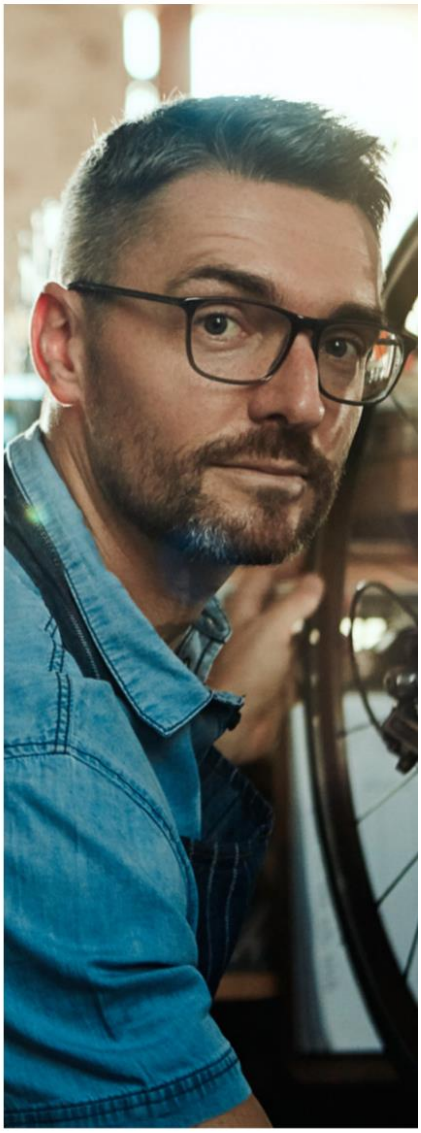
Other than a substance use disorder, what would you say is the most pressing need of the people you serve? Please check your top two areas of need.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Mental Health Issues		10	90%
Specialized Services for Professionals		0	0%
MAUD/MOUD (Medication Assisted Treatment)		1	9%
Housing Issues		8	72%
Employment/Occupational Issues		3	27%
Education/Literacy Issues		1	9%
Hunger/Access to Healthy Foods		1	9%
Community Engagement		2	18%
Health Coverage/Access to Quality Care		2	18%
Transportation		4	36%
Wound Care or other Acute Care Services		1	9%
Other		1	9%
	Total Responses	**11**	**100%**

Appendix C: Recovery Community Survey

Survey Results

Recovery Community Survey
Conducted June 1, 2025 - July 30, 2025



Total Respondents: 69

How would you describe yourself?

Answer Choice	0% 100%	Number of Responses	Responses Ratio
In recovery		63	95%
A loved one of someone in recovery		1	1%
Other		2	3%
	Total Responses	66	100%

What best describes your gender?

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Male		35	53%
Female		30	45%
Other		1	1%
	Total Responses	66	100%

What race do you consider yourself to be?

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Asian or Pacific Islander		0	0%
Black or African-American		1	1%
Hispanic or Latino		0	0%
Native American		0	0%
White		65	98%
One or More/Mixed Race		0	0%
Other		0	0%
	Total Responses	66	100%

Zip Codes Represented:
44023 15904 44126 44084 44060 44054 23452 44116 44515 15774 15202 44256 44077 44420 16335 44133 44266 44087 15206 44483 44133 44705 44663 26104 44141 44039 44141 44481 16101 44143 16412 44004 44236 44138 43537 44685 44118 16428 44149 27707 44709 44483 15301 44023 15239 15228 89122 16316 16046 44094 16506 15473 44708 16335 44436 44041 14085 4405 44483 15217 44256 44512 16505 44030 15122 15012

Survey Results

Recovery Community Survey

What is your age group?

Answer Choice	0% 100%	Number of Responses	Responses Ratio
18-29		1	1%
30-39		1	1%
40-49		9	13%
50-64		39	59%
Over 65		16	24%
Prefer not to answer		0	0%
	Total Responses	**66**	**100%**

What is the highest level of education you have completed?

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Less than 12th grade (no diploma)		1	1%
High School/GED		9	13%
Some college (no degree)		10	15%
Associate's degree		10	15%
Bachelor's degree		11	16%
Graduate or professional degree		25	37%
	Total Responses	**66**	**100%**

Survey Results

Recovery Community Survey

Are you currently employed?

Answer Choice	0% 100%	Number of Responses	Responses Ratio
No, I am seeking employment		4	6%
No, I am unable to work		5	7%
Yes, part time (38 hours or less per week)		11	16%
Yes, full time (39 hours or more per week)		31	46%
Other		15	22%
	Total Responses	66	100%

Survey Results

Recovery Community Survey

If working, would you say you found sustainable employment? If no, what is your greatest barrier to finding a well-paying job?

Yes- sustainable

Yes

80 years

Retired. Working as a way to help others in an entry level position not sustainable by itself.

I'm a professional who works for a reputable contractor in northeast Ohio. My ability to find gainful employment is based on my ability to perform my job. I am reliable because of my time At Glenbeigh!

Yes, I've found sustainable employment

Increased supply of available talent in my field

I've been employed with the same company for 26 years

Yes, I teach high school. I remain at the job I was working before I started my recovery.

Yes

Yes

Yes

Been employed with the same company for 32 years.

Yes

Yes

Yes

I'm self-employed cleaning businesses and residents. In a way it's sustainable because there's always cleaning jobs. The last couple years though it's been tougher to maintain. People are financially not happy.

Worked at the same place 28 years before during and after recovery.

Yes I have sustainable employment

Survey Results

Recovery Community Survey

Yes

Yes

Yes, I just Graduated with my CNA

I have found sustainable employment as a teacher in Ashtabula.

Yes

Yes

Yes, sustainable.

Yes

Yes sustainable employment

I'm happily employed. Jobs are out there if people apply.

Yes

Bipolar depression prevents me from being able to work consistently. Even if I can work for a few months I would end up losing the job from severe depression mood swings.

Retired

N/A

Yes

I have the same employment as before recovery.

Parkinsons Disease

Yes

Yes

Retired

Yes I have but still barrier.is no diploma!

Yes

Yes

I work full-time as a school counselor.

N/A

Yes

Yes

Yes

Survey Results

Recovery Community Survey

In the workplace, do you feel stigma continues or that employers help employees secure treatment confidentially and support their return to work plans?

N/A

Both. They'll tolerate you finding help, but there's still a stigma and people are going to talk about it. Dr

n/a

Feel that more understanding about individuals in recovery are good people and with giving a chance.

Nope, I've found that I am looked at as the standard for newly sober coworkers- that makes me work harder.

My employer supports employees secure treatment confidentially and supports return to work plans

There is still a stigma

My Employer kept my recovery confidential and supported me the whole way.

My employer has been very supportive of recovery.

The stigma continues

N/A

No

I feel employers help support their return to work.

I think the stigma continues

I have no FMLA or feel it would be supported. I just got off a medical leave for depression and they were very supportive. I'm back now.

No

Current job(peer supporter), no stigma. But , in previous jobs I believe there was some.

NA

My company was very supportive. The owner was also in recovery.

Survey Results

Recovery Community Survey

We support each other

Employers help employees secure treatment confidentially and support their return to work.

I am fully supported in my place of employment. Many of my co-workers know I am in recovery and many have relatives that are either still using or in recovery.

Seems to be improving with a new EAP program they never had.

No

In my case, very supportive!!

No

Feel stigma

It's corporate, HR has eeap and people get 2nd chances generally, unless they are inappropriate or hurt someone.

Yes

I never felt safe or supported while working to seek recovery. For me, I always had to choose between being employed or being in recovery. I abused drugs largely to be able to work nonstop and not sleep. Without the drugs I cannot work.

Employers are usually willing help. The cost of help is less that the cost of recruiting and training a replacement employee

Not sure

I feel there is still a stigma. My company does not know about my addiction or stay at Glenbeigh.

Was helpful for employment

It's become more socially acceptable but most don't seek treatment

continues

Work supports treatment

Yes

I feel that my employer helps their employees get the help they need and are very supportive.

N/A

Stigma continues

Supportive

Not sure

Survey Results

Recovery Community Survey

Do you believe healthcare providers understand the needs of family members seeking help for a loved one and/or the needs of individuals seeking treatment or living in recovery?

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Yes		29	44%
No		28	43%
Other		8	12%
	Total Responses	**65**	**100%**

Do you believe people have access to quality healthcare in your community? This includes in-person and telehealth options.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Yes		52	78%
No		14	21%
	Total Responses	**66**	**100%**

Other than a substance use disorder, what would you say is the most pressing need of the people affected by substance use? Please check your top two areas of need.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Mental Health Issues		57	87%
MAUD/MOUD (Medication Assisted Treatment)		4	6%
Housing Issues		12	18%
Employment/Occupational Issues		20	30%
Education/Literacy Issues		12	18%
Hunger/Access to Healthy Foods		5	7%
Community Engagement		10	15%
Health Coverage/Access to Quality Care		21	32%
Transportation		10	15%
Improving Overall Wellness		20	30%
Other		1	1%
	Total Responses	**65**	**100%**

Survey Results

Recovery Community Survey

What is the most significant barrier you feel people encounter when seeking treatment for substance use problems? (This can be lack of transportation, insurance or local services.)

Insurance

Affording it. It's definitely more expensive than most bad habits.

Transportation if legal issues precede attempt to seek help.

Have not found any.

Step 1.

There are many barriers. I think it depends on the person. I had a car, insurance and services, I lacked the motivation to want to get sober.

Insurance

Insurance

I would say the cost if you don't have Insurance coverage

I live in a very rural area. There is only one medical office of any kind within 10 miles of here. The closest 12 step meeting is also 10-12 miles from here.

Insurance

Local

Possibly understanding options.

Insurance

I think local services are questionable in my area. I was automatically shipped off to the local detox/rehab & spent 5 days trying to get moved to a better quality rehab to meet my needs. I felt no one listened or assisted in helping me arrange that. I had little access to a phone to work with outsiders to help. I didn't see a social worker for days. Thank goodness for friends & family who worked hard setting things up for me.

Insurance dictating what they feel you need. Limitations by insurance companies

I'm not sure maybe insurance.

Themselves

We had great difficulty finding a bed for detox; also had trouble finding follow up placement while he gained independence and strength to safely return home.

Survey Results

Recovery Community Survey

Themselves & Insurance.

Finances, stigma, lack of family support.

Lack of financial resources and available free help. They may not realize there's financial assistance as well.

Lack of insurance

The price if you don't have insurance

na

Anxiety, fear

Insurances

For a lot of people its dependable transportation. Its also a issue of pride. Sometimes its hard to ask for help.

Lack of support.

Determination and motivation

Definitely lack of transportation help.

Lack of knowledge or resources that help exists and they are not alone in their addiction.

Money

Themselves. You cannot be treated properly if you aren't being honest. At least in my experience

Insurance, reluctance to get help

I don't really know but i would think insurance

Lack of long term resources and qualified staff.

No

People get in treatment centers if they try hard enough or find a community spot that helps anyone. Insurance is sketchy on what is spent / services offered...length of inpatient stay..or who knows if doc / counselor can request an extension or go home early.

Survey Results

Recovery Community Survey

Tell us a little more about your main mode of transportation. Do you...

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Have a car or someone to drive you where and when needed.		65	98%
Use a bus or other public transportation		1	1%
Use private transportation like a Taxi, Uber or Lift		1	1%
Use a bike, scooter, skateboard or walk		1	1%
Have no affordable means of transportation and it is a significant barrier		0	0%
Other		0	0%
	Total Responses	**66**	**100%**

Do you believe there are enough recovery support options in the area? These include recovery housing, recovery events, AA/NA meetings, etc.

Answer Choice	0% 100%	Number of Responses	Responses Ratio
Yes		48	72%
No		18	27%
	Total Responses	**66**	**100%**

Survey Results

Recovery Community Survey

In your opinion, what is being done well in the community in terms of addressing substance use disorders and improving quality of life? Include any suggestions you may have.

Medical doctors -I feel could have more training on recognizing addictive behavior.

