Cleveland Clinic

Community Health Needs Assessment

2025

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Cleveland Clinic Main Campus 2025 Community Health Needs Assessment

Introduction

Cleveland Clinic Main Campus (Main Campus), a 1,273 bed[1] academic medical center located in downtown Cleveland, Ohio, serves as the flagship facility of the Cleveland Clinic health system. The hospital integrates patient care, research, and education. It provides 24-hour emergency services and comprehensive specialty care, supported by a highly skilled and multidisciplinary team. Main Campus is recognized for its clinical excellence and serves as a trusted healthcare provider for residents of Cleveland and surrounding communities.

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

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

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

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

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

Main Campus is a trusted part of the community and continues to grow and improve to meet the needs of its patients. The hospital cares for the sick and improves patient care through research and education. Through research, Cleveland Clinic discovers cures and treatment of diseases affecting its communities. Education programs train qualified healthcare providers to support the needs of patients and communities, reducing healthcare access issues. This has been of historical importance to the work, care and mission of Cleveland Clinic and will continue to be incorporated as Cleveland Clinic Main Campus moves toward development of the implementation strategy report. To learn more, visit: my.clevelandclinic.org/locations/directions/231-cleveland-clinic-main-campus

CHNA Background

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

Main Campus Community Definition

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

Figure 1: Main Campus Community Definition

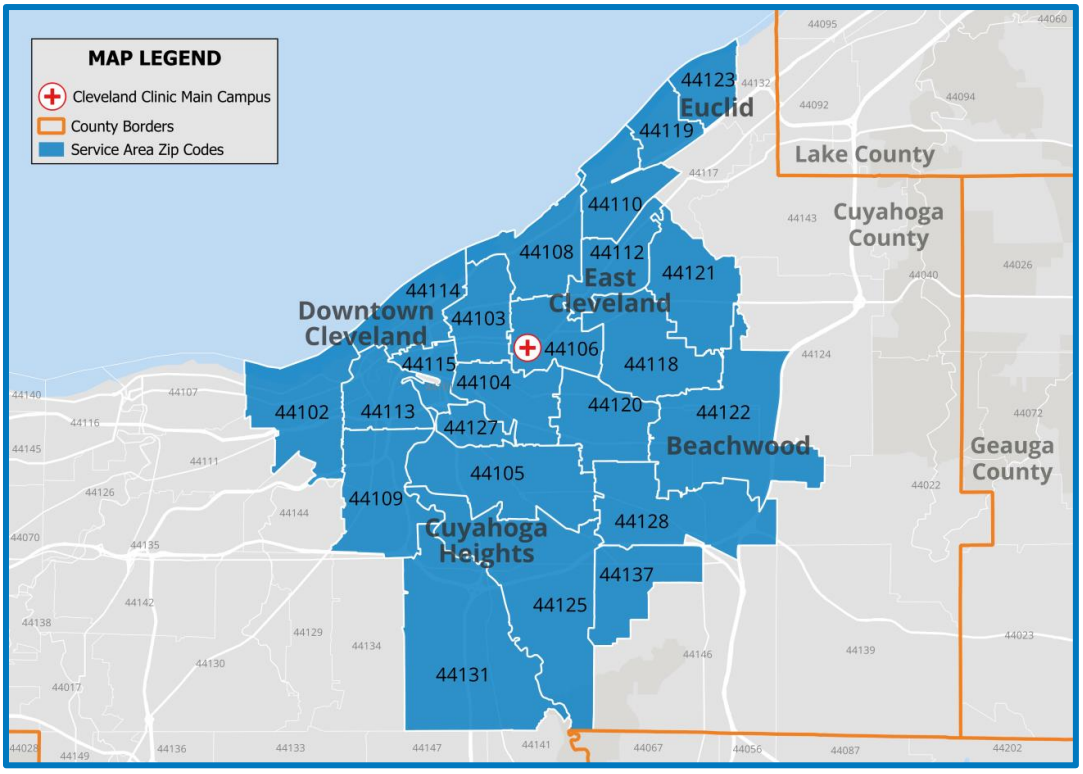


Table 1: Main Campus Community Definition

Zip Code	Postal Name	Zip Code	Postal Name
44102	Cleveland (Detroit-Shoreway)	44118	Shaker Heights
44103	Cleveland (Hough)	44119	Euclid
44104	Cleveland (Kinsman)	44120	Shaker Heights
44105	Garfield Heights	44121	South Euclid
44106	Cleveland Heights	44122	Beachwood
44108	Bratenahl	44123	Euclid
44109	Brooklyn Heights	44125	Garfield Heights
44110	Bratenahl	44127	Cuyahoga Heights
44112	East Cleveland	44128	Bedford Heights
44113	Cleveland (Tremont)	44131	Independence
44114	Cleveland (Downtown)	44137	Maple Heights
44115	Cleveland (Industrial Valley)		

Secondary Data Methodology and Key Findings

Secondary Data Scoring

Secondary data used for this assessment were collected and analyzed from Conduent Healthy Communities Institute's (HCI) community indicator database. The database, maintained by researchers and analysts at HCI, includes 300 community indicators covering at least 28 topics in the areas of health, health-related social needs, and quality

of life. The data are primarily derived from state and national public secondary data sources such as the U.S. Census American Community Survey (ACS Survey), Centers for Disease Control & Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), County Health Rankings, Feeding America, and the National Cancer Institute. These indicators were analyzed at both the county level and within a defined 23-zip-code community area for the hospital. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced five key health priorities, Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, highlighting differences in outcomes by group.

Other Community Assessment and Improvement Plans
An environmental scan was conducted to supplement quantitative data and further contextualize health needs across the hospital's defined community. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts, including reports from the United Way, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs prioritized in this 2025 CHNA process for Main Campus.

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

Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations with community stakeholders were conducted across the Main Campus community. These conversations included individuals from 20 organizations who spoke directly to the needs within the Main Campus community. Participants represented sectors including public health, mental health, housing, food access, child and family services, and grassroots organizations. Feedback consistently reinforced the five identified health priorities and revealed community-specific challenges affecting health outcomes, such as long wait times for pediatric care, gaps in behavioral health support, housing-related health risks, and challenges accessing culturally responsive prenatal care. Financial hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and systems-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

Main Campus' 2025 Community Health Needs Assessment reaffirms its commitment to addressing five core health priorities based on a rigorous synthesis of primary data in the form of community stakeholder interviews, secondary indicators from national and state data sources, and a regional environmental scan. The following five prioritized health needs will help shape the hospital's Implementation Strategy Reports (ISR) for the subsequent three years:

These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that Cuyahoga County continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to address differences in health outcomes and improve health outcomes for all populations in the community served by Main Campus.

The five prioritized community health needs identified in this 2025 Main Campus CHNA are summarized below. Within each summary, pertinent information pertaining to secondary data findings, primary data findings and relevant demographics, social drivers of health, and differences in health outcomes are highlighted. Full data details are included in the appendices section at the end of this report.

Prioritized Health Need #1: Access to Healthcare

Access to Healthcare

Key Themes from Community Input

- Cost and insurance barriers
- Provider and specialist shortages
- Long wait times for appointments
- Transportation challenges
- Limited care navigation and awareness
- Cultural and language barriers
- Mistrust and lack of continuity in care

Warning Indicators

- Preventable Hospital Stays: Medicare Population
- Adults with Health Insurance: 18+
- Adults who go to the Doctor Regularly for Checkups
- Adults who Visited a Dentist
- Health Insurance Spending-to-Income Ratio

Access to Healthcare was consistently identified as a major concern across stakeholder interviews in Cuyahoga County, reflecting both systemic and community-level barriers that limit residents' ability to obtain timely and affordable care. Participants emphasized that while the region benefits from a robust network of hospitals and safety-net providers, many residents still face significant obstacles related to cost, transportation, and insurance coverage. Stakeholders noted that affordability remains a leading issue, particularly for low-income and uninsured residents who often delay or forgo needed care. Even those with insurance struggle with high copays, deductibles, and coverage limitations that make regular healthcare visits difficult to sustain. These challenges are compounded by a shortage of primary care and behavioral health providers in certain neighborhoods, leading to long wait times and inconsistent access to preventive and specialty services.

Participants also described how geographic and social differences shape access to care across Cuyahoga County. Residents in impoverished neighborhoods experience limited availability of primary care offices, pharmacies, and behavioral health providers, forcing many to rely on emergency departments for non-urgent needs. Transportation was cited as a major barrier, especially for residents without reliable vehicles or those dependent on public transit, which can make traveling to appointments time-consuming and costly. Several stakeholders discussed the importance of trust, cultural awareness, and language accessibility, noting that some residents avoid care due to past negative experiences.

Stakeholders agreed that improving access requires community-based approaches that bring care directly to residents where they live and work. The expansion of community health workers, care navigation programs, and mobile health services was frequently cited as an effective strategy to close gaps and build trust. Participants also emphasized the need for stronger partnerships between hospitals, health departments, and community organizations to coordinate care and ensure residents are aware of available resources. Collectively, the feedback underscores that while Cuyahoga County has strong healthcare assets, differences in affordability, provider access, and trust continue to prevent many residents from obtaining consistent access to care.

Secondary data from trusted national and state data sources reveal concerning trends related to healthcare access for the community served by Cleveland Clinic's Main Campus. The typical cost of insurance in Cuyahoga County is relatively high (7.1% of household income), and the county's insured rates are among the lowest across Ohio. Insured rates are lower for the county's Hispanic/Latino and Black/African American populations (11.7% and 7.1% uninsured, respectively), compared to the overall county rate (5.5% uninsured). Even for Medicare recipients, healthcare access is a challenge. The county's rate of preventable hospital stays (3,677 per 100,000 Medicare enrollees) is among the highest in the nation, and this rate is higher for Black/African American and Hispanic/Latino residents (5,651 and 5,458 per 100,000 Medicare enrollees, respectively).

Geospatial data from Conduent HCI's Community Health Index (CHI) can help to estimate health risk at a more granular level, based on health-related social needs. Across the Main Campus community, the zip codes with the greatest healthcare needs are 44115 (Cleveland, Industrial Valley) and 44104 (Cleveland, Kinsman), with CHI values of 99.9 and 99.8, respectively. In fact, most of the zip codes in the region (15 out of 23) have a CHI value above 75, indicating significant healthcare challenges for this population, broadly. Additional details about the CHI, including charts, maps, and additional findings from primary and secondary data for this health need can be found in the appendices section of this report.

Prioritized Health Need #2: Behavioral Health

Behavioral Health, encompassing both Mental Health and Substance Use Disorder, was identified by stakeholders as one of the most pressing and interconnected issues facing the Main Campus community. Participants described a community experiencing high levels of stress, depression, and anxiety, compounded by economic strain, housing insecurity, and exposure to trauma. Stakeholders emphasized that while mental health awareness has improved in recent years, the availability of timely, affordable, and culturally responsive care remains limited. Long wait times for counseling and psychiatric services were frequently mentioned, as were the challenges of connecting individuals to ongoing treatment after initial diagnosis or crisis intervention. The need for integrated models of care that address both behavioral and physical health in the same setting was a recurring theme across discussions.

Substance Use Disorder, particularly opioid and alcohol misuse, was also cited as a continuing concern across the Main Campus community. Stakeholders noted that while overdose deaths have stabilized due to expanded harm reduction and naloxone distribution efforts, the underlying drivers of addiction, such as poverty, trauma, and lack of stable housing, remain unresolved. Participants discussed the cyclical nature of substance use, incarceration, and relapse, emphasizing that access to long-term recovery and supportive housing is insufficient to meet community demand. They also pointed to the stigma surrounding addiction and mental illness as a persistent barrier that prevents individuals and families from seeking help early.

Overall, stakeholders described behavioral health as a complex challenge that cannot be separated from broader health-related social needs such as housing, safety, and economic stability. They called for greater coordination among hospitals, behavioral health agencies, and community-based organizations to create a more seamless system of care. Expanding crisis response teams, community-based counseling, and wraparound recovery supports was seen as critical to addressing gaps and reducing the long-term burden of untreated behavioral health conditions. Stakeholders agreed that building

trust, normalizing conversations about mental health, and expanding accessible behavioral health resources are essential to improving overall community well-being.

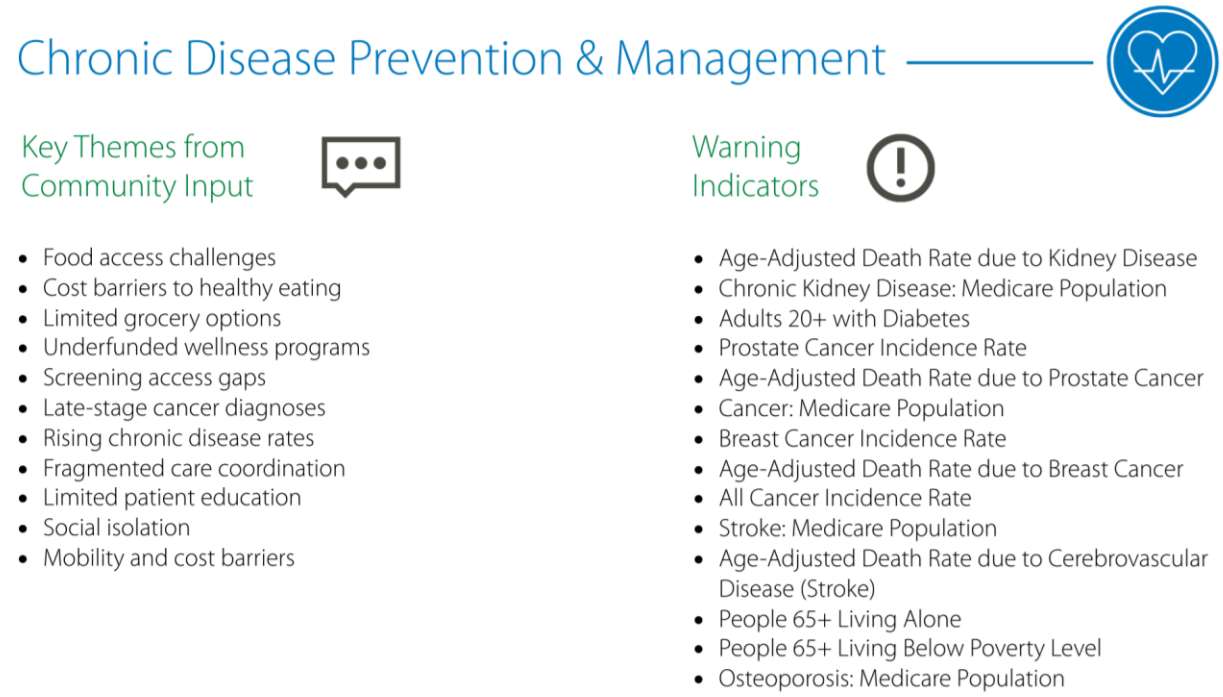
Secondary data findings underscore the urgency of behavioral health needs for the population served by Main Campus. Across Cuyahoga County, the average number of days residents report their mental health as poor has been trending upward since 2019. Medicare data indicate high rates of depression among the county's American Indian/Alaska Native residents that are more than twice that of the overall county population (33% vs. 16% of Medicare recipients).

Cuyahoga County's drug poisoning death rate (45.5 per 100,000) exceeds both state-wide and national rates (44.7 and 27.2, respectively) and is more than twice the Healthy People 2030 target (20.7). Additionally, the percentage of driving deaths involving alcohol (42.5%) is among the highest across the country.

Geographic analysis using Conduent HCI's Mental Health Index (MHI), which assesses mental health risk based on local health-related social needs indicators, demonstrates a high burden of behavioral health needs across the population served by Cleveland Clinic's Main Campus. Nearly all zip codes in the community (21 out of 23) scored above 90 on the MHI scale, indicating severe challenges throughout the community. The zip code 44104 (Cleveland, Kinsman) had the highest index score (100).

Together, these primary and secondary findings highlight the profound and intersecting challenges of mental health and substance use disorder within the Main Campus community.

Prioritized Health Need #3: Chronic Disease Prevention and Management



Stakeholders consistently identified Chronic Disease Prevention and Management as a top health concern for the Cleveland Clinic Main Campus community. Participants described how preventable conditions such as diabetes, heart disease, and cancer are deeply influenced by social and environmental factors, including access to nutritious food, opportunities for physical activity, and economic stability. Many noted that while the region has world-class clinical care, differences in prevention and management persist across neighborhoods.

The following section highlights key primary and secondary data findings across all subtopics, including nutrition, cancer, cardiovascular disease, and aging.

Nutrition, Healthy Eating, and Wellness
Stakeholders emphasized that nutrition and healthy lifestyle behaviors are critical yet challenging components of chronic disease prevention. Access to affordable, nutritious food remains uneven, with food deserts and limited grocery options contributing to reliance on fast food or processed meals. Many residents face financial barriers that make healthy eating difficult to sustain, despite awareness of its importance. Participants noted that community wellness initiatives, such as fitness programming, walking groups, and nutrition education, are effective but often underfunded or limited to specific neighborhoods. Sustained investment in community-based wellness programs was seen as key to improving long-term outcomes.

Secondary data on consumer behaviors indicate that Cuyahoga County residents are more likely to rely on fast food and less likely to cook at home than nearly all other U.S. counties. Conduent HCI's Food Insecurity Index (FII) further illustrates where food access

concerns are most concentrated in the Main Campus population. In fact, the majority of zip codes in this region (15 out of 23) have an FII value above 90, indicating significant food insecurity across the area. The highest scores are in zip codes 44104 (Cleveland, Kinsman) and 44115 (Cleveland, Industrial Valley), with FII values of 100 and 99.9, respectively.

Cancer

Cancer continues to be a major health issue across the Main Campus community. Stakeholders cited differences in both incidence and outcomes for some groups. Participants highlighted that while screening resources exist, barriers such as transportation, insurance limitations, and mistrust of the healthcare system reduce participation in early detection programs. Expanding culturally relevant outreach and ensuring equal access to preventive screenings were identified as priorities for reducing cancer-related differences in health outcomes and improving survival rates.

Based on data from trusted state and national sources, Cuyahoga County residents experience elevated cancer risks. Prostate cancer occurs at a rate 23% higher than the U.S. average (139.3 vs. 113.2 per 100,000 males), while breast cancer is 5% more common (136.1 vs. 129.8 per 100,000 females). Black/African American men in Cuyahoga County experience significantly higher rates of prostate cancer incidence and death than the overall county male population. By comparison, Black/African American women experience higher rates of death due to breast cancer but similar rates of new cases, suggesting potential differences in access to timely diagnosis, treatment, or follow-up care.

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions

Diabetes, hypertension, and cardiovascular disease were among the most frequently discussed chronic conditions. Stakeholders described how these conditions often co-occur and are linked to diet, physical inactivity, and stress. Several participants expressed concern about increasing rates of obesity and early-onset chronic disease among younger adults. They noted that care coordination and patient education remain critical gaps, with many residents struggling to manage their conditions due to fragmented care or lack of support for medication adherence and lifestyle changes. Expanding chronic disease management programs in primary care settings and integrating nutrition and behavioral health services were viewed as essential next steps.

Secondary data indicate that diabetes affects a tenth of Cuyahoga adults (9.9%), and nearly a quarter of Medicare recipients (23%). Medicare data also demonstrate higher rates of diabetes among the county's Black/African American, Asian American/Pacific Islander, and Hispanic/Latino Medicare recipients (35%, 33%, and 32%, respectively). Chronic kidney disease, a typical complication of unmanaged diabetes, is also more common among the county's Black/African American Medicare recipients (30%), and the county-wide death rate due to kidney disease is one of the highest in the nation.

The rate of death due to stroke in Cuyahoga County (40.8 per 100,000) is substantially higher than the Healthy People 2030 target (33.4 per 100,000) and rising. Medicare data indicate that rates of hypertension (66% of Medicare recipients) and heart failure (12%) are comparable to state-wide benchmarks but, as with diabetes, the county's

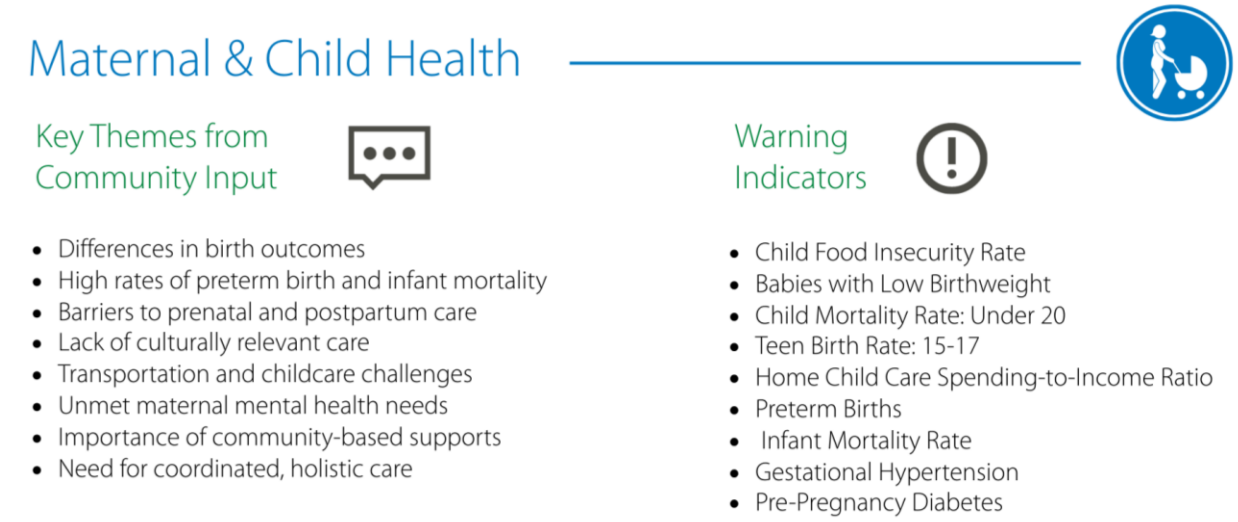
Black/African American population experiences higher risks for both health outcomes (74% and 16% of Medicare recipients, respectively).

Older Adult Health

The aging population in Cuyahoga County was also a recurring topic among stakeholders. Participants observed that many older adults live alone and experience mobility challenges, social isolation, and limited access to affordable home- and community-based services. The high cost of adult day care and in-home support further compounds these barriers, leading to increased risk of falls, poor nutrition, and unmanaged chronic conditions. Stakeholders underscored the need for coordinated aging services, improved transportation options, and stronger social networks to help older adults remain healthy, connected, and independent.

Based on scoring of secondary data indicators, Older Adult Health was ranked as the fourth most concerning health need in Cuyahoga County. The older adult population in the county is more likely than nearly anywhere else in Ohio to live in poverty (12.3% of those age 65+) or to live alone (36.1%), with each of these figures continuing to rise. Home care for older adults is also especially expensive in the county, with a typical cost of 13.4% of one's income, and even higher cost burdens for the county's Hispanic/Latino and Black/African American households (24.3% and 18.6%, respectively). These factors, combined with transportation and care coordination barriers, place older adults at elevated risk for unmanaged chronic illness.

Prioritized Health Need #4: Maternal and Child Health



Maternal and Child Health emerged as a significant area of concern among stakeholders for the Main Campus community. Participants described persistent differences in birth outcomes for some community groups. Stakeholders noted that these differences reflect broader social and structural challenges, including poverty, stress, housing instability, and unequal access to prenatal and postpartum care. Many emphasized that while high-quality obstetric and neonatal services exist within the region, these resources are not equally accessible or trusted by all communities.

Stakeholders also discussed barriers that prevent women and families from receiving consistent care throughout the prenatal and postpartum periods. Lack of transportation, limited access to providers who are culturally aware, and inadequate coordination between medical and social service systems were repeatedly cited as challenges. Participants described that for many families, social needs such as food insecurity, unstable housing, and childcare demands take precedence over preventive and reproductive care. They also noted that mental health concerns among pregnant and postpartum women, including depression and anxiety, often go unaddressed due to stigma and limited screening or follow-up.

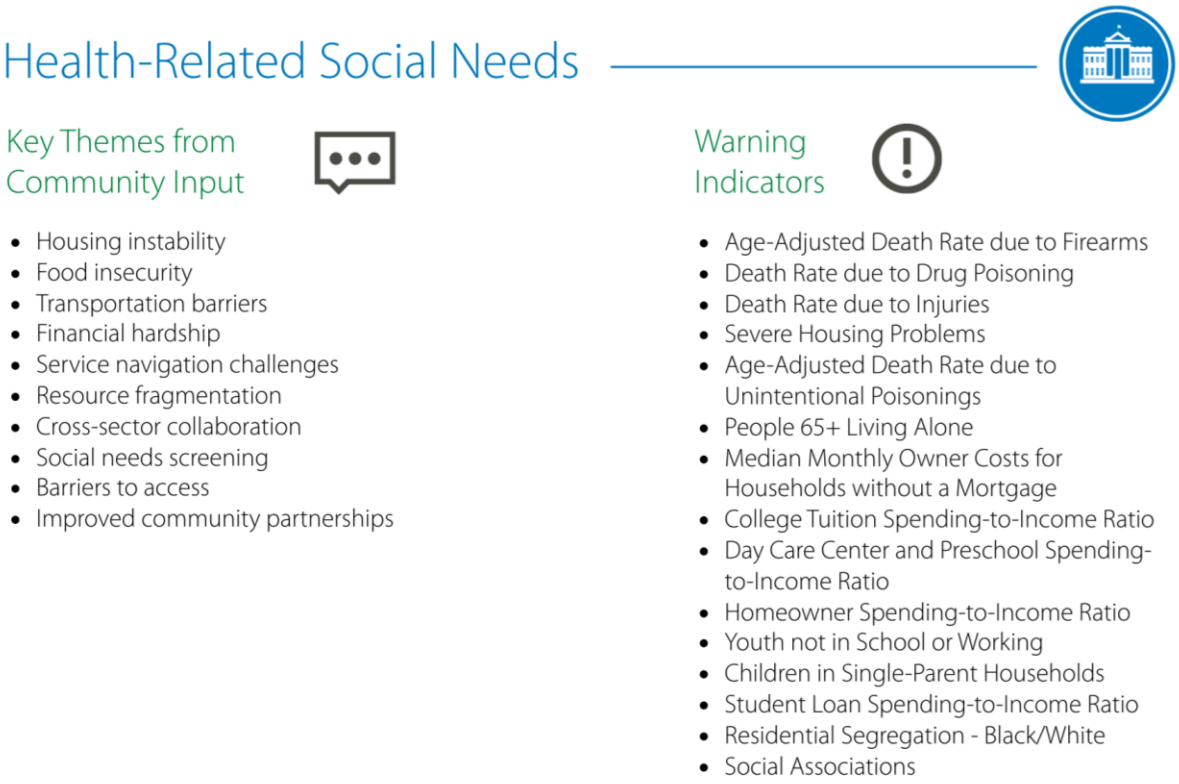
Participants highlighted the critical role of community-based programs and trusted local organizations in improving maternal and infant health. Efforts that provide home visiting, doula support, and culturally specific education were viewed as effective strategies for improving outcomes. Stakeholders emphasized that partnerships between healthcare providers, public health agencies, and community organizations must continue to expand to ensure that women and families receive holistic, continuous support. Addressing the social drivers of maternal and child health, such as housing, nutrition, and mental health, was viewed as essential to improving birth outcomes and supporting long-term family well-being for all populations.

Secondary data underscore many concerns related to maternal health and birth outcomes. The county's teen birth rate (7.3 per 1,000 female teens) is decreasing but remains higher than state-wide and national rates. Rates of preterm births (12.0%) and low birthweight (10.8%) are among the highest across all of Ohio, and preterm births are

more common among the county's Black/African American population (14.8%). Infant mortality is also high (7.7 deaths per 1,000 live births), compared to state-wide and national rates. Some of these birth outcomes may be related to chronic disease, with county rates of gestational hypertension and pre-pregnancy diabetes also surpassing state-wide rates.

Children's health in particular ranked as the third most concerning health topic in Cuyahoga County, based on scoring of secondary data indicators. Childhood lead exposure remains more prevalent in Cuyahoga County than nearly all other Ohio counties, despite significant improvements over time. Perhaps most concerning is the county's overall child mortality rate (70.8 per 100,000), one of the highest across the state. This rate is nearly double for the county's Black/African American children (129.1 per 100,000). Especially high rates of violent crime coupled with high rates of youth who are not in school or working may help to exacerbate these risks across the county.

Prioritized Health Need #5: Health-Related Social Needs



In the 2025 CHNA for Main Campus, stakeholders consistently identified Health-Related Social Needs as major influencers of health outcomes across the community. Participants described how poverty, unemployment, and housing instability contribute to chronic stress and create barriers to maintaining good health. Many residents face competing priorities such as food, housing, and transportation costs that take precedence over preventive care or medication adherence. Stakeholders noted that while health and social service programs exist throughout the community, navigating them can be difficult, particularly for residents without internet access, transportation, or familiarity with available resources. These challenges were viewed as deeply

interconnected with differences in health outcomes for chronic disease, behavioral health, and maternal health outcomes.

Access to safe and affordable housing was one of the most frequently cited needs. Participants described how housing instability, substandard living conditions, and the high cost of rent contribute to physical and mental health problems. Food insecurity was also highlighted as a persistent concern, particularly in neighborhoods with limited access to fresh produce and grocery stores. Stakeholders observed that transportation barriers limit access not only to medical appointments but also to employment, education, and healthy food options. They emphasized that while the region has numerous community-based organizations addressing social needs, service fragmentation and lack of coordination often lead to duplication of efforts and unmet needs.

Stakeholders called for stronger cross-sector collaboration to address the root causes of health-related social needs and to reduce barriers to essential resources. Expanding partnerships between hospitals, housing agencies, food banks, and local nonprofits was seen as critical to improving social and health outcomes. Participants also emphasized the importance of embedding social needs screening within healthcare settings and ensuring that patients are connected to appropriate supports. Addressing Health-Related Social Needs such as housing, food access, and transportation was viewed as essential for improving quality of life, reducing avoidable hospitalizations, and achieving more equal health outcomes across the Main Campus community.

Based on scoring of secondary data indicators, the topics of Economy and Education both ranked among the top four health and quality of life concerns across Cuyahoga County. The specific population served by Main Campus experiences an unemployment rate even greater than that of the surrounding county (10.3% vs. 7.3%), and about twice the state-wide rate (5.2%). The hospital's population also has a low median income ($49,106), and the region's Black/African American, Hispanic/Latino, and American Indian/Alaska Native residents all have a median income below $40,000. Poverty is especially widespread in the zip code 44115 (Cleveland, Industrial Valley) where most households are below the poverty level (58.5%).

Many basic needs, including education, are financially burdensome across the county. The typical costs of housing (19.3% of household income for renters), health insurance (7.1%), and adult day care (13.4%) surpass state and national averages. Cuyahoga County also has higher costs of college tuition (14.7% of household income), day care and preschool (8.7%), and home childcare (3.8%), compared to state-wide and nation-wide rates.

Secondary data also illustrate concerns regarding social well-being. County-wide rates of violent crime (856.5 per 100,000 residents) and homicide (20.7 per 100,000) are twice the state-wide rates, and the death rate due to firearms (20.2 per 100,000) is twice the Healthy People 2030 target.

Prioritized Health Needs in Context

Each of the five community health needs explored above reflect persistent and interconnected challenges shaped by broader social, economic, and environmental conditions. Together, these findings underscore the importance of place-based, needs-based approaches to improve health outcomes. The following sections provide an overview of the demographic and social factors influencing health in the Main Campus community, offering additional context for understanding the differences and opportunities outlined in this report.

Secondary Data Overview

Demographics and Health-Related Social Needs

The demographics of a community significantly impact its health profile.[2] Different groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community served by Main Campus, including the economic, environmental, and social drivers of health. The social drivers of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.[3] In addition to these highlights, detailed findings from the secondary data analysis can be found in Appendix B.

Geography and Data Sources

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

All demographic and health-related social needs estimates are sourced from Claritas Pop-Facts® (2024 population estimates) and American Community Survey one-year (2023) or five-year (2019-2023) estimates unless otherwise indicated.

[2] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/
[3] Centers for Medicare and Medicaid (CMS) (2025). Social Drivers of Health and Health-Related Social Needs. https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs

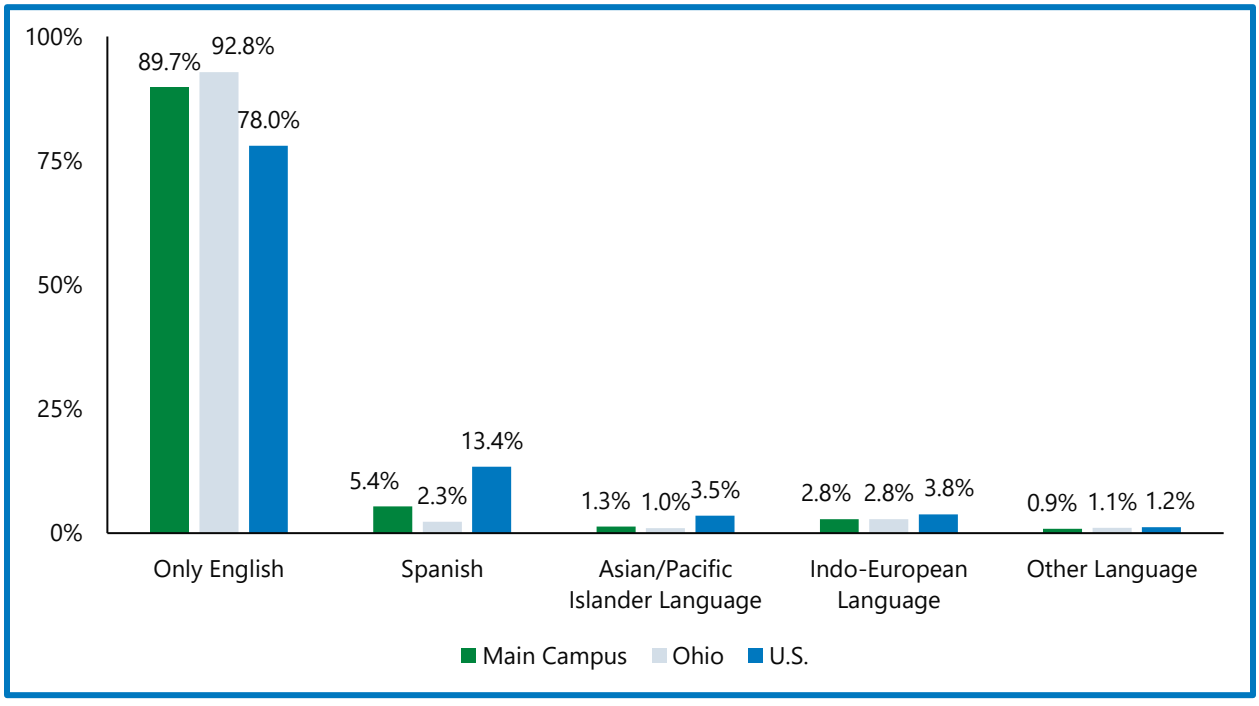
Population Demographics of the Main Campus Community

According to the 2024 Claritas Pop-Facts® population estimates, the community served by Main Campus has an estimated population of 535,016 persons. The median age in the community is 39.0 years, which is younger than that of Ohio (40.3 years). More than a quarter of the population (27.3%) is between 25-44 years old.