We have meetings in our areas 7 days a week and a huge support group - help is available when one is ready. We are always ready to helo!

Advertisements and also work being done to reduce the stigma, as seen in some of them.

All DUI verdicts should wear an ankle bracelet for 1-3 months to help keep the mind clear which then would help recovery attempts

Providing a strong support network to those in addiction who when ready for treatment have a caring and understanding place to go.

AA meetings abound - Many resources available - Treatment facilities, AA & NA group support meetings & events

The Treatment centers are requiring people to attend AA/NA meeting and get papers stamped and signed. I feel the treatment centers need to focus more on the AA/NA programs within
their programs.

Removing the stigma, letting people know this is a disease.

I have attended Al Anon meetings, I found one that fit pretty well and I attended a few. They were helpful.

More resources for certain parts of recovery, but more support is needed. More centers seem to be opening, but not fully addressing all needs. Mental health is still lacking in resources.

I believe that people who are in recovery and like myself have recovered, are extremely active in doing whatever we can and referring addicted people and mentally ill people toward help. There are several meetings available

In the past ten years our community has added several rehab centers.

Prefer in person meeting/support. Lectures on substance abuse.

In my opinion not much is done right as far as the general community is concerned because their will always be a stigma involved when talking about addiction.

More women's groups after treatment has been completed.

Very little of what should be. More education needs to start at home and school

AA is out there for those who want it. Cleveland has picnics, akron founders day, cook forest conferences...much more than meetings.

I appreciate my local NA groups when they do what they should be doing. I hear too much internal gossip and judgement lately though to really feel safe or comfortable at meetings. Addicts need the support of other addicts.

Young people seem to have a variety of ways to be exposed to recovery resources and it seems that the stigma is reduced in that population.

Medically Assisted Treatment, Psychiatry

AA. Only suggestions. Ego deflation can only come from within, through the grace of YOUR higher power not just a higher power.

Many providers publicized, raised awareness thru ASAP to emphasize recovery options

It seems that after COVID there was a decline in support groups such as AA

Not enough being done

Various sanctioned meetings, sober houses, AA Intergroup support, and a general awareness that there is a need for recovery.

Sponsors for discharged clients is a great tool. Good use of social media advertising available services.

Not enough, people with substance problems trying to recover are still looked at like criminals.

Stigma is being reduced

A number of dedicated people who lead community behavioral health efforts.

Again, have a place for medicare recipients

Survey Results

Recovery Community Survey

Please share any other comments or concerns about access to care and recovery support in your community.

Family encouragement and knowledge of the disease process.

Additional housing for people in recovery is still needed.

A barrier that I have found. Was lack of confidence to get into treatment and understanding treatment. Embarrassment, was a barrier that I personally had.

Dual diagnosis. More attention to mental health because so many self medicate due to trauma, PTSD and other health issues. Addiction and mental health issues are not a choice but recovery is.

I feel their need to be more recovery places available that are free and transportation available and for people to know about it. Having it available is only good if the people who need it know about it

Doing away with the stigma of addiction.

We have a treatment center for opioids. I think they have the right idea. They don't dismiss you if you have relapses. I think too many treatment centers throw people out of their specific program because someone has a relapse. It doesn't need to be a program where your told you fail if you have a relapse. Most programs are understanding. I just wish the judicial system was the same way. They throw people in jail if there on parole or probation for a failed drug test. It's the wrong approach.

Need free community lectures. There are many lectures for finance, retirement, Medicare, health issues, ect, but none to educate on how to help the abuser/ caregiver/ family on why, person can't quit drug of choice

I personally checked myself into detox and afterwards i found it difficult to get into a treatment plan and was delayed by over a week. This was due to an answer i gave while at detox in which i didn't even realize what i was saying no to. The process from detox to treatment should be simplified and streamlined.

It is available you just have to be willing and look for it

Lack of understanding of what addiction is and isn't. To much ignorance in the community about those who suffer from addiction. Individuals recover in the community. Next to impossible to recover if the community is toxic.

It's for those that want it. Cops, judges, po, courts help...put people on paper vs jail. Education helps... people are done when their done, and ready when they are ready.

Having a hard time finding quality meetings

I feel unsupported and underserved as an older person seeking recovery resources. Thank God for AA which is all I really have as a recovery resource.

Zip Code 15301 could use a SMART Recovery meeting.

I think access to recovery care is very good in my community. It has been for me.

One day at a time.

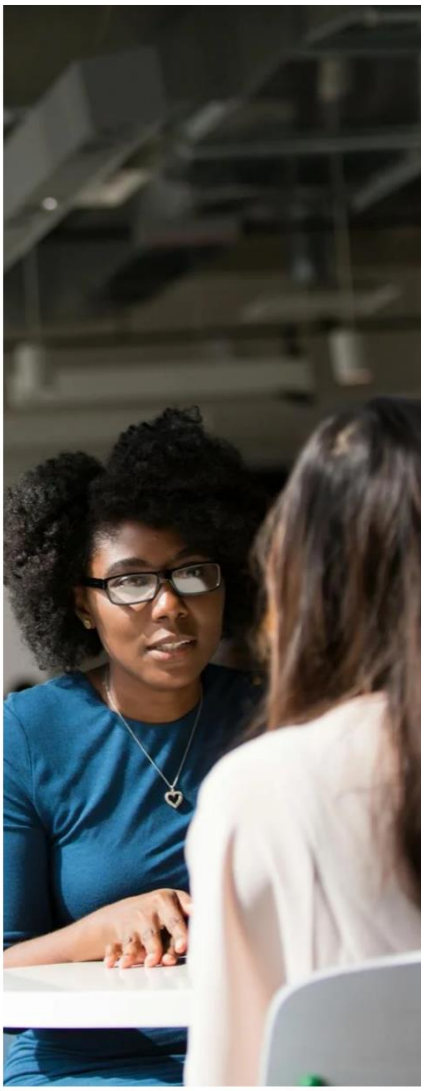
Nice to have great facility in our area.

Many medical professionals do not have a good understanding of substance abuse or how to treat it. Many suffer themselves and continue to profit from the pharmaceutical companies. So I believe more education is needed at all levels

Appendix D: Key Informant Interview Results – Conducted by Conduent

Interview Results

Glenbeigh, ARMC Healthcare System Qualitative Data Analysis for Cuyahoga, Summit and Stark Counties



Total Participants: 8

Primary Data Overview Provided by Conduent (September 23, 2025)

Community Stakeholder Conversations
In total individual community stakeholders from eight organizations from Cuyahoga, Summit, and Stark counties provided feedback specifically for the Glenbeigh community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes.
Individuals from the following organizations participated as key informants for the hospital's community:

- ADAMHS Board of Cuyahoga County
- City of Cleveland Department of Public Health
- County of Summit ADM Board
- Cuyahoga County Board of Health
- NAMI Greater Cleveland
- Stark County Health Department
- Stark County Mental Health & Addiction Recovery
- Summit County Public Health

Stakeholders for the Glenbeigh community consistently emphasized that mental health care remains one of the most urgent priorities for the community. They described gaps in access to timely and affordable services, particularly for those experiencing crisis situations. Provider shortages and long wait times for appointments were cited as recurring challenges, leaving individuals without necessary support when needs are most acute. Stakeholders also underscored the lack of sufficient crisis stabilization options, which often results in reliance on emergency departments rather than specialized behavioral health resources.

Concerns about youth and young adult mental health emerged repeatedly across the conversations. Participants highlighted rising levels of anxiety, depression, trauma, and suicidal ideation among adolescents, driven by factors such as family instability, substance use and lingering impacts from the COVID-19 pandemic. Schools and youth-serving organizations were described as under-resourced in their ability to respond effectively, leaving many families struggling to find accessible care.

Interview Results

Substance use disorders, especially related to opioids, alcohol and polysubstance use, were identified as a continuing crisis. Stakeholders described the cyclical connection between untreated mental health concerns and substance misuse, with stigma preventing many from seeking help. The need for expanded recovery services, medication-assisted treatment and long-term support programs was highlighted, along with approaches that meet individuals where they are.

Finally, stakeholders noted that issues such as stigma, fragmented services and lack of services contribute to delayed or missed treatment. Many emphasized that a coordinated, community-based approach is essential to address mental health needs comprehensively. Investment in prevention, education, crisis response infrastructure and workforce expansion was described as critical to improving outcomes for individuals and families.

Community Input Key Findings
Stakeholder conversations for the Glenbeigh community highlighted mental health as a top community priority. Participants described persistent issues including provider shortages, long wait times, affordability issues and limited crisis response services. Youth mental health concerns were especially pronounced, with rising rates of anxiety, depression and trauma among adolescents. Substance use disorders remain prevalent and intertwined with untreated mental health conditions. Stigma and a lack of responsive care continue to deter individuals and families from seeking timely treatment.

Health-related Social Needs
Stakeholders emphasized the strong influence of health-related social needs on mental health outcomes. Issues such as housing instability, unemployment, poverty, transportation barriers and food insecurity were frequently cited as drivers of mental distress. Stakeholders described how financial strain, unstable living environments and lack of access to basic resources create cycles of stress that exacerbate depression, anxiety and substance use. Addressing these upstream social conditions was described as critical to any sustainable mental health strategy.

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

- Provider Shortages: Limited availability of behavioral health professionals restricts timely access.
- Crisis Care Gaps: Few options for immediate intervention leave residents dependent on emergency departments.
- Youth Mental Health: Increasing concerns around depression, anxiety and trauma in younger populations.
- Substance Use Disorders: Continued challenges with opioids, alcohol and multiple drug use.
- Stigma: Fear of judgment continues to prevent individuals from seeking treatment.
- Social Drivers: Housing, employment, poverty and food insecurity strongly influence mental health.

Interview Results

The following are a few select quotes illustrating feedback from key informants:

"There are just not enough mental health providers, and people wait months to get seen."

"So many families are struggling with housing and jobs, and those stresses lead directly to mental health crises."

"Youth mental health is worse than ever, with more anxiety and depression in teens than we have ever seen."

"People are afraid of the stigma, so they avoid care until things get really bad."

Conclusion

In summary, stakeholders consistently affirmed that mental health is among the most urgent needs in the community served by the Glenbeigh. Youth and families are at the center of growing concerns, while substance use and stigma remain persistent challenges. Importantly, health-related social needs such as housing, poverty and food insecurity were identified as critical factors that both drive and compound mental health struggles. Addressing mental health effectively will require a coordinated approach that integrates clinical services with broader community and social supports to create sustainable solutions.

Primary Data Summary

- Of the professionals responding to the survey, 18.2% identified as in recovery; 63.6% identified as not in recovery and 18.2% identified as having a loved one in recovery
- 54% listed transportation as a barrier to treatment; 36.5% listed Insurance or Financial reasons and 9.1% did not provide input
- 81.8% of survey respondents agree that there is a continued need for professional education on addiction, treatment and recovery
- 63% believe there is not enough recovery support in the region
- 45% reported having client's dependent on bus or public transportation
- 27% reported clients that have no affordable transport which is a barrier to treatment
- 42% of professionals responding to the survey stated that they are not familiar with community ProjectDawn sites where the public can secure free naloxone kits
- 90% agree that mental health issues are a pressing need for SUD clients in the region
- 72% believe housing issues (safe, affordable, available) continue to be a top priority

Appendix E: State of Ohio Health Assessment 2019

State of Ohio Health Assessment

2019

At the time of the compilation of the 2025 CHNA, the latest Ohio State Health Improvement Plan was not yet published. Consequently, this report continues to site information from the 2019 Ohio assessment. In mid-September 2019, the state of Ohio published the 2019 State Health Assessment online at https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship/. The 2020-2022 State Health Improvement Plan was developed from that document. The executive summary, prepared by the Health Policy Institute of Ohio, identifies the key findings along with next steps the state of Ohio plans to implement between 2020 and 2022. Glenbeigh's CHNA complements the state improvement plan areas that are in line with the mission of Glenbeigh – with a focus on addiction and recovery from substance use disorders.