Black and African American residents are the largest share of the population at 51.6%. Just over a third of the population (34.9%) are White, 2.8% are Asian, and 8.2% are Hispanic or Latino of any race.

As seen in Figure 2, the majority of the Main Campus's population aged five and above speaks primarily English at home (89.7%). About one in twenty residents (5.4%) speak Spanish at home and 2.8% speak another Indo-European language. Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

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



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

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

Income and Poverty

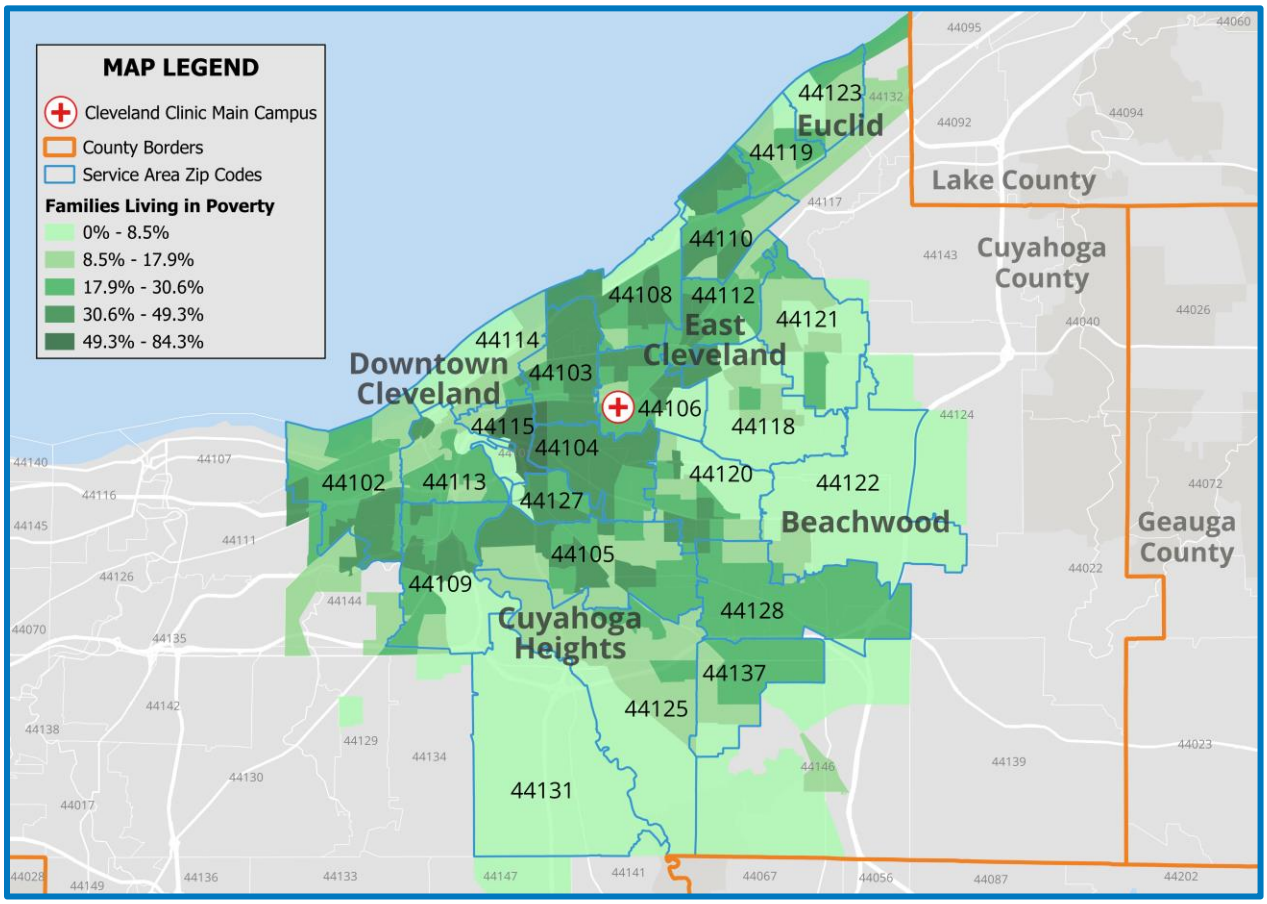
Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk

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

The median household income for the Cleveland Clinic Main Campus community is $49,106 which is less than that of Ohio overall ($68,488).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Across the Main Campus community, 19.9% of families live below the poverty level, more than twice the state-wide and national poverty rates (9.4% and 8.8%, respectively). Poverty levels differ geographically across the hospital community (Figure 3), and poverty is most common in the zip code 44115 (Cleveland, Industrial Valley) and 44104 (Cleveland, Kinsman), where 58.5% and 48.8% of families live in poverty, respectively.

Figure 3: Families in Poverty by Census Tract, Main Campus Community



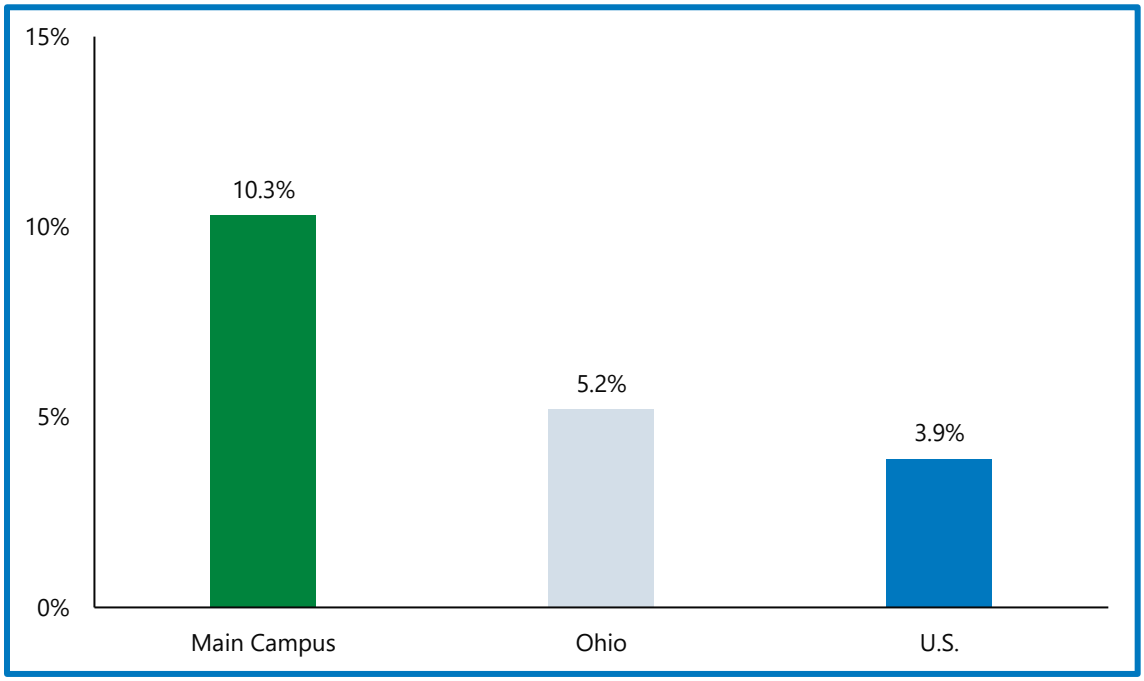
Claritas Pop-Facts® (2024 population estimates)

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

Education and Employment

The vast majority of the population within the Main Campus community have a high school degree or higher (87.3%) and more than a third have a bachelor's degree or higher (29.8%). These rates are higher than state-wide and nation-wide rates. As seen in Figure 4, the unemployment rate is 10.3%, about twice the Ohio unemployment rate (5.2%).

Figure 4: Population 16+ Unemployed: Hospital Community, State, and Nation



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

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

Education is an important indicator of health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health.[5] Higher levels of education may also lead to better job opportunities which, in turn, impact health. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes.[6]

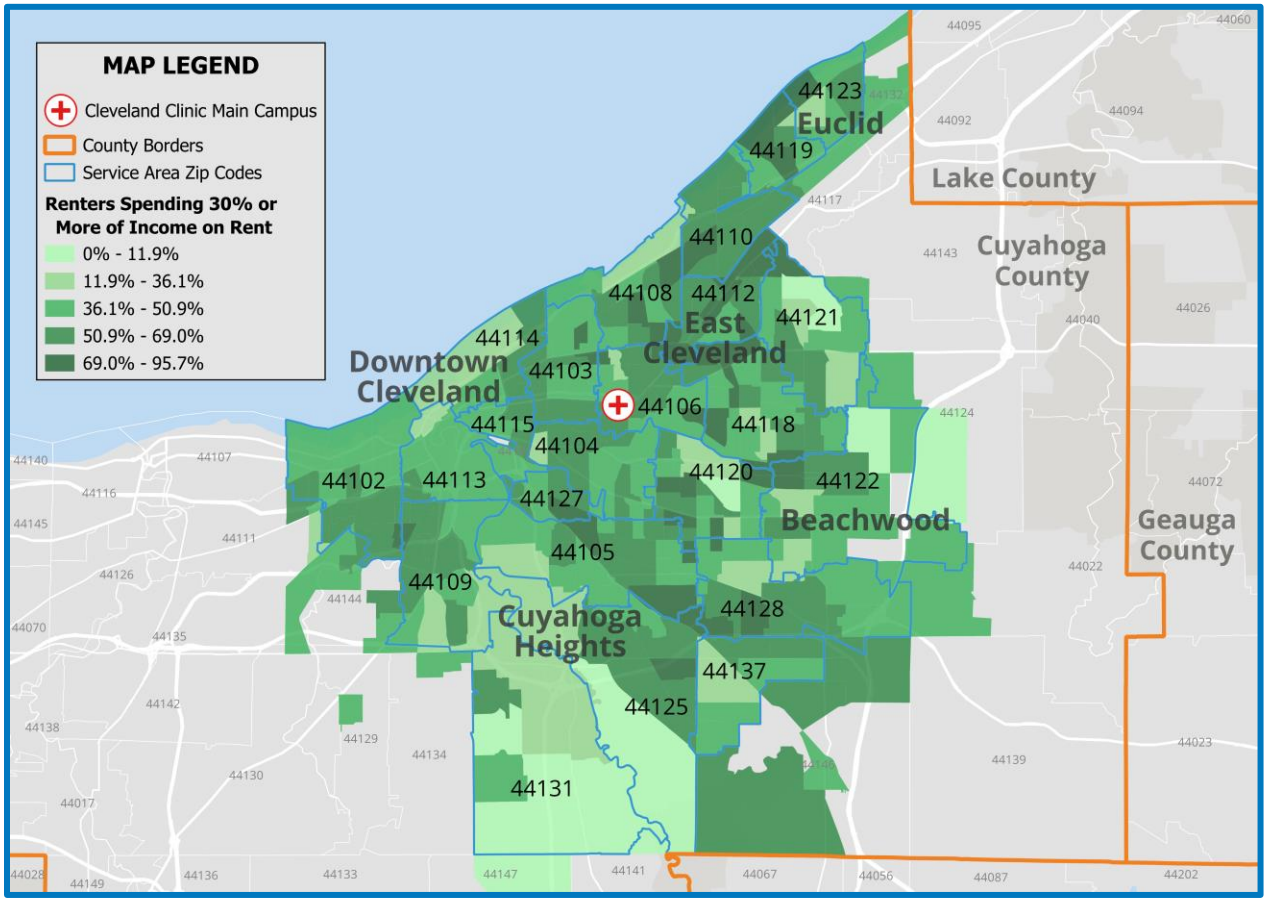
[5] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

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

Housing and Built Environment

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Across Cuyahoga County, 15.9% of households have severe housing problems, such as: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Housing costs in particular are burdensome across the county. Nearly half of renters in Cuyahoga (47.5%) spend at least 30% of their income on rent (Figure 5).

Figure 5: High Rent Burden by Census Tract, Main Campus Community



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

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. The majority of the Cuyahoga population has internet access (87.5% of households). However, at the zip code level, the lowest levels of internet access in the Main Campus community are in the zip codes 44104 (Cleveland, Kinsman) and 44127 (Cuyahoga Heights), where only 69.3% and 70.3% of households have an internet subscription, respectively.

Community Health Indices

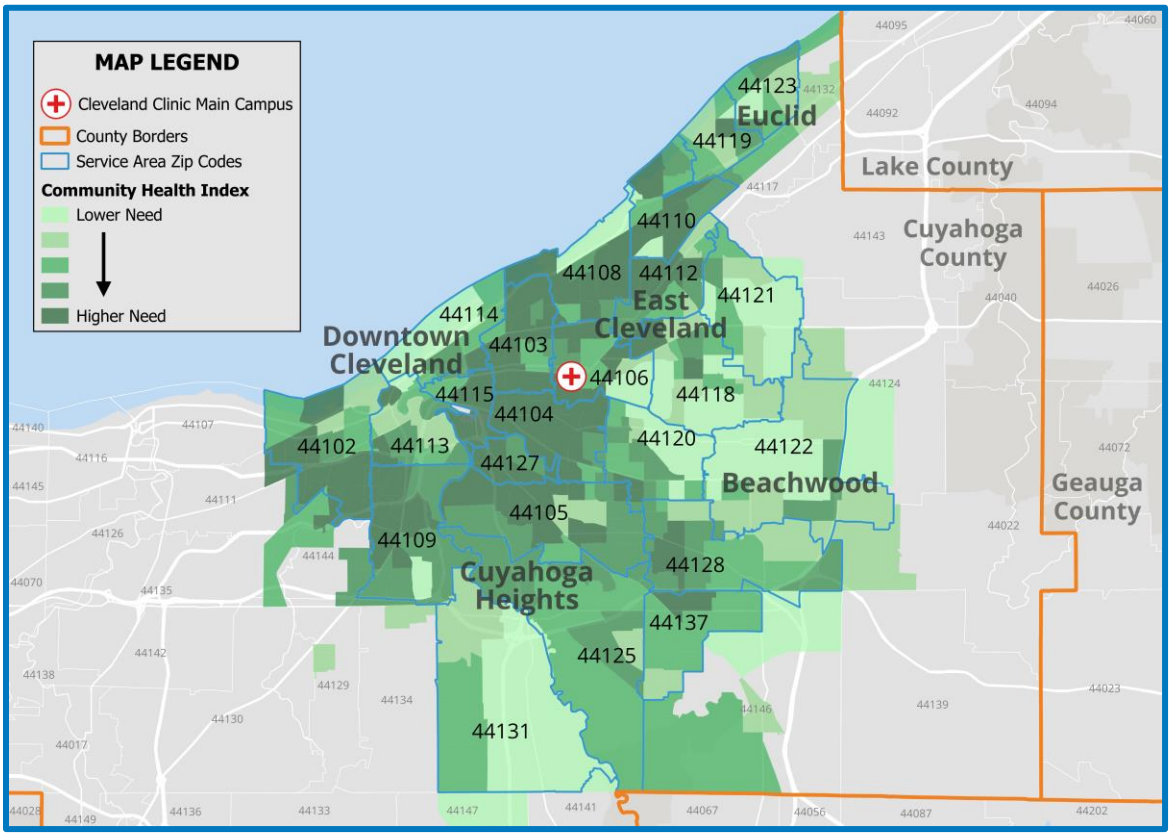
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the Main Campus community at the zip code level.

Community Health Index

Conduent HCI's Community Health Index (CHI) can help to identify geographic differences in health outcomes across the county, down to the census tract level. The CHI uses health-related social needs data that is strongly associated with poor health outcomes, such as preventable hospitalization or premature death, to estimate which geographic areas have the greatest health needs. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 6 illustrates which census tracts experience the greatest relative health needs in the Main Campus community, as indicated by the darkest shade of green. At the zip code level, 44115 (Cleveland, Industrial Valley) and 44104 (Cleveland, Kinsman) have the highest index values, at 99.9 and 99.8, respectively. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the community.

Figure 6: Community Health Index by Census Tract, Main Campus Community

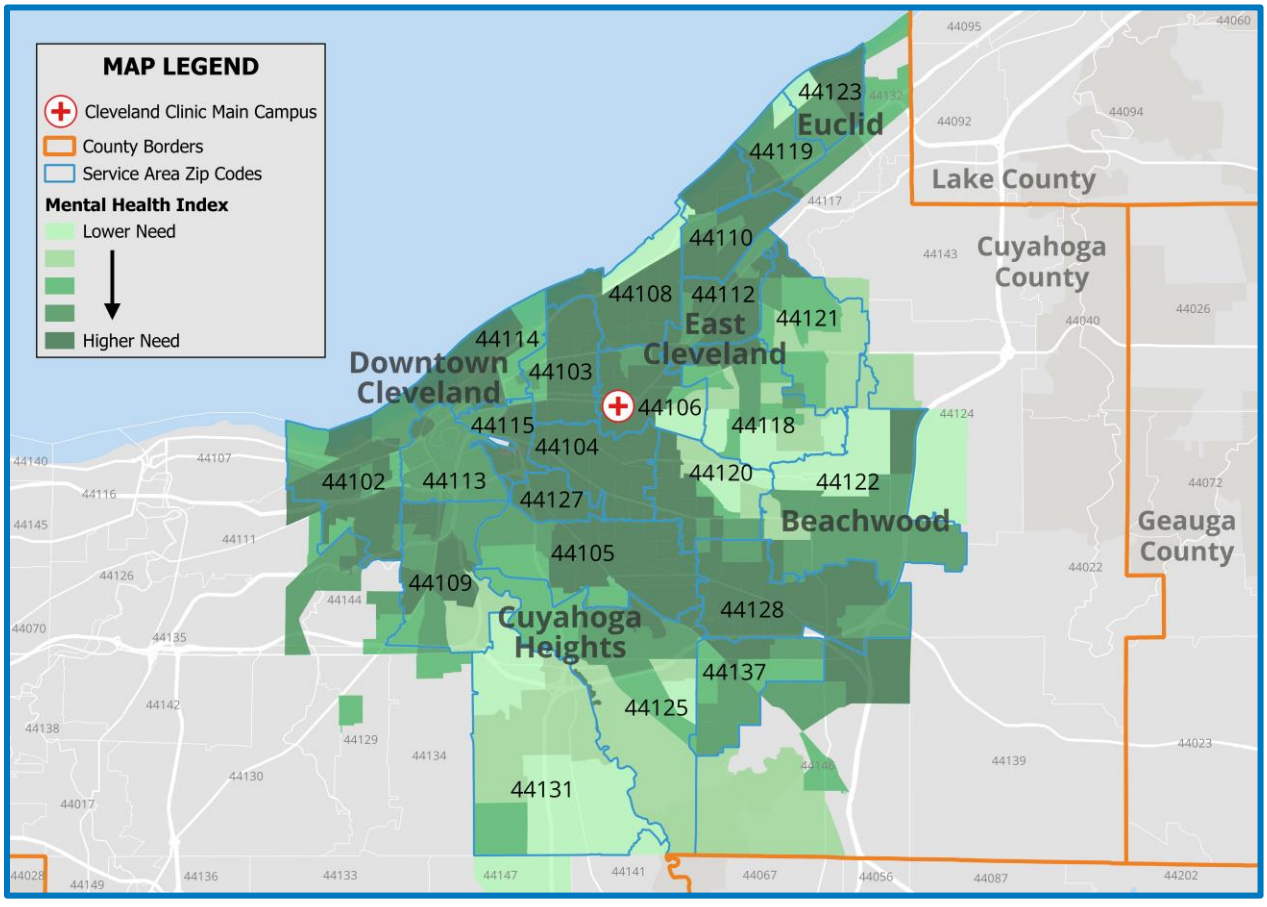


Mental Health Index

Conduent HCI's Mental Health Index (MHI) can help to identify geographic differences in mental health outcomes across the county, down to the census tract level. The MHI uses health-related social needs data that is strongly associated with self-reported poor mental health to estimate which geographic regions have the greatest mental health needs. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 7 illustrates which census tracts experience the greatest relative need related to mental health in the Main Campus community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44104 (Cleveland, Kinsman) with an MHI value of 100. Notably, nearly all zip codes in the region (21 out of 23) have an MHI value above 90. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Main Campus community.

Figure 7: Mental Health Index by Census Tract, Main Campus Community

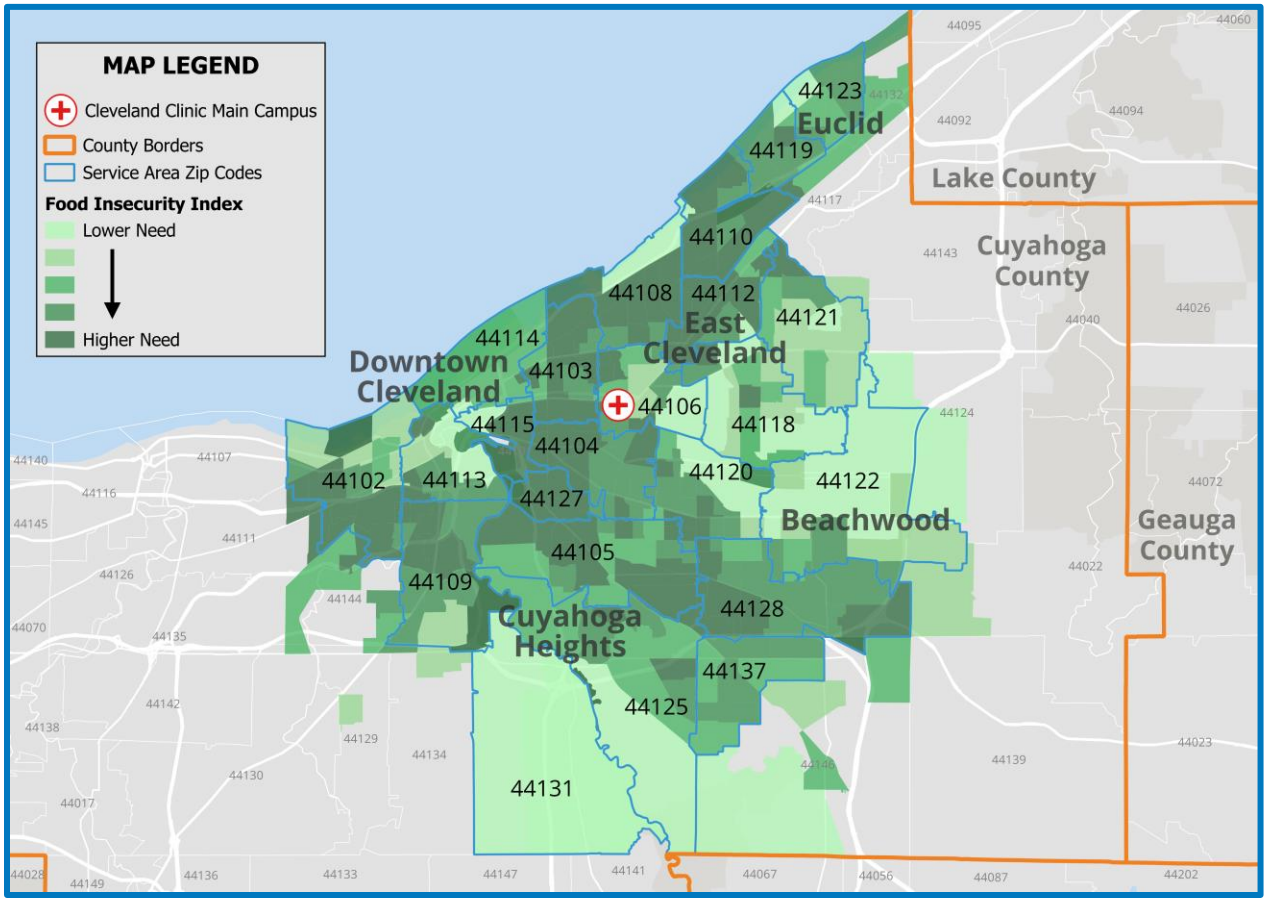


Food Insecurity Index

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

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the Main Campus community, as indicated by the darkest shade of green. At the zip code level, the highest level of need is in 44104 (Cleveland, Kinsman), with a FII value of 100. Notably, the majority of zip codes in the region (15 out of 23) have an FII value above 90. See Appendix B for additional details about the FII and a table of FII values for each zip code in the hospital community.

Figure 8: Food Insecurity Index by Census Tract, Main Campus Community



Other Community Assessment and Improvement Plans

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

2023 Ohio State Health Assessment[7]

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

- Access to Healthcare:
    - Widespread healthcare provider shortages, especially in primary care and mental health.
    - Many Ohioans face barriers such as limited insurance coverage, low health literacy, and lack of culturally and linguistically appropriate care.
- Behavioral Health:
    - Increased rates of depression, anxiety, and suicide among both youth and adults.
    - Significant unmet mental health needs and elevated levels of substance use, including youth drug use and adult overdose deaths.
- Chronic Disease Prevention and Management:
    - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
    - Obesity and poor nutrition identified as key contributors to chronic conditions.
- Maternal and Child Health:
    - Stagnant or worsening maternal morbidity and infant mortality rates.
    - Persistent differences in birth outcomes, particularly for Black and low-income populations.
- Health-Related Social Needs:
    - Ongoing challenges related to poverty, housing affordability and quality, food insecurity, and transportation.
    - These social drivers of health are strongly linked to poor health outcomes across all priority areas.

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

2023 City of Cleveland Parks and Recreation Community Needs Assessment[8]

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

2024 Cuyahoga County ADAMHS Board Needs Assessment[9]

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

2023 Cuyahoga County Planning Commission Data Book[10]

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

2022 Greater Cleveland LGBTQ+ Community Needs Assessment[11]

- Promote a culture of respect, empathy, and mutual support within and beyond the LGBTQ+ community

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[8] Cleveland Parks & Recreation Plan Team. (2024). *Community needs assessment report* [PDF]. City of Cleveland Department of Parks & Recreation. https://cleparksrecplan.com/wp-content/uploads/240102_Community-Needs-Assessment-Report_web.pdf

[9] Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County (2024). *Community health needs assessment* [PDF]. https://www.adamhscc.org/about-us/budgets-reports/needs-assessments

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

[11] Kent State University College of Public Health. (2024). *Greater Cleveland LGBTQ+ community needs assessment* [PDF]. The Greater Cleveland LGBTQ+ Community Needs Assessment Research Team. https://www.lgbtqohio.org/sites/default/files/docs/KSU-028_CommunityReport_102124_FA.pdf

- Implement and enforce anti-discrimination laws related to healthcare, workplace rights, reproductive and family rights, identification, housing, and taxation
- Combat community helplessness by offering clear, actionable solutions and encouraging engagement
- Expand access to community education in health, civic matters, cultural awareness, and emergency preparedness

Joint 2022 Cuyahoga County CHNA (Collaborating Organizations: University Hospital, Cuyahoga County Board of Health, and the City of Cleveland Department of Health)[12]

Priority Health Areas Identified:

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

Prioritized Populations:

- Maternal, Fetal, and Infant Health
- Older Adults

2023 Livable Cuyahoga Needs Assessment[13]

Community & Health Services

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

Outdoor Spaces

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

Transportation

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

Housing

- Older adults want to age in place in Cuyahoga County
- Renters face higher housing cost burdens than homeowners

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

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

- Support needed to find housing that meets mobility and accessibility needs

Social Participation

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

Respect & Engagement

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

Workforce & Civic Engagement

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

2023 United Way of Greater Cleveland Community Needs Assessment[14]

Economic Mobility

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

Health Pathways

- Gaps in life expectancy across communities
- Elevated levels of food insecurity and poor air quality
- Poor mental health outcomes; need for trauma-informed approaches

Housing Stability

- Rent affordability challenges, especially for older adults on fixed incomes
- High volume of homeless shelter information requests

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

Primary Data Overview

Community Stakeholder Conversations

A total of 20 organizations provided feedback for the Main Campus community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

Individuals from the following organizations participated as key informants for the Main Campus community:

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Birthing Beautiful Communities
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- City of Cleveland, Division of Fire
- Cleveland Clinic Children's
- Cuyahoga County Board of Health
- Cuyahoga Metropolitan Housing Authority
- Esperanza
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- NAMI Greater Cleveland
- Neighborhood Family Practice (FQHC)
- Positive Education Program (PEP)
- ThirdSpace
- Towards Employment

Across stakeholder interviews conducted for the 2025 Community Health Needs Assessment, participants emphasized the ongoing and interconnected challenges facing residents in the Cleveland Clinic Main Campus community. Behavioral Health, including Mental Health and Substance Use Disorder, was identified as one of the most urgent needs. Stakeholders described widespread stress, anxiety, and depression, particularly among youth and low-income populations, alongside rising concerns about suicide, trauma, and substance use. Fentanyl-related overdoses remain a leading issue, with many noting that recovery resources and long-term support options are insufficient to meet community demand. Participants cited long wait times, provider shortages, and affordability as major barriers to accessing care, particularly for those without insurance or those seeking culturally responsive and trauma-informed services.

Chronic Disease Prevention and Management were also highlighted as persistent priorities. Stakeholders discussed the high prevalence of diabetes, hypertension, obesity,

and heart disease, noting that these conditions are strongly linked to poor nutrition, food insecurity, and stress. Many residents, especially those in low-income neighborhoods, face difficulty affording healthy food or finding safe spaces for physical activity. Interviewees also underscored the importance of preventive education and care coordination, explaining that many individuals delay screenings and management because of transportation issues, financial strain, or a lack of trust in healthcare institutions.

Health-Related Social Needs were repeatedly identified as key drivers of health outcomes. Poverty, unstable housing, community violence, and limited economic opportunity were described as barriers that prevent residents from achieving and maintaining good health. Participants also raised concerns about the broader built environment, including neighborhood safety, sidewalk conditions, and exposure to environmental hazards such as lead. Transportation and digital access barriers further limit opportunities to connect with healthcare and social supports. Despite these challenges, stakeholders highlighted the strong presence of community-based organizations, local schools, and faith groups as trusted partners that can expand outreach and connect residents to needed services.

Overall, stakeholder feedback underscores that improving health in the Cleveland Clinic Main Campus community requires coordinated, cross-sector strategies that integrate healthcare, behavioral health, and social services. Investments in prevention, affordable care, and neighborhood-level supports were viewed as essential to improving health outcomes and strengthening trust across the community.

The following quotes highlight key themes from community feedback.

Priority Area	Key Quote	Additional Context
Access to Healthcare	"Even if you have insurance, it doesn't mean you can afford to use it. The copays, transportation, and time off work are real barriers for people."	Stakeholders frequently highlighted that affordability extends beyond insurance status. This quote demonstrates how the total cost of care, including travel, time, and lost wages, creates barriers even for insured residents. It exemplifies the broader theme that access is shaped by structural, financial, and logistical factors that limit continuity of care, particularly for working adults and low-income households.
Behavioral Health	"People are struggling with anxiety and depression, but they can't get in to see anyone for months. When they finally do, it's often too late, or they've given up trying."	This quote captures the access issues described across interviews, such as long wait times, provider shortages, and delays in behavioral health treatment. It also reflects the frustration and hopelessness felt by many residents who face ongoing stress and limited timely support. The statement illustrates how delayed access can worsen mental health outcomes and lead to crisis-level interventions instead of prevention.
Chronic Disease Prevention and Management	"People know they should eat better or exercise, but when healthy food costs more and parks don't feel safe, it's just not realistic."	This quote succinctly ties chronic disease outcomes to health-related social needs such as cost, food access, and neighborhood safety. It demonstrates how health behaviors are constrained by circumstance rather than lack of knowledge, echoing stakeholder discussions on the need for community-based wellness programs and policy-level interventions that make healthy living more feasible.
Maternal and Child Health	"Too many women fall through the cracks after giving birth. Once the baby is healthy, the system forgets about the mother."	This quote reflects a common theme identified by stakeholders: gaps in postpartum care and maternal support. Participants emphasized that while clinical attention is strong during delivery, follow-up for maternal mental health, physical recovery, and social supports is often inadequate. The statement underscores the need for comprehensive,

		continuous maternal care that extends beyond childbirth and better integrates social, behavioral, and family support services.
Health-Related Social Needs	"You can't tell someone to manage their diabetes when they don't know where they're sleeping next week or how they'll get to the pharmacy."	This quote powerfully illustrates the intersection of social needs and health outcomes. Stakeholders consistently described how housing instability, transportation challenges, and economic stress interfere with disease management and preventive care. It captures the broader insight that addressing health outcomes requires meeting basic social needs first.

Prioritization Methodology

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

Collaborating Organizations

The fifteen regional hospitals within the Cleveland Clinic health system in Northeast Ohio collaborate to share community health data and resources throughout the CHNA and implementation strategy processes. Main Campus collaborates with East Submarket (Mentor, Hillcrest, Euclid, Marymount, and South Pointe hospitals), West Submarket (Lutheran, Fairview, and Avon hospitals), South Submarket (Akron General, Medina, Lodi, Mercy, and Union hospitals), and Cleveland Clinic Children's Hospital for Rehabilitation.

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[15] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services. In Ohio, the Ohio Association of Community Health Centers (OACHC) represents 57 Community Health Centers operating at over 400 locations, including mobile units, and supports access to care through federal funding and enhanced Medicaid and Medicare reimbursement. Within the geography served by Main Campus, community health services are further supported by local public health agencies, including the Cleveland Department of Public Health. The following FQHC clinics and networks operate in the Cleveland Clinic Main Campus Community:

- Asian Services in Action, Inc.
- Care Alliance
- MetroHealth Community Health Centers (MHCHC)
- Neighborhood Family Practice
- Northeast Ohio Neighborhood Health Services
- Signature Health, Inc.
- The Centers

Hospitals

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

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

Other Community Resources

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

- Donations and Volunteering
- Education, Recreation, and the Arts

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

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

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

Comments Received on Previous CHNA

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

Request for Public Comment

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

Appendices Summary

A. Cleveland Clinic Main Campus Community Definition

B. Secondary Data Sources and Analysis

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

C. Environmental Scan and Key Findings

Environmental scan findings from the region comparing significant and prioritized health needs as well as identifying other relevant contextual data and associated programs and interventions.