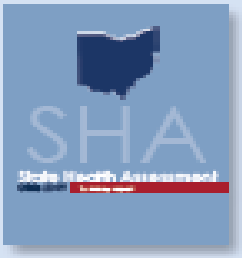
Executive Summary of the 2019 Ohio Health Assessment (SHA)

- Key Findings
    - Overall wellbeing for Ohioans has declined. Unintentional injuries (including drug overdose), cancer and heart disease were the leading causes of premature death in 2017.
    - Many Ohioans lack opportunities to reach their full health potential. Demographics that experience much worse outcomes than the state overall include African/American/black, people with lower incomes, those with disabilities or those who live in Appalachian counties.
    - Underlying drivers of health must be addressed. Crosscutting factors the state will address include: physical activity, tobacco use, access to dental and mental health care, income and unemployment, adverse childhood experiences, transportation, lead poisoning risk and racism.
    - Mental health and addiction, chronic disease, and maternal and infant health continue to be significant challenges in Ohio. These areas have worsened or remained unchanged in recent years.
    - New concerns emerge in the wake of Ohio's addiction crisis. Drug use has contributed to increases in hepatitis C and children in foster care.

Other information from the 2019 Ohio Health Assessment

- Life expectancy among Ohioans has dropped over the last seven years.
- Impact of racism and discrimination persists – particularly among African American/black population.
- Underlying drivers of inequity include: poverty, racism, discrimination, trauma, violence and toxic stress.
- In order to improve, the SHA recommends sharing priorities across rural, urban and Appalachian regions of the state.
- Build cross-sector partnerships to address the factors that shape health.

How to access the SHA



Summary report
prepared by HPIO
www.hpio.net/2019-state-health-assessment-summary-report

Online, interactive data website
prepared by ODH
https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/2019-Online-State-Health-Assessment

The road to improvement

SHA findings emphasize that improvement must build upon:

- A comprehensive framework with clear priorities and measurable objectives
- Shared priorities across rural, urban and Appalachian regions of the state
- Cross-sector partnerships to address the many factors that shape our health
- State and local efforts to achieve health equity

Next steps

A collaborative of stakeholders from across Ohio are developing the 2020-2022 State Health Improvement Plan (SHIP), to be released later in 2019. This plan will provide a roadmap to address the challenges highlighted in the SHA.

The 2020-2022 SHIP will include a strategic menu of priorities, outcome objectives and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners, including sectors beyond health.

How was the SHA developed?

Led by ODH, the SHA was developed with input from hundreds of Ohioans through:

- Five regional forums held in October 2018 with 521 participants
- Online survey completed by 308 stakeholders
- Advisory Committee with 101 participants (as of April 2019)
- Steering Committee made up of representatives from 13 state agencies, including sectors beyond health

The Online SHA includes data on a wide range of topics, including:

- Health outcomes and behaviors
- Healthcare spending, access and quality
- Public health and prevention
- Social, economic and physical environment factors, such as education, employment, poverty, housing, violence and transportation
- Disparities, trends and comparisons between Ohio and the U.S. overall

Regional forum insights

While each community is unique, results from SHA regional forums and an online survey found that there were many shared strengths, challenges and priorities across the state. Top priorities overall included:

Health outcomes
- Mental health and addiction
- Chronic disease
- Maternal and infant health

Cross-cutting factors
- Poverty
- Transportation
- Physical activity and nutrition
- Access to care

Funded by ODH, the SHA and SHIP provide information and guidance for many state agencies. The 2020-2022 SHIP will align state agency priorities toward a shared vision of improved health and economic vitality.

Source: https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship/

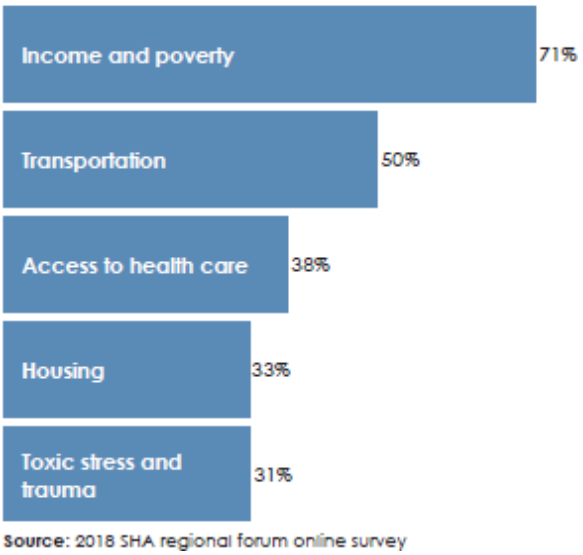
Throughout the course of obtaining qualitative data for the Glenbeigh CHNA, informants reported barriers to treatment for substance use disorders. Comparing this information to the top-five barriers reported in the 2019 State Health Assessment (SHA), similarities exist.

Transportation was listed in the SHA and remains a reported barrier for individuals in 2025. Quantitative and qualitative data both confirm that many individuals within Glenbeigh's defined service area do not have access to transportation in order to obtain or sustain treatment. While 2025 data and surveys indicate more access to private transportation, it remains a significant barrier in rural areas and in urban areas that do not offer public transportation options. It would also be safe to assume that transportation would be a key barrier to participation in recovery support programing and family education programming.

Limited access to health care remains a significant barrier to treatment for substance use disorders. Community input highlights insurance limitations as well as a lack of insurance.

The need for facilities that treat alcohol and other substances remains high. A secondary factor limiting access to health care in the Glenbeigh region remains a shortage of licensed, educated professionals to treat substance use disorders. Areas of Northeast Ohio and Western Pennsylvania are predominantly rural and fall within the Appalachian Region, which has unique challenges.

Figure 3.5. **Top-five barriers to equity**
"Which of the following barriers do you think are most important to address in order to improve [health outcomes for priority populations in your county(ies)]?" (n=302)

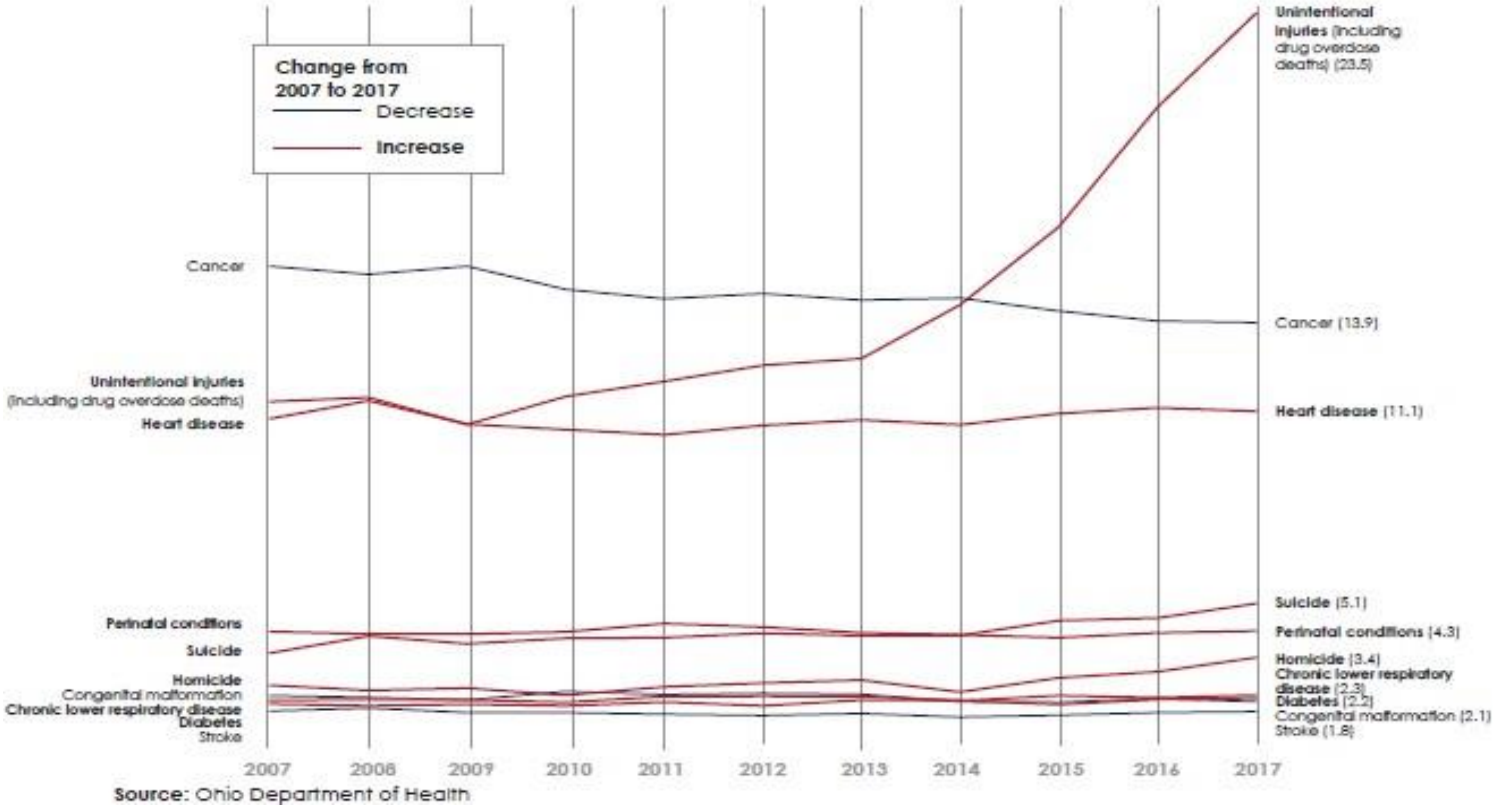


Source: 2018 SHA regional forum online survey

According to the 2019 Ohio SHA, priority topics identified in the 2017-2019 State Health Improvement Plan (SHIP) remain relevant as both mental health and addiction continue to be among the significant challenges in the state. Moreover, Ohio's performance, as reported in the 2019 SHA, did not improve for the mental health and addiction priority outcomes detailed in the 2017-2019 SHIP. Drug overdose deaths increased from 27.7 deaths per 100,000 population in 2015 to 44.1 deaths per 100,000 in 2017.

Figure 5.2. **Years of potential life lost before age 75**

Ten leading causes of premature death, Ohio 2007-2017 per 1,000 population (age-adjusted rates)



Source: Ohio Department of Health

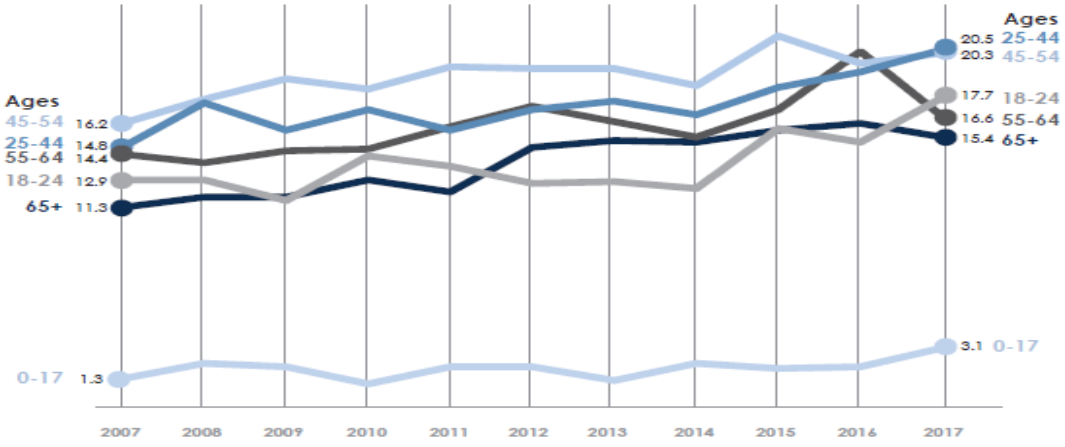
The Ohio SHA reports that drug overdose deaths, adolescent depression, and suicide deaths along with heart disease, diabetes and infant mortality are major threats to the health of Ohioans. Depression, suicide, heart disease, diabetes and infant mortality are often interlinked to, and compounded by, alcohol and drug abuse or addiction.