D. Community Input Assessment Tools and Key Findings

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

- Key Stakeholder Interview Questions
- Summary Qualitative Findings

E. Impact Evaluation

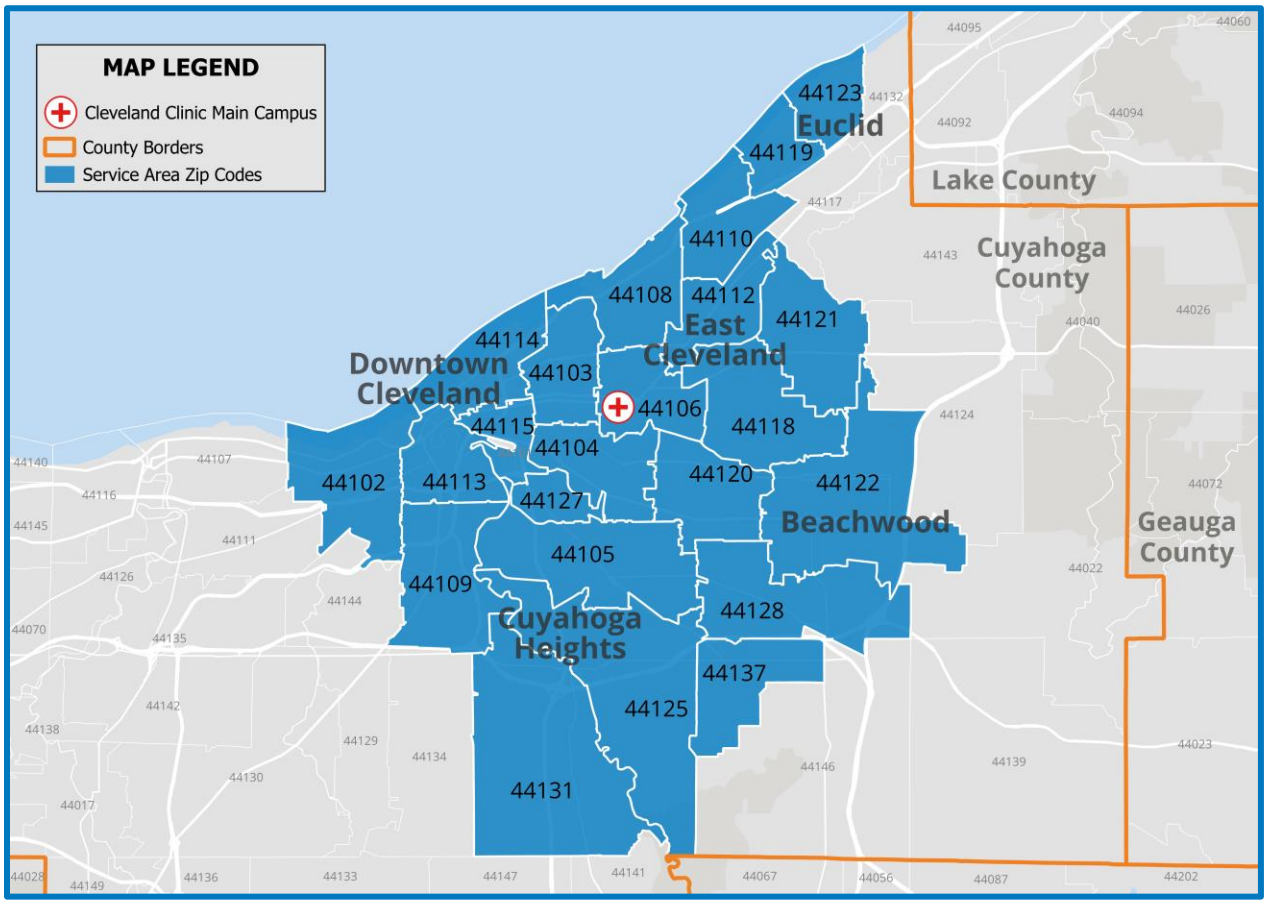
An overview of progress made on the 2022 Implementation Strategies.

F. Acknowledgements

Appendix A: Cleveland Clinic Main Campus Community Definition

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

Figure 9: Main Campus Community Definition



Appendix B: Secondary Data Sources and Analysis

Secondary Data Sources & Analysis

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

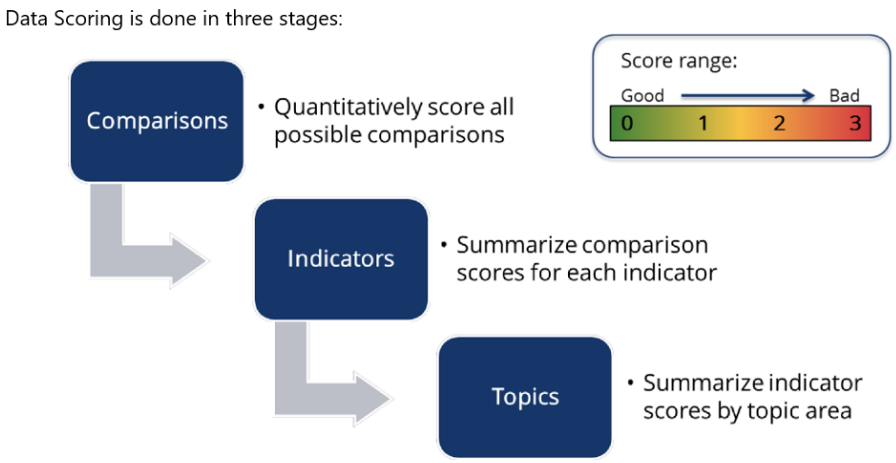
The following is a list of both local and national sources used in the Main Campus Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Early Ages Healthy Stages
- Feeding America
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Ohio Department of Education
- Ohio Dept. of Health, Infectious Diseases
- Ohio Dept. of Health, Vital Statistics
- Ohio Dept. of Health's Ohio Healthy Homes Lead Poisoning Prevention Program
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- Prevention Research Center for Healthy Neighborhoods
- Purdue Center for Regional Development
- The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Census Bureau - Small Area Health Insurance Estimates
- U.S. Environmental Protection Agency
- United For ALICE

Secondary Data Scoring

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

Figure 10: Summary of Topic Scoring Analysis



For the purposes of the Main Campus community, this analysis was completed for Cuyahoga County. A complete breakdown of topic and indicator scores can be found below.

Comparison to a Distribution of County Values: State and Nation

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

Comparison to Values: State, National, and Targets

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

Trend Over Time

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

Missing Values

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

Indicator Scoring

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

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0 to 3, where a higher score indicates more concerning outcomes. A topic score is only calculated if it includes at least three indicators. See Figure 11 for a complete list of the potential health and quality of life topic areas examined in this analysis.

Figure 11: Health and Quality of Life Topic Areas

Topics that received a score of 1.50 or higher were considered a significant health need. Eight topics scored at or above this threshold in Cuyahoga County (see Tables 2 and 3).

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 2 and 3 below. The highest scoring health need in Cuyahoga County was *Sexually Transmitted Infections* with a score of 2.04.

Table 2: Health Topic Scores: Cuyahoga County

Health Topic	Score
Sexually Transmitted Infections	2.04
Other Chronic Conditions	1.85
Children's Health	1.65
Older Adults	1.60
Family Planning	1.56
Wellness & Lifestyle	1.55
Weight Status	1.52
Maternal, Fetal & Infant Health	1.51
Nutrition & Healthy Eating	1.47
Diabetes	1.46
Prevention & Safety	1.40
Alcohol & Drug Use	1.38
Cancer	1.37
Adolescent Health	1.33
Health Care Access & Quality	1.30
Mental Health & Mental Disorders	1.29
Immunizations & Infectious Diseases	1.27
Heart Disease & Stroke	1.24
Respiratory Diseases	1.23
Women's Health	1.17
Oral Health	1.16
Tobacco Use	1.05
Physical Activity	0.96

Table 3: Quality of Life Topic Scores: Cuyahoga County

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

Conduent's SocioNeeds Index Suite®

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

Table 4: Community Health Index, Food Insecurity Index, and Mental Health Index Values for Main Campus Community Zip Codes

Zip Code	CHI Value	FII Value	MHI Value
44102	95.9	96.4	98.5
44103	98.4	98.6	99.9
44104	99.8	100	100
44105	96.5	97.7	99.7
44106	83.7	82.6	97.6
44108	96.6	98.0	99.9
44109	94.5	93.8	97.9
44110	95.0	99.0	99.7
44112	93.9	97.0	99.9
44113	82.0	84.1	91.7
44114	91.2	62.1	96.3
44115	99.9	99.9	99.6
44118	31.9	62.9	88.6
44119	78.8	92.5	97.2
44120	57.1	87.9	98.7
44121	22.1	79.4	90.9
44122	13.3	35.0	90.6
44123	55.6	91.9	97.1
44125	72.3	91.2	94.8
44127	99.1	98.4	98.3
44128	86.9	97.2	99.7
44131	23.6	13.2	42.0
44137	72.9	91.2	97.4

Census Tract Key

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

Figure 12: Census Tract Key (Main Campus, North)

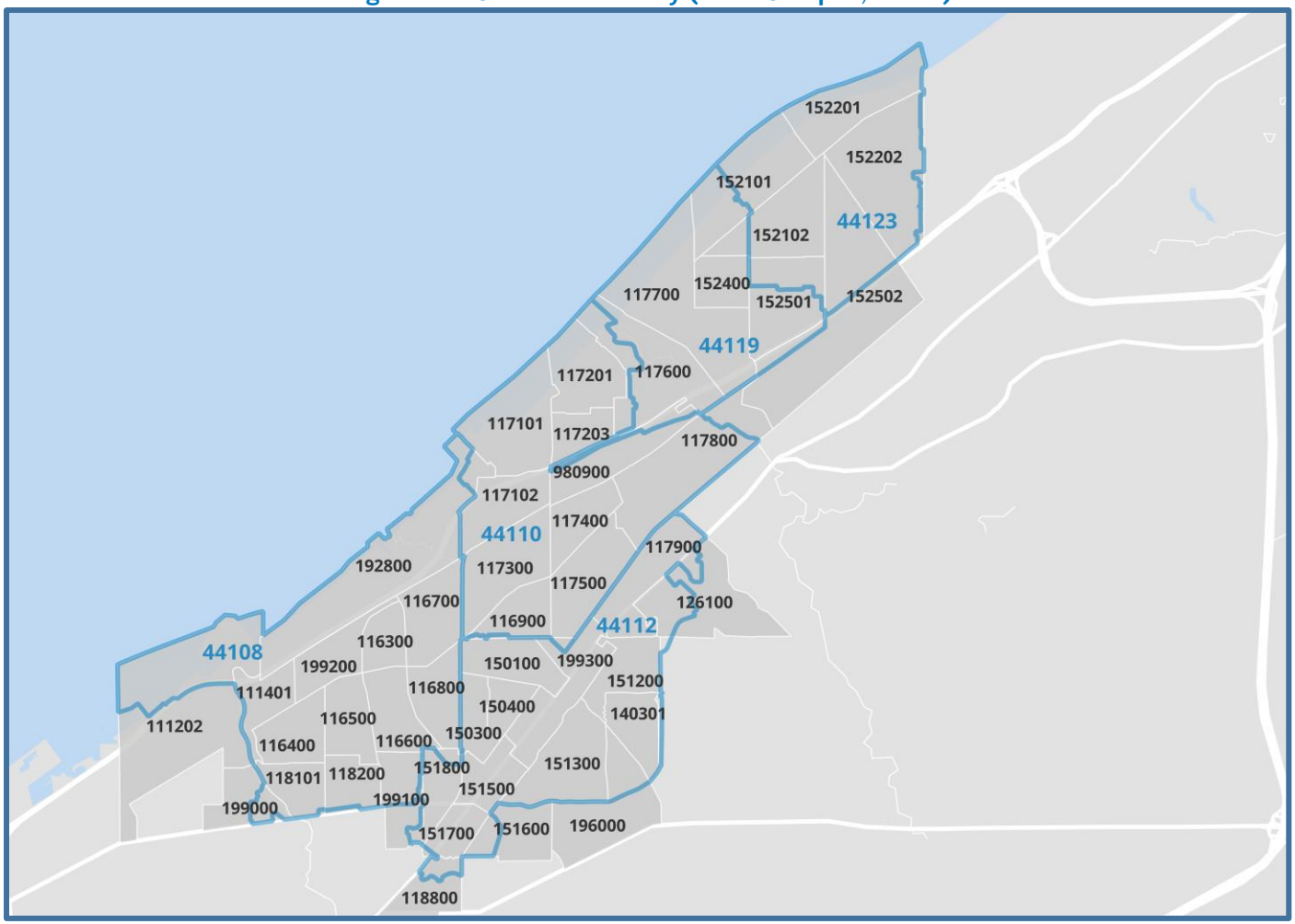


Table 5: Census Tracts by Zip Code (Main Campus, North)

44108	44110	44112	44119	44123
111202	116900	116900	117600	152101
111401	117101	117900	117700	152102
116300	117102	118800	152101	152201
116400	117201	126100	152102	152202
116500	117203	140100	152400	152301
116600	117300	140301	152501	152303
116700	117400	140302	152502	152501
116800	117500	150100	980900	152502
118101	117600	150300		
118200	117800	150400		
150300	192800	151200		
151500	199300	151300		
151800	980900	151500		
192800		151600		
199000		151700		
199100		151800		
199200		196000		
		196800		
		199100		
		199300		

Figure 13 and Table 6 show the census tracts for each zip code in the eastern portion of the Main Campus Community.

Figure 13: Census Tract Key (Main Campus, East)

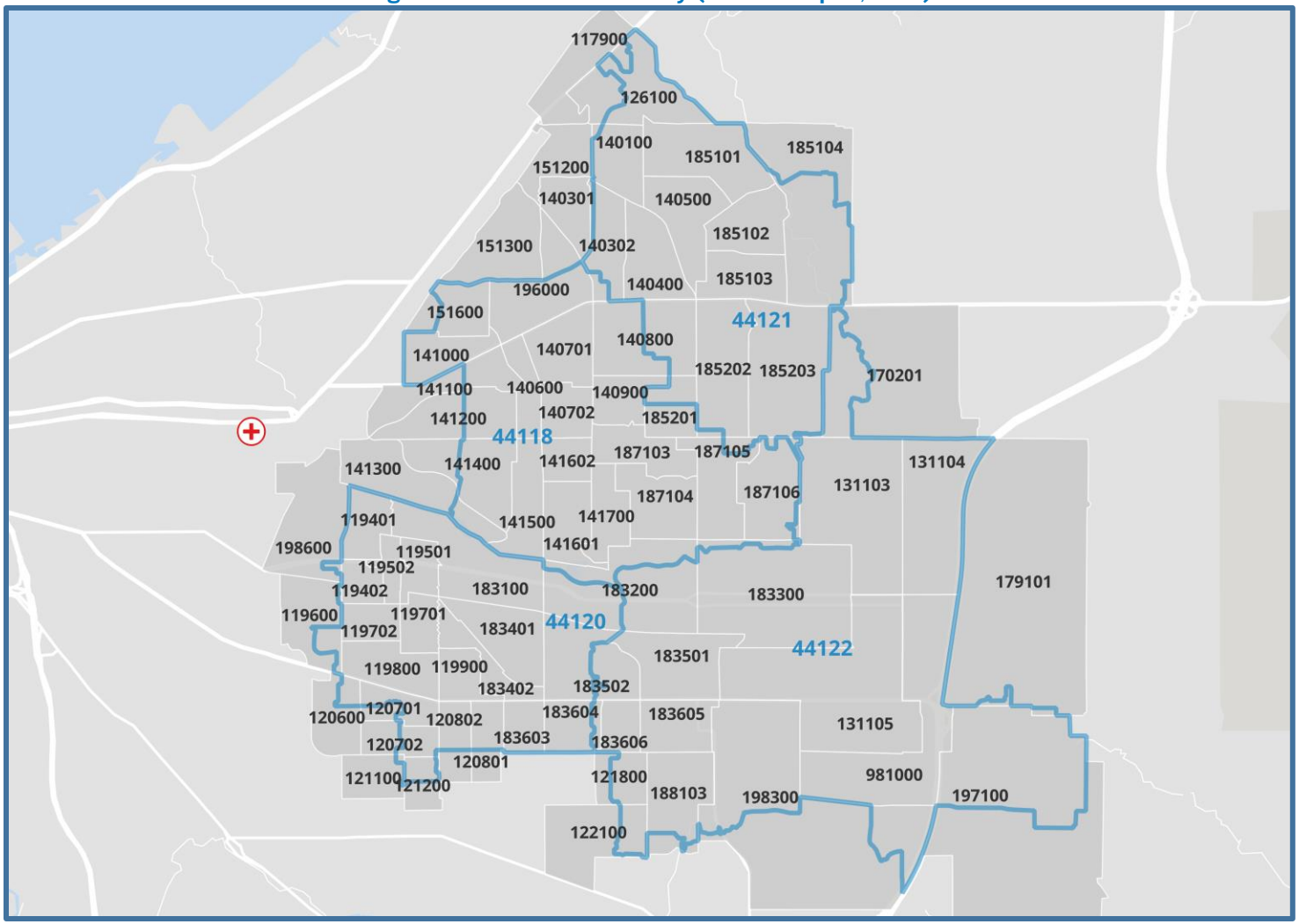


Table 6: Census Tracts by Zip Code (Main Campus, East)

44118	44120	44121	44122
140302	119401	117900	121800
140600	119402	126100	122100
140701	119501	140100	131103
140702	119502	140301	131104
140800	119600	140302	131105
140900	119701	140400	170201
141000	119702	140500	179101
141100	119800	140800	183200
141200	119900	151200	183300
141300	120600	170201	183501
141400	120701	185101	183502
141500	120702	185102	183604
141601	120801	185103	183605
141602	120802	185104	183606
141700	121100	185201	185203
151300	121200	185202	187106
151600	121700	185203	188103
183200	183100	187105	197100
183300	183200	187106	198300
185201	183401		981000
185202	183402		
187103	183502		
187104	183603		
187105	183604		
187106	183605		
196000	198600		

Figure 14 and Table 7 show the census tracts for each zip code in the southern portion of the Main Campus Community.

Figure 14: Census Tract Key (Main Campus, South)

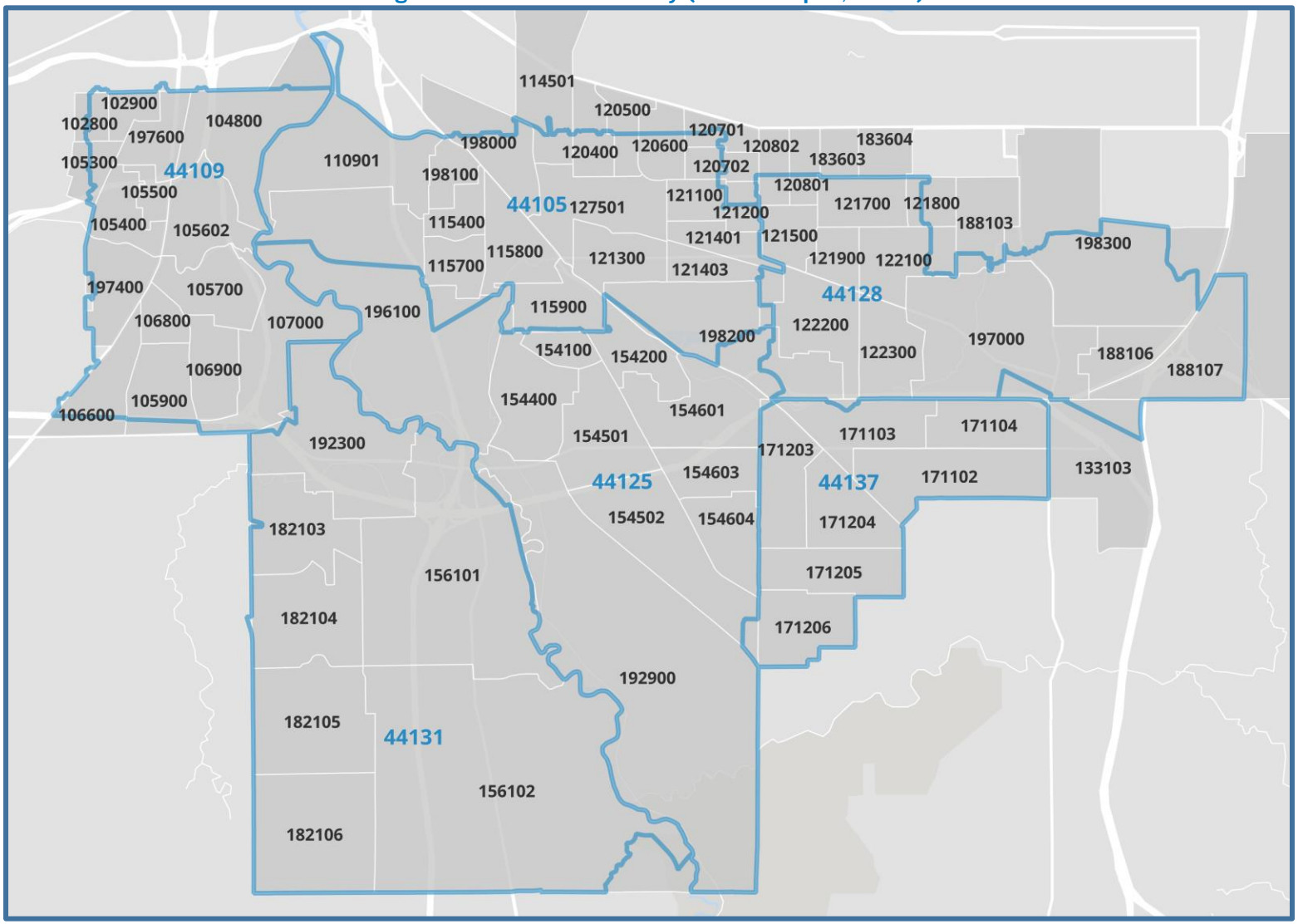


Table 7: Census Tracts by Zip Code (Main Campus, South)

44105	44109	44125	44128	44131	44137
110901	102700	115900	120702	107000	132100
114501	102800	154100	120801	136103	132302
115400	102900	154200	120802	156101	154502
115700	103800	154400	121200	156102	154604
115800	104400	154501	121401	182103	171102
115900	104800	154502	121403	182104	171103
120400	105300	154601	121500	182105	171104
120500	105400	154603	121700	182106	171203
120600	105500	154604	121800	192300	171204
120701	105602	156101	121900	192900	171205
120702	105700	171103	122100		171206
121100	105900	171203	122200		
121200	106200	192900	122300		
121300	106500	194100	133103		
121401	106600	196100	133104		
121403	106800	198200	171103		
127501	106900		183603		
154200	107000		183604		
154400	177303		188103		
196100	192300		188106		
198000	196100		188107		
198100	197400		197000		
198200	197600		197100		
980100	197700		198200		
			198300		

Figure 15 and Table 8 show the census tracts for each zip code in the western portion of the Main Campus Community.

Figure 15: Census Tract Key (Main Campus, West)

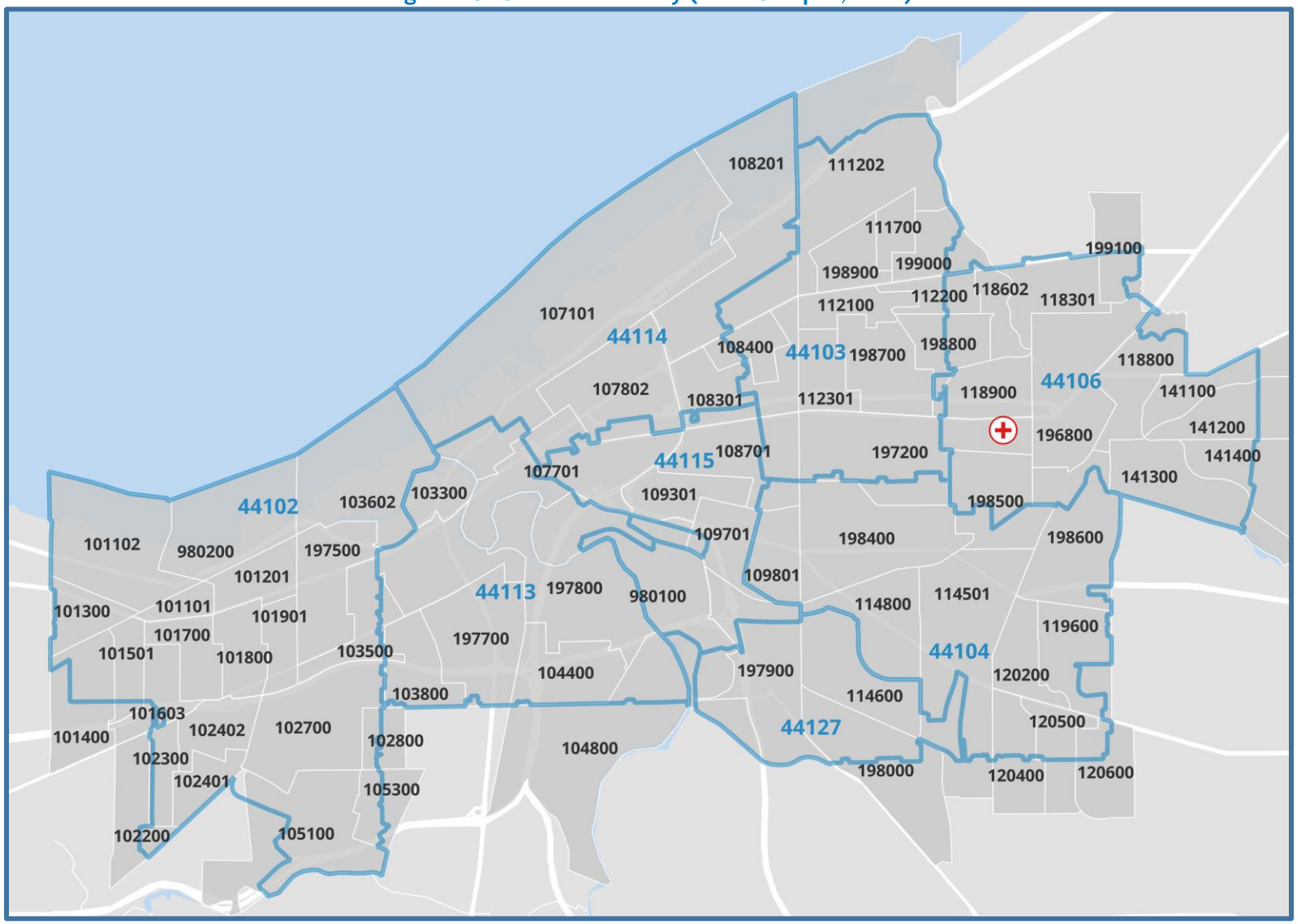


Table 8: Census Tracts by Zip Code (Main Campus, West)

44102	44103	44104	44106	44113	44114	44115	44127
101101	108201	108701	112200	102700	107101	107701	114501
101102	108301	109701	118101	103300	107701	107802	114600
101201	108400	109801	118200	103500	107802	108301	197900
101300	108701	114501	118301	103602	108201	108701	198000
101400	111202	114600	118602	103800	108301	109301	980100
101501	111401	114800	118800	104400	108400	109701	
101603	111700	119401	118900	104800	111202	109801	
101700	112100	119600	141000	107101		132302	
101800	112200	120200	141100	107701		197900	
101901	112301	120400	141200	197700		980100	
102200	118900	120500	141300	197800			
102300	154400	120600	141400	980100			
102401	197200	197200	151700				
102402	198500	198400	196800				
102700	198700	198500	197200				
102800	198800	198600	198400				
103500	198900		198500				
103602	199000		198600				
105100			198800				
105300			199000				
137101			199100				
177403							
197500							
980200							

Community Health Index (CHI)

Every community can be described by various demographic and economic factors that can contribute to differences in health outcomes. Conduent HCI's Community Health Index considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing concerning health outcomes.

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Food Insecurity Index (FII)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Mental Health Index (MHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Data Considerations

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

Data scores represent the relative community health need according to the secondary data for each topic and should be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or health-related social needs that are much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to represent the population at large, these measures are subject to instability, especially for smaller populations.

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

Indicators of Concern for Prioritized Health Needs

Below are details regarding indicators of concern for all prioritized health needs discussed in this report. Each indicator includes a county-level value and standardized score, as well as the following comparison data, where available: state value, national value, state county distribution, national county distribution, and over-time trend. Table 10 describes how to interpret the icons used to describe county distributions and trend data.

Table 9: Icon Legend

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

Indicators of Concern: Access to Healthcare

The topic *Health Care Access and Quality* was ranked as the fifteenth highest scoring health need, with a score of 1.30 out of 3. Those indicators scoring at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.38	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3,677.0	--	3,269.0	2,769.0			--
2.35	Adults with Health Insurance: 18+	*percent*	72.1	--	74.7	75.2			
2.21	Adults who go to the Doctor Regularly for Checkups	*percent*	63.3	--	65.2	65.1			--
2.00	Adults who Visited a Dentist	*percent*	43.3	--	44.3	45.3			
1.85	Health Insurance Spending-to-Income Ratio	*percent*	7.1	--	6.8	6.1			--
1.68	Adults With Group Health Insurance	*percent*	36.0	--	37.4	39.8			--
1.65	High School Students who had a Dental Check-up, Exam, Cleaning or Other Dental Work	*percent*	69.6	--	--	--	--	--	--

Indicators of Concern: Behavioral Health

The prioritized health topic *Behavioral Health* was captured under three health topic areas: *Mental Health and Mental Disorders*, *Alcohol and Drug Use*, and *Tobacco Use*. The most concerning of these topics was *Alcohol and Drug Use* (Score: 1.38), followed by *Mental Health and Mental Disorders* (1.29), and the least concerning was *Tobacco Use* (1.05). Indicators from these three topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5	--	32.1	--			
2.29	Self-Reported General Health Assessment: Good or Better	*percent*	84.2	--	85.4	86.0			
2.03	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	39.2	--	40.4	23.5			--
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7	--			--
1.76	Adults who Binge Drink	*percent*	18.1	--	--	16.6			--
1.74	Adults who Drink Excessively	*percent*	21.0	--	21.2	--			
1.68	Cigarette Spending-to-Income Ratio	*percent*	2.2	--	2.2	1.9			--
1.68	Poor Mental Health: Average Number of Days	*days*	6.0	--	6.1	--			
1.59	Poor Mental Health: 14+ Days	*percent*	17.5	--	--	15.8			--
1.50	Adults who Feel Life is Slipping Out of Control	*Percent*	24.1	--	24.1	23.9			--

Indicators of Concern: Chronic Disease Prevention and Management

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

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

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

Indicators of Concern: Maternal and Child Health

The prioritized health topic *Maternal and Child Health* was captured under two health topic areas: *Maternal, Fetal, and Infant Health* and *Children's Health*. The most concerning of these topics was *Children's Health*, with a score of 1.38, followed by *Maternal, Fetal, and Infant Health*, with a score of 1.51. Indicators from these topic areas which scored at or above 1.70 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.71	Child Food Insecurity Rate	*percent*	26.7	--	19.8	18.5			
2.44	Babies with Low Birthweight	*percent*	10.8	--	8.7	8.6		--	
2.38	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	70.8	--	58.5	50.6			--
2.26	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.3	--	6.1	5.6		--	
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8	--	3.3	3.4			--
2.18	Preterm Births	*percent*	12.0	9.4	10.8	--		--	
1.97	Infant Mortality Rate	*deaths/ 1,000 live births*	7.7	5.0	6.7	5.4	--	--	
1.91	Gestational Hypertension	*percent*	22.3	--	18.3	--	--	--	
1.91	Pre-Pregnancy Diabetes	*percent*	4.8	--	4.2	--	--	--	
1.91	Stopped Breastfeeding Due to Resuming Work	*percent*	26.6	--	17.5	--	--	--	
1.88	Babies with Very Low Birthweight	*percent*	1.9	--	1.5	--		--	

1.85	Ever Breastfed New Infant	*percent*	88.8	--	88.7	--	--	--	
1.74	Chronic Health Condition(s) During Pregnancy	*percent*	50.6	--	49.6	--	--	--	
1.74	Postpartum Depression	*percent*	16.4	--	16.3	--	--	--	
1.74	Pre-Pregnancy Hypertension	*percent*	7.6	--	7.0	--	--	--	

Indicators of Concern: Health-Related Social Needs

The prioritized health topic *Health-Related Social Needs* was captured under the quality of life topics *Community, Economy,* and Education, as well as the health topic *Prevention and Safety*. The topic *Prevention and Safety* was the eleventh highest scoring health topic with a score of 1.40. The most concerning quality of life topic was *Economy* (Score: 1.90), followed by *Education* (1.72), and the least concerning topic was *Community* (1.56). Indicators from these four health and quality of life topic areas which scored at or above 2.00 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
3.00	People 65+ Living Alone	*percent*	36.1	--	30.2	26.5			
2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	654	--	570	612			
2.82	People 65+ Living Below Poverty Level	*percent*	12.3	--	9.5	10.4			
2.71	Child Food Insecurity Rate	*percent*	26.7	--	19.8	18.5			
2.56	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	8.7	--	7.5	7.4			--
2.56	College Tuition Spending-to-Income Ratio	*percent*	14.7	--	12.9	12.4			--
2.56	Homeowner Spending-to-Income Ratio	*percent*	16.7	--	14.6	14.0			--
2.53	Veterans Living Below Poverty Level	*percent*	9.7	--	7.4	7.2			
2.44	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	20.2	10.7	13.5	12.0			--
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5	--	32.1	--			

2.41	Children in Single-Parent Households	*percent*	37.3	--	26.1	24.8			
2.41	Youth not in School or Working	*percent*	2.7	--	1.7	1.7			
2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4	--	11.3	12.3			--
2.38	Home Renter Spending-to-Income Ratio	*percent*	19.3	--	16.8	17.7			--
2.38	Student Loan Spending-to-Income Ratio	*percent*	5.5	--	4.8	4.7			--
2.35	Adults with Internet Access	*percent*	78.6	--	80.9	81.3			
2.26	Residential Segregation - Black/White	*Score*	71.5	--	69.6	--			
2.26	Social Associations	*membership associations/ 10,000 population*	8.9	--	10.8	--			
2.26	People 65+ Living Below 200% of Poverty Level	*percent*	31.9	--	28.4	28.1	--		
2.21	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	83.4	--	84.9	85.1			--
2.21	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	20.7	5.5	9.0	--	--	--	
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8	--	3.3	3.4			--
2.21	Income Inequality	*Gini Index*	0.504	--	0.467	0.483			
2.21	Vocational, Technical, and Other School Tuition	*percent*	1.8	--	1.6	1.6			--

	Spending-to-Income Ratio								
2.21	Student-to-Teacher Ratio	*students/ teacher*	16.9	--	16.6	15.2			
2.18	Linguistic Isolation	*percent*	2.7	--	1.5	4.2			
2.18	Food Insecurity Rate	*percent*	15.1	--	14.1	13.5			
2.12	Median Household Gross Rent	*dollars*	1,005	--	988	1,348			
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,529	--	1,472	1,902			
2.12	Adults with Disability Living in Poverty	*percent*	33.1	--	28.2	24.6			
2.12	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	2.3	--	2.0	2.0			
2.03	Households Living Below Poverty Level	*percent*	16.7	--	14.0	--		--	
2.03	Utilities Spending-to-Income Ratio	*percent*	6.7	--	6.2	5.8			--
2.00	Voter Turnout: Presidential Election	*percent*	65.7	58.4	71.7	--		--	
2.00	Renters Spending 30% or More of Household Income on Rent	*percent*	47.5	25.5	45.1	50.4			

All Indicator Scores by Topic Area

Below is a complete list of all indicators that were scored as part of the secondary data analysis. Indicators are grouped under their respective health and quality of life topic areas and include information about both the indicator data source and measurement period. Please refer to Table 10 below as a reference key for indicator data sources.