Heart Disease: According to the American Heart Association, illegal drugs can adversely affect the cardiovascular system and heart function. Cocaine, heroin and some amphetamines can affect the central nervous system and may cause changes in heart rates, blood pressure and heart tissue. Both recreational and habitual cocaine use increases the risk for heart attack. Amphetamines increase heart rates and blood pressure.

Diabetes: The Mayo Clinic affirms that individuals who consume greater amounts of alcohol may experience chronic inflammation of the pancreas that can potentially lead to diabetes.

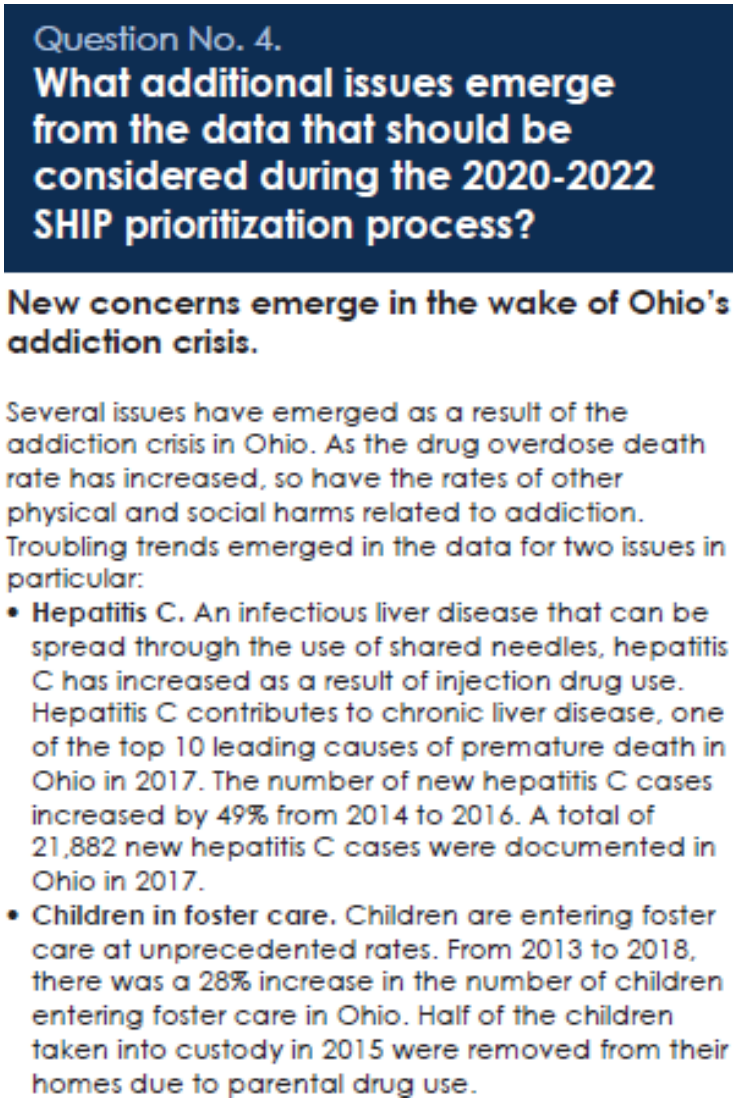
Depression and Suicide: In 2010, the National Center for Biotechnology Information reported (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872355/) that suicide was an escalating public health issue and that alcohol use often led to suicidal behaviors. Depression and substance abuse are often associated with cases of suicide. The report predicted increased suicide rates worldwide through 2020 based on a rate of increase of 60% in suicides from 1965 to 2010. According to the report, suicide links to socioeconomic factors. The 2019 SHA noted that Ohio suicide deaths increased gradually between 2007 and 2017. Suicide rates increased during the pandemic. Mental health is reported as a top concern in 2025.

Figure 5.3. **Suicide deaths per 100,000 population, by age group, Ohio, 2007-2017**



Source: Ohio Department of Health, Ohio Public Health Data Warehouse. Accessed by HPIO on April 9, 2019.

Also mentioned in the 2019 Ohio SHA were concerns directly connected to the opioid epidemic and subsequent drug addiction crises, which was at its plateau when the report was published. Since, the number of overdose deaths due to opioids has decreased, however, drug use of other substances and alcohol remains at elevated levels.



Question No. 4.

What additional issues emerge from the data that should be considered during the 2020-2022 SHIP prioritization process?

New concerns emerge in the wake of Ohio's addiction crisis.

Several issues have emerged as a result of the addiction crisis in Ohio. As the drug overdose death rate has increased, so have the rates of other physical and social harms related to addiction. Troubling trends emerged in the data for two issues in particular:

- **Hepatitis C.** An infectious liver disease that can be spread through the use of shared needles, hepatitis C has increased as a result of injection drug use. Hepatitis C contributes to chronic liver disease, one of the top 10 leading causes of premature death in Ohio in 2017. The number of new hepatitis C cases increased by 49% from 2014 to 2016. A total of 21,882 new hepatitis C cases were documented in Ohio in 2017.
- **Children in foster care.** Children are entering foster care at unprecedented rates. From 2013 to 2018, there was a 28% increase in the number of children entering foster care in Ohio. Half of the children taken into custody in 2015 were removed from their homes due to parental drug use.

Source: Ohio 2019 State Health Assessment at https://odh.ohio.gov/wps/wcm/connect/gov/64b4e06c-b1ec-45fa-921c-de2be8f84943/2019SHA_SummaryReport_Final.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-64b4e06c-b1ec-45fa-921c-de2be8f84943-mQx5M1O

Appendix F: State Health Improvement Plan (SHIP) Ohio 2020-2022

State Health Improvement Plan

OHIO 2020-2022

The following material is from the published Ohio State Health Improvement Plan, which is a high-level compilation of SHIP strategies presented as a quick guide at https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

How will the SHIP be implemented?

The SHIP is designed to be implemented by a wide range of public and private partners. The menu of objectives and strategies in the SHIP provides flexible options for rural, Appalachian, suburban and urban communities, as well as approaches to improve outcomes for Ohioans of all ages.

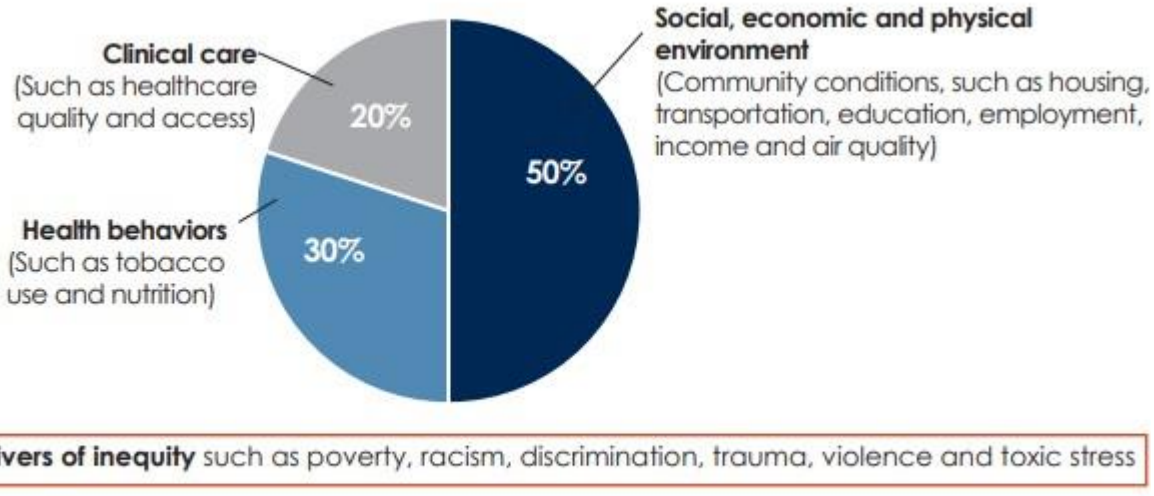
State and local partners

There are many partners at the state and local levels that contribute to achieving the vision of the SHIP, such as:

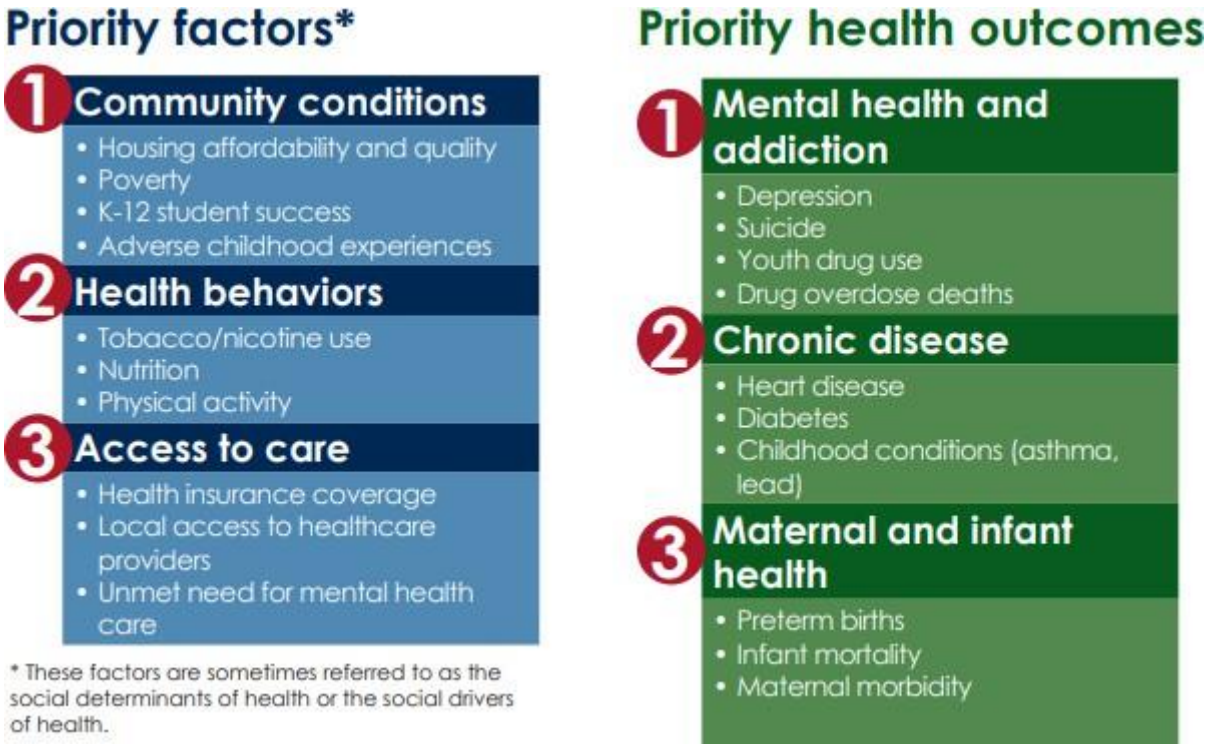
- State agencies and other statewide organizations
- Hospitals
- Local health departments
- Alcohol, Drug and Mental Health (ADAMH) boards
- Area Agencies on Aging
- Boards of developmental disabilities
- Community behavioral health providers
- Employers and workforce development organizations
- Housing organizations
- Medicaid managed care plans
- Philanthropy
- Schools
- Other local agencies and organizations

Public and private partners must row in the same direction to achieve the **SHIP vision: Ohio is a model of health, well-being and economic vitality**

Figure 1.1. **Factors that influence health***



* These factors are sometimes referred to as the "social determinants of health" or the "social drivers of health."
Source: Booske, Bridget C. et. al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.



Source: State Health Improvement Plan Ohio 2020-2022 https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

The Ohio SHIP listed nutrition as an emerging health behavior priority factor in 2019. It should be noted that nutrition and food insecurity have become top level factors that affect not only the general population, but individuals and families living with substance use disorders. Food insecurity is noted in both ALICE Threshold data and in the Ashtabula County 2025 Community Health Needs Assessment. Food insecurity and adverse nutrition can also be tied to poverty and financial instability.

Local access to healthcare providers

What shapes our health and well-being?

Ensuring local access to healthcare providers makes it easier for residents to get to primary and specialty healthcare services. Increasing access to local healthcare providers in underserved areas can reduce disparities in access to care and improve health outcomes.

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for increasing local access to healthcare providers in Ohio.

Featured strategies	Includes
Comprehensive and coordinated primary care	• Medical homes, such as Ohio Comprehensive Primary Care practices • Healthcare safety net providers, including federally qualified health centers (FQHCs) and school-based health centers (SBHCs)
Culturally competent workforce in underserved communities	• Community health workers • Community-based training for health professions students in rural and other underserved areas • Financial incentives to recruit and retain health professionals in underserved areas
Telehealth	Telemedicine

Additional strategies	Includes
Healthcare workforce professional development	• Health career recruitment for minority students and other underrepresented or disadvantaged students (for example, Career Academies)
Telehealth for mental health	Telemental health services
Public transportation	Develop, improve and maintain public transportation systems
Other access supports	• Paid sick leave laws • Health literacy interventions

= Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- Community Health Worker Statewide Assessment, Ohio Department of Health
- Community Paramedicine Compendium, Ohio Department of Public Safety
- RecoveryOhio Advisory Council's Initial Report
- Rural Health Care Access, Ohio University
- Community Commons Initiative
- CARES Engagement Network, University of Missouri

Source: https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing unmet need for mental health care in Ohio.

Featured strategies	Includes
Comparable insurance coverage for behavioral health (parity)	Mental health benefits legislation, along with monitoring for implementation and compliance
Telehealth for mental health	Telemental health services

Additional strategies	Includes
Culturally competent workforce in underserved communities	• Certified community health workers • Support and expand the role of peer support specialists • Health career recruitment for minority students and other underserved communities (for example, Career Academies) • Rural training in medical education and other underserved communities • Higher education financial incentives for health professionals serving underserved areas
Coordinated care for behavioral health conditions	• Integration of behavioral health services into primary care • Chronic disease management programs
Digital access to treatment services and crisis response	• mHealth for mental health • Crisis lines (for example, text "4hope")

= Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- Ohio Peer Recovery Supporter Certification and Recertification Process, Ohio Department of Mental Health and Addiction
- Healthchek Services for Children Younger than Age 21, Ohio Department of Medicaid

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Strategies▲ (cont.)	Includes
Addiction treatment access (cont.)	
Culturally competent workforce in underserved communities	• Certified community health workers ⊖ • Support and expand the role of peer support specialists • Health career recruitment for minority students ⊖ and other underserved communities (for example, Career Academies ⊖) • Rural training in medical education ⊖ and other underserved communities • Higher education financial incentives for health professionals serving underserved areas ⊖
Recovery supports	
Recovery communities and peer supports	Support recovery-friendly communities and workplaces, including: • Peer recovery organizations • Recovery community organizations • Recovery-oriented high schools • Collegiate recovery communities • Alternative peer groups
Housing programs for people with behavioral health conditions	• Certified recovery housing • Housing First ⊖

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.
⊖ = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- RecoveryOhio Advisory Council Initial Report
- Addiction Evidence Project, Health Policy Institute of Ohio
- Parity at 10 initiative, Legal Action Center

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Ohio's response to improve mental health and addiction

Student Wellness
Kids today are facing unprecedented challenges at home that come with them into the classroom, creating challenges for both students and teachers. The operating budget included a brand-new funding stream called Student Wellness and Success. This $675 million fund can be used to support student health, mental wellbeing, and academic success by providing schools with the financial resources to embed mental health counseling, physical health services, mentoring, after-school programs, and much more into their school buildings. As a result, schools will have more support and students will be better equipped for a brighter future.

Mental Health Care When and Where It is Needed
Immediate access to treatment and support to help people who are struggling with mental health or substance use disorders is critical. That is why Governor DeWine directed more than $22 million to local Alcohol, Drug and Mental Health Boards so communities can provide crisis response efforts to families when they need it the most.

Suicide
The Ohio Department of Health (ODH)'s Violence and Injury Prevention Section (VIPS) supports suicide prevention by collecting and analyzing data and supporting a statewide coalition specifically for sharing best practices on youth suicide prevention.

VIPS houses the Ohio Violent Death Reporting System (OH-VDRS), which collects information from multiple sources in an attempt to better understand the circumstances surrounding suicides and other violent deaths. To create a comprehensive record of each death, OH-VDRS links information from: the ODH Bureau of Vital Statistics (including death certificates); coroners and medical examiners; state and local law enforcement agencies; and the Ohio Automated Rx Reporting System.

Additionally, VIPS is implementing a project to monitor state and local emergency department (ED) visits to identify nonfatal suicide-related outcomes. This project will disseminate collected data to local health departments and the public using dashboards. This will allow for the studying of trends, the identification of risk factors, and the development of data-to-action intervention and prevention strategies.

Further, VIPS, through the Ohio Injury Prevention Partnership's Child Injury Action Group, facilitates a youth suicide subcommittee to identify and share best practices from local projects.

VIPS also has provided funding to three local sub-grant programs to facilitate community engagement, strategic planning and implementation of prevention strategies including:

- Partnering with emergency departments to establish policies requiring Counseling on Access to Lethal Means (CALM) trainings.
- Providing technical assistance to EDs to establish patient safety planning and crisis support plans for parents.

Drug Overdose Death
The Ohio Department of Health (ODH) Violence and Injury Prevention Section (VIPS) collects timely, high-quality surveillance data on fatal and nonfatal unintentional drug overdoses to identify, focus, and implement appropriate and timely prevention strategies at the state and local levels. Specific prevention strategies and programs include:

- ***Community naloxone distribution,*** with an emphasis on reaching high-risk people through community agencies, jails, recovery housing, emergency departments, homeless outreach, mail, drug courts, syringe access programs, and Federally Qualified Health Centers.
- ***Local supports and linkages,*** through funding local projects in high-burden areas to facilitate local coalitions, strategic plan implementation, overdose fatality reviews, community response plans, community/clinical links, and implementation of comprehensive care systems.
- ***Health care systems support,*** through emergency department projects to support comprehensive care and resources for primary care providers to implement Ohio prescribing rules and guidelines.
- ***Public/prescriber engagement,*** through social media campaigns aimed at informing the public; reducing stigma on use of Medication-Assisted Treatment among health care providers; and educating people who use drugs on the dangers of fentanyl in Ohio's drug supply.

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

SHIP topic area	Featured strategies
Access to care	
Health insurance coverage Indicators AC1 and AC2	• Outreach and advocacy to maintain Ohio Medicaid eligibility level and enrollment assistance • Insurance enrollment assistance for adults and children
Local access to healthcare providers Indicators AC3 and AC4	• Comprehensive and coordinated primary care • Culturally competent workforce in underserved communities ★ • Telehealth
Unmet need for mental health care Indicators AC5 and AC6	• Comparable insurance coverage for behavioral health (parity) ★ • Telehealth for mental health
Mental health and addiction	
Depression Indicators MHA1 and MHA2	• Social and emotional instruction • Coordinated care for behavioral health • Digital access to treatment services and crisis response ★ • Physical activity programs • Parenting programs
Suicide Indicators MHA3 and MHA4	• Suicide awareness, prevention and peer norm programs • Limits on access to lethal means
Youth drug use Indicators MHA5 and MHA6	• K-12 drug prevention education • Alcohol policy changes • Alcohol and other drug use screening (SBIRT)
Drug overdose deaths ▲ Indicator MHA7	• Naloxone education and distribution programs • Prescription drug monitoring programs (PDMPs) • Syringe services programs (SSPs) • Medication-assisted treatment (MAT) access • Comparable insurance coverage for behavioral health (parity) ★ • Culturally competent workforce in underserved communities ★ • Recovery communities and peer supports • Housing programs for people with behavioral health conditions

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Appendix G: Defined Service Community by County and Zip Code

Defined Service Community by County and Zip Code

Ohio Defined Counties

ZIP	**CITY AND STATE**	**COUNTY**
44099	Windsor, OH	Ashtabula
44093	Williamsfield, OH	Ashtabula
44088	Unionville, OH	Ashtabula
44030	Conneaut, OH	Ashtabula
44032	Dorset, OH	Ashtabula
44041	Geneva, OH	Ashtabula
44010	Austinburg, OH	Ashtabula
44003	Andover, OH	Ashtabula
44004	Ashtabula, OH	Ashtabula
44005	Ashtabula, OH	Ashtabula
44082	Pierpont, OH	Ashtabula
44084	Rock Creek, OH	Ashtabula
44085	Rome, OH	Ashtabula
44076	Orwell, OH	Ashtabula
44047	Jefferson, OH	Ashtabula
44048	Kingsville, OH	Ashtabula
44068	North Kingsville, OH	Ashtabula
44111	Cleveland, OH	Cuyahoga
44130	Parma, OH	Cuyahoga
44130	Parma Heights, OH	Cuyahoga
44112	Cleveland, OH	Cuyahoga
44110	Cleveland, OH	Cuyahoga
44130	Middleburg Heights, OH	Cuyahoga
44130	Cleveland, OH	Cuyahoga
44108	Cleveland, OH	Cuyahoga
44109	Cleveland, OH	Cuyahoga
44129	Parma, OH	Cuyahoga
44143	Cleveland, OH	Cuyahoga
44117	Euclid, OH	Cuyahoga
44144	Cleveland, OH	Cuyahoga
44149	Strongsville, OH	Cuyahoga
44124	Mayfield Heights, OH	Cuyahoga
44116	Rocky River, OH	Cuyahoga
44126	Cleveland, OH	Cuyahoga
44142	Brookpark, OH	Cuyahoga
44125	Cleveland, OH	Cuyahoga
44124	Pepper Pike, OH	Cuyahoga
44142	Cleveland, OH	Cuyahoga

44145	Westlake, OH	Cuyahoga
44119	Cleveland, OH	Cuyahoga
44120	Cleveland, OH	Cuyahoga
44122	Beachwood, OH	Cuyahoga
44121	Cleveland, OH	Cuyahoga
44146	Bedford, OH	Cuyahoga
44147	Broadview Heights, OH	Cuyahoga
44124	Lyndhurst, OH	Cuyahoga
44124	Cleveland, OH	Cuyahoga
44118	Cleveland, OH	Cuyahoga
44123	Euclid, OH	Cuyahoga
44017	Berea, OH	Cuyahoga
44114	Cleveland, OH	Cuyahoga
44198	Cleveland, OH	Cuyahoga
44195	Cleveland, OH	Cuyahoga
44197	Cleveland, OH	Cuyahoga
44113	Cleveland, OH	Cuyahoga
44199	Cleveland, OH	Cuyahoga
44139	Solon, OH	Cuyahoga
44129	Cleveland, OH	Cuyahoga
44022	Chagrin Falls, OH	Cuyahoga
44140	Bay Village, OH	Cuyahoga
44188	Cleveland, OH	Cuyahoga
44190	Cleveland, OH	Cuyahoga
44115	Cleveland, OH	Cuyahoga
44181	Cleveland, OH	Cuyahoga
44127	Cleveland, OH	Cuyahoga
44128	Cleveland, OH	Cuyahoga
44193	Cleveland, OH	Cuyahoga
44194	Cleveland, OH	Cuyahoga
44192	Cleveland, OH	Cuyahoga
44141	Brecksville, OH	Cuyahoga
44191	Cleveland, OH	Cuyahoga
44104	Cleveland, OH	Cuyahoga
44131	Independence, OH	Cuyahoga
44137	Maple Heights, OH	Cuyahoga
44131	Seven Hills, OH	Cuyahoga
44131	Parma, OH	Cuyahoga
44105	Cleveland, OH	Cuyahoga