Table 10: Indicator Scoring Data Source Key

Key	Data Source
1	American Community Survey 1-Year
2	American Community Survey 5-Year
3	American Lung Association
4	Annie E. Casey Foundation
5	CDC - PLACES
6	Centers for Disease Control and Prevention
7	Centers for Medicare & Medicaid Services
8	Claritas Consumer Profiles
9	Claritas Consumer Spending Dynamix
10	County Health Rankings
11	Early Ages Healthy Stages
12	Feeding America
13	National Cancer Institute
14	National Center for Education Statistics
15	National Environmental Public Health Tracking Network
16	Ohio Department of Education
17	Ohio Department of Health, Infectious Diseases
18	Ohio Dept. of Health, Vital Statistics
19	Ohio Dept. of Health's Ohio Healthy Homes Lead Poisoning Prevention Program
20	Ohio Dept. of Public Safety, Office of Criminal Justice Services
21	Ohio Public Health Information Warehouse
22	Ohio Secretary of State
23	Prevention Research Center for Healthy Neighborhoods
24	Purdue Center for Regional Development
25	The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
26	U.S. Bureau of Labor Statistics
27	U.S. Census - County Business Patterns
28	U.S. Census Bureau - Small Area Health Insurance Estimates
29	U.S. Environmental Protection Agency
30	United For ALICE

Table 11: All Cuyahoga County Secondary Data Indicators

SCORE	ADOLESCENT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	SOURCE
2.26	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.3		6.1	5.6	*2022*	18
1.94	High School Students who Did Not Eat Any Fruit in the Past 7 Days	*percent*	6.7				*2023*	23
1.94	High School Students who have Ever Been Taught About AIDS or HIV Infection in School	*percent*	64.4				*2023*	23
1.94	High School Students who were Ever Tested for HIV	*percent*	6.2				*2023*	23
1.65	High School Students who are Obese	*percent*	17.3				*2023*	23
1.65	High School Students who had a Dental Check-up, Exam, Cleaning or Other Dental Work	*percent*	69.6				*2023*	23
1.35	High School Students who are Overweight	*percent*	15.7				*2023*	23
1.35	High School Students who Carried a Weapon on School Property	*percent*	2.0				*2023*	23
1.35	High School Students who Described Health as Excellent or Very Good	*percent*	47.9				*2023*	23
1.35	High School Students who Did Not Eat Breakfast Every Day	*percent*	74.7				*2023*	23
1.35	High School Students who Did Not Go to School Because They Felt Unsafe at School or	*percent*	9.1				*2023*	23

	on Their Way To or From School				
1.35	High School Students who Did Something to Purposefully Hurt Themselves Without Wanting to Die	*percent*	16.3	*2023*	23
1.35	High School Students who Drove After Drinking Alcohol	*percent*	3.2	*2023*	23
1.35	High School Students who Engage in Regular Physical Activity	*percent*	42.8	*2023*	23
1.35	High School Students who Ever Misused Prescription Pain Medication	*percent*	9.5	*2023*	23
1.35	High School Students who Feel Like They Matter to People in Their Community	*percent*	48.4	*2023*	23
1.35	High School Students who had a Check-up or Physical Exam	*percent*	73.4	*2023*	23
1.35	High School Students who had Been Stopped, Questioned, or Searched by Police	*percent*	15.3	*2021*	23
1.35	High School Students who had Mostly Negative or Negative Encounters With Police	*percent*	20.4	*2021*	23
1.35	High School Students Who Have Attempted Suicide: Past Year	*percent*	7.6	*2023*	23
1.35	High School Students who Obtained 8+ Hours of Sleep	*percent*	23.5	*2023*	23

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

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

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

2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5		32.1		*2018-2022*	10
2.03	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	39.2		40.4	23.5	*2018-2020*	6
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7		*2020-2022*	10
1.76	Adults who Binge Drink	*percent*	18.1			16.6	*2022*	5
1.74	Adults who Drink Excessively	*percent*	21.0		21.2		*2022*	10
1.35	High School Students who Ever Misused Prescription Pain Medication	*percent*	9.5				*2023*	23
1.35	High School Students who Usually Used Marijuana by Smoking it as a Blunt	*percent*	54.8				*2023*	23
1.06	High School Students who Ever Drank Alcohol	*percent*	31.3				*2023*	23
1.06	High School Students who Ever Used an Illicit Drug	*percent*	2.1				*2023*	23
1.06	High School Students who Ever Used Marijuana	*percent*	24.7				*2023*	23
1.06	High School Students who Use Alcohol	*percent*	14.9				*2023*	23
1.06	High School Students who Use Marijuana	*percent*	15.4				*2023*	23
0.82	Liquor Store Density	*stores/ 100,000 population*	6.1		5.6	10.9	*2022*	27
0.62	Mothers who Smoked During Pregnancy	*percent*	3.8	4.3	7.9	3.7	*2022*	18

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Demographic Data

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

Table 12: Population Size of Hospital Community by Zip Code

Zip Code	Population
44102	41,880
44103	13,419
44104	19,808
44105	32,344
44106	25,926
44108	18,700
44109	37,444
44110	17,069
44112	17,532
44113	21,091
44114	7,489
44115	10,323
44118	39,323
44119	11,541
44120	33,198
44121	31,296
44122	36,554
44123	17,271
44125	28,805
44127	3,857
44128	26,872
44131	20,272
44137	23,002
Main Campus Community (Total)	535,016

Table 13: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Main Campus Community	Cuyahoga County	Ohio
0-4	5.5%	5.2%	5.6%
5-9	5.9%	5.4%	5.7%
10-14	6.0%	5.6%	6.1%
15-17	3.7%	3.5%	3.8%
18-20	4.5%	3.9%	4.4%
21-24	5.4%	4.8%	5.3%
25-34	14.6%	13.5%	12.4%
35-44	12.7%	12.7%	12.2%
45-54	10.7%	11.2%	11.7%
55-64	12.4%	13.2%	13.0%
65-74	11.0%	12.1%	11.6%
75-84	5.3%	6.2%	6.1%
85+	2.3%	2.6%	2.2%
Median Age	39.0 years	41.4 years	40.5 years

Table 14: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	Main Campus Community	Cuyahoga County	Ohio	U.S.
White	34.9%	57.3%	75.7%	63.4%
Black/African American	51.6%	29.2%	12.8%	12.4%
American Indian/Alaskan Native	0.3%	0.2%	0.3%	0.9%
Asian	2.8%	3.6%	2.7%	5.8%
Native Hawaiian/Pacific Islander	<0.1%	0.0%	0.1%	0.2%
Another Race	3.9%	3.1%	2.1%	6.6%
Two or More Races	6.4%	6.5%	6.4%	10.7%
Hispanic or Latino (any race)	8.2%	7.3%	5.0%	19.0%

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

Table 15: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	Main Campus Community	Cuyahoga County	Ohio	U.S.
Only English	89.7%	88.5%	92.8%	78.0%
Spanish	5.4%	4.3%	2.3%	13.4%
Asian/Pacific Islander Language	1.3%	1.5%	1.0%	3.5%
Indo-European Language	2.8%	4.3%	2.8%	3.8%
Other Language	0.9%	1.5%	1.1%	1.2%

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

Table 16: Household Income of Hospital Community and Surrounding Geographies

Income Category	Main Campus Community	Cuyahoga County	Ohio
Under $15,000	19.3%	12.8%	9.5%
$15,000 - $24,999	11.8%	9.1%	7.8%
$25,000 - $34,999	10.0%	8.7%	8.0%
$35,000 - $49,999	13.0%	12.5%	12.2%
$50,000 - $74,999	15.1%	16.5%	17.0%
$75,000 - $99,999	10.1%	11.9%	13.0%
$100,000 - $124,999	6.6%	8.4%	9.9%
$125,000 - $149,999	4.2%	5.8%	7.0%
$150,000 - $199,999	4.3%	6.2%	7.2%
$200,000 - $249,999	2.1%	3.0%	3.5%
$250,000 - $499,999	2.3%	3.4%	3.4%
$500,000+	1.3%	1.7%	1.6%
Median Household Income	$49,106	$60,568	$68,488

Table 17: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Main Campus Community	19.9%
Cuyahoga County	12.2%
Ohio	9.4%
U.S.	8.8%
Main Campus Zip Codes	-
44102	25.7%
44103	32.5%
44104	48.8%
44105	26.1%
44106	19.3%
44108	27.5%
44109	21.0%
44110	28.7%
44112	24.1%
44113	20.3%
44114	18.2%
44115	58.5%
44118	9.6%
44119	18.2%
44120	16.8%
44121	12.0%
44122	6.1%
44123	15.4%
44125	15.2%
44127	32.6%
44128	21.8%
44131	3.0%
44137	20.1%

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

Table 18: Educational Attainment of Hospital Community and Surrounding Geographies

	Main Campus Community	Cuyahoga County	Ohio	U.S.
Less than High School Graduate	12.7%	9.3%	8.6%	10.6%
High School Graduate	28.4%	27.2%	32.8%	26.2%
Some College, No Degree	21.2%	20.4%	19.6%	19.4%
Associate Degree	8.0%	8.3%	8.9%	8.8%
Bachelor's Degree	15.8%	20.4%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	14.0%	14.4%	11.5%	13.7%

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

Table 19: High Rent Burden in Hospital Community and Surrounding Geographies

	Renters Spending 30% or More of Income on Rent
Cuyahoga County	47.5%
Ohio	45.1%
U.S.	50.4%
Main Campus Zip Codes	-
44102	50.1%
44103	53.6%
44104	51.3%
44105	51.8%
44106	47.5%
44108	61.6%
44109	50.6%
44110	61.6%
44112	64.0%
44113	48.4%
44114	48.4%
44115	44.6%
44118	54.8%
44119	53.8%
44120	49.6%
44121	41.4%
44122	42.2%
44123	45.7%
44125	61.7%
44127	57.1%
44128	49.3%
44131	31.7%
44137	45.4%

All values: American Community Survey (2019-2023)

Table 20: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Cuyahoga County	87.5%
Ohio	89.0%
U.S.	89.9%
Main Campus Zip Codes	-
44102	83.7%
44103	73.3%
44104	69.3%
44105	78.8%
44106	84.6%
44108	73.3%
44109	85.0%
44110	75.5%
44112	72.8%
44113	87.5%
44114	81.8%
44115	74.6%
44118	92.3%
44119	84.6%
44120	78.9%
44121	90.6%
44122	92.8%
44123	84.4%
44125	86.7%
44127	70.3%
44128	83.4%
44131	94.3%
44137	88.0%

All values: American Community Survey (2019-2023

Appendix C: Environmental Scan and Key Findings

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

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

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

- 2023 Ohio State Health Assessment[16]
- 2023 City of Cleveland Parks and Recreation Community Needs Assessment[17]
- 2024 Cuyahoga County ADAMHS Board Needs Assessment[18]
- 2023 Cuyahoga County Planning Commission Data Book[19]
- 2022 Greater Cleveland LGBTQ+ Community Needs Assessment[20]
- Joint 2022 Cuyahoga County CHNA[21]
- 2023 Livable Cuyahoga Needs Assessment[22]

[16] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[17] Cleveland Parks & Recreation Plan Team. (2024). *Community needs assessment report* [PDF]. City of Cleveland Department of Parks & Recreation. https://cleparksrecplan.com/wp-content/uploads/240102_Community-Needs-Assessment-Report_web.pdf
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[19] Cuyahoga County Planning Commission. (December 2023). *Our County: The 2023 data book* [PDF]. Cuyahoga County Planning Commission. https://s3.countyplanning.us/wp-content/uploads/2023/12/Our-County-2023-reduced.pdf?
[20] Kent State University College of Public Health. (2024). *Greater Cleveland LGBTQ+ community needs assessment* [PDF]. The Greater Cleveland LGBTQ+ Community Needs Assessment Research Team. https://www.lgbtqohio.org/sites/default/files/docs/KSU-028_CommunityReport_102124_FA.pdf
[21] Cuyahoga County CHNA Steering Committee. (2022). *2022 Cuyahoga County community health needs assessment* [PDF]. Conduent Healthy Communities Institute & Cuyahoga County Community Partners. https://www.healthyneo.org/content/sites/cuyahoga/Resources/CHNA-Cuy-Cty-11.22.pdf
[22] Cuyahoga County Department of Health and Human Services, Division of Senior & Adult Services. (2023). *Livable Cuyahoga needs assessment report*. Cuyahoga County. Retrieved June 2025, from https://hhs.cuyahogacounty.gov/docs/default-source/default-document-library/reports/livable-cuyahoga-needs-assessment-report.pdf?sfvrsn=b1f65b31_1

Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health Questions and Probes

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

- **What are the top health-related issues that residents are facing in your community that you would change or improve?**
    - What makes them the most important health issues?

- What do you think is the cause of these problems in your community?

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

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

- **What could be done to promote equal access to care? (The idea that everyone should have the same chance to be healthy, regardless of their circumstances)**

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

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

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

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

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

Community Input Key Findings

A total of 20 organizations provided feedback for the Main Campus community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

Individuals from the following organizations participated as key informants for the Main Campus community:

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Birthing Beautiful Communities
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- City of Cleveland, Division of Fire
- Cleveland Clinic Children's
- Cuyahoga County Board of Health
- Cuyahoga Metropolitan Housing Authority
- Esperanza
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- NAMI Greater Cleveland
- Neighborhood Family Practice (FQHC)
- Positive Education Program (PEP)
- ThirdSpace
- Towards Employment

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

Access to Healthcare

Access to Healthcare emerged as one of the most frequently discussed concerns among stakeholders across the Cleveland Clinic Main Campus community. Participants described a region with world-class medical facilities but persistent barriers that limit residents' ability to access affordable, timely, and coordinated care. Affordability and insurance coverage remain central challenges, with many residents forgoing care due to high out-of-pocket costs, copays, and prescription expenses. Stakeholders also emphasized gaps in primary care and behavioral health availability, particularly for low-income residents, older adults, and those living in neighborhoods with fewer local providers. Geographic and transportation barriers, long wait times for appointments, and limited culturally responsive services were also described as major deterrents to preventive and follow-up care.

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

- High costs and insurance limitations continue to restrict healthcare access.
- Long wait times for primary, specialty, and behavioral health appointments.
- Transportation and geographic barriers prevent consistent care, particularly for low-income residents.
- Limited culturally and linguistically appropriate services reduce trust and engagement.
- Gaps in awareness and care navigation make it difficult for residents to find available resources.
- Distrust in healthcare institutions discourages preventive visits and early treatment.
- Stakeholders called for more integrated, community-based, and affordable care delivery models.

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

"Even if you have insurance, it doesn't mean you can afford to use it. The copays, transportation, and time off work are real barriers for people."

"People have to wait months for an appointment. By the time they get in, their situation has usually gotten worse."

"There are excellent services here, but people don't know how to find them or don't have the support to get there."

"Language and trust matter. Some people avoid care altogether because they've felt dismissed or misunderstood in the past."

Overall, stakeholder feedback reveals that Access to Healthcare in the Cleveland Clinic Main Campus community is shaped by affordability, availability, and trust. While the region benefits from extensive healthcare infrastructure, differences persist in who can readily use these services. Participants emphasized that improving access will require reducing cost barriers, expanding transportation options, increasing culturally relevant care, and strengthening care navigation. Building trust through community-based care, patient engagement, and coordinated communication among healthcare and social service providers was seen as essential to ensuring that all residents can access the care they need.

Behavioral Health: Mental Health and Substance Use Disorder

Behavioral Health, including both Mental Health and Substance Use Disorder, was consistently identified by stakeholders as one of the most urgent and complex health priorities for the Main Campus community. Participants described growing behavioral health needs across all age groups, noting that stress, depression, and anxiety have become more widespread and often go untreated due to barriers in access and affordability. Long wait times, provider shortages, and the cost of care were described as major challenges, particularly for low-income individuals, youth, and older adults. Stakeholders also discussed how stigma continues to prevent people from seeking help, while limited coordination between behavioral health and primary care settings contributes to fragmented treatment.

The following are highlights of participant feedback regarding substance use disorder:

- Increasing rates of depression, anxiety, and stress among both youth and adults.
- Significant shortage of behavioral health providers and long wait times for appointments.
- Cost and insurance barriers limit access to therapy, psychiatry, and recovery services.
- Persistent stigma prevents residents from seeking help or disclosing mental health needs.
- Gaps in crisis response and ongoing recovery supports after hospitalization.
- Fentanyl-related overdoses and substance use remain major community concerns.
- Strong need for integrated behavioral and primary care and expanded community-based supports.

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

"People are struggling with anxiety and depression, but they can't get in to see anyone for months. When they finally do, it's often too late."

"The stigma is still strong. A lot of people won't talk about mental health until they are in crisis."

"There are not enough recovery or long-term housing options. People get sober, but they have nowhere stable to go."

"Behavioral health has to be part of primary care. Right now, it feels like two separate systems that don't talk to each other."

Stakeholders described behavioral health as a growing crisis that cuts across social and economic lines in the Main Campus community. Participants emphasized that while resources exist, they remain out of reach for many residents due to affordability, limited capacity, and lack of coordination. The combination of mental health stigma, rising substance use, and inadequate long-term recovery options creates ongoing cycles of instability for individuals and families. Stakeholders called for a more comprehensive behavioral health system that integrates mental health and addiction services with

primary care, expands community-based supports, and addresses the underlying social and economic conditions that contribute to differences in behavioral health outcomes.