44101	Cleveland, OH	Cuyahoga
44103	Cleveland, OH	Cuyahoga
44131	Cleveland, OH	Cuyahoga
44040	Gates Mills, OH	Cuyahoga
44131	Brooklyn Heights, OH	Cuyahoga
44136	Strongsville, OH	Cuyahoga
44133	North Royalton, OH	Cuyahoga
44135	Cleveland, OH	Cuyahoga
44134	Cleveland, OH	Cuyahoga
44107	Lakewood, OH	Cuyahoga
44102	Cleveland, OH	Cuyahoga
44138	Olmsted Falls, OH	Cuyahoga
44106	Cleveland, OH	Cuyahoga
44070	North Olmsted, OH	Cuyahoga
44132	Euclid, OH	Cuyahoga
44601	Alliance	Stark County
44608	Beach City	Stark County
44613	Brewster	Stark County
44614	Canal Fulton	Stark County
44626	East Sparta	Stark County
44630	Greentown	Stark County
44632	Hartville	Stark County
44640	Limaville	Stark County
44641	Louisville	Stark County
44643	Magnolia	Stark County
44646	Massillon	Stark County
44647	Massillon	Stark County
44648	Massillon	Stark County
44650	Maximo	Stark County
44652	Middlebranch	Stark County
44657	Minerva	Stark County
44662	Navarre	Stark County
44666	North Lawrence	Stark County
44669	Paris	Stark County
44670	Robertsville	Stark County
44685	Uniontown	Stark County
44688	Waynesburg	Stark County
44689	Wilmot	Stark County
44701	Canton	Stark County
44702	Canton	Stark County
44703	Canton	Stark County
44704	Canton	Stark County
44705	Canton	Stark County
44706	Canton	Stark County

44707	Canton	Stark County
44707	North Industry	Stark County
44708	Canton	Stark County
44709	Canton	Stark County
44709	North Canton	Stark County
44710	Canton	Stark County
44711	Canton	Stark County
44714	Canton	Stark County
44718	Canton	Stark County
44718	Jackson Belden	Stark County
44720	Canton	Stark County
44720	North Canton	Stark County
44721	Canton	Stark County
44730	Canton	Stark County
44730	East Canton	Stark County
44735	Canton	Stark County
44056	Macedonia	Summit County
44056	Northfield	Summit County
44067	Northfield	Summit County
44067	Sagamore Hills	Summit County
44087	Twinsburg	Summit County
44203	Barberton	Summit County
44203	Norton	Summit County
44210	Bath	Summit County
44216	Clinton	Summit County
44221	Cuyahoga Falls	Summit County
44222	Cuyahoga Falls	Summit County
44223	Cuyahoga Falls	Summit County
44224	Cuyahoga Falls	Summit County
44224	Silver Lake	Summit County
44224	Stow	Summit County
44232	Green	Summit County
44236	Hudson	Summit County
44250	Lakemore	Summit County
44262	Munroe Falls	Summit County
44264	Peninsula	Summit County
44278	Tallmadge	Summit County
44286	Richfield	Summit County
44301	Akron	Summit County
44302	Akron	Summit County
44303	Akron	Summit County
44304	Akron	Summit County
44305	Akron	Summit County
44306	Akron	Summit County

44307	Akron	Summit County
44308	Akron	Summit County
44309	Akron	Summit County
44310	Akron	Summit County
44311	Akron	Summit County
44312	Akron	Summit County
44313	Akron	Summit County
44314	Akron	Summit County
44319	Akron	Summit County
44320	Akron	Summit County
44321	Akron	Summit County
44321	Copley	Summit County
44322	Akron	Summit County
44333	Akron	Summit County
44333	Fairlawn	Summit County
44334	Akron	Summit County
44334	Fairlawn	Summit County
44372	Akron	Summit County
44446	Niles, OH	Trumbull
44444	Newton Falls, OH	Trumbull
44453	Orangeville, OH	Trumbull
44450	North Bloomfield, OH	Trumbull
44440	Mineral Ridge, OH	Trumbull
44437	Mc Donald, OH	Trumbull
44430	Leavittsburg, OH	Trumbull
44439	Mesopotamia, OH	Trumbull
44438	Masury, OH	Trumbull
44485	Warren, OH	Trumbull
44484	Warren, OH	Trumbull
44491	West Farmington, OH	Trumbull
44486	Warren, OH	Trumbull
44483	Warren, OH	Trumbull
44473	Vienna, OH	Trumbull
44470	Southington, OH	Trumbull
44482	Warren, OH	Trumbull
44481	Warren, OH	Trumbull
44410	Cortland, OH	Trumbull
44417	Farmdale, OH	Trumbull
44404	Burghill, OH	Trumbull

44402	Bristolville, OH	Trumbull
44403	Brookfield, OH	Trumbull
44424	Hartford, OH	Trumbull
44420	Girard, OH	Trumbull
44418	Fowler, OH	Trumbull
44425	Hubbard, OH	Trumbull
44428	Kinsman, OH	Trumbull

Pennsylvania Defined Counties

Code	City	County
15001	Macarthur	Beaver County
15001	West Aliquippa	Beaver County
15001	Aliquippa	Beaver County
15003	Fairoaks	Beaver County
15003	Ambridge	Beaver County
15005	Baden	Beaver County
15009	West Bridgewater	Beaver County
15009	Beaver	Beaver County
15009	Vanport	Beaver County
15010	Racine	Beaver County
15010	Beaver Falls	Beaver County
15010	Patterson Heights	Beaver County
15026	Clinton	Beaver County
15027	Conway	Beaver County
15042	Freedom	Beaver County
15043	Georgetown	Beaver County
15050	Hookstown	Beaver County
15052	Industry	Beaver County
15059	Midland	Beaver County
15061	Monaca	Beaver County
15066	New Brighton	Beaver County
15074	Rochester	Beaver County
15077	Shippingport	Beaver County
15081	South Heights	Beaver County
16115	Darlington	Beaver County
16123	Fombell	Beaver County
16136	Koppel	Beaver County
16141	New Galilee	Beaver County
16110	Adamsville	Crawford County
16111	Atlantic	Crawford County
16131	Hartstown	Crawford County
16314	Cochranton	Crawford County
16316	Conneaut Lake	Crawford County
16327	Guys Mills	Crawford County
16328	Hydetown	Crawford County

16335	Meadville	Crawford County
16354	Titusville	Crawford County
16360	Townville	Crawford County
16403	Cambridge Springs	Crawford County
16404	Centerville	Crawford County
16406	Conneautville	Crawford County
16422	Harmonsburg	Crawford County
16424	Espyville	Crawford County
16424	Linesville	Crawford County
16432	Riceville	Crawford County
16433	Saegertown	Crawford County
16434	Spartansburg	Crawford County
16435	Springboro	Crawford County
16440	Venango	Crawford County
16401	Albion	Erie County
16401	Lundys Lane	Erie County
16407	Corry	Erie County
16410	Cranesville	Erie County
16411	East Springfield	Erie County
16412	Crossingville	Erie County
16412	Edinboro	Erie County
16413	Elgin	Erie County
16415	Fairview	Erie County
16417	Girard	Erie County
16421	Harborcreek	Erie County
16423	Lake City	Erie County
16426	McKean	Erie County
16427	Mill Village	Erie County
16428	North East	Erie County
16430	North Springfield	Erie County
16438	Union City	Erie County
16441	Waterford	Erie County
16442	Wattsburg	Erie County
16443	West Springfield	Erie County
16501	Erie	Erie County
16502	Erie	Erie County
16503	Erie	Erie County
16504	Erie	Erie County
16505	Erie	Erie County
16506	Erie	Erie County
16507	Erie	Erie County
16508	Erie	Erie County
16509	Erie	Erie County
16510	Erie	Erie County

16511	Erie	Erie County
16512	Erie	Erie County
16514	Erie	Erie County
16515	Erie	Erie County
16541	Erie	Erie County
16544	Erie	Erie County
16546	Erie	Erie County
16550	Erie	Erie County
16563	Erie	Erie County
16565	Erie	Erie County
15004	Atlasburg	Washington County
15019	Bulger	Washington County
15021	Burgettstown	Washington County
15021	Paris	Washington County
15022	Charleroi	Washington County
15022	North Charleroi	Washington County
15033	Donora	Washington County
15036	Eldersville	Washington County
15038	Elrama	Washington County
15053	Joffre	Washington County
15054	Langeloth	Washington County
15055	Lawrence	Washington County
15057	McDonald	Washington County
15060	Midway	Washington County
15063	Monongahela	Washington County
15067	New Eagle	Washington County
15078	Slovan	Washington County
15301	Washington	Washington County
15311	Amity	Washington County
15312	Avella	Washington County
15312	Reade	Washington County
15313	Beallsville	Washington County
15314	Bentleyville	Washington County
15317	Canonsburg	Washington County
15317	Mcmurray	Washington County
15321	Cecil	Washington County
15323	Claysville	Washington County
15324	Cokeburg	Washington County
15329	Prosperity	Washington County
15330	Eighty Four	Washington County
15331	Ellsworth	Washington County
15332	Finleyville	Washington County
15333	Fredericktown	Washington County
15336	Gastonville	Washington County
15339	Hendersonville	Washington County

15340	Hickory	Washington County
15342	Houston	Washington County
15345	Marianna	Washington County
15347	Meadow Lands	Washington County
15348	Millsboro	Washington County
15350	Muse	Washington County
15358	Richeyville	Washington County
15360	Scenery Hill	Washington County
15361	Southview	Washington County
15363	Strabane	Washington County
15365	Taylorstown	Washington County
15366	Van Voorhis	Washington County
15367	Venetia	Washington County
15368	Vestaburg	Washington County
15376	West Alexander	Washington County
15377	West Finley	Washington County
15378	Westland	Washington County
15379	West Middletown	Washington County
15412	Allenport	Washington County
15419	California	Washington County
15423	Coal Center	Washington County
15427	Daisytown	Washington County
15429	Denbo	Washington County
15432	Dunlevy	Washington County
15434	Elco	Washington County
15477	Roscoe	Washington County
15483	Stockdale	Washington County
15062	Monessen	Westmoreland County
15068	Arnold	Westmoreland County
15068	Barking	Westmoreland County
15068	Parnassus	Westmoreland County
15068	Lower Burrell	Westmoreland County
15068	New Kensington	Westmoreland County
15072	Pricedale	Westmoreland County
15083	Sutersville	Westmoreland County
15085	Trafford	Westmoreland County
15087	Webster	Westmoreland County
15089	West Newton	Westmoreland County
15448	Jacobs Creek	Westmoreland County
15479	Van Meter	Westmoreland County
15479	Smithton	Westmoreland County
15601	Greensburg	Westmoreland County
15610	Acme	Westmoreland County
15611	Adamsburg	Westmoreland County

15612	Alverton	Westmoreland County
15613	Apollo	Westmoreland County
15615	Ardara	Westmoreland County
15616	Armbrust	Westmoreland County
15617	Arona	Westmoreland County
15618	Avonmore	Westmoreland County
15619	Bovard	Westmoreland County
15620	Bradenville	Westmoreland County
15621	Calumet	Westmoreland County
15622	Champion	Westmoreland County
15623	Claridge	Westmoreland County
15624	Crabtree	Westmoreland County
15625	Darragh	Westmoreland County
15626	Delmont	Westmoreland County
15627	Derry	Westmoreland County
15628	Donegal	Westmoreland County
15629	East Vandergrift	Westmoreland County
15632	Export	Westmoreland County
15633	Forbes Road	Westmoreland County
15634	Grapeville	Westmoreland County
15635	Hannastown	Westmoreland County
15636	Harrison City	Westmoreland County
15637	Herminie	Westmoreland County
15638	Hostetter	Westmoreland County
15639	Hunker	Westmoreland County
15640	Hutchinson	Westmoreland County
15641	Hyde Park	Westmoreland County
15642	Irwin	Westmoreland County
15642	North Huntingdon	Westmoreland County
15642	North Irwin	Westmoreland County
15644	Jeannette	Westmoreland County
15646	Jones Mills	Westmoreland County
15647	Larimer	Westmoreland County
15650	Latrobe	Westmoreland County
15655	Laughlintown	Westmoreland County
15658	Wilpen	Westmoreland County
15658	Ligonier	Westmoreland County
15660	Lowber	Westmoreland County
15661	Loyalhanna	Westmoreland County
15662	Luxor	Westmoreland County
15663	Madison	Westmoreland County
15664	Mammoth	Westmoreland County
15665	Manor	Westmoreland County
15666	Mount Pleasant	Westmoreland County
15668	Murrysville	Westmoreland County

15670	New Alexandria	Westmoreland County
15671	New Derry	Westmoreland County
15672	New Stanton	Westmoreland County
15674	Norvelt	Westmoreland County
15675	Penn	Westmoreland County
15676	Pleasant Unity	Westmoreland County
15677	Rector	Westmoreland County
15678	Rillton	Westmoreland County
15679	Ruffs Dale	Westmoreland County
15680	Salina	Westmoreland County
15683	Scottdale	Westmoreland County
15684	Slickville	Westmoreland County
15685	Southwest Greensburg	Westmoreland County
15687	Stahlstown	Westmoreland County
15688	Tarrs	Westmoreland County
15689	United	Westmoreland County
15690	Parker	Westmoreland County
15690	Vandergrift	Westmoreland County
15691	Wendel	Westmoreland County
15692	Westmoreland City	Westmoreland County
15693	Whitney	Westmoreland County
15695	Wyano	Westmoreland County
15696	Youngstown	Westmoreland County
15697	Youngwood	Westmoreland County
15698	Yukon	Westmoreland County
15779	Torrance	Westmoreland County
15923	Bolivar	Westmoreland County
15944	New Florence	Westmoreland County
15954	Seward	Westmoreland County

Appendix H: Patient Demographics

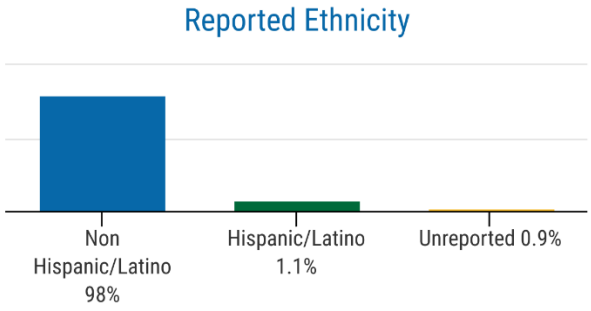
Patient Demographics

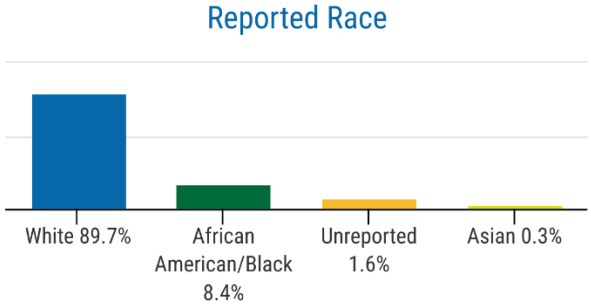
January 1, 2024 - December 31, 2024

Glenbeigh Reported Numbers
(Data Integrity Report - Ohio Hospital Association)

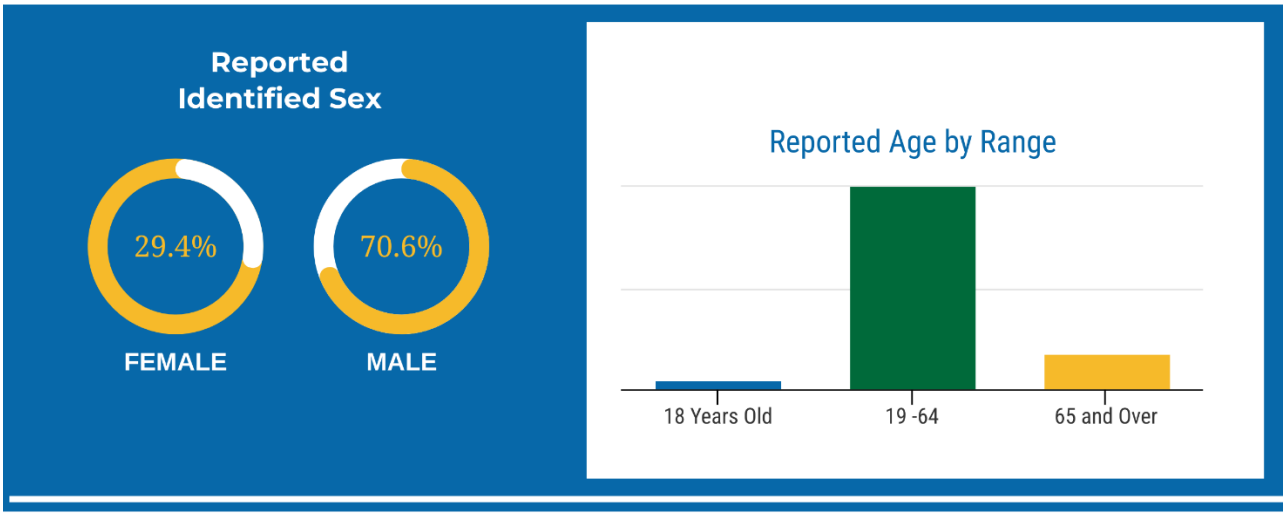
Glenbeigh 2024 Patient Demographics

Inpatient Statistics for Ethnicity and Race





Source: Data Integrity Report - Ohio Hospital Association Glenbeigh



Appendix I: Health Equity and Social Determinants of Health

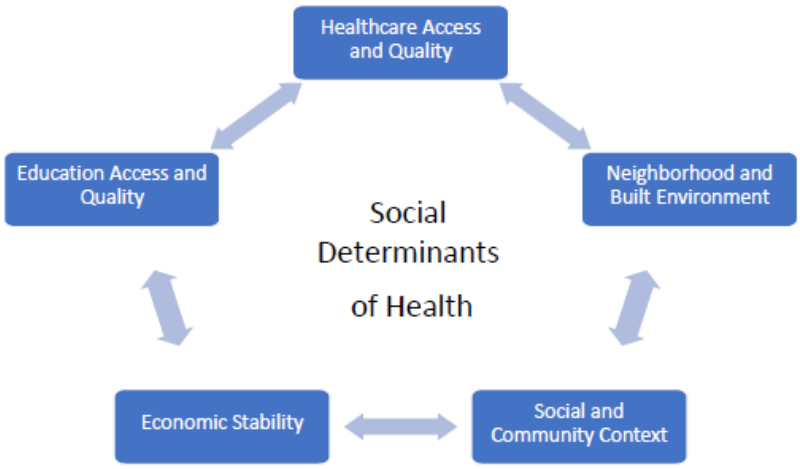
The purpose of addressing healthcare equity is to create an environment where individuals can access the care they need regardless of outside factors. This aligns with Glenbeigh's Mission Statement and Vision to provide the highest quality care to individuals and families impacted by alcohol and drugs. Consequences of healthcare inequity can manifest in worse health outcomes throughout the lifespan of an individual. The main goals of health equity are to:

- Allocate resources based on need
- Impact the individual at the micro-level
- Prioritize groups that have been excluded or marginalized
- Implement practices to overcome disparities in resources, access and opportunities

Healthcare equity is different from healthcare equality. Equality implies giving the same advantages to everyone while equity refers to personalizing the advantages based on individual need.

Social Determinants of Health

At Glenbeigh, we strive to meet the individual where they are. This allows us to tailor our efforts to the needs of the population we serve. In determining the needs that require our attention, social determinants of health need to be evaluated and assessed. Our goal is to promote equity through building on work that is already underway.



Education Access and Quality – This may include literacy, language, vocational training, early childhood education and higher education. It also may include a focus on the type of learning that can be individualized such as materials geared toward reading, writing, drawing, person to person interactions/specialty group and audio formats

Economic Stability – This often includes employment, income, expenses, debt, medical bills and other support. Questions about use of public assistance, debt and job-related concerns may offer insight. For individuals that may lose health insurance coverage during treatment, Charity Care applications are available. Glenbeigh may also offer other assistance such as basic hygiene products and clothing to those in need.

Social and Community Context – This can include social integration, support systems, community engagement, discrimination and stress. Patients are asked about their living environment and if this is a safe place for them to continue their recovery journey. Glenbeigh employs Care Coordinators that offer assistance in helping patients with finding recovery housing.

Neighborhood and Built Environment – This often includes housing, transportation, safety, parks/playgrounds, walkability, zip code/geography and access to healthy food. Glenbeigh employs Care Coordinators that offer assistance in helping patients with locating regional recovery housing.

Healthcare Access and Quality – This may include insurance coverage, health literacy, transportation to health care facilities, copays, quality of care and provider availability. Glenbeigh evaluates this throughout the treatment process. Limited transportation assistance may be available for those who experience significant barriers and meet specific criteria. For outpatient treatment, Glenbeigh offers a telehealth option. Telehealth psychiatric service is available on a case by case basis for those seen during their inpatient treatment and would like to continue to see a provider during outpatient treatment.

Appendix J: Glenbeigh Impact Matrix 2022 – August 2025

Glenbeigh Impact Matrix

Community Benefit Initiatives
2022 through August 2025

Guided by 2022 CHNA Identified Needs and
2022 Implementation Strategy

Glenbeigh Impact Matrix

2022 to August 2025

Socioeconomic

Substance use and abuse continues to impact people of all races and ages. Poverty, lack of insurance coverage and transportation barriers are interrelated and can significantly impact access to treatment as well as successful recovery. Key Informant interviews revealed a need for mental health services in combination with treatment for substance use disorders. Investment in education and workforce expansion was described as critical to improving outcomes for individuals and families.

- Glenbeigh collaborated with other agencies as part of a regional referral network that remains a means of connecting people seeking treatment with the most appropriate level of care.
- Glenbeigh continued to participate in a structured referral program however few people were referred through that referral network, which was designed to assist physicians and other healthcare professionals with connecting clients to addiction treatment providers.
- Continue to provide limited financial assistance, charitable care and discounts to maximize access to treatment. Collaborate with other regional agencies to provide underserved communities with improved access to health services.
- Continue to maintain a referral network to assist individuals in need of support services.
- Expanded continuum of care to include inpatient and outpatient mental health care.
- All Glenbeigh recovery housing was certified by Ohio Recovery Housing per Ohio mandate. Invested in upgrades to meet new housing criteria. Glenbeigh operates a total of eight peer run recovery houses where residents have access to clinical and other support services.
- Glenbeigh continues to work with other recovery housing providers creating a referral network for individuals seeking long-term housing.
- Collaborate with other agencies offering GED and continued education. These organizations provide job training and other programs to help those in recovery reenter the workforce.
- Created a workforce development program to assist individuals entering the treatment field.
- Expanded the provision of outpatient level Telehealth services. Telehealth services allow Ohio residents to establish and continue treatment. Telehealth is available to clients with transportation barriers or who do not have the means to participate in-person.
- Leadership remains engaged with community organizations in order to provide a continuum of care to people in need.
- Offer assistance to social service agencies and reestablished connections with regional drug courts.
- Continue to provide information to the public and to patients on screening for infectious diseases that often accompany addiction such as Hepatitis C and HIV. Provide follow-up resources and prevention information.
- Work with ARMC Healthcare System to provide wound care for those with complications from Xylazine use.

Glenbeigh Impact Matrix

2022 to August 2025

Socioeconomic

While improvements have been made, people living with substance use disorders may not understand how to get assistance or help a loved one or client sustain recovery. There continues to be a lack of education and information available regarding substance use, treatment and recovery support. In some areas, less stigma is reported, while people in other areas within the region report that stigma remains a barrier.