Chronic Disease Prevention & Management

Chronic Disease Prevention and Management was widely discussed by stakeholders as a major and persistent concern for residents within the Main Campus community. Participants identified diabetes, hypertension, heart disease, and obesity as the most prevalent and burdensome conditions, often linked to diet, food insecurity, stress, and limited access to preventive resources. Stakeholders noted that while the region benefits from advanced medical care, differences in prevention and disease management remain significant. Many described how competing financial pressures, limited transportation, and poor neighborhood infrastructure make it difficult for residents to sustain healthy behaviors or attend regular medical appointments.

Nutrition & Healthy Eating and Wellness & Lifestyle
Stakeholders described food insecurity and the high cost of healthy foods as major contributors to poor nutrition and chronic disease. Many residents rely on fast food or processed options because fresh produce and healthy groceries are often unaffordable or unavailable in their neighborhoods. Interviewees emphasized that awareness of healthy eating is not the issue; rather, structural barriers limit the ability to make healthy choices. Participants called for more investment in community wellness initiatives that promote accessible physical activity and nutrition education tailored to local needs.

The following are highlights of participant feedback regarding nutrition and healthy eating and wellness and lifestyle:

- Food insecurity and cost barriers to healthy food choices.
- Limited access to grocery stores and fresh produce.
- Reliance on fast food and processed meals.
- Underfunded community wellness and fitness programs.
- Safe spaces for recreation and exercise remain limited in some neighborhoods.

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

"People know what they should eat, but when fresh food is expensive and fast food is everywhere, it's not an easy choice."

"We need more affordable programs that make wellness accessible, walking groups, community classes, anything that meets people where they are."

Cancer
Cancer was identified as one of the most serious chronic health issues in the Main Campus community. Stakeholders discussed both the high prevalence of cancer and differences in screening, diagnosis, and treatment outcomes. Delayed screenings and mistrust in healthcare systems contribute to later-stage diagnoses. Participants also cited financial and logistical barriers that prevent residents from completing recommended

cancer screenings. Stakeholders stressed the need for improved education, culturally relevant outreach, and enhanced access to affordable preventive services.

The following are highlights of participant feedback regarding cancer:

- High cancer burden, particularly breast, prostate, and colorectal cancers.
- Delays in screening due to cost, access, and mistrust.
- Need for culturally responsive and community-based cancer education.
- Gaps in coordination between screening programs and primary care.

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

"People wait too long to get screened because they can't afford it or don't trust the system."

"We see cancer caught too late. Access and outreach make all the difference."

Diabetes, Heart Disease, & Stroke

Diabetes, hypertension, and cardiovascular disease were among the most commonly mentioned conditions in stakeholder discussions. Participants linked these diseases to stress, poor diet, and a lack of preventive care. Many noted that lifestyle-related factors, combined with limited access to affordable medication and ongoing support, lead to frequent emergency room use and avoidable complications. Stakeholders also discussed the growing prevalence of these conditions among younger adults, emphasizing the importance of prevention and education in schools and workplaces.

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

- High rates of diabetes, hypertension, and cardiovascular disease.
- Stress and lifestyle factors contribute to chronic disease risk.
- Limited coordination and follow-up after diagnosis.
- Financial barriers to medication and ongoing management.
- Growing prevalence of chronic conditions in younger adults.

The following is a quote from a key informant about diabetes, heart disease, stroke, and other chronic conditions:

"We're seeing diabetes and heart disease in people in their thirties now. Prevention has to start much earlier."

"People are prescribed medication but can't afford to stay on it long term. That's a huge gap in management."

Older Adult Health
Stakeholders described Older Adult Health as a growing concern in the Main Campus community. Many older adults live alone and face mobility limitations, financial strain, and social isolation. Participants also noted challenges with transportation and the high cost of home-based or adult day care services. These barriers contribute to falls, poor nutrition, and unmanaged chronic conditions. Stakeholders emphasized that more coordinated aging services, accessible transportation, and social support networks are needed to help older adults remain independent and healthy.

The following are highlights of participant feedback regarding Older Adult Health:

- High rates of isolation among older adults.
- Mobility barriers and transportation challenges limit access to care.
- High cost of in-home and adult day care services.
- Falls and chronic disease complications are common.
- Increased need for coordinated aging and social support services.

These findings suggest that diagnosing and managing chronic conditions in older adults requires a combination of clinical care, social support, environmental modifications, and stigma reduction, especially around mental and cognitive health.

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

"Many older adults are living alone with limited mobility and no transportation. They just stop going to appointments."

"Day care and home health options are too expensive, so families are struggling to keep their loved ones safe and supported."

Stakeholders described Chronic Disease Prevention and Management as closely tied to broader social and environmental conditions in the Main Campus community. Poor nutrition, stress, and unsafe or under-resourced neighborhoods create barriers to healthy living and increase the risk of preventable diseases. Participants emphasized that lasting improvements will require more than clinical care; they depend on addressing the social factors that shape health behaviors and access. Strengthening community-based wellness programs, expanding access to affordable healthy foods, and improving preventive screening and education were all identified as critical steps toward reducing chronic disease and improving long-term health outcomes across the community.

Maternal and Child Health

Maternal and Child Health emerged as a significant focus in stakeholder discussions for the Cleveland Clinic Main Campus community, with participants emphasizing persistent differences in birth outcomes. These outcomes were attributed to a combination of chronic stress and limited access to comprehensive prenatal and postpartum care. While the region has exceptional hospital-based maternal services, participants emphasized that many families experience gaps in care before and after delivery. Health-Related Social

Needs such as transportation, childcare, housing instability, and financial hardship were repeatedly cited as major barriers to maintaining maternal and infant health.

The following are highlights of participant feedback regarding Maternal and Child Health:

- Differences in maternal and infant outcomes.
- High rates of preterm birth, low birthweight, and infant mortality.
- Inconsistent access to prenatal and postpartum care.
- Maternal stress and systemic bias contribute to poor outcomes.
- Limited availability of culturally relevant and trauma-informed care.
- Gaps in maternal mental health screening and follow-up.
- Transportation, childcare, and cost barriers to consistent care.
- Strong value placed on community-based programs such as doulas and home visiting.

The following are a selection of quotes illustrating feedback about Maternal and Child Health by key informants:

"Sometimes people are calling ambulances to get to their birthing facilities."

"Too many women fall through the cracks after giving birth. Once the baby is healthy, the system forgets about the mother."

"Transportation and childcare are major issues. Even when women want care, they can't always get to it."

"Programs that include doulas, home visiting, and peer support really make a difference. People trust them."

Stakeholders described Maternal and Child Health as an area that reflects broader differences in both healthcare access and social conditions. Despite strong clinical capacity, many women and families face persistent barriers to care continuity, safety, and trust. Participants emphasized that improving maternal and infant outcomes will require stronger coordination between hospitals, community organizations, and public health programs. Expanding access to culturally responsive prenatal and postpartum care, supporting maternal mental health, and addressing the social stressors that affect families were viewed as essential strategies to improve outcomes and strengthen family well-being for all populations across the Main Campus community.

Health-Related Social Needs

Stakeholders across the Cleveland Clinic Main Campus community consistently identified Health-Related Social Needs as fundamental drivers of health. Participants described how challenges related to housing, food access, transportation, and income stability shape residents' ability to engage in healthy behaviors and maintain consistent medical care. Many residents struggle to meet basic needs, leaving limited time or resources for preventive health. Stakeholders noted that poverty, unemployment, and unstable housing create ongoing stress that contributes to poor physical and mental health. While Cuyahoga County has a range of organizations addressing these issues, participants

emphasized that access to these supports is uneven and that system navigation remains difficult, particularly for residents without reliable transportation or digital access.

The following are highlights of participant feedback regarding Health-Related Social Needs:

- Poverty, unemployment, and unstable housing are major drivers of poor health outcomes.
- Food insecurity and limited access to affordable, nutritious food are widespread concerns.
- Transportation barriers limit access to healthcare, employment, and healthy food options.
- High housing costs and substandard living conditions increase physical and mental health risks.
- Neighborhood safety, violence, and environmental exposures such as lead affect well-being.
- Many residents struggle to navigate fragmented social service systems.
- Digital access limitations make it difficult to connect with services or healthcare.
- Strong need for cross-sector collaboration and screening for social needs in healthcare settings.

The following are a selection of quotes illustrating feedback about Health-Related Social Needs:

"You can't tell someone to focus on managing their health when they don't know where they're sleeping next week."

"Food and housing come first. When people are struggling with those, healthcare takes a back seat."

"There are resources out there, but the system is confusing. People need help connecting to the right services."

"Transportation and safety are constant challenges. If people don't feel safe walking to a bus stop, they won't make it to their appointments."

Stakeholders described Health-Related Social Needs as both widespread and deeply interconnected across the Cleveland Clinic Main Campus community. Poverty, food insecurity, transportation gaps, and housing instability create barriers that extend beyond healthcare access to affect nearly every aspect of residents' daily lives. Participants emphasized that addressing these needs requires collaboration among hospitals, community organizations, and local government to align resources and improve navigation for residents. Embedding social needs screening into healthcare settings, expanding partnerships with housing and food assistance providers, and investing in neighborhood infrastructure were identified as key strategies to improve stability and promote long-term health and well-being.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

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

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

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

Access to Affordable Healthcare

Actions and Highlighted Impacts:

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

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

C. Main Campus continued to embed community and clinical services at the Cleveland Clinic Langston Hughes Community Health and Education Center in Fairfax neighborhood. Langston Hughes provided a medical home and free healthcare services for over 3,300 community residents 2023 – 2025.

D. Through a collaborative effort between Cleveland Clinic and DigitalC, local seniors acquired the knowledge and technology to stay virtually connected. The community partners piloted a program in 2023 to provide free computer literacy training to residents aged 60 and over. The eight-week course at Cleveland Clinic's Langston Hughes Community Health and Education Center included topics of basic laptop operation and safe internet browsing.

E. Main Campus collaborated with Fatima Family Center, City Mission, and the City of Cleveland to provide clinical services. ensuring continuity of care, reduced gaps in treatment, and strengthened community health support.

F. Shared medical appointments (SMAs) were provided for community members at Langston Hughes and faith-based organizations.

G. Cleveland Clinic provided transportation on a space-available basis to 1) patients within 5 miles of the Stephanie Tubbs Jones Health Center and Marymount, Euclid, Lutheran, and South Pointe Hospitals and 2) radiation oncology patients within 25 miles of Cleveland Clinic Main Campus, Hillcrest, and Fairview Hospitals.

Behavioral Health

Actions and Highlighted Impacts:

A. Through the Opioid Awareness Center, the hospital participated in the Northeast Ohio Hospital Opioid Consortium and Cuyahoga County Opiate Task Force, and community-based classes and presentations.

B. In partnership with the Cuyahoga County Sheriff's Office Rx Drug Drop Box Program, Main Campus collected unused opioid and controlled substance medications through community-based drop boxes and a collection service.

C. In collaboration with University Hospital, Cleveland Clinic distributed Narcan kits and Fentanyl test strips as well as supported National Overdose Awareness Day. To raise awareness about the dangers of drug abuse, Cleveland Clinic and University Hospitals partnered to offer free fentanyl testing strips at a pharmacy location and community events in Northeast Ohio.

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

E. Cleveland Clinic supported The Hitchcock Center for Women in expanding their residential treatment and recovery facility. Hitchcock Center for Women is one of the oldest drug rehabilitation programs for pregnant and parenting women in the country. It empowers individuals to achieve and maintain productive, chemical-free lives at home, at work, and in the community. The expansion allows the center to double the number of mothers served annually. Collaborating organizations for the Hitchcock Center and support programs include the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County, Cleveland Clinic, the City of Cleveland, Cuyahoga County, and the Finch Group.

F. In collaboration with community partners and schools, Main Campus continued to provide education and resources to caregivers, patients, and their families to prevent and address mental health issues. Langston Hughes offered mental health services for children and community support classes.

The *Be the Boss of Your Stress*, an 8-week school mental health and wellness program, was offered at Bolton Elementary School.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

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

B. Cleveland Clinic's Taussig Cancer Center:

- Provided mammograms and lung screenings at Langston Hughes Health and Education Center.
- Launched the Mobile Mammography Unit in 2024 to help bring mammograms close to home for those who may not have access to these routine screenings.
- Promoted early cancer detection through community outreach and education, screening promotion, and patient navigation. Through the Faith-Based Partnerships, known as Stopping Cancer in Its Tracks (SCIIT), provided monthly meetings with the United Pastors in Mission, Cleveland Clergy Coalition meetings and email updates to help strengthen the connections between Cleveland Clinic's Cancer Institute and faith leaders.
- Provided the annual *Health Within Reach* event, which took place at our Main Campus and at Euclid, South Pointe, and Main Campus.

C. Cleveland Clinic's Heart Vascular Thoracic Institute provided heart health education sessions and screenings in Main Campus communities.

D. Langston Hughes Health Education Center provided health screenings, exercise courses, health education, cooking and nutrition classes, and mental health programs for the surrounding communities.

E. In 2024, Langston Hughes opened a Technogym "smart gym" that offers free access to high-tech equipment to the community. Cleveland Clinic Endocrinology and Community Health partnered to provide advanced equipment to improve the physical health of communities surrounding Main Campus. Since opening, 1,326 residents have enrolled in the gym.

F. Cleveland Clinic's Wellness Center provided community classes focused on physical and emotional health and provided resources to address issues of child development, fall prevention, pregnancy and postpartum health, heart disease, arthritis, cognitive aging, diabetes, dementia, stroke awareness, and breast cancer prevention.

Maternal and Child Health

Actions and Highlighted Impacts:

A. Cleveland Clinic continued to participate in First Year Cleveland and the Cuyahoga County Infant Mortality Task Force to gather data, align programs,

and coordinate a systemic approach to improving infant mortality. Supported expanded evidence-based health education to expecting mothers and families.

B. Cleveland Clinic opened the Center for Infant and Maternal Health in 2023. The Center for Infant and Maternal Health provides services for pregnant women to improve health for mothers and babies reaching their first birthday. Cleveland Clinic's Community Health Workers (CHWs) provided education on safe sleep, diet, nutrition, and screened for social drivers of health. CHWs connected families to resources and reinforced healthcare access. If eligible, mothers received food vouchers.

C. The hospital continued to offer and expand capacity for Stephanie Tubbs Jones Family Health Center's *Parenting Centering Pregnancy* group, providing a prenatal care model to expecting mothers.

D. The hospital provided trauma informed care for perinatal patients through the M-Power Program, a specialized care for patients who may be affected by previous traumatic events. Led by a dedicated team of nurses, this program is designed to educate healthcare providers and support community members.

Health-Related Social Needs

Actions and Highlighted Impacts:

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

B. Cleveland Clinic provided a $10.4 million commitment to addressing food insecurity across our communities by helping families access the resources they need to thrive. Resources included food pantries, food distribution centers, and nutrition education.

C. Cleveland Clinic supported the Summer Meals Program, which ensures children and teens have access to nutritious meals during the summer when schools no longer provide student meals. We partnered with over 100 local organizations to provide more than 200,000 meals to approximately 10,000 children across Northeast Ohio.

D. Cleveland Clinic demonstrated our commitment to improving access to healthy foods and reducing food insecurity by opening a Meijer grocery store in Fairfax, a neighborhood which hadn't had a grocery store in over 50 years. The partnership included City of Cleveland, Meijer, Fairfax Renaissance Development Corporation, and Fairmount Properties that included a new 40,000-square-foot grocery market.

E. Cleveland Clinic launched the Lead Safe Child Care Pilot Program to award thirty selected Cleveland childcare providers with grant funds and services to address and eliminate lead hazards at their sites. This program is the first-of-its-kind in the nation and an urgent response to eliminate lead poisoning in Cleveland children, who are four times more likely to have elevated blood lead levels than the national average. Cleveland Clinic pledged over $50 million for a lead-safe Cleveland.

F. Cleveland Clinic's Center for Youth and College Education provided youth and college learners with career exploration opportunities in a healthcare environment, offering programming that prepares the next generation of caregivers to join the healthcare workforce. Cleveland Clinic created initiatives to develop a skilled community youth workforce. Examples include:

- Connected Career Rounds provided 4,233 middle and high school students from 76 schools across 7 states.
- Louis Stokes Summer Internships provided high school interns with paid experience and exposure to clinical and non-clinical healthcare roles.
- Students Pathways, in partnership with Tri-C Eastern Campus, provided a program for graduating high school seniors to gain exposure to in-demand clinical and non-clinical roles.

Appendix F: Acknowledgements

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

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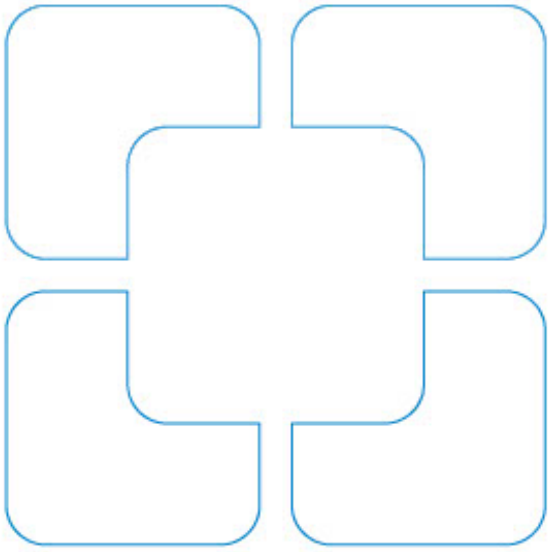

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