- Continue to sponsor and participate in programs to increase awareness of substance use, treatment and recovery. Includes sponsorship of Ashtabula and Trumbull Mental Health and Recovery Board programs as well as the Scrappers family section in Niles, Ohio.
- Provide and participate in educational and social events to benefit the recovery community or other agencies throughout the region.
- Sponsor and provide in-kind donations to a multitude of agencies, organizations, non-profits as well as treatment and recovery support agencies throughout northeast Ohio and western Pennsylvania.
- Participate in law enforcement appreciation and training events. Host educational events for the benefit of the regional law enforcement community.
- Continue to provide space for recovery support groups and host social events for the recovery community. Social events welcome friends, family, sponsors and anyone who positively supports the recovery community.
- Host Bridges to Recovery speaker event for the Pennsylvania region recovery community.
- Continue to host a weekly virtual support meeting for professionals in recovery.
- Distribute naloxone to the public through the inpatient and outpatient facilities. Participate in naloxone distribution events. Provide free naloxone at annual picnic open to the recovery community.
- Attend public and private health fairs to provide information on addiction, treatment and recovery. Distribute resource materials and items to help people in the community reach out for information.
- Regional participation in community events and programs held to bring awareness to substance use and reduce stigma.
- Provide free educational programs to businesses, agencies and other entities that are interested in learning more about substance use disorders and regional programs that offer help.
- Build relationships throughout the region as a means of reducing stigma and raising awareness on how to provide support for employees and family members.

Glenbeigh Impact Matrix

2022 to August 2025

Socioeconomic

In many areas there continues to be a lack of recovery support options. Recovery support includes recovery housing and recovery oriented events.

- Completed recovery housing certification process and successfully completed survey through Ohio Recovery Housing. Refer patients seeking Ohio recovery housing to locations that meet State of Ohio certification requirements.
- Exploring the need for Level 1 recovery housing.
- Glenbeigh currently operates eight recovery houses creating two recovery communities. One located in Ashtabula County and consisting of three houses along with one community located in Trumbull County and consisting of five residences.
- Collaborating with other agencies and private donors, rent assistance, food and other services are provided to residents in need.
- Glenbeigh renovated and update the 2,000 square foot facility, which houses up to eight women.
- Renovation was also completed on several of the men's recovery housing enhancing the living experience.
- Explore new ways to engage people in recovery in order to prevent isolation and potential relapse.
- Continue to provide meeting space to local support groups that met pandemic standards.

Health Needs

Barriers exist that affect access to treatment either limiting or excluding certain demographics from obtaining treatment services.

- Transportation remains as a significant barrier. Individuals living in Glenbeigh's defined service community often have no transportation, limited transportation or no access to public transport services.
- The Appalachian population is aging and often requires accommodation that may include transportation and access to telehealth services due to financial limitations.
- The Appalachian population has a higher rate of poverty than non-Appalachian regions. People living in poverty may experience multiple barriers when seeking access to health care.
- Continue to work with individuals having limited resources to secure detoxification and treatment.
- Provide charitable care to individuals who meet clinical and financial eligibility when possible.
- Maintain a referral network to assist individuals in need of support services. Collaborate with other agencies to find and secure the best level of care.
- Provide education and information on testing services within the community. Distribute information on where and how to seek further care for HIV and Hepatitis.

Glenbeigh Impact Matrix

2022 to August 2025

Health Needs

Treatment providers agree there is a lack of qualified, educated, licensed individuals to work in the field of addiction treatment: from entry level positions to specialized physicians and nurses.

- Glenbeigh continues to foster partnerships and collaborative efforts with other entities to address the need for qualified workers and workforce development initiatives.
- Through the Earn/Learn/Live program, individuals in recovery had the opportunity to pursue educational opportunities to complete the education and experience needed to apply for entry level certification to work in the addiction treatment field. CDCA, Peer Support and STNA educational opportunities were made available. This program also addressed barriers that include housing, transportation and internet access.
- Continue to work with colleges, universities and local agencies. Developed a resident training for future physicians attending LECOM in cooperation with ARMC Healthcare System.
- Provide internship opportunities for nursing, social work and counseling students as well as other healthcare professionals to provide education on addiction, treatment and recovery.
- Provide speakers and resource materials on the topics of addiction, treatment and recovery.
- Provide reference materials to healthcare providers, clergy and others to help guide individuals seeking information on addiction and treatment.
- Work with community agencies to provide helpful information to the public.
- Create and distribute information about trends affecting addiction, treatment and recovery.

Other

- Planning is underway to develop a nutrition/life skills course to help people in recovery learn to eat healthy within a budget. Healthy Ashtabula County reported a need for more focus on life skills including cooking healthy food to that can help break the cycle of generational poverty. According to ALICE data, older adults, the fastest growing population, also struggle with food insecurity.
- Deliver messaging at health fairs and public events to connect with demographics that do not use or have limited access to social media.
- Social media and other online platforms offer a means of connecting with people affected by substance use disorders as well as those living in recovery. Glenbeigh maintains the use of online platforms to provide treatment and to promote recovery to reduce the risk of relapse caused by isolation. Platforms include: Glenbeigh websites, Facebook, Twitter, LinkedIn and Instagram.

Appendix K: Approach to Prioritizing Health Issues

The 2025 CHNA utilized a cross-sectional study as the tool to prioritize health issues. Multiple approaches were used to collect data and prioritize qualitative data. Secondary (quantitative) data was used in a supporting role to confirm information gleaned from stakeholders.

Community perspective (qualitative data) was a key component to construct a complete community resource inventory. Over 90 community stakeholders were engaged across a diverse cross-section of northeast Ohio and western Pennsylvania encompassing health and non-health disciplines. Using a semi-structured data collection methodology, Glenbeigh conducted electronic surveys combined with direct communication with various participants. Interviews conducted by Conduent, were completed using Cleveland Clinic CHNA standards as detailed in the 2025 Cleveland Clinic Community Health Needs Assessment. Survey questions remained focused on community needs in order to deliver clarity on health equity issues throughout the region.

Quantitative data was obtained from the U.S. Census Bureau, the Ashtabula County Health Assessment, state health analysis, Appalachian Regional Commission reports, the Ohio Department of Health, the Centers for Disease Control and Prevention, the ALICE Threshold Report and an assortment of federal agency reports. Data was collected to ascertain population characteristics, including socioeconomic factors, along with substance use trends.

The congregate data provide important context to guide how and where Glenbeigh may provide resources for the greatest impact. As the nature of substance use continually changes, the 2025 assessment was broken into two areas that emerged as priority areas based on the evidence gathered. Key findings concentrate on socioeconomic and health needs as it did in the 2019 and 2022 CHNAs. Many of the social determinants of health, the conditions that influence health disparities changed while the Glenbeigh service area shifted, both due to the continued impact of the COVID-19 virus public health emergency, which ended in May 2023.

Glenbeigh continues to undertake a system-based approach to address the key needs of the defined service area. Glenbeigh may also undertake community benefit initiatives within other communities served by Glenbeigh that did not qualify as part of the CHNA defined service area.

In order to provide transparent information on Glenbeigh Community Benefit activities, the 2025 CHNA, along with the Implementation Strategy, will be posted on Glenbeigh's main website at www.glenbeigh.com. Community members are welcome to submit input or comments by contacting Glenbeigh at https://www.glenbeigh.com/community-benefit-feedback.

Appendix L: Overview of the Glenbeigh 2025 Community Health Needs Assessment

The Glenbeigh 2025 Community Health Needs Assessment fulfills requirements as defined by the State of Ohio and the federal government under the Patient Protection and Affordable Care Act. Glenbeigh is an owned subsidiary of ARMC Healthcare System. ARMC Healthcare System reports community benefit initiatives to the Ohio Department of Health and the Internal Revenue Service on behalf of Glenbeigh.

Glenbeigh submitted the 2025 Community Health Needs Assessment to ARMC Healthcare System management for review prior to Board presentation. The finalized CHNA was presented to the Board for adoption with the final vote occurring on October 29, 2025.

Per federal requirements, Glenbeigh will publish the approved 2025 CHNA no later than December 31, 2025. Afterwards, using key findings along with supporting data, Glenbeigh will formulate and publish an accompanying Implementation Strategy within the established timeline.

The following is an overview of the 2025 CHNA process:

Process Management: Glenbeigh, working with oversight provided by ARMH Healthcare System and Cleveland Clinic, was the lead agency in undertaking the formation of the 2025 CHNA. Prior to starting the process, the 2019 and 2022 CHNAs and community benefit data were reviewed. Survey questions were reviewed for relevance and updated as needed.

Defined Service Area: The defined service area was determined based on the geography from which the majority of Glenbeigh patients emanated. The data used to determine this was Glenbeigh inpatient admissions volumes from 2022, 2023 and 2024. Taken into consideration was how the service area differed from the 2022 defined service area as well as the locations of Glenbeigh's outpatient centers. From that data, five Ohio counties and five Pennsylvania counties were identified as Glenbeigh's defined service area for 2025.

Primary Data Collection and Analysis

Input from Diverse Populations: Due to the nature of Glenbeigh's services, many clients represent vulnerable populations. Glenbeigh took measures to ensure the inclusion of myriad populations in the primary data collection process. To include a broad group of insights from various demographics, across a large geographic region, surveys were created and sent electronically. Recipients include professionals working with people living with substance use disorders, individuals living in recovery, those supporting people living in recovery and community leaders. This provided input that provides sound insight reflecting people living in the defined service area. The majority of Glenbeigh's 2025 defined service area is in the

nationally defined Appalachian Region. Much of the region is rural, with urban pockets. The region still has areas with limited access to broadband service, which can limit access to care through telehealth services. The aggregate feedback from data collected from this cohort provided information on issues directly affecting individuals living with substance use disorders.

Inclusion of Community Leaders and Individuals Working in the Field: Interviews and electronic surveys were utilized to collect information from professionals working in the field of addiction treatment as well as individuals providing services to people affected by substance use. This provided a comprehensive overview of the issues affecting those who provide services within the defined area. Respondents include individuals in recovery, with a loved-one in recovery or an individual working in the field. These interviews provided insight from community members and leaders and offer input on direct addiction services as well as ancillary services.

Secondary Data Collection and Analysis

Research: Glenbeigh revisited data collected in 2022. During the formulation of the 2025 CHNA, much of the data was updated with current information. However, some data sets were no longer available or not updated. Within the 2025 CHNA, data inconsistencies are noted. Research was expanded to define ever-changing material relevant to addiction, treatment and recovery. It is important to note that drug and alcohol statistics take several years to compile and may change after original publication. Local, state and federal reports and statistics were researched. All sources are documented throughout the 2025 CHNA and include URL's active at the time of publication.

Formulating the 2025 CHNA

Assessment: After completing the research phase, data was reviewed, analyzed and tabulated. Issues that appeared in multiple forums were counted and factors mentioned multiple times in responses were prioritized as community needs. Primary data was used similarly, noting issues that were repeatedly mentioned as affecting the service area.

Defining Key Findings: Through quantitative and qualitative data analysis, Glenbeigh prioritized the needs of the defined service community. Due to the extensive nature of addiction on multiple communities, key findings were categorized into two groups: socioeconomic needs and health needs. This methodology provides a strategic means of assessing the significant health needs within Glenbeigh's defined service area and provides an overview of areas to address in the Implementation Strategy.

Community Assets and Resources: Glenbeigh's defined service area extends throughout Northeast Ohio and Western Pennsylvania, a territory that includes 10 non-contiguous counties. Throughout each county, non-profit healthcare systems complete community health needs assessments that list community assets and resources. Glenbeigh's CHNA includes a truncated list of resources in place of a full list encompassing all 10 counties. For detailed information on community assets and resources, it is recommended that readers contact their local hospital or health system, health department or social/mental health board for a comprehensive list of local resources. Publication of community resources should be included in the individual county issued needs assessments.

Glenbeigh

ARMC Healthcare System

Cleveland Clinic affiliate

